"THEY WILL COME BACK FOR ME": LIVED EXPERIENCES OF NURSES THREATENED ON DUTY

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Abstract : Threats against nurses can compromise their sense of safety while they continue to provide care. This qualitative study explored nurses' experiences of workplace threats, their coping responses, and the professional insights they developed. Nine registered nurses from a Level II Hospital in Maguindanao del Norte, Philippines, were purposively selected for individual interviews lasting 20–40 minutes. Audio-recorded interviews and field notes were examined using an analysis informed by Colaizzi's seven-step method. Fifteen cluster themes were organized into three overarching themes: enduring workplace hostility amid vulnerable patient encounters; drawing on interpersonal and institutional support and personal resources to restore professional equilibrium; and cultivating professional resilience and humanistic nursing through adversity. Participants described verbal threats, physical intimidation, appeals to social influence, and vulnerability during understaffed shifts. They sought supervisory and family support, regulated their emotions, engaged in leisure activities, and reflected on their communication. Accounts of renewed empathy and professional commitment coexisted with fear and distress. The findings suggest that nurses' coping efforts should be supported by accessible incident reporting, timely supervisory and security responses, adequate staffing, and voluntary psychosocial support. These accounts provide contextual insight into workplace threats and coping but do not establish the effectiveness of strategies or a uniform progression toward recovery.

Index Terms **- Coping; Nursing; Occupational threats; Philippines; Qualitative research; Workplace violence**

I. INTRODUCTION

Threats directed at nurses are an occupational safety concern with emotional and professional consequences. Workplace violence encompasses threatening behavior and intimidation as well as physical assault. Nurses may therefore feel insecure even when an encounter does not result in bodily injury. Kafle et al. (2022) described how workplace violence affects nurses' well-being, satisfaction, and relationships with patients. Its consequences also extend into the organization of care. In a cross-sectional study, Arnetz et al. (2025) found that exposure to workplace violence was associated with workplace cognitive failure primarily through work-related exhaustion. These findings make protecting nurses relevant to both staff welfare and the conditions under which care is delivered.

The experience of being threatened involves more than the incident itself. A nurse may need to interpret the seriousness of a warning, decide whether assistance is available, and continue caring for patients while feeling unsafe. Lanctôt and Guay's (2014) review documented psychological, emotional, and occupational consequences of workplace violence among healthcare workers. Understanding these experiences requires attention to how staff interpret a confrontation and manage its aftermath, as well as the organizational circumstances in which it occurs.

Philippine research shows the personal burden of hostile clinical interactions. Cabillo and Daño (2020) identified destructive experiences, reactive responses, and evasive strategies in nurses' accounts of verbal abuse. Local service conditions also matter. In Maguindanao Provincial Hospital, Uda and Bagolong (2023) reported challenges involving staffing, cultural health beliefs, language barriers, and continuing education. Their study focused on nursing service operations rather than workplace threats, but it identifies contextual pressures relevant to examining encounters among nurses, patients, and accompanying family members. In this study, these companions are referred to as watchers, the term used in participants' narratives.

Coping is shaped by the resources available within and beyond the workplace. Cooper et al. (2020) conceptualized nurse resilience as a dynamic process involving individual attributes and external resources. Cooper et al. (2022) subsequently highlighted the influence of workplace conditions, management, and teams. This perspective is useful because the ability to continue working after a threatening encounter can coexist with unresolved distress. Continued attendance or professional composure alone does not establish recovery.

The study drew on complementary perspectives on stress and coping. Lazarus and Folkman's (1984) transactional model focuses on the appraisal of demands and available coping resources. Antonovsky's (1987) salutogenic perspective emphasizes comprehensibility, manageability, and meaningfulness when people encounter adversity. A trauma-informed perspective further prioritizes safety, trust, choice, and supportive relationships in organizational responses to distress (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). These perspectives provided conceptual context for understanding threat experiences and coping; they did not constitute predetermined findings.

NEED OF THE STUDY.

Existing accounts of workplace violence do not fully explain how nurses in a particular hospital interpret threats, draw on available support, and sustain their professional roles. A contextual account is especially relevant where family participation in care, staffing pressures, and perceived differences in social influence intersect. This study therefore explored the lived experiences of nurses who received threats during professional duty at a Level II Hospital in Maguindanao del Norte. It examined the encounters they described, the strategies they used to cope, and the insights they developed for nursing practice and workplace protection.

METHODOLOGY

Research Design

The study used a descriptive qualitative design to examine nurses' accounts of threats during professional duty. Qualitative description supports a detailed account that remains close to participants' experiences and language (Sandelowski, 2000). The inquiry focused on lived experience and used a constructivist–interpretivist understanding of accounts as situated within personal, professional, and social contexts. Analysis was informed by Colaizzi's (1978) approach to identifying significant statements and organizing meanings into themes. The emphasis was on describing participants' understandings rather than estimating the prevalence of threats or testing causal relationships.

Study Setting and Participant Selection

The study was conducted at a Level II Hospital in Barangay Ungap, Sultan Kudarat, Maguindanao del Norte, Philippines. The hospital serves patients from surrounding communities, including North Cotabato and the Bangsamoro Autonomous Region in Muslim Mindanao. Its clinical services provided the context for accounts of encounters in emergency, triage, neonatal, and ward settings. Purposive sampling identified registered nurses employed at the hospital who had at least six months of clinical experience, had personally encountered a threat during professional duty, and were willing to discuss their experiences. Nurses experiencing a severe psychological crisis or unable to complete the interview process were excluded. Ten nurses were initially considered for participation; one withdrew because of scheduling difficulties, leaving nine participants. The researcher judged that no new themes were emerging by the ninth interview. This judgment concerned the adequacy of the accounts for the study questions rather than statistical representation of the hospital's nursing workforce.

Data Collection

Individual, in-depth interviews were conducted using a researcher-developed interview guide reviewed by three graduate research panelists for clarity, relevance, comprehensibility, and capacity to elicit experiential accounts. The guide addressed threatening encounters, their emotional and professional implications, coping responses, and lessons for practice. The adviser also reviewed the guiding questions following the panelists' recommendations. Participants selected convenient interview schedules, and interviews took place in quiet settings that supported privacy. Each interview lasted approximately 20–40 minutes and was audio-recorded with consent. The researcher recorded observations of nonverbal behavior, emotional responses, and contextual details during or immediately after the sessions. Recordings were transcribed verbatim, and the accounts were translated into English for analysis and presentation. The researcher checked the translations twice for consistency with the intended meaning. Participants were invited to review the accuracy of their accounts and the researcher's interpretations. Quotations below use the English translations prepared during the study.

Researcher Positioning and Reflexivity

The researcher was a registered nurse affiliated with the study hospital and served as the primary interviewer and data interpreter. Familiarity with the clinical environment facilitated access and scheduling, while also creating the possibility that shared experiences or professional assumptions could influence questioning and interpretation. The researcher sought to avoid suggesting preferred answers and encouraged participants to describe events in their own terms. This insider position required reflexive attention to prior clinical experiences, relationships with participants, and assumptions about coping and professional responsibility.

Data Analysis

The analysis followed Colaizzi's (1978) seven-step approach. The researcher read the transcripts to become familiar with the accounts, extracted statements relevant to threats and their aftermath, and formulated meanings that remained connected to the original context. Related meanings were organized into cluster themes, which were integrated into a fuller description of the experience. The researcher then condensed this description into an account of the phenomenon's central features and returned it to participants for validation. The researcher transcribed and translated the interviews, submitted the material to a content analyst for thematic tabulation, and interpreted the organized findings. The analysis produced 15 cluster themes grouped under three overarching themes. Participant codes were retained with quotations to connect the interpretation to the accounts. The themes organize experiences, coping responses, and professional insights; they do not establish that every participant experienced each theme or followed the same recovery sequence.

Trustworthiness

The study considered trustworthiness through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Verbatim transcription, translation checks, field notes, and participant review supported attention to the accuracy of the accounts. The description of the setting, eligibility criteria, and interview procedures provides contextual information for readers assessing relevance to other settings. The stated analytic sequence makes the progression from statements to meanings and themes more transparent, while participant quotations allow readers to assess the relationship between the interpretation and the evidence. These

procedures support the inquiry without eliminating the researcher's interpretive influence or guaranteeing equivalent findings elsewhere.

Ethical Considerations

Ethics review and institutional permission were obtained before data collection, followed by authorization to conduct the study at the hospital. Participants received information about the study's purpose, procedures, audio recording, and their rights before giving informed consent. Participation was voluntary, and nurses could decline questions, pause or terminate the interview, or withdraw without penalty. These options were relevant because recalling threatening encounters could cause discomfort. Participant codes replaced names in the research accounts. Audio recordings and digital files were password-protected, and printed materials were kept in sealed storage. The presentation of findings excluded identifying personal details. Confidentiality was particularly important because the researcher and participants worked within the same institution and the narratives concerned sensitive workplace events.

RESULTS AND DISCUSSION

The nine participants were 25–42 years old and had 3–19 years of professional experience. Five were women, representing 55.6% of the sample. Most were assigned to the emergency department, although the accounts also concerned triage, neonatal, and ward care. Fifteen cluster themes were organized into three overarching themes addressing exposure to threats, efforts to restore equilibrium, and professional meaning. These themes reflect related aspects of participants' accounts rather than mutually exclusive categories or a measured developmental pathway.

Enduring Workplace Hostility Amid Vulnerable Patient Encounters

The first overarching theme concerned the ways routine clinical responsibilities became threatening encounters. Participants described verbal warnings, intimidating behavior, appeals to social influence, and heightened vulnerability when staff was few or clinical demands were urgent. Their accounts also showed that fear remained after the confrontation ended.

Experiencing Verbal Threats and Intimidation from Watchers

Threats often arose during exchanges about a patient's condition or care. Participants described warnings that linked them personally to possible adverse outcomes. P2 recalled, "*If something happens to their patient, they will come back for me*." P7 similarly reported, "*Ma'am do not say that. Because if something happens to my grandmother, you already know what will happen to you*." Such statements made the anticipated consequences of clinical events feel personal and potentially dangerous. The accounts locate threatening speech within the working relationship between nurses and distressed companions. Nurses were expected to explain care while also judging whether a warning might extend beyond the encounter. Cabillo and Daño (2020) likewise documented the distress and coping responses associated with verbal abuse among Filipino nurses. In the present study, the significance of the warnings lay in the fear they generated during ordinary duties, even where no physical assault was reported.

Confronting Physical Intimidation and Perceived Bodily Threat

Participants also described threatening behavior communicated through physical proximity, posture, and forceful speech. P2 stated, "*He came close to me, really close, and there was force in every word he said*." P9 explained, "*His actions made me feel like he was going to hurt me. My feeling at that time was that he wanted to humiliate me in front of everyone*." One account additionally described seeing the handle of a firearm during a confrontation. These narratives show that perceived danger could arise before bodily contact occurred. The nurse had to assess the encounter while remaining responsible for patient care. The accounts support attention to intimidation as an occupational safety issue. They do not establish that perceived threats and completed assaults have identical psychological effects, or that participants developed a particular trauma-related disorder. What is evident is that intimidating behavior altered how safe nurses felt in the clinical environment.

Navigating Threats Rooted in Sociocultural Power Disparities

Some encounters involved references to political connections, familiarity with the hospital, or presumed authority over staff. P1 recalled, "*He said he would report me to the Governor at that time*." P8 described being told, "*You are all still new here. Do you not know who we are?*" These remarks were experienced as challenges to the nurses' standing and ability to exercise their professional role without personal repercussions. The theme concerns the perceived coercive use of influence during a confrontation. The accounts do not verify that the individuals held the power they claimed, nor do they establish a pattern across the wider community. They nevertheless show how anticipated consequences could intensify an encounter beyond the immediate disagreement. Transparent complaint procedures and consistent supervisory responses may help staff distinguish legitimate concerns about care from conduct that intimidates or threatens them.

Facing Threats During High Acuity and Understaffed Situations

Participants connected some threatening encounters with urgent care demands and limited staffing. P5 recalled, "*I was alone in the NICU then, no one else was there. There would be no other witness if he did something bad to me*." P4 linked a confrontation to leaving triage to assist with resuscitation: "*I realized that there were not enough staff, because if there were enough people inside the ER I would not have left my triage post to help with the CPR*." The accounts suggest that working alone and covering competing clinical responsibilities constrained immediate access to assistance. Uda and Bagolong (2023) also identified staffing challenges in nursing service operations in Maguindanao, although their findings do not establish the causes of the incidents reported here. For this sample, staffing was part of how nurses understood their vulnerability. The study did not measure staffing ratios, waiting times, or incident rates, so the relationship should be interpreted as participants' contextual explanations rather than a tested causal association.

Suffering Emotional and Psychological Impact Immediately After Threats

Fear was expressed through bodily reactions and private emotional release. P4 reported, "*While I was writing, my hands were trembling. I almost drew blood from biting my lip trying to hold back.*" P9 described withdrawing from view: "*I went to the comfort room after the encounter because I could no longer stop my tears from falling. I cried hard in the comfort room*." P7 also recalled trembling while contacting a spouse after an incident. These accounts convey immediate distress while work responsibilities continued. They are consistent with the emotional and psychological consequences described by Lanctôt and Guay (2014). Arnetz et al. (2025) further identified associations involving workplace violence, exhaustion, and cognitive failure, suggesting a reason to attend to staff functioning after threatening events. The present interviews did not assess cognitive performance or clinical errors. Their contribution is to show how nurses described fear and efforts to contain it within the course of a shift.

Drawing on Interpersonal and Institutional Support and Personal Resources to Restore Professional Equilibrium

The second overarching theme concerned the resources nurses used to manage distress and regain a workable sense of safety. Coping involved turning to supervisors and family, regulating outward emotion, using leisure activities, and reflecting on the encounter. These strategies varied across participants and were described as responses they found available or meaningful, rather than interventions whose effectiveness was formally assessed.

Seeking Supervisory and Institutional Support Following Incidents

Nurses sought assistance when their own attempts to manage a confrontation were no longer sufficient. P2 explained, "*I immediately reported it to my supervisor. We had a one-on-one with the head nurse to figure out why it happened*." P5 recalled, "*I decided to call the supervisor on duty that day, because he no longer wanted to listen to me*." Supervisory involvement offered a way to share responsibility for the encounter and review the nurse's actions. The accounts indicate that support had practical and emotional functions. A supervisor could intervene in the immediate interaction and provide reassurance afterward. Cooper et al. (2022) similarly identified managers, teams, and workplace conditions as relevant to nurse resilience. These findings support attention to the accessibility and quality of supervisory responses. However, reporting an incident in an interview does not demonstrate that a formal reporting system was consistently used or that institutional follow-up was adequate in every case.

Relying on Family and Personal Social Networks for Emotional Release

Family members offered a space to express feelings that nurses had contained during duty. P4 stated, "*At home the one I always talk to is my husband, I pour everything out to him; if I need to say everything, he just listens*." P5 described encouragement from a parent and being accompanied to and from work. P7 recalled going out with a spouse after becoming visibly distressed by an encounter. These examples show that support sometimes extended beyond listening to practical assistance and companionship. The home environment became part of how participants managed the effects of workplace events. Social support is also an attribute identified in Cooper et al.'s (2020) concept analysis of nurse resilience. These accounts show its perceived value for these nurses without establishing that all staff have comparable family resources or that informal support can meet every need after a severe threat.

Practicing Emotional Compartmentalization and Professional Detachment

Some participants described setting distress aside sufficiently to resume care. After crying privately, P9 recalled, "*I came out as if nothing had happened. Of course, life goes on for all of us."* The same participant described becoming accustomed to difficult encounters and trying not to carry the incident emotionally after expressing the feelings it produced. P3's account of enduring a companion's shouting also reflected the effort required to remain composed while tired. These accounts can be understood through Hochschild's (1983) concept of emotional labor, particularly managing outward expression in response to occupational expectations. A composed appearance may help a nurse continue a task while concealing distress from others. The interviews do not show whether compartmentalization was helpful or harmful over time. They do suggest that supervisors should avoid returning to work or that an outwardly calm manner means that the emotional consequences have resolved.

Engaging in Physical and Recreational Activities for Stress Release

Participants described exercise, music, food, and outings as ways to disengage temporarily from the emotional demands of an incident. P6 explained, "*The gym is truly my therapy*." P2 described another routine: "*I eat, stress eating, then I listen to music for good vibes only*." P7's account of eating out and shopping with a spouse combined recreation with companionship and attention from a trusted person. The range of activities shows that coping was adapted to personal preferences and circumstances. P6's use of the word therapy expressed the personal importance of exercise; it did not indicate formal psychological treatment. Likewise, the reporting of stress eating should not be interpreted as evidence that it is a beneficial health practice. The finding is that nurses sought accessible activities that they perceived as helping them redirect attention or release emotion after difficult encounters.

Reframing the Experience Through Reflection and Meaning Making

Reflection involved reviewing the encounter and identifying possible changes in future communication. P6 stated, "*I see it as an opportunity to grow and to improve yourself in communicating yourself to others. I always process it*." Participants also considered their tone, facial expressions, gestures, and whether a message was received differently than intended. Reflection allowed them to identify actions within their control. Lazarus and Folkman's (1984) model helps interpret this process as reappraisal of an event and the resources available for responding to it. The accounts also call for care in how reflective practice is supported. Considering one's communication should not transfer responsibility for threatening behavior to the nurse who experienced it. A constructive review can examine communication and clinical circumstances while recognizing institutions' responsibility to protect staff and address threatening conduct.

Cultivating Professional Resilience and Humanistic Nursing Through Adversity

The third overarching theme concerned how participants interpreted their work after threatening encounters. They described efforts to remain empathic, communicate more deliberately, affirm the value of nursing, advocate for protection, and attend to families' emotional needs. These were accounts of perceived professional meaning and learning. They do not establish that threats consistently improve practice or that every nurse experiences growth after adversity.

Deepening Empathy and Compassion for Patients and Families

Some nurses tried to understand the fear and strain that accompanied a patient's illness. P9 explained, "*I just tried to understand what they were going through, so it would be easier for me to accept why they had that attitude toward me*." P3 likewise emphasized the difficulty of being either a patient or a companion. Empathy helped participants interpret behavior within the distress surrounding hospitalization. The same accounts also reveal tension between compassion and a perceived obligation to tolerate mistreatment. A nurse's understanding of another person's distress can coexist with a need to protect them. Interpreting aggression through fear or helplessness does not establish the aggressor's actual motivation. For practice, the theme supports communication that acknowledges family concerns while allowing nurses to seek assistance and maintain safe boundaries during an escalating encounter.

Strengthening Communication and Interpersonal Practice

Participants described becoming more attentive to how they expressed and received information. P1 reflected that a message could be misunderstood even when the nurse had no harmful intention. P6 advised, "*Always choose the right words when talking, the right tone, everything. You always use your heart; you should have heart-to-heart talks*." P8 described looking for another way to explain information when a patient appeared unconvinced. The reported changes concerned tone, wording, and responsiveness to another person's understanding. Kwame and Petrucka (2021) identified communication, institutional, environmental, and personal barriers to patient-centered interaction. Their review supports considering these influences together, rather than attributing every conflict to an individual nurse's delivery. The present accounts suggest areas for communication training and reflection, but they do not demonstrate that these changes reduced subsequent threats or improved measured patient outcomes.

Affirming Nursing as a Vocation of Compassionate Service

Participants also described renewed appreciation for their professional role. P5 stated, "*I love nursing so much; I appreciate it more now. You discover many things every day in being a nurse*." P6 similarly reported appreciating the role more and recalling why they chose the profession. P3 framed nursing as a privilege associated with being trusted during a patient's vulnerability. These narratives suggest that a sense of purpose was one resource participants used when making sense of difficult work. Antonovsky's (1987) emphasis on meaningfulness offers a way to interpret that resource without assuming that the threat itself was beneficial. Commitment to nursing also cannot be equated with recovery, retention, or freedom from distress. The study captures the professional meaning participants expressed at interview, rather than documenting how their commitment changed over time.

Advocating for a Safer and Better Supported Nursing Workforce

Participants' reflections included practical concerns about staffing, security, and public understanding of care processes. P4 connected vulnerability in triage with insufficient staff during resuscitation. P6 described a perceived improvement in protection: "*Now we can feel more that there is someone to protect us; we already have more guards*." P5 emphasized health education for patients and watchers to improve understanding and participation in care. These insights place workplace protection within the organization of services. The additional security described by P6 was a perceived change, not an evaluated intervention. Occupational Safety and Health Administration (2016) guidance similarly treats workplace violence prevention as an organizational program involving management participation, hazard assessment, controls, training, and evaluation. Such guidance can inform local planning, but any hospital response should be adapted to its own risks, resources, and patient population.

Recognizing the Importance of Holistic Nursing Care

Nurses described broadening their attention to include companions' emotional needs. P4 explained, "*Listen to their side. I was no longer focused only on the clinical management of the patient but also the emotional state of the patient's companions*." P5 stated, "*Being a nurse is truly not just clinical; you touch the personal lives of people. You truly need to become holistic.*" P6 similarly described listening more and allowing watchers time to talk. The accounts position family communication as part of nursing's relational work. Attending to companions' concerns may support a shared understanding of care, consistent with the patient-centered communication discussed by Kwame and Petrucka (2021). However, the interviews do not establish that unmet emotional needs caused the threats or that greater attention would have prevented them. The implication is to create opportunities for communication within a service that also provides adequate staffing and clear employee protections.

Integrated Interpretation of the Findings

Taken together, the themes describe the overlap of occupational vulnerability, coping, and professional meaning. A threatening encounter could involve immediate fear, uncertainty about assistance, and pressure to continue caring for patients. Nurses drew on resources such as supervisory intervention, family relationships, personal routines, and reflection. These resources were uneven in form and availability, making the organizational context central to understanding the accounts.

The findings are consistent with viewing resilience as a process supported by both personal and environmental resources (Cooper et al., 2020; Cooper et al., 2022). They also show why professional commitment should be interpreted alongside distress rather than used as evidence that a nurse has fully recovered. Manomenidis et al. (2019) found associations between resilience, anxiety,

education, and mental preparation strategies in a different national context. That study supports attention to multiple influences on resilience, while the present inquiry adds descriptions of how nurses used available resources after specific encounters.

The three overarching themes should therefore be read as connected dimensions of experience. Retrospective interviews cannot establish a necessary progression from threat to coping and growth. Participants' accounts of learning and compassion remain meaningful, but responsibility for safety rests within the organization as well as the immediate interaction. A trauma-informed response emphasizes safety and choice while recognizing the potential for distress to persist beyond an outward return to duty (SAMHSA, 2014).

Study Limitations

The findings reflect the accounts of nine purposively selected nurses in one hospital. Their relevance to other settings depends on similarities in service organization, clinical demands, and social context. Most participants worked in the emergency department, which may have given greater prominence to urgent and emotionally charged encounters. The study did not compare experiences systematically across departments, genders, or levels of experience.

Retrospective self-report may be affected by recall, willingness to disclose, and concerns about workplace relationships. The researcher's affiliation with the hospital could facilitate understanding while also influencing what participants felt comfortable sharing. Translation into English may have reduced some linguistic nuance despite repeated checks. Incident records, direct observations of the threatening encounters, and accounts from patients or companions were not included as corroborating evidence.

The judgment that themes were no longer emerging by the ninth interview does not establish that all possible experiences were captured. The study also lacked longitudinal follow-up and standardized measures of distress, resilience, care quality, or retention. It consequently cannot determine the prevalence of threats, diagnose psychological conditions, establish causes, or demonstrate the effectiveness of coping strategies and institutional responses. The themes provide a contextual description and identify issues for further investigation.

CONCLUSIONS

Nurses in this study described threats during professional duty as experiences of personal insecurity within relationships that required continued care and communication. Verbal warnings, physical intimidation, and perceived use of social influence were accompanied by fear and emotional distress. Working alone or managing competing urgent responsibilities intensified the vulnerability described in some accounts. Participants sought support from supervisors and family, used personal routines to manage emotion, and reflected on their professional practice. Their reports of renewed empathy and commitment coexisted with the burden of the encounters.

Hospital leaders should coordinate responses that allow nurses to obtain timely assistance, document threats, and receive feedback on follow-up. Staffing and security arrangements should be reviewed where nurses work alone or cover competing urgent responsibilities. Reporting and complaint procedures should protect staff from intimidation while allowing patients and families to raise concerns fairly. Monitoring incident patterns and staff feedback can help assess whether these protections work in practice. After an incident, staff should have a private opportunity to discuss immediate needs and obtain supervisory, peer, or voluntary psychosocial support. Communication education should cover triage explanations, recognizing escalation, and access to assistance. Reflection should support learning without blaming nurses for threats. Organizational support should also be accessible to nurses with limited family resources.

Future research should include multiple institutions, a wider range of clinical assignments, and attention to nurses who remain distressed or consider leaving their roles. Longitudinal studies could examine how threat experiences, support, and professional meaning change over time. Evaluations of reporting systems, staffing and security responses, communication education, and voluntary support programs are needed to determine which approaches improve safety and well-being in Philippine hospitals. Such work would extend the contextual insights provided by these interviews into evidence for service improvement.

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