Exploring the Lived Experience of Nursing Students who Encounter Inter-Colleague Violence during Clinical Placements: A Phenomenological Study

by

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Abstract

Inter-colleague violence during clinical placements can profoundly affect student well being, learning, and professional socialization. The experiences of students who encounter inter-colleague violence in the clinical setting have been examined by researchers internationally. There is a significant lack of research on the experiences of Canadian students in the literature. The purpose of this phenomenological study was to explore the lived experience of nursing students who encounter inter-colleague violence during clinical placements. The population of interest was baccalaureate nursing students in an Atlantic province in Canada. Eight students representing three programs from two different sites participated in the study. Interviews were audio recorded and transcribed for analysis. Five themes were determined using the approach of van Manen (1990/1997). The identified themes are a sense of foreboding, playing hide and seek, I had no options, we are all in this together, and letting go, moving on. Similarities were noted between the participants' experiences and those of nursing students in other studies. Apparent in this study but not evident in the literature was the influence of word-of-mouth communication between students prior to the start of clinical placements. Word-of-mouth communication included the verbal exchange of stories and rumours about clinical instructors, nurses, and clinical units. Implications for nursing education, administration, and research are discussed and include the importance of teaching students to recognize inter-colleague violence and providing safe, supportive environments for students to report incidents of inter-colleague violence.

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Chapter 1

Introduction

Through the course of undergraduate nursing education students are exposed to a selection of clinical placement opportunities, all of which offer various perspectives and experiences within the scope of current nursing practice. These clinical placements are a mandatory component of nursing education in Canada, intended to prepare nursing students for the realities of actual professional practice. It is anticipated by students that such learning opportunities are didactic, constructive, supportive, and complement theory based classroom learning. However, the stark reality is that some students have less than ideal clinical experiences that include encounters with inter-colleague violence. Inter-colleague violence includes acts of verbal and physical abuse and psychological violence that occur between members of the nursing profession or academic faculty belonging to that profession. While experiences with inter-colleague violence may subjectively vary from one nursing student to the next in severity and complexity, it is likely that students are profoundly and negatively affected by encounters with inter-colleague violence during the clinical education process.

In this thesis I describe the lived experience of inter-colleague violence as encountered by nursing students during clinical placements. I chose to conduct a phenomenological study because my own experiences as a registered nurse and clinical educator have provided both direct and indirect encounters with inter-colleague violence. When I moved to a clinical nurse educator position from a direct care position, the

concept of inter-colleague violence became both more intriguing and concerning. Inherently, a genuine and deep interest in the subject under study is paramount to phenomenology (van Manen, 1990). Qualitative investigation and thematic analysis of interviews with nursing students who have experienced this phenomenon will also lead to a deeper, richer understanding of their lived experience. Further, the research that has been done about violence during nursing students' clinical experience includes few studies from the perspective of Canadian nursing students especially students from Atlantic Canada. This chosen method of inquiry therefore addresses an absence of qualitative research on students' lived experience of inter-colleague violence in Newfoundland and Labrador.

Background

Nursing is a practice based profession; therefore, clinical placements are an integral aspect of undergraduate nursing education. Clinical practice is a transition that begins with students practicing under the supervision of clinical educators in predetermined clinical settings and gradually builds to preceptorship with staff nurses. During preceptorship nursing students work closely with co-signed staff nurses who help them achieve a greater level of clinical experience and independent practice. Specifically, these placements provide undergraduate nursing students with the opportunity to affect nursing knowledge and skills obtained in the academic arena to various health care settings (Anthony & Yastik, 2011; Dunn & Hansford, 1997; Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007; Jackson et al., 2011; Lash, Kulakac, Buldukoglu, &

Kukulu, 2006). It is also suggested that clinical time orientates students to other nursing obligations and duties not easily practiced in the classroom environment (Chapman & Orb, 2000; Hartigan-Rogers et al., 2007).

Of equal importance, clinical placements provide students with the opportunity to observe and interact with various nursing professionals in the healthcare context, thus influencing professional socialization (Atack, Comacu, Kenny, LaBelle, & Miller, 2000; Lash et al., 2006). Socialization with nurse peers is a critical process that allows students to engage with nurses in real clinical settings, thus influencing the students' professional image of themselves and the profession as a whole (Clark & Ahten, 2012). When students have the opportunity to observe nurses as positive role models in the clinical area their self-confidence is enhanced contributing to the development of clinical competence (Chesser-Smyth & Long, 2013). Conversely, where students feel ignored and excluded in the clinical environment, student confidence and learning is negatively affected (Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Students who experience violence and abuse from nurses may also struggle with conformity to survive professional socialization in the clinical setting, which negatively impacts their view of nursing as a caring profession (Randle, 2003).

It is suggested that the quality of clinical placements is influenced by several interactive variables, including the reception of staff and management to students, the support and advocacy of clinical faculty (Dunn & Hansford, 1997), the relationships formed between staff and students (Atack et al., 2000), and the teaching style of nurse preceptors (Foley, Myrick, & Yonge, 2012). Additionally, as students progress through different clinical areas within the program they can anticipate new experiences and

challenges, along with the expectation of more independent practice and technical efficiency in skills. This can be an exciting time in the learning process but it can also be a source of trepidation as students transition from the relative safety of classroom learning to real world professional experiences. As such relationships developed in the clinical area with faculty and staff may significantly impact the clinical experience.

Students engage in a variety of inter-professional relationships and rely on the guidance and leadership of educators, other nurses, and fellow students to achieve successful clinical experiences (Dunn & Hansford, 1997). Moreover, these relationships are an important factor in the student socialization process (Atack et al., 2000). Positive relationships between students and nursing colleagues are most significant to students and as such influence self confidence, decrease student anxiety, and enhance student learning (Chesser-Smyth & Long, 2013; Dunn & Hansford, 1997). Quality relationships and clinical contexts are those students deem to be respectful, supportive, and inclusive of students as team members (Atack et al., 2000; Chesser-Smyth & Long, 2013). Therefore it is suggested that environments that foster positive relationships are associated with student satisfaction and constructive development during clinical placements (Anthony & Yastik, 2011; Dunn & Hansford, 1997; Hartigan-Rogers et al., 2007). Specifically, relationships that promote support and a sense of belonging are particularly memorable and rewarding for nursing students (Curtis, Bowen, & Reid, 2006; Levett-Jones et al., 2007).

While it is recognised that supportive staff and receptive environments are conducive to rewarding experiences for students, the reality is that not all student interactions are positive. Students are not impervious to inter-colleague violence in the

health care setting (Jackson et al., 2011; Magnavita & Heponiemi, 2011). Like their registered nurse peers, students are considered a vulnerable sub-group within the healthcare organization (Anthony & Yastik, 2011; Celebioglu, Akpinar, Kucukoglu, & Engin 2010; Lash et al., 2006; Thomas, 2010; Unal, Hisar, & Gorgulu, 2012). It has been suggested that student vulnerability evolves from the premise that students have little organizational power (Anthony & Yastik, 2011; Hinchberger, 2009; Thomas & Burk, 2009), and that they often lack the skills necessary to thwart violent behaviours (Curtis et al., 2006; Unal et al., 2012). Other factors suggested to influence student vulnerability in the clinical area include differing or unclear expectations between staff nurses and clinical educators (Lash et al., 2006) and inexperience communicating within the healthcare context (Celebioglu et al., 2010; Thomas, 2010). The climate of the clinical environment may also amplify student vulnerability. Healthcare settings can be volatile and stressful environments fuelled by high workload demands, poor management, and entrenched organizational dynamics. Consequently, these are contextual issues not conducive to supportive staff-student relations or effective student learning.

Rationale and Significance

Clinical environments that are not receptive to and supportive of students and their learning needs can lead to student disengagement and impaired learning (Jackson et al., 2011; Levett-Jones et al., 2007), can negatively affect student perceptions of their chosen profession (Lash et al., 2006), and can compromise patient care (Randle, 2003). The psychological effects of non-physical abusive encounters, especially those at the hands of

nurse colleagues, can be more damaging to student well-being than physical violence (Magnavita & Heponiemi, 2011). Even in clinical placements where negative encounters are infrequent, the influence of such interactions on students' self confidence may be greater than prevailing positive experiences (Anthony & Yastik, 2011).

Besides impaired learning, a variety of emotional and psychological symptoms including anger, anxiety, shame, hopelessness (Celebioglu et al., 2010), stress, isolation (Magnavita & Heponiemi, 2011), low self esteem, and powerlessness (Curtis et al., 2006; Randle, 2003) afflict students following violent and abusive encounters. Students may also ruminate about their interactions and what they perceive as organizational injustice, leading to more intense anger and other psychological problems (Magnavita & Heponiemi, 2011; Thomas & Burk, 2009). Physical symptoms such as headaches, poor sleep, and fatigue also plague students exposed to verbal abuse (Lash et al., 2006). On a collective scale, it has been suggested that unsatisfactory clinical education experiences can influence student attrition rates and where graduate nurses decide to work upon program completion (Clark, Ahten, & Macy, 2013; Curtis et al., 2006; Dunn & Hansford, 1997; Levett-Jones et al., 2007; Thomas, 2010).

There is also valid concern that students who experience violence may go on to perpetuate similar behaviours as practicing nurses. As a vulnerable group, it is suggested that students may be easily subjugated by the prevalent nursing culture within the clinical setting and feel compelled to assimilate (Chesser-Smyth & Long, 2013). Students also frequently lack the assertiveness training and skills necessary to prevent and effectively address violence in the clinical education area (Unal et al., 2012). Randle (2003) found that students adopted bullying behaviours in an effort to quell further negative

interactions and continue with the placement. This constitutes a grave concern for future practice and the profession. The notion that students may adapt to violent encounters or negative institutional cultures by assimilating behaviours in an effort to protect themselves is plausible given their low level of organizational power and options during the clinical placement process. As clinical placements provide an opportunity for professional socialization (Atack et al., 2000; Lash et al., 2006), students may come to observe these behaviours amongst registered nurses as the natural order within the healthcare setting, thus perpetuating the cycle of violence amongst nurses following graduation (Longo & Sherman, 2007; Unal et al., 2012).

Comprehensive knowledge of inter-colleague violence in nursing requires a sound understanding of students' experiences. It has been established that nurses are exposed to violence at the hands of peers in the healthcare setting, and it is also suggested that students face that same risk during clinical placements (Anthony & Yastik, 2011; Celebioglu et al., 2010; Lash et al, 2006; Thomas, 2010; Unal et al., 2012). However, nursing students' experiences of violence in the clinical setting have not been researched in the same depth as graduate nurses' experiences. We do not know the extent to which nursing students experience violence during clinical placements because they may underreport it or they may be unaware of what constitutes violence in the clinical setting (Celebioglu et al., 2010), and they fear reporting incidents of violence because it may adversely affect evaluation of their clinical performance (Curtis et al., 2006; Randle, 2003).

In addition to not knowing the extent to which nursing students experience violence during clinical placements, there is a lack of research that describes what this

experience is like for nursing students. Students are considered to be a vulnerable group within the healthcare organization and therefore it is particularly important to research their experiences. Contemplating how students perceive, define, and interpret inter-colleague violence in the clinical setting will open dialogue about how nurse colleagues can better support students in the clinical setting, thus enhancing the clinical learning experience.

Research Purpose

The purpose of this research is to describe the lived experience of nursing students who encounter inter-colleague violence during clinical placements and to gain a more meaningful understanding of that lived experience. The research question explored is: What is the lived experience of nursing students who encounter inter-colleague violence during clinical placements?

Chapter 2

Literature Review

Investigation and review of applicable research revealed there are some studies on the subject of inter-colleague violence and registered nurses in Canada. However, to my knowledge, there are no qualitative studies that explored undergraduate student experiences of inter-colleague violence in Newfoundland and Labrador. There is however an abundance of international literature that explored and described the complexity, prevalence, and severity of violence within healthcare organizations. Of importance to this particular study is the body of research specifically addressing the phenomenon of inter-colleague violence within healthcare settings. Exploring what is known about violence in the nursing profession contributes to our understanding of inter-colleague violence involving students. In the first part of this chapter I will provide a review of what is currently known and understood about violence and inter-colleague violence in nursing. This will include a review of the prevalence of violence in nursing and an examination of conceptualizations of inter-colleague violence and theoretical assumptions about inter-colleague violence. In the second part of this literature review I will provide an overview of the prevalence of violence, including inter-colleague violence, reported by students. As well, I will present qualitative studies on inter-colleague violence in the clinical area as perceived by nursing students and studies that examined the importance of positive relationships and clinical contexts on clinical experiences.

Violence and Inter-Colleague Violence in the Nursing Profession

Violence involving registered nurses in the healthcare setting has been well established by researchers globally. In fact, nurses as a group are considered to be high risk for exposure to violence (Celebioglu et al., 2010; Farrell & Shafiei, 2012; International Council of Nurses [ICN], 2006; Jackson, Clare, & Mannix, 2002; Rodwell, Demir, & Flower, 2013; Unal et al., 2012). Though the occurrence of violence may vary from setting to setting, it is suggested the prevalence of workplace violence in healthcare is increasing (Celebioglu et al., 2010; Cox Dzurec & Bromley, 2012; Farrell, Bobrowski, & Bobrowski, 2006; Hinchberger, 2009; Jackson et al., 2002; Magnavita & Heponiemi, 2011; Rodwell et al., 2013). This type of violence may be perpetrated by peers, patients, family members of patients, management, physicians, and other personnel.

Prevalence of Violence in Nursing

Internationally, researchers have reported varying rates of violence and aggression in the healthcare setting. Farrell and Shafiei (2012) reported that of 1495 Australian nurses 52% experienced workplace aggression within a four week time frame. Pejic (2005) examined the prevalence of verbal abuse amongst pediatric nurses in Eastern Ontario and found that 33 of 35 (94.3%) nurses had experienced verbal abuse over a three month time frame. In a study of American nurses' experiences it was reported that 778 or 82% of respondents either experienced or witnessed various acts of violence on a weekly or daily basis (Dumont, Meisinger, Whitacre, & Corbin, 2012). In Turkey, 86.7% of 476

registered nurses surveyed experienced verbal abuse in the healthcare setting (Uzun, 2003). Similarly in a study conducted in southern Taiwan 81.5% of nurses surveyed (N = 791) reported workplace violence over a one year period (Chen, Ku, & Yang, 2012). Though the statistics are alarming, more disturbing is the suggestion that workplace violence, including encounters with nursing colleagues, lacks sufficient acknowledgement and may be under reported by nurses (Hinchberger, 2009; Jackson et al., 2002; Magnavita & Heponiemi, 2011).

While any violent encounter is distressing, it is suggested that inter-colleague violence is more damaging, and has significant consequences for the individual and healthcare organization (Corney, 2008; Farrell, 2001; Luparell, 2011). It has recently been shown that nurses can be the most common perpetrators of violent behaviours in the workplace (Cevik Akyil, Tan, Saritas, & Altuntas, 2012; Dumont et al., 2012). The implications of such behaviour likely have a negative effect on the individual, the profession, patients, and the entire healthcare organization. Consequently, despite the identification of variables, contexts, and factors that may serve as precursors and enablers of such behaviour, it is suggested the prevalence and severity of violence within the profession continues to raise concerns internationally (Farrell & Shafiei, 2012).

Conceptualizations of Inter-Colleague Violence

Nurse-on-nurse, or inter-colleague violence has been called, amongst other things, the profession's 'dirty little secret.' It is also likely that most registered nurses and senior nursing students have been acquainted with the now infamous phrase 'nurses eating their

young;' a concept that Meissner (1986), in describing nursing educators, more vividly characterized as a "kind of genocide" and "insidious cannibalism" (p. 52). Sadly, the behaviours implied by these expressions may even be considered a part of nursing lore, an initiation or routine of sorts (Ditmer, 2010; Griffin, 2004), or as part of the norm or job (Farrell, 2001; Longo & Sherman, 2007; Sheridan-Leos, 2008) by both perpetrator and victim. Fostering supportive and positive collegial relationships suggests mutual respect, and the sharing of knowledge, wisdom, and experience. However, menacing behaviours of a violent or aggressive nature are cycled and shared amongst colleagues as well (Longo & Sherman, 2007; Walrafen, Brewer, & Mulvenon, 2012).

The concept of violence between nurses has taken on many names over the last three decades. Lateral violence, also called horizontal violence (Griffin, 2004; Sheridan-Leos, 2008) and vise versa (Thomas & Burk, 2009), are the two most common terms used to describe violence perpetrated by one nurse to another. The terms bullying and aggression (Griffin, 2004) and workplace bullying (Johnson, 2009) have also been used to describe lateral and horizontal violence. Horizontal violence has also been used interchangeably with the terms workplace bullying and harassment (Curtis et al., 2006). Other terms that have appeared in the research literature on the subject include vertical violence (Thomas & Burk, 2009), workplace aggression (a term that includes occupational violence and workplace bullying) (Farrell & Shafiei, 2012), incivility (Clark, 2008), mobbing (Cevik et al., 2012), direct and indirect violence (Thomas, 2010), and horizontal hostility (Thomas, 2003).

Griffin (2004) described lateral violence "as nurses covertly or overtly directing their dissatisfaction inward toward each other, toward themselves, and toward those less

powerful than themselves" (p. 257). Likewise, Longo and Sherman (2007) defined horizontal violence as "an act of aggression that's perpetrated by one colleague toward another colleague" (p. 35). While this type of violence may escalate to physical violence (Longo and Sherman, 2007; Sheridan-Leos, 2008) it is behaviours that inflict psychological and emotional trauma that are the hallmarks of lateral and horizontal violence (Farrell, 2001; Griffin, 2004). These behaviours include but are not limited to ignoring, belittling, criticizing, backstabbing, withholding information, and non-verbal innuendos like eye rolling (Griffin, 2004; Longo & Sherman, 2007; Sheridan-Leos, 2008).

The concept of bullying is a more recent term to describe lateral and horizontal violence (Griffin, 2004; Johnson, 2009). Some authors have differentiated bullying from lateral or horizontal violence by the increased frequency and duration of episodes, the inclusion of physical aggression, and the presence of a status gap between victim and perpetrator (Jackson et al., 2002; Stanley, 2010). It is suggested bullying has often been associated with nursing managers who both exhibit behaviours inherent of bullying and perpetuate those behaviours as a result of poor leadership (Johnson, 2009). Other notable bullying behaviours include sarcasm, criticism, humiliation (Curtis et al., 2006; Jackson et al.; Johnson, 2009), verbal abuse, and intimidation (Farrell & Shafiei, 2012).

The profusion of terms is indicative of the suggestion that a unified definition of workplace violence and bullying does not exist (Corney, 2008; Farrell et al., 2006; Hinchberger, 2009; Jackson et al., 2002; Roberts, Demarco, & Griffin, 2009; Rodwell et al., 2013; Thomas, 2010). It has been suggested that a unified definition may be unrealistic given differences in populations and healthcare contexts (Farrell & Shafiei,

2012). Individual tolerance to certain behaviours may also further impede a universally accepted definition of horizontal violence (Hinchberger, 2009). However, it is suggested that ill defined concepts and variations of inclusive behaviours, paired with the interchangeable and often overlapping nature of terms and behaviours may contribute to conceptual and definitional ambiguity (Budin, Brewer, Chao, & Kovner, 2013; Roberts et al., 2009; Stanley, 2010), thereby complicating efforts and strategies to address the subject (Stevenson, Randle, & Greyling, 2006). Consequently, it is suggested the myriad of terms may perplex nurses as they attempt to identify and rationalize such behaviours, and so influence their decision to report the encounters (Ventura-Madangeng & Wison, 2009).

The directional nature of the behaviours is at the heart of the most common terms used to describe inter-colleague violence. The terms lateral and horizontal imply that behaviours or actions are directed at individuals perceived to have the same status or power structure within an organization (Griffin, 2004; Longo & Sherman, 2007). The term vertical implies there is a top down direction of violence, as in registered nurse to student (Thomas & Burk, 2009). The terms horizontal and lateral violence are not particular to the nursing profession. However, the oppressed context in which the term originated has frequently been paralleled to healthcare contexts, where nursing has historically been viewed as a subordinate and oppressed profession.

While it was not my intention to add another term to the mix, it was important to remain cognizant of the fact that the concept of violence is broadly defined. Therefore, it was necessary to avail of a definition that would be inclusive of common terms and behaviours explored in the literature. The term inter-colleague violence was adopted

from a definition of workplace violence outlined by the Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU). The definition of colleague is defined as a fellow member of the nursing profession or academic faculty belonging to that profession. Hence, inter-colleague violence includes:

> Actual and attempted incidents of verbal, physical, psychological (including bullying) and sexual abuse, in circumstances related to work, that result in personal injury, either physical or psychological, or give reasonable cause to believe that risk of injury or detrimental impact on an individual's health exists (CNA/CFNU, 2007, para. 2)

Theoretical Assumptions of Inter-Colleague Violence

The term 'horizontal violence' was originally proposed by Fanon (1961/2004) to describe the manifestation of hostility and aggression that colonized Algerians displayed towards each other in the wake of oppression under French rule. Similarly, the term lateral violence later surfaced among Canadian First Nations people to describe the infighting and incivility that occur among individuals in oppressed communities (Native Women's Association of Canada, 2011). Consequently, explanations of violence and conflict between nurses have also frequently relied on oppressed group theory (Farrell, 2001; Longo & Sherman, 2007; Roberts, 1983; Roberts et al., 2009; Sheridan-Leos, 2008).

References to Freire's (1971) oppressed group model and oppressed group behaviours imply that nurses, as a predominantly female group, exhibit characteristics

like self hatred, lack of group cohesion, and low self-esteem in relation to their perceived lack of autonomy and control at the hands of a traditionally male dominated medical discipline (Farrell, 2001; Johnston et al., 2009; Roberts, 1983; Sheridan-Leos, 2008; Thomas & Burk, 2009). When oppressed groups or individuals cannot adequately address the oppressor or situation, retaliation in the form of passive-aggressive behaviour is directed at someone perceived as being of equal or lesser status (Longo & Sherman, 2007; Roberts, 1983; Roberts et al., 2009; Sheridan-Leos, 2008). A manifest feeling of powerlessness resulting from such behaviour victimizes peers or co-workers and ultimately perpetuates further oppression (Farrell, 2001; Longo & Sherman, 2007; Roberts et al., 2009; Sheridan-Leos, 2008).

Despite the popularity and value of oppressed group theory as a contextual framework for violence in nursing, Farrell (2001) proposed that explanations of conflict should not be theoretically pigeonholed by the oppressed group model and encouraged study of organizational variables like staff demographics and stressors in the workplace that may contribute to disempowering relationships amongst nurses. Likewise, other researchers suggested that violence and incivility are also a product of tolerant organizations and cultures (Johnston et al., 2009), generational differences (Martin, Slaney, Dulaney, & Pehrson, 2008), and changes to previously common norms that dictated appropriate behaviour and conduct (Marchiondo, Marchiondo, & Lasiter, 2010). Other factors suggested to contribute to violence and bullying within the healthcare organization, specifically the nursing workplace, include workload, management skills, and interpersonal skills (Croft & Cash, 2012).

Violence and Nursing Students

Student encounters with violence in the clinical setting, specifically inter-colleague violence, has been identified by several researchers as an area that requires further investigation (Anthony & Yastik, 2011; Celebioglu et al., 2010; Hinchberger, 2009; Jackson et al., 2011; Longo, 2007). It is also worthy to note that literature on student encounters with various types of violence and on student perceptions of the clinical environment is more predominant from certain countries notably, Turkey (Celebioglu et al., 2010; Celik & Bayraktar, 2004; Lash et al., 2006; Unal et al., 2012; Uzun, 2003), Australia (Curtis et al., 2006; Dunn & Hansford, 1997; Jackson et al., 2002; Jackson et al., 2011; Levett-Jones et al., 2007), the United Kingdom (Bradbury-Jones, Sambrook, & Irvine, 2007; Ferns & Merrabeau, 2009; Levett-Jones et al., 2007; Randle, 2003; Stevenson et al., 2006), and the United States (Anthony & Yastik, 2011; Hinchberger, 2009; Lasiter, Marchiondo, & Marchiondo, 2012; Thomas, 2010; Thomas & Burk, 2009).

Prevalence of Violence Involving Students

Internationally researchers indicate that students experience varying rates of violence and inter-colleague violence in the clinical setting. There is also contrast between perpetrators and the reporting behaviors of students. In an American study by Hinchberger (2009) all of the 126 student participants in an online survey reported experiencing or witnessing violence in clinical placements, with 75% of the perpetrators

noted as staff members. Celebioglu et al. (2010) conducted a study of Turkish nursing students' experiences with clinical violence and reported that of 380 student participants over 50% experienced violence, with verbal violence from patients being predominant followed by verbal violence from other nurses. These findings differ from those in a study by Unal et al. (2012) who found that students experienced more verbal abuse from teachers in the clinical setting than from nurses. Faculty incivility in the form of threatening remarks and belittling was also reported in a study of 94 senior nursing students from two Midwestern universities (Lasiter et al., 2012). Likewise in a study of Italian students by Magnavita and Heponiemi (2011) that compared the experiences of nurses and nursing students, the researchers indicated that students were more subject to "internal" violence that included physical and nonphysical violence from colleagues, staff, and teachers than were the nurses.

Researchers who specifically examined student encounters with horizontal violence were also compared. In a study of 47 senior American nursing students 53% reported being put down and 40% reported being humiliated by staff nurses (Longo, 2007). Approximately 34% of the participants witnessed an act of horizontal violence involving a classmate. Significantly 72% of the participants believed the statement that "nurses eat their young" (Longo, 2007). In an Australian study Curtis et al. (2007) surveyed 152 nursing students and 57% had either experienced or witnessed an act of horizontal violence, though more students reported observing rather than experiencing behaviours associated with horizontal violence.

It has been suggested that students face the same risk of violence as do registered nurses (Celebioglu et al., 2010), and that they experience violence at the same rate as

registered nurses (Hinchberger, 2009). Reporting behaviours of students from various studies, however, indicated that students are not likely to address violent incidents with proper authorities in the healthcare context. Celebioglu et al. (2010) stated that none of the study participants who encountered violence in the clinical setting reported the violence to anyone following the incident. Approximately 70% of students in the study by Unal et al. (2012) reported inaction following a violent encounter in the clinical placement, with less than 4% even reporting the event to other teachers. Longo (2007) indicated that when directly involved in an incident, 49% of participants did not report, and 53% did not report witnessed incidents involving classmates. More students (66%) reported they spoke of the incident with fellow students or "significant others" instead (p.178).

Nursing Students' Experiences of Inter-colleague Violence

Qualitative studies pertinent to this thesis were identified and will be reviewed in greater detail. Each study describes students' experiences of violence during clinical placements. Researchers utilized various terms to conceptualize violence in each study like bullying, horizontal violence, vertical violence, incivility, and verbal abuse. Despite conceptual and definitional differences, several similarities regarding the behaviours perpetrated toward students and the emotional effects of violence on students and the learning process were identified.

Exploring bullying and horizontal violence in the nursing profession, Randle (2003) conducted a grounded theory study with unstructured interviews to examine the

development self-esteem of nursing students in the United Kingdom. Students representing all branches of clinical nursing were interviewed at the beginning and end of their clinical placement. Changes to self-esteem in the process of becoming a nurse were found to be influenced by nurses' power over students and nurses' power over patients (Randle, 2003). Negative experiences and bullying behaviours such as belittling and humiliation encountered directly by students and witnessed amongst patient interactions contributed to students' sense of powerlessness and decreased self-esteem. Students did not have the resources or knowledge to deal effectively with bullying behaviours in the clinical area. To cope with bullying behaviours students began to assimilate such behaviours, compromising patient care, their own professional self-esteem, and their self-identity in the process. Feelings of anger and anxiety were reported by students who felt powerless to defend themselves against such behaviours. By the end of the course students who initially reported anxiety and concern were demonstrating some of the same behaviours as the nurses. Randle (2003) suggested that socialization to the nursing profession is stressful for students when their ideas and expectations about nursing do not match with the reality of nursing. Further, Randle (2003) suggested that dealing with bullying and effecting changes in the clinical environment requires education about the historical, social, and contextual factors that influence oppressed group behaviour and feelings of powerlessness.

Vertical violence is a term proposed by Thomas and Burk (2009) to describe abuse between individuals with perceived power or status differences and is reflective of the term "nurses eating their young." The authors used content analysis to examine 221 narratives from American junior nursing students who were asked to write about feelings

of anger incurred during class and clinical time. Student anger was reported more often during clinical time and related to four identified levels of perceived injustice (Thomas & Burk, 2009). The levels were arranged to represent the severity of the negative staff behaviour and ranged from being ignored to being publicly humiliated. Similar to Randle's (2003) findings, students were upset with their own treatment and with the treatment of patients by nurses. These feelings were often suppressed which led students to ruminate about the incidents long after they occurred. Additionally, students were not forthcoming to educators about the severity of abuse and were upset by excuses that were made by educators to explain the negative behaviours of staff nurses. Findings from the study were limited due to the fact that students at only one American university were included.

Perceptions of faculty incivility in the teaching and learning environment have also been reported by students. In a study of American student experiences Clarke (2008) reported themes similar to those described by Randle (2003) and by Thomas and Burk (2009). Colaizzi's (1978) phenomenological research methodology was used and themes were extracted from one-on-one interviews with seven former and current nursing students from four different nursing schools. Only two questions were asked, the first to ascertain students' perceptions of faculty incivility and the second to determine student responses to perceived incivility. A conceptual model detailed major themes and subthemes elicited from the interviews. Major themes included being subjected to demeaning and belittling behaviours, unfair treatment, pressure to conform to demands of faculty, and feelings of helplessness, powerlessness, and anger (Clark, 2008). Students reported feeling powerless, angry, and traumatized following episodes of incivility and

expressed experiencing physical symptoms such as nausea and headaches (Clarke, 2008). Behaviourally, students felt powerless and feared the repercussions of challenging faculty incivility, a sentiment supported in a more recent study by Lasiter et al. (2012). One student left the program and the remainder felt it necessary to conform and submit to the rigidity of educators. Clarke (2008) suggested that incivility is damaging to student well-being and is not conducive to healthy and supportive academic settings. The themes identified by Clarke (2008) provided a detailed description of faculty incivility but she did not discuss any other type of behaviours like vertical violence or bullying. Further only some of the incidents reported by students occurred in the clinical setting. Some of the participants recalled incidents from as long ago as seven years and this could impact the quality of the data, as could the fact that all participants were Caucasian and had a mean age of over 42 years.

In a study by Lash et al. (2005), a phenomenological approach explored incidents of verbal abuse among nursing and midwifery students in Turkey. A purposive sample of third and fourth year students who had accumulated the most clinical time was included in the study. Using the Colaizzi (1978) method of analysis the authors formulated clusters of themes and various categories following 2-hour focus group interviews with eight different groups of students (N = 66). Themes that were identified by the authors included students' experiences of verbal abuse, students' perceptions of the effects of verbal abuse, coping with verbal abuse, and student recommendations to prevent abusive encounters (Lash et al., 2006). Participants encountered intimidation, belittling, humiliation, and derogatory comments from healthcare staff and instructors during the clinical learning process. Students also reported a loss of confidence when their

education and holistic approach to care was criticized by staff. Students expressed feeling powerless, humiliated, and unprepared to effectively deal with verbal abuse. The consequence of abusive encounters included physical and emotional symptoms such as helplessness, anxiety, fatigue, and decreased self-esteem. Additionally, students felt that acceptance of such behaviour in clinical practice was the only option available to them. The researchers indicated that "virtually none" (p.400) of the students reported the behaviours and coped by sharing experiences with fellow students instead. The researchers suggested that exposure to and tolerance of verbal abuse during clinical rotations negatively influences the professional socialization of students to nursing (Lash et al., 2006). While the sample size was considerable for a phenomenological methodology, I question whether students are as forthcoming about verbal abuse in a focus group when compared to the privacy and confidentiality assured by individual interviews.

Students' Perceptions of Quality Clinical Environments

As important as it is to understand the negative emotions and consequences that accompany inter-colleague violence, it is equally important to contrast those findings with research on quality clinical environments. Student perceptions of factors and elements that create clinical settings conducive to development and learning are the focus of this section. Two relevant qualitative studies conducted by Levett-Jones et al. (2007) and Atack et al. (2000) were identified that demonstrate the importance of positive relationships and healthcare contexts during clinical placements.

Exploring the Lived Experience

In the first of the two studies, Levett-Jones et al. (2007) utilized a constant comparison method to analyse in-depth narratives from 18 nursing students in the United Kingdom and Australia. The analyses of student narratives provided preliminary findings for the qualitative phase of a mixed methods study on the concept of 'belongingness.' Four narratives were used to create a montage exploring the experience and consequences of belongingness and alienation during clinical placements. Belongingness, according to the researchers is a well known social and psychological concept that had not been critically studied in the nursing context. They suggested that a sense of belonging, and conversely alienation, impact student perceptions of the clinical learning environment and experience. In their narratives students frequently identified interpersonal and contextual factors that impacted their sense of belongingness. In clinical environments where leaders, staff, and mentors were welcoming, supportive, and inclusive of students, clinical learning and self-esteem flourished. Feeling like part of the team and being valued and cared for by staff not only enhanced student well-being but also inspired students to begin looking at those particular clinical areas as potential career options. Conversely, students also experienced alienation in the clinical area that negatively affected the clinical experience and also made them question their pursuit of a nursing career. Alienation resulted from experiences of horizontal violence perpetrated by staff and when students' caring values conflicted with care provided in the clinical environment. The experience of alienation made students feel uneasy, distressed, and powerless. Narratives also described students disengaging from clinical contexts in an effort to survive the placement. Levett-Jones et al. (2007) suggested that achieving a sense of belonging and

acceptance through collegial relationships and welcomed involvement is a critical component of the clinical learning experience for students.

The importance of belonging, mutual respect, and inclusiveness was also expressed by participants in a Canadian study of diploma nursing students and staff nurses (Atack et al., 2000). The researchers aimed to study the lived experience of student and staff relationships in the clinical area and the impact of those relationships on student learning. Researchers utilized a phenomenological method with focus group interviews and open-ended questions. Themes were elicited using reduction analysis as suggested by van Manen. Several commonalities emerged, but for clarity, student and staff perceptions were presented separately.

Students recognized that staff relationships were critical to achieving positive clinical experiences (Atack et al., 2000). Such relationships formed when students were included as "junior colleagues" (p.389). These relationships were based on respect, open communication, and positive feedback. Other important aspects of the student-staff relationship included the mutual sharing of knowledge and decision making and professional socialization. Students noted that small actions by the nurses made them feel welcome and included, contributing to constructive socialization into the profession. Nurses who welcomed students, identified themselves, and demonstrated confidence and attentiveness with questions and feedback were recognized as role models by students. Patience, understanding, and communication were also recognized by staff participants as important characteristics when engaging students in the clinical area. Students also quickly identified nurses who were confident in teaching and role modelling from those who were less confident or uncertain about their role.

Based on their findings Atack et al. (2000) suggested that relationships between staff and students are an important component of clinical practice learning. Specifically that staff nurses are imperative to the socialization process of nursing students into the profession. Recommendations for effective teaching and development of staff-student relationships included helping staff with teaching strategies, developing communication skills, preparing orientation activities to facilitate bonding, and extending student hours in the clinical area to enhance learning and relationships (Atack et al., 2000).

Summary

Researchers have long asserted that nurses are in fact a high risk group for exposure to violence in the workplace. That sentiment continues to emerge in more recent violence literature. It has been implied that violent encounters pose negative consequences for the individual, profession, and healthcare organization. Some differences in the rates of violence reported by nurses were identified by researchers internationally, however it is also suggested that reporting behaviours may differ depending on the perpetrator of violence. Nurses report that violence in the workplace is stressful but inter-colleague violence is especially distressing for nurses. This is also significant as nurses have been identified by some researchers as the most common perpetrators of violence.

Several terms that describe inter-colleague violence have been identified throughout the literature. Frequently these terms overlap and at times have been used interchangeably. The resulting conceptual and operational differences have no doubt

contributed to how nurses both perceive and report violent encounters. Commonly used terms such as horizontal and lateral violence are indicative of the directional nature of abuse and have been utilized in the research involving students. Only one term, vertical violence (Thomas & Burk, 2009), was identified that aimed to differentiate the status gap that exists between students and registered nurses.

The terms horizontal and lateral violence are not exclusive to violence in nursing. The origins of the terms are instead based on concept of violence and hostility expressed amongst oppressed groups. Much of the research on violence in nursing has used oppression theory for the theoretical or conceptual framework. More recently nurse researchers have indicated the need to explore other causative factors such as healthcare contexts, workload, and generational differences that contribute to aggression and violent behaviour in the workplace.

Researcher findings presented here indicate that students encounter inter-colleague violence during clinical placements, and that such encounters can significantly affect student well being and the clinical learning process. Students consistently identified similar abusive behaviours despite the variety of definitional and operational terms used by researchers. Students recalled belittling, humiliation, intimidation, and verbal abuse in studies utilizing the terms incivility, vertical violence, bullying, and horizontal violence. Consequently students expressed pressure to conform, assimilate, and accept these encounters as a part of the clinical experience and the nursing profession.

Researchers have identified interpersonal relationships as a significant component of the clinical learning process. They also suggest the importance of staff and student

relationships during the clinical experience. The researchers identified concepts perceived by students as contributing to quality professional relationships and effective clinical learning experiences. A sense of belonging derived from being welcomed, supported, and nurtured by nursing colleagues positively influenced students' clinical learning experiences, confidence in their ability, and choice of profession. Staff who included students and made them feel like part of the team promoted professional socialization, an important component of the clinical experience.

Conclusion

The literature reviewed here is largely qualitative in method as it relates more with my chosen research method. Several quantitative studies were also identified but often lacked a rich description of the experience of inter-colleague violence. Those studies more frequently described the prevalence and type of violence experienced by students. While it is important to capture the rates at which students experience inter-colleague violence in the clinical setting, understanding how students experience and perceive inter-colleague violence is necessary to understand how those events affect students' clinical placement experience.

The qualitative studies that I reviewed in this literature review provide rich descriptions of nursing students' encounters with horizontal and vertical violence, as well as incivility, bullying, and verbal abuse. However, the research studies reviewed have limitations. Conceptual and definitional differences in the literature on violence are a concern, and inherently this carried over into the research on violence involving student

nurses. Despite much overlap in the behaviours inclusive of all the definitions, it was difficult to find any consistency in the use of terms and definitions. Study settings were also diverse and included Turkey, Australia, United Kingdom, United States, and Canada, but it is worthy to note that comparably there is much less known about the experiences of Canadian students. Differences in program requirements, demographics, healthcare contexts, and cultural considerations may therefore contribute to differences in student experiences, and more importantly how students interpret and report violent encounters.

The written narratives utilized by some researchers (Thomas & Burk, 2009) for data collection may not produce the same quality and detail as one-on-one interviews, as researchers are unable to fill gaps that may be absent from student accounts. Phenomenological studies that utilized large numbers of student participants and focus groups (Atack et al., 2000; Lash et al., 2005) to illicit data may also compromise the depth and richness of data associated with the methodology. As previously noted students may have been more reluctant to disclose their true feelings in the presence of other students. In another study some of the participants were former students who recalled experiences that occurred several years prior to interviewing (Clarke, 2008), potentially affecting the recall and detail of those experiences.

Despite the differences in the aims and study methods of the chosen research, similar findings and themes consistently emerged in the literature. The experience of inter-colleague violence during clinical placements is damaging to student confidence, professional image (Lash et al, 2006; Randle, 2003), and learning (Levett-Jones et al., 2007). In all of the literature reviewed students who encountered inter-colleague violence consistently reported feelings of powerlessness, helplessness, humiliation (Clarke, 2008;

Lash et al., 2006; Randle, 2003), and anger (Thomas & Burk, 2009) as a result of the experience. Those feelings were also repeatedly noted by students specifically when encounters involved clinical educators (Clarke, 2008), and when inaction by clinical educators followed staff encounters (Thomas & Burk, 2009). Researchers who examined the importance of student-staff relationships also found that students enjoyed and thrived in clinical placements where staff and educators were supportive, encouraging, and inclusive of students as members of the healthcare team (Atack et al., 2000; Levett- Jones et al., 2007).

Much of the literature reviewed here, though relevant to my study, examined specific elements of student encounters with violence such as the effects of violence and bullying on self-esteem (Randle, 2003), students' feelings of anger (Thomas & Burk, 2009), and the experience of belongingness and alienation (Levett-Jones et al., 2007). I did not identify any phenomenological studies that broadly examined the lived experience of inter-colleague violence during clinical placements. Therefore my study addressed this gap in the literature by using phenomenology to inclusively explore nursing students' lived experience of inter-colleague violence. The use of one-on-one interviews also permitted the students in this study to speak more freely and openly about their experiences. As those experiences occurred within the last 12 months of clinical experiences, the students were also able to recall their encounters in rich detail.

Chapter 3

Methodology

Phenomenology was the chosen methodology for this research study. Phenomenology is concerned with understanding the lived experience. Personal interest in the phenomenon paired with a dearth of research on the experiences of students in this region provided the impetus for choosing this particular methodology. In the first part of this chapter I will describe phenomenology as a research methodology. In the second part, or remaining sections of this chapter I will discuss how I utilized this approach to explore the lived experience of nursing students who encounter inter-colleague violence during clinical placements.

Phenomenology as Research Methodology

Phenomenology is a methodology within the qualitative paradigm of research. It is a human science (van Manen, 1990). From the phenomenological perspective, "to do research is always to question the way we experience the world, to want to know the world in which we live as human beings" (van Manen, 1990, p. 5). This particular method of inquiry has an established history and is frequently utilized by nursing researchers to enhance understanding of lived experiences relevant to nursing practice (Dowling, 2007; Earle, 2010). Phenomenology has been largely influenced by the work of German philosophers Husserl and Heidegger who based their ideologies on the epistemology

(how do we know?) and ontology (what is being?) of human experience (Earle, 2010; Pringle, Hendry, & McLafferty, 2011; van Manen, 1997).

Husserlian phenomenology is concerned with the key principle of intentionality, or an "inseparable connection to the world" (van Manen, 1990, p.5). Based on the assumption of an inseparable connection Husserl purported that researcher attitudes and preconceived ideas should be bracketed or set aside, a concept known as eidetic reduction (Earle, 2010; Pringle et al., 2011). The concept of bracketing has created debate among followers of this research method (Pringle et al., 2011). Of concern is the ability of researchers to maintain a truly objective or bracketed perspective as they uncover the essence, or structure of the phenomenon under study (Dowling, 2004; Pringle et al., 2011). Husserl's student Heidegger did not agree with the concept of intentionality and developed another distinct phenomenological research tradition (Earle, 2010).

Heidegger is most associated with the development of modern hermeneutic phenomenology (Annells, 1996; Crist & Tanner, 2003; Earle, 2010). The methodology is both descriptive and interpretive of the meaning of lived experience as it is captured through interviews and interactions with participants (Van der Zalm & Bergum, 2000; van Manen, 1997). Hermeneutic phenomenology does not embrace the concept of bracketing but endorses the idea that the researcher's preconceived attitudes, beliefs, and knowledge are impossible to defer and necessary of the interpretive method (van Manen, 1990, 1997). Instead the researcher evaluates and considers his or her own ideas and knowledge of the phenomenon under study and contemplates the influence of that knowledge and experience on the research process, but never aspires to bracket or reduce that knowledge (van Manen, 1990).

Exploring the Lived Experience

The hermeneutic circle is a major concept of the hermeneutic phenomenology framework (Annells, 1996). The circle is a reciprocal process of interpreting the phenomenon that involves movement between the parts and the whole of the text, and our pre-understanding and understanding of a phenomenon (Annells, 1996; Crist & Tanner, 2003; Dowling, 2007; Earle, 2010). The researcher weaves throughout the metaphorical circle repeatedly connecting parts to make a whole thus enhancing their understanding with each rotation. It is the hermeneutic circle and concepts of Heidegger's phenomenology that inform Max van Manen's phenomenological methodology (van Manen, 1990), which has been chosen for this study.

van Manen's methodological approach is frequently utilized by nurse researchers to explore the lived experience (Dowling, 2007). According to van Manen (1990) phenomenology is both the "description of the lived-through quality of lived experience, and on the other hand, description of meaning *of the expressions* of lived experience" (p.25). Interpretation of the experience emerges as the researcher describes the experience through writing. Reflectively and descriptively writing text is therefore integral to this phenomenological research process (van Manen, 1990). The idea that there is an interpretive element inherent of all descriptions is the basis for van Manen's refutation of rigid methodological procedures in favour of six dynamic research activites. These activities include, "turning to a phenomenon which seriously interests us and commits us to the world, investigating experience as we live it rather than as we conceptualize it, reflecting on the essential themes which characterize the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strong

and oriented pedagogical relation to the phenomenon;" and, "balancing the research context by considering parts and whole" (van Manen, 1990, p. 30).

Research Methods

Research Design

The interplay of these six activities provided the framework for this research study. The first activity, "turning to a phenomenon which seriously interests us and commits us to the world" is the formulation of the research question. Revealing the essence and structure of a phenomenon is determined by the construction of a research question that is effectively orientated to the phenomenon under study (van Manen, 1990). For this particular study that question is: What is the lived experience of nursing students who encounter inter-colleague violence during clinical placements? As a registered nurse and researcher I have a distinct interest in this particular research topic. Also as an educator I am genuinely interested in how students not only perceive and interpret inter-colleague violence, but also how it affects students' perceptions of the clinical education process. In turning to the phenomenon the researcher both "lives" and "becomes" the research question in an effort to give the phenomenon hermeneutic significance (van Manen, 1990, p. 43). This process requires that the researcher confronts his or her knowledge and assumptions of the phenomenon, not in an attempt to suspend what is known, but to reveal how it limits a deeper understanding (van Manen, 1990). Having personal experience with the phenomenon of interest can be problematic when pursing

this methodology, therefore it was important to continually recognize and assess my own biases. Stepping back from the study and continually reflecting on my own experience prevented the incorporation of my pre-understanding into the research process thus making explicit my own knowledge of the phenomenon. Maintaining orientation to the phenomenon requires the researcher to remain cognizant of the research question throughout all six research activities.

The second activity, "investigating experience as we live it rather than as we conceptualize it," is concerned with making contact with the initial experience, and the methods that are used to collect or gather information about the lived experience. This involves 'obtaining experiential descriptions from others' (van Manen, 1990, p. 62). Essentially by obtaining or collecting the participants' experiences and reflections, we not only reach a greater understanding of the specific phenomenon, but the true nature of the lived experience. In depth interviews, digital voice recordings of participant descriptions, and researcher notes were used in my study. The interview also provided the opportunity to explore the experience and served as a method to develop a "conversational relation" with the participants about the experience (van Manen, 1990, p. 66). The purpose of my interview questions was to elicit as much description as possible about the lived experience of inter-colleague violence. That sometimes required prompting and clarifying questions designed to explore the phenomenon more descriptively and to maintain an orientation to the original research question. The rich descriptions provided by the participants assisted me to better understand the meaning of the lived experience.

"Reflecting on essential themes which characterize the phenomenon" is the third research activity. In this analytical step of the hermeneutic phenomenological process the

researcher reflects on the essential and multi-dimensional meaning of the experience (van Manen, 1990). Themes are the "*structures of experience*" (van Manen, 1990, p. 79), and as such provide the researcher with the tools to reveal the true meaning of a phenomenon. van Manen (1990) suggested three approaches for isolating thematic statements (1) the wholistic or sententious approach, in which the essential meaning of the whole text may be captured in a single phrase; (2) the selective or highlighting approach, that involves reading or listening to the text repeatedly and highlighting statements that capture the essential nature of the experience; and (3) the detailed or line-by-line approach where individual or groups of sentences are examined for insight and understanding of the experience under study. For the purpose of this study, all three approaches were used to isolate thematic significance from transcribed interviews.

van Manen (1990) suggests that human science is a linguistic endeavour that requires reflective and descriptive writing to reveal lived experience. "Describing the phenomenon through the art of writing and rewriting" is the fourth activity of the research process. Writing invites the researcher to externalize thoughts, feelings, and interpretations that might not be realized internally (van Manen, 1990). It is a reflective process that initially separates, abstracts, and objectifies what is known about the life world to bring the researcher to a deeper understanding and awareness of the experience (van Manen, 1990). The process of re-writing indicates the researcher's movement between the parts and the whole of the phenomenon, the ongoing textual reflection that gives the meaning of the experience its depth and structure (van Manen, 1990). This process involved thematic analysis of individual interviews through writing. Then,

comparing the interviews together, I was able to re-write the themes and capture a deeper understanding of the students' collective experience.

For the fifth activity, "maintaining a strong and oriented pedagogical relation to the phenomenon," van Manen (1990) suggests that the researcher remain truthful to the original question. The researcher must establish a strong relationship and commitment to the experience of interest, and resist speculation that compromises the integrity of the research process and belies the meaning of the phenomenon (van Manen, 1990). A strong commitment to the question is reflected in thoughtful textual descriptions that possess strength, depth, and richness that is truly introspective of the phenomenon (van Manen, 1990). To maintain this orientation I continually referred back to my original research question, and sought feedback from my thesis supervisor.

The final activity "balancing the research context by considering parts and whole," represents the dynamic interplay of all the research activities (van Manen, 1990). At several points within phenomenological inquiry it may become easy for the researcher to lose sight of the goal and to become textually estranged from the original question and purpose. To this end van Manen (1990) suggests that the researcher "needs to constantly measure the overall design of the study/text against the significance that the parts must play in the total textual structure" (van Manen, 1990, p. 33). To maintain a broad direction during the process the researcher must both frequently examine the entirety of the text and how the parts contribute to the whole of the text (van Manen, 1990).

Participants

Third and fourth year Bachelor of Nursing (BN) students and second year fast-track BN students enrolled and attending classes at two schools of nursing in Newfoundland and Labrador was the population of interest for this study. The fast-track nursing program is an accelerated nursing program completed over a two year period. Third and fourth year students and second year fast-track students were chosen because they have completed more clinical rotations in various healthcare settings, and therefore potentially have more experience and knowledge of the phenomenon of interest. Eight students participated in the study. Participants' ages ranged from twenties to early thirties, and the sample included both male and female students. Students who had previous healthcare experience, for example as licensed practical nurses (LPN) or personal care attendants (PCA), or post secondary education in another field were not excluded. However they were asked to discuss only those experiences pertaining to clinical rotations while enrolled in the Bachelor of Nursing program.

Inclusion criteria of participants for the study included: (1) present enrolment in the BN program at either of the two schools; (2) minimum of two years experience in the BN program or one year in the fast-track program (3) may be of any age, gender (4) willing to participate in the research study; (5) have experienced an incident of inter-colleague violence with a staff nurse, manager, educator or fellow student within the clinical setting; and (6) the incident of inter-colleague violence occurred within the last 12 months. Incidents of inter-colleague violence occurring outside of the clinical area,

occurring longer than twelve months prior to the study date, and from previous healthcare experience were not included in this study.

Procedure

Purposive, convenience sampling of participants was achieved by electronically sending flyers to student accounts at both schools (see Appendix A) with permission from administration at both sites. With permission from both schools I attended the classrooms of third, fourth year BN Students, and second year fast track students for a five minute information session, and provided copies of my flyer which stated the purpose, inclusion criteria, and the researchers' contact information (Appendix A). Copies of the flyer were also posted on bulletin boards at both schools. After potential participants contacted me, I mailed or delivered in person (if requested) a cover letter describing the study (Appendix B) and the consent form (Appendix C) for review by the participant. I informed potential participants that I would contact them within two weeks (by telephone or e-mail) of receipt of the cover letter and consent form to confirm participation, discuss consent, answer any questions, and arrange convenient times and locations for initial interviews. The consent form was signed by participants and witnessed by me at the beginning of the interview. Recruitment of potential participants occurred from September of 2012 to January of 2014. I was contacted by eleven potential participants during that time but two decided not to participate, and one student did not meet the inclusion criteria of the study.

Participants were informed that the interview would be audio recorded, and they could choose not to answer any question(s) or withdraw from the study at any time. In

keeping with the methodology of phenomenology participants were asked to talk about their experience of inter-colleague violence in the clinical setting. Prompting and clarifying questions were asked to assist the participants' recall of the experience. The main questions and probing questions are shown in Appendix D. Interviews ranged in time from 25 minutes to one hour. All audio taped interviews were transcribed verbatim by a researcher assistant and checked for accuracy of the verbalized data by me.

A second meeting (either by telephone or in person) was solicited by me to review the thematic elements with participants after the data analysis was complete. van Manen (1990) suggests this is a reflective collaboration between the researcher and participant, and an opportunity to interpret significant themes as they relate to the original question. Of the eight participants, three replied for the second interview to review themes by telephone. These second interviews ranged from 10 to 30 minutes. Themes and interpretive summaries were disclosed to the three participants who agreed and confirmed that the summary of themes accurately described their experience of inter-colleague violence.

Analysis

The data were analyzed using the approach of van Manen (1990) and included reading and listening to the text several times, looking for significant phrases that captured the entirety of the text, highlighting essential phrases that revealed something about the phenomenon, and looking at each sentence individually for meaning. Through the process of writing and rewriting the interpretive structure of the phenomenon began to

emerge. Meanings derived from significant statements were then organized into clusters of themes. All raw data, audit trails and a summary of themes were reviewed by Dr. Alice Gaudine, my thesis supervisor and professor of graduate nursing studies, Memorial University. In the event that any discrepancies arose between me and Dr. Gaudine pertaining to the data analysis those issues would have been clarified by the participants at the second meeting to further establish trustworthiness and authenticity of the data. However a consensus of the data analysis was established in discussions between me and Dr. Gaudine, and confirmed by the participants.

Ethical Considerations

Approval of this study was granted by the appropriate research ethics committee at the research site. The sensitive nature of the subject dictated the necessity of clearly stated assurances and researcher obligations to ensure participant privacy and confidentiality. While no harm was anticipated to participants during this study, there was a possibility that a participant could become emotional or upset while discussing violence in the clinical setting. In the event that discussion regarding the phenomenon of study evoked an emotional response a referral would have been made to campus counselling services in consultation with the participant. No referral was necessary during the interview process. Participants were explicitly informed by the principal researcher throughout the study, of their freedom to withdraw from the study at anytime

without any penalties. Every effort was taken to ensure no identifying information was revealed in the data or final summary.

Due to the potentially sensitive nature of this research area, I provided participants with every opportunity for privacy, confidentiality, and comfort during the interview process. Flexibility in choice of setting was offered to all participants. For convenience, I made myself available at both schools where a private, comfortable, and quiet meeting room could be arranged. Participants who wished to secure a private room elsewhere on the campuses were accommodated. All interview times were arranged around participant schedules so to not conflict with regular academic and clinical schedules.

In following the guidelines of the research ethics committee, all data, transcriptions, and tapes will be held in a secure area for five years post publication of study findings. To ensure the safety of data and confidentiality of participants, transcriptions and tapes are kept in a locked cabinet in a research unit at one of the research sites. All individuals having contact with the study data including me, the research assistant, and my supervisor have signed an Undertaking of Confidentiality per research ethics committee guidelines.

Rigor and Trustworthiness

Qualitative research, in particular phenomenology focuses on the depth of an experience, the objective of which is to gain a more sensitive and truthful understanding of a phenomenon (Thomas and Magilvy, 2011). The very nature of rigor or ‘rigidity’ defies the nature of qualitative methodology, especially the work of van Manen (1990)

who rejected such inflexibility in favour of the dynamic interplay of six research activities. This does not imply that qualitative research is held to a lower standard than quantitative research, only that different strategies may be employed to establish the qualitative equivalent of credibility and validity (Thomas and Magilvy, 2011).

For this study I used Lincoln and Guba's (1985) model of trustworthiness that addresses four components pertinent to qualitative research endeavours. Those components include credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). 'Credibility' is achieved by reviewing all the data for common themes, and confirming the interpretations with participant feedback and peer review (Lincoln & Guba, 1985). This was achieved in consultation with my supervisor, and with participants who completed a second interview. People need to be able to associate with and relate to the experiences interpreted and described in the study, and that arises from the researcher's ability to present truthful and significant meaning (Lincoln and Guba, 1985). Clear inclusion and exclusion criteria were also established for this study and were maintained throughout the recruitment process. 'Transferability' includes providing an in-depth description of the study participants, the study contexts, and the participants' relationship to the phenomenon under study (Lincoln & Guba, 1985). Though careful to maintain privacy and confidentiality, participant inclusion criteria, demographics, and study contexts help determine whether the research findings are useful for practice (Lincoln and Guba, 1985). 'Dependability' is achieved by keeping an audit trail that details all steps of recruitment, data collection, and data analysis (Lincoln and Guba, 1985). Dependability is also established when findings are reviewed and discussed with peers. For this particular study findings were reviewed with study participants for

accuracy, and with my thesis supervisor. 'Confirmability' has been likened to the maintenance of researcher objectivity (Lincoln and Guba, 1985). van Manen (1990) suggests that we are inseparable from the life world but that reflexivity is critical to phenomenological research endeavours. Reflexive thinking does not imply a suspension of preconceived attitudes and beliefs (van Manen, 1990). Instead the researcher acknowledges his or her awareness of the experience and how that knowledge may influence the understanding of the phenomenon (van Manen, 1990). As a researcher I continuously confronted that existing knowledge through reflective thought and writing as it potentially limited achieving a deeper understanding of the phenomenon under study.

Chapter 4

Findings

In this chapter I will present the findings from the research. I identified five themes as I maintained an orientation to my original research question: What is the lived experience of students who encounter inter-colleague violence during clinical placements? Student participants discussed encounters of inter-colleague violence with instructors, staff nurses, and preceptorship nurses. None of the students reported an incident of inter-colleague violence involving another nursing student. Incidents involving clinical instructors dominated seven of the interviews. However many of the students also reported concurrent incidents with staff nurses during the same clinical placement. The first section of this chapter will provide a brief overview of the participants who took part in the research. In the second part of this chapter I will discuss in detail the themes that were identified.

Participants

Recruitment efforts resulted in 8 participants, 6 women and 2 men, representing the undergraduate nursing programs at two sites, and the fast track program at one site. The age of participants ranged between twenties and early thirties. It should be noted that several students expressed some trepidation about revealing their age as it might be an identifying factor. As such participants were reassured exact ages would not be used in

the presentation of findings. Participants also had various educational backgrounds. Approximately half of the participants had acquired undergraduate degrees in other disciplines, and the remaining participants were in the process of attaining their first university degree in nursing. At the time of the interviews all the participants were enrolled as either third or fourth year students in the regular baccalaureate stream, or in the second year of a fast track stream.

Themes

Analysis of the interview transcripts revealed five major themes: a sense of foreboding, playing hide and seek, I had no options, we are all in this together, and letting go, moving on. It should be noted that while distinct themes emerged, they are naturally interwoven with each other. The linking of these themes therefore provides the structure of the experience as lived by each of the students individually, and collectively as a group.

A Sense of Foreboding

The theme *a sense of foreboding* is reflective of the experience of apprehension and fear related to anticipation of interpersonal conflict in the clinical setting. Foreboding was a superfluous apprehension above what the students perceived to be "normal" anxiety associated with clinical placements. As such it contributed to the students' perceptions of interpersonal relationships and their experience of inter-colleague

violence. The experience of foreboding was precipitated by either one of two events. The first and most prevalent occurred *prior* to the start of clinical placement, but was pertinent to the perception and experience of inter-colleague violence *during* the clinical placement. The second event precipitating a sense of foreboding was an actual encounter of inter-colleague violence during the clinical placement. While the onset of foreboding was relative to students' experiences prior to or during the clinical placement, collectively their feelings of apprehension, fear, and dread indicative of foreboding were unanimous.

The experience of foreboding prior to the start of the clinical placement was related to verbal interactions and exchanges with fellow nursing students and sometimes clinical instructors. It was evident that the students talk to each other, they share their experiences including those perceived as good and bad. The sharing of information, and the context in which it is exchanged, is not only an important element of this theme but also to the theme *we are in this together* to be discussed later. In the academic context pertinent student interactions included the collegial exchange of information about particular instructors, staff nurses, or teaching units prior to the start of clinical placements. While such exchanges are likely not an uncommon occurrence in any academic setting, the stories and recollections relayed by other nursing students, and less frequently instructors, to the participants significantly contributed to the experience of foreboding about the clinical placement.

Students recalled hearing "stories," "rumours," and being "warned" about various instructors, nurses, nurse preceptors, and units. Foreboding about the clinical placement was especially heightened when the stories or rumours pertained to a clinical instructor. The exchange of stories with other students included being directly told or having "heard"

that certain instructors and staff nurses were "drill sergeants" or they had a "bad personality," "bad reputation," "made a lot of people cry," and "liked embarrassing students." Students also recalled being informed by instructors of existing conflicts and issues between nurses in a particular clinical area. As noted by one student "the instructor warned us that the nurses didn't get along well themselves on that floor...and said we might have some issues with them."

The anticipation of adversity or conflict with instructors and nurses based on the verbal relay of stories from fellow students negatively influenced their perceptions of the upcoming clinical placement. A notable consequence of that experience was that students reported feeling more nervous than usual prior to the start of the placement. Heightened anxiety created a sense of foreboding about the clinical placement that was specifically related to the anticipation of negative interpersonal interactions and conflict. Some variation in the degree or severity of foreboding was noted amongst the students, but it was particularly evident when the stories related to an instructor. A student spoke of his thoughts prior to starting clinical:

> *...I heard those stories so I guess there was a little bit of uncomfort (sic) there because you were just, you didn't know what she was going to do to you.*

For other students, a sense of foreboding was more immediate and significant. A third year student admitted the stories she heard from other students profoundly influenced her level of anxiety prior to the start of the placement. She stated:

> *I was terrified to go to the clinical just because of stories like that... and then I got put in with this person and everyone was like, oh you're going to hate it. Like it's going to be horrible.*

Likewise another student spoke of the "reputation" of a clinical instructor:

> *I had a clinical instructor last semester who has a really bad reputation and I was really nervous going into that clinical, and she lived up to her reputation. It was really bad.*

Less frequently a sense of foreboding was related to stories and warnings from clinical instructors prior to the start of a clinical placement. Upon hearing about staff conflict on her assigned unit from a clinical instructor prior to the start of a clinical placement one student surmised, "*I guess I was already prepared to be treated like dirt."*

Others admitted that the stories circulating prior to the start of clinical created a feeling of uneasiness, but they expressed a hope that what they heard was exaggerated and would not be their experience. They described attempts to refrain from being unduly influenced by stories prior to the start of clinical placements. For those students, attempts to reserve judgement or remain neutral were short lived. As noted by one student:

> *I had heard some negative thoughts towards her but I said, you know, I will give her the benefit of the doubt and see what happens kind of thing, and right from day one from our orientation, it was kind of, you could tell she was the kind of power stricken instructor and she was just like, very rough with us like, don't do this, don't do that.*

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Likewise, another student recalled her experience on the first clinical day:

> *I had heard rumours that she was really bad but in our meetings with her for our orientation she was really, she seemed really good so I thought that probably isn't true...and it got worse throughout the day.*

Even in situations where an incident of inter-colleague violence took place well into the clinical placement, the stories heard prior to clinical were never far from students' thoughts. One student stated:

> *Like the first little while it was okay like the first couple of weeks of clinical I was thinking oh maybe it's not, maybe she's not as bad as everyone says but then when I got to know her a little bit better it was just as bad as everybody said.*

Once the feelings of angst and foreboding evoked by stories were rooted, the students maintained them throughout the clinical placement. This was largely due to students hearing or observing what they perceived as some element of truth to the stories early in the clinical placement. When students witnessed behaviours or interactions relatable to the stories, their recollection of warnings from other students achieved credibility.

For other students, a real sense of foreboding about the clinical placement did not start until an encounter of inter-colleague violence occurred. The students expressed a sense of fear about having to return to the clinical area following an encounter. They described anxiety, apprehension, and uncertainty about forthcoming interactions and the remainder of the clinical placement. As one student noted:

> *It was horrible. It was nerve wrecking, besides just for your normal pre-clinical jitters there was an extra nervousness knowing that you were going to have to go face her...I remember getting like hardly any sleep the night before and just being so nervous and scared to go in.*

Another student described a feeling of dread returning to the clinical area following an encounter of inter-colleague violence with her instructor:

> *...and to be completely honest with you I dreaded to go that clinical everyday because I never knew how she was going to react to anything.*

There is no doubt that stories, initial encounters, and the consequent foreboding about the placement created anxiety beyond their expectations prior to the start of a new clinical rotation. The feelings of anxiety, apprehension, and anticipation that contributed to a sense of foreboding shaped the experience of the students' encounters of inter-colleague violence during the clinical placement. Differences in both the onset and

severity of feelings associated with a sense of foreboding were related to the students' perceived ability to remain neutral and their perceptions of initial encounters during the clinical placement. However, even when there were expressions to give "the benefit of the doubt," an underlying sense of foreboding was present.

Most of the students reported that feelings related to the experience of foreboding were significantly alleviated only once the clinical was successfully completed. However there was some evidence that feelings associated with a sense of foreboding continued to resonate with students in subsequent clinical placements. As one student recalled:

> *Well those feelings actually carried over to the next clinical too because I had said it to my other colleagues too that she basically put the fear of God in me when I stepped onto a clinical floor because from then on like even though my instructors weren't the same I was still sort of um, intimidated by them even before I met them because of how my experiences had been with this particular instructor.*

Playing Hide and Seek

It goes without saying that most people would not voluntarily seek help from an individual they perceived to be intimidating or mean. One would be less likely to approach that same individual following a hostile or threatening encounter. How does one navigate that situation when the individual is perceived as an "educator," "role model," or most significantly a person of "authority?" Students who encountered inter-colleague violence during clinical placements understood the challenges of that dilemma intimately.

Exploring the Lived Experience

The theme Playing Hide and Seek refers to the students' use of avoidance to minimize personal and professional interactions with instructors and nurses. Students engaged in avoidance behaviours when instructors and staff nurses were perceived as "intimidating" and "unapproachable." However, the use of avoidance was most significant and prevalent following an encounter of inter-colleague violence. Avoidance tactics included "looking busy" and "going in the other direction." It also included efforts to physically isolate themselves from their perpetrators as often as possible.

Avoidance was viewed by the students as a necessary self preservation strategy that decreased the likelihood of further negative interactions and conflict with the perpetrator. The students expressed varying degrees of avoidance ranging from trying not to speak during post-clinical conferences to timing care so that the perpetrator would not be present. Significant levels of avoidance were engaged by some students who purposefully missed clinical days by calling in sick. Fears of confrontation and making mistakes in front of their perpetrators compelled and justified the students' use of avoidance. Students would instead actively seek out individuals they perceived to be less threatening and more supportive. However, the use of avoidance was not without its challenges. Students were torn between avoiding potentially negative encounters and engaging with their perpetrators because they recognized they were also being evaluated.

Students acknowledged that some of their registered nurse peers were "unapproachable." They also expressed feeling negatively challenged by instructors for asking questions or seeking advice. The students frequently spoke of feeling too "intimidated" to ask questions which led to the use avoidance. One student explained why she and her classmates avoided the clinical instructor:

> *...alot of the times myself and the other students would sort of busy ourselves while she was going around and we'd just kind of go to the nurses instead of her to ask questions because if we asked her she'd always come back with sort of like why are you asking me? She didn't take into the account that we were still learning and like we had all tried to come prepared before we came but obviously we were still going to have questions going along, and she didn't really, I guess acknowledge that, yeah.*

The need to avoid instructors and staff heightened following an experience of inter-colleague violence. Students frequently described feeling "humiliated," "embarrassed," "inadequate," "useless," and "stupid" following an encounter. Inter-colleague violence negatively affected the students' perception of the perpetrator, the clinical placement, and most importantly their confidence. Efforts to protect themselves from additional encounters frequently resulted in overt avoidance strategies. For some students there was a sense of necessity, even desperation regarding their avoidance efforts. A student who described being yelled at by an instructor in front of staff nurses explained the lengths she took to avoid any future interactions:

> *I'd do everything in my power to not have to ask her and so I'd try to ask other students, a nurse first or anything possible and then if I had to I'd ask her, but I'd be terrified.*

Probably the most significant use of avoidance utilized by some of the students was missing clinical days by calling in sick. As one student admitted,

> *Yeah, I was just like if it was a different instructor like I don't miss a lot of school but I was just like, I'm not going in today. Like I know that I've been there all semester and I can miss at least two days of clinical so I made sure I missed two days of clinical. I wanted the least amount of time in there with her.*

When students did not believe that missing clinical days was an option, avoidance on the clinical floor was the only option available. However avoidance was not without its

challenges. Avoidance for some of the students reached the point of trying to make themselves invisible which ultimately led to a significant level of disengagement from the clinical learning process. Following an experience of inter-colleague violence with an instructor a student described how she engaged in avoidance tactics both on the floor and in the post-clinical conferences. She explained:

> *I mean you can't call in sick and you can't do anything about it. You just kind of got to go and I used to just basically avoid her the whole day, like I made sure I didn't see her. If I saw her I went in the other direction. Like it was pretty obvious. Like you would have your conferences but you would try not to speak. So it kind of makes learning very difficult.*

Students admitted feeling more nervous and scared following an encounter with inter-colleague violence. One student stated that with increased anxiety comes an increased chance to make a mistake or error, which they feared would further disrupt the clinical experience and increase the likelihood of a poor evaluation or failure. The fear of making mistakes and being uncomfortable around the perpetrator thus justified engaging in avoidance, the student stated:

> *Like I felt uncomfortable and I felt a fair amount of frustration towards her and then I felt like I was walking on pins and needles around her the rest of the day. It made me feel really uncomfortable if she came into the room to check a medication or to see how I was making out and it made me even more nervous which makes me even more prone to make mistakes*

Therefore avoiding the instructor or nurse by carefully timing care and whereabouts was often seen as the only tactic available. Even when students thought it was an element of care or procedure the instructor would want to witness they looked elsewhere. The intentional use of avoidance meant seeking out someone perceived as less threatening. For students who encountered inter-colleague violence with their instructors, the safer

individual was most often a staff nurse on the unit. Timing care so that "helpful" staff could assist or observe was perceived by students as a necessary element of avoidance in the clinical area. One student explained:

> *Yeah, like to the point where like if I had something big to do and I knew that she would probably want to be there while I was doing it it, and even though I know I could do it I would wait until she went on break and then I would do it with a co-signed nurse because then when she'd come back I'd be like, oh I did that vac dressing with my co-signed nurse. She was like, oh, okay, that's fine. Just because I didn't want her there.*

The use of avoidance presented challenges for students who wanted nurses in evaluator roles to know that they were engaged in the clinical learning experience. They wanted to approach those nurses and ask questions but were more compelled to ask another individual when possible. As one student related:

> *I felt like I could approach her but only because like I had to because if there was a question I had to ask, I almost had to ask her just to let her know that I was interested and that I wanted to learn but I do admit that if there was somebody else around I would ask them before her. Like if she were around I would probably try to find somebody else...*

The students also recognized the cost of inter-colleague violence, and consequently of avoidance on their clinical experience, and they lamented about potentially missed learning opportunities because of their need to avoid certain nurses. This was especially evident when the perpetrator was an instructor. One student reflected:

> *...I like tried really hard to find things I hadn't done before but like I couldn't, I don't know, I could have taken a lot more from it if I had a different instructor. Like if I had an instructor who, like the nurses are so busy and that's who I was relying on to like show me the unit because I didn't want to go to her, but if I had a different instructor there I probably would have been able to go talk to her or she could have grabbed me to*

> *go look at something or learn something when really I was trying to avoid her, trying to get in with the co-signed nurses in between patients, and I think if it was a different person there I would have been able to take a lot more from the floor.*

The intentional and carefully timed use of avoidance, while not always the easiest option, was the most readily available and obvious option. Students recognized that avoidance tactics often made learning in the clinical environment more challenging, but adapted it to their needs in an effort to complete the placement without any further encounters.

I Had No Options

The students' experience of inter-colleague violence included the belief that they had "no options whatsoever" to either act on, confront, or report encounters of inter-colleague violence. The belief that they had no options refers to the students' perception of powerlessness in the clinical area. The students believed they lacked power individually and collectively as a group. Students understood that what was happening to them in the clinical placement was wrong but associated their endurance of it with the belief there was no course of action available to them. They believed themselves powerless to do anything thing except try to complete the clinical rotation and move on.

The experience of powerlessness was accompanied strongly by feelings of frustration, fear, and anger. The students expressed concern that confronting and reporting would "make the situation worse" for themselves and/or their peers. They perceived an ever present fear that reporting would further strain their academic or working relationship with the perpetrator(s) or worse, negatively affect their clinical

evaluations. The students did not feel confident in the options they believed were available to them. They believed that the process of confronting their perpetrators would create more work for them during an already stressful and challenging clinical placement, which further exacerbated their sense of powerlessness. Additionally, the sentiment that "nothing is going to happen" was often expressed by students who considered their reporting options. They also expressed frustration and anger about the treatment of students by nurses who were supposed to facilitate and support them in the clinical area. Feelings of powerlessness also lingered after the clinical placement was complete.

The students' perceived sense of powerlessness resulted in feelings of frustration that were strongly evident throughout the interview process. One female student reflected on her experience with staff nurses during a clinical placement:

> *I was really frustrated and then I felt like you can't really go to them and say anything because then it was the beginning of the clinical so then it makes your whole clinical experience bad because of course they're right and you're wrong. So then you can't really go to anybody else and there's nothing you can really do. You just kind of like got to take it.*

The belief of "having to take it" was an integral component of students' powerlessness, and was largely the result of how students perceived themselves and their perpetrators in the clinical area. Students admitted that they were "scared," "didn't have a lot of confidence," and were "intimidated" by instructors and staff nurses. Additionally several of the students asserted their knowledge that those individuals "had the power" or "authority" over students. More descriptively one student described her instructor as being "power stricken." Powerlessness was amplified when students perceived that

instructors and nurses preyed on students' fear and lack of confidence. A student observed "I was really scared of her and I was really nervous, and I think she knew that."

Students' expressed their awareness of the status gap that existed between themselves, instructors and staff nurses, and often expressed their beliefs that such power was knowingly wielded to the detriment of students. For example, when one student reported that he questioned an instructor about the seriousness of a threatening comment she made regarding discipline, the student stated she replied "yes, I can do what I want." Such experiences resulted in students' manifest feelings of powerlessness in the clinical area. Accordingly their response, or lack thereof to situations they perceived as hostile was most often inaction, compliance, and silence. One student observed that agreement was her safest option when interacting with staff nurses during the clinical placement. She stated:

> *...like it just makes you feel kind of (sigh) like you can't do anything, you're basically like you don't have any opinions. You just suck up basically the whole time. You're just kind of, oh yes, like this is exactly how I feel. Yes, that question was stupid. Because you need to, like that's the only way you're going to pass, you just don't have any opinions because if you voice your opinion it's going to be like, your clinical experience is going to be hell which like it does because we've seen it. So you just kind of got to suck it up which kind of makes you bitter...*

Students were disinclined to report nurses to instructors, instructors to school administrators, and preceptors to instructors. Even when students confided in other instructors outside the clinical area and were encouraged by those instructors to report the incidents they chose to remain silent. One student reported that students were discouraged from reporting incidents involving staff to anyone but the instructor because "that ended up reflecting poorly on us...and how we were treated then for the rest of the

clinical experience." An ever present fear of making the clinical more difficult, receiving a poor evaluation, or worse, failing the clinical placement was verbalized by all the students who considered taking action against their perpetrators. In this sense, the students perceived instructors power over them most acutely, and frequently verbalized their fears that instructors could fail them almost at leisure. One student noted:

> *But everyone was sort of like we don't know what to do because there's the thing where she's the one who's marking us so if we have this meeting with her and tell her all these problems and stuff she could fail us all. So I mean that's the fear that profs like her put in everybody.*

Another student expressed her reluctance to report her instructor either during or after the clinical placement, despite repeated verbal affronts during the clinical that left the student feeling "incompetent" and "stupid." She stated:

> *While you're in clinical with the instructor you don't want to do anything about it because then you don't want to get bad evaluation like you don't want it to affect your evaluation because she can fail you or pass you and she has that power.*

Students perceived that reporting the incidents would not only compromise their clinical evaluation, but make the remainder of the clinical unbearable. Worse still was the belief that reporting the encounter would create more work and stress for the student. Several of the students expressed the sentiment that reporting incidents would actually make their own lives and the clinical placement more difficult. The fears associated with reporting the encounters served as a deterrent for students, silencing any pursuit of action, and perpetuating the students' sense of powerlessness. Explaining an experience of inter-colleague violence with a clinical preceptor and consequent ambivalence about reporting one student explained:

> *So you already got a rocky relationship with you preceptor.... So at*

> *the end of the day when the instructor goes back home, what do you think the rest of the clinical is going to be like if the preceptor knew that you went and said something to the instructor, that they knew that they were not an adequate preceptor, that you were having troubles communicating and things like that? So at the end of the day you're almost making it worse for yourself I think because the preceptor knows that you said something. The instructor will probably be breathing down your back all the time. I probably would have to write 16 self-appraisals then. Do you know what I mean? It just makes it harder for yourself.*

The students believed there were no options available to students, or did not see their options as practical. Even when they contemplated pursuing action against their perpetrators a sense of powerlessness was evident, expressed as premature defeat about the reporting process. One student lamented:

> *...it never turns out in the student's favour, it's just this is your professor, this is your instructor, they are higher than you and they're right. Like that's not my thinking. I don't think that at all. But I think that that's the way that they think and that's the way people like higher up in the school think as well. Like if we were to go somewhere about a professor I really believe that nothing would be done...*

Students also expressed that reporting incidents as a group was discussed but never pursued. Most often the reason was that collectively the group did not believe that anything would be done. One student reflected:

> *So we talked a lot about that like trying to talk to somebody about it and like to just tell someone but we were all kind of, we just felt it's not our place to do it because we're not going to get anywhere with it and it will only be bad for us.*

Another student stated:

> *But then other people started being like oh, we should all report it and then they were kind of like oh well, nothing is going to happen so we never. But I never really thought of any other options.*

In addition to concerns about making the situation worse, reporting the incident was viewed as time consuming and potentially problematic by students who wanted to pursue specific clinical placements and positions in the future. The idea of reporting was especially challenging when students received positive evaluations from the same individual(s) who perpetrated the violent incidents. A student who contemplated reporting the experience at the end of the clinical placement noted:

> *You know, I'm busy with my program. I don't really have time for a lot of like sit down meetings, interviews, writing letters, like I really don't have time for that type of stuff. And so is it worth it, I guess is the biggest thing. But I think I've pretty much decided that I'm just going to let it go because the evaluation that I had from her was so good and I don't want to compromise having a good reference if I want it...*

The experience of powerlessness in the clinical area left students feeling frustrated and fearful. However there was also evidence that students harboured malingering feelings of anger, and to a lesser extent a sense of betrayal. They described feeling "bitter" about the clinical experience. They resented the idea that they were treated poorly because they were students. Anger was also associated with the students' perceived inability to defend themselves in the clinical area. Those feelings of anger were especially pervasive when the students observed that perpetrators were key individuals responsible for facilitating learning experiences. One student stated:

> *...it made me feel angry because a part of me wanted to say something to them and just be like, you know what, I'm new here, this is my first, second, third day, you're the one who is suppose to be like guiding me and teaching me stuff and not make me feel that like I can't ask you a question or you're going to bite my head off type of thing...you were in my position before too. Like you know, how did you feel if a nurse treated you like this?*

Even as students reflected on their experiences in hindsight there were still clear indications that feelings of powerlessness lingered. One student lamented that they would have liked the opportunity to address it but continued to consider the potential consequences. In this sense students considered the consequences of pursuing action against obtaining a desired clinical placement or professional reference for employment. The student stated:

> *Um, I would have liked to have addressed it with her but even now I'm not sure I would have felt comfortable doing it. If I had gone back the outcome probably would have been the same, I wouldn't have. But I would have liked to have felt that I could have went to her without her getting defensive and without her like causing hard feelings and have the discussion you know.*

Another student also reflected on whether or not she would have reported given the opportunity again. She stated:

> *I don't think I would have because I think now I'd still be afraid...So I don't know. Now I think I'd just try to suck it up and get through it, again.*

We are All in This Together

Communication between students was discussed as a major element of the first theme, *a sense of foreboding*. That theme explored the exchange of information that occurred between students prior to the start of clinical placement, and the foreboding participants experienced because of that information. Conversely the fourth theme that emerged, *we are all in this together*, refers to the students' experience of peer or classmate support as a coping behaviour following an incident of inter-colleague

violence. Students perceived themselves as powerless in the clinical area, and as having no options following incidents of inter-colleague violence. However there was one source of support they could rely on during the clinical experience and that was each other. The reciprocal process of receiving and providing peer support in the form of verbal reassurance occurred between students both inside and outside the clinical placement area. Peer support that was encouraging, honest, genuine, and empathetic was valued by the students.

Following an encounter with inter-colleague violence the students turned to their peers for validation and emotional support. They expressed the importance of having that peer support in the clinical area, especially following encounters with inter-colleague violence. The students valued such support because they trusted their peers would maintain their confidentiality, and be honest with them about their encounters. Being honest meant that the students felt the support they were receiving was genuine and understanding. The verbal support and affirmation provided by fellow clinical classmates consequently made the participants' experiences more endurable. The process of sharing and supporting encouraged a sense of connection between the students, especially when it was understood that the entire group was having similar experiences. Sharing relatable experiences was also an element of peer support that helped the students to depersonalize their experiences. One female student who recalled being publicly belittled by her instructor and the staff stated it was important that her clinical peers supported her and provided reassurance that she did nothing wrong.

> *... it's good when you talk to other students because you know that they've been through it and especially like the students who saw when that happened to me. They were like don't worry, it wasn't*

> *stupid, she's just, I don't know why she did that to you and it kind of helps you deal with it a bit more.*

The students suggested their experiences would have been worse had they felt singled out "if it was just me getting bullied then it would have been a lot worse." As a result when participants found out fellow students also experienced inter-colleague violence it created a sense of solidarity amongst members of the clinical group.

Several students explained that because of the small class size and length of time in the program classmates "get to know each other very well, very quickly." Therefore students availed of opportunities to talk about their experiences both inside and outside of the clinical area. Communication between students involved venting and "bitching," but was also mutually supportive. Students were comforted when classmates agreed that what happened to them in the clinical area was "not right," and when they reciprocated with their own experiences. Those exchanges provided an opportunity for students to debrief, and also helped students to depersonalize their experiences of inter-colleague violence. Students were then able to more objectively reflect on their encounter, and more importantly reframe the experience. Students then expressed they were able to rationalize their experiences as a consequence of the perpetrators character, for example "*we* accepted that it's her personality." Depersonalizing the experience also helped students recover confidence in the clinical area. One student stated:

> *It was good that, like I said, that it just wasn't me. Like it was good that I had the other five and six people in the group that I could talk to, to be like, because if it was just me, I think probably, my confidence would have gone down a lot but how she was treating all these other people the same way then we could kind of talk to each other about it and that made me feel better....I think the main thing was having other people in the clinical group who were going through the same things.*

Exploring the Lived Experience

Being able to "relate" to each other was a powerful element of we are all in it together. It was helpful for students to feel like they were not alone, and their relatable experiences contributed to a sense of camaraderie that helped them cope and continue with the clinical placement. The sense of being in it together was especially evident in the students' frequent us of the terms "we" and "us." As one student stated:

> *It was very helpful just talking about it because then we can relate to each other that it's not just me that she's yelling at and being mean to, you know. And then we just come to the conclusion that it's just the way she is and you know we just got to get through it...*

Another student reflected that being able to "deal with it" correlated with the ability of the individuals in the group to relate stories. Students shared their mutual experiences to rally and encourage each other, offering supportive statements like "we can deal with it for another six days." The difficulty students experienced following their encounters was seemingly lessened when they perceived themselves to be part of a peer group who shared similar experiences. Interestingly not one of the participants switched out of their clinical groups following an incident or in some cases several incidents of inter-colleague violence. While that decision was likely also related to the students' perceived sense of powerlessness during the clinical, there was evidence that students felt obliged to continue with the group once they established they were not alone. One student commented:

> *Yeah if she was having this kind of attitude towards only me I would have definitely asked to go somewhere else, but where it was everybody we kind of just felt like it was just this instructor. Everybody else can handle it then I should too.*

Students also understood that being in it together also meant working together. This concept was more evident in some interviews, especially where students were part of

a clinical group. The concept of working together included helping each other with patient care, being vigilant about perpetrator whereabouts, and helping each other with questions about skills and medications. The students reflected on experiences where they were helped by classmates. One student recalled:

> *So like one time one of my friends came to me and she said, oh she asked me this today and I was like okay, good. So then when she came and asked me about it I was ready for it. So that was helpful*.

Another student spoke about a group attempt to help another student:

> *She got really mad because she didn't know the answer so then the rest of us were flipping through the drug book as fast as we could to find the answer for her so that she could get it. So we worked together like that when we saw someone else being bullied, we'd try to do whatever we could to get things so that we could help them out you know.*

Students also spoke with other individuals outside the clinical area. Most often that included parents, partners, and sometimes friends. Some of the students confided in nursing instructors outside the clinical area. Students expressed that talking about their experiences to others did help, but they perceived the greatest level of verbal and emotional support from their peers. "Talking" to friends, "complaining" to parents, and "venting" to partners outside of nursing was helpful but did not compare to the validation they received from their nursing peers. Students understood that it was more difficult to relate their experiences to individuals outside of nursing. Reflecting on support from his parents, one student summed it up this way:

> *So for them to really know what I'm experiencing, they don't. I mean they get it but they don't at the same time.*

Another student admitted that talking it out with parents was helpful but it did not lessen the difficulty she experienced during the clinical placement. She stated:

> *I told my parents about it a lot....I mean I guess it helped a little bit. I mean if you're stressed out about something, it always helps for me to just kind of talk it out but I mean it never really, when I would go to clinical it never really made it better like the fact that I talk to my Mom the night before...*

Letting Go, Moving On

The feelings of anger and frustration students experienced following an encounter of inter-colleague violence continued throughout the remainder of the clinical placement. Students often indicated that the clinical placement or semester could not be over soon enough. There was also evidence to suggest those feelings malingered once the placement was over. However the students associated the end of the clinical placement as an opportunity to try to put their encounters behind them. They acknowledged that dwelling on the encounters was not beneficial to their confidence and progression in the program. *Letting go, moving on* reflects the students' understanding that bad experiences must be left behind as students progress forward in the nursing program.

A central element to letting the experience go and moving on was the students' perception of their perpetrators and their clinical contexts. Students attributed their encounters of inter-colleague violence to the character or "personality" of their perpetrators, and to the context of the actual unit. The students understood they had a short amount of time in the clinical area and focused on getting it done, and getting "it over with." Other students were confidently able to move on because they knew they would not have to return to the same clinical placement area.

Exploring the Lived Experience

Accepting that encounters of inter-colleague violence were more the result of the perpetrators "personality" or "style" was one way students rationalized and minimized their experiences. Students conveyed they had no control over perpetrators personalities or clinical contexts. Reflecting on their experiences from that perspective did not make violent encounters acceptable to the students, rather they understood the hostile behaviours of nurses and instructors was less likely the result of students' behaviour. When students came to an understanding or realization that "it's not me that's really the problem," they were more effectively able to let go of the experience and move on. As one student noted:

> *It's just better now that I've sort of come to the realization that not all of them (nurses) are going to be very nice and it's just like I guess I'm there for myself now to get the best learning experience that I can get...*

Another student observed:

> *These are just mean nurses who obviously don't like their jobs. Or it's just something going on at home or whatever...*

Other students attempted to view the situation from a broader perspective. One student reflected:

> *Well it's just kind of like what you do in life in general I guess when you meet people like that. You can't always have good instructors I guess. Most times, we're lucky to be here and most instructors are wonderful and great but I mean when you get one who's a little more intimidating and not as friendly you just learn to deal with it, I guess. Just accept that some people have their own style, and that's just her style.*

The students' perception that "not all of them are going to be very nice" or "good" was an important factor in letting go of the experience. They frequently talked about their negative experiences with nurses and instructors as the exception rather than a norm in their nursing program. They also acknowledged their understanding that experiences of

inter-colleague violence were not reflective of all the nurses or the units they were assigned to. One student stated:

> *It gave me a bad outlook on that floor that I was on, even though the nurses were amazing my experience in that area to me, I mean right now I wouldn't want to go back and work there but I have to tell myself it's just because I had a bad instructor not because the area was bad.*

There was also evidence that students remained hopeful as they moved onto the next clinical placement that their experiences would be better. Maintaining a sense of hope was an important element of letting go and moving on. That hope was often related to positive past clinical experiences, and the positive experiences shared by classmates in other clinical groups. As one student noted:

> *I knew that all instructors weren't like her because I knew from speaking to, hearing other students talking about their clinical that there were amazing instructors. So I always said if I had her again I don't know if I would have continued on with nursing school but because I knew there were amazing instructors out there I knew I just had to get through that clinical.*

Letting go and moving on did not imply that the students would forget about their experiences. They expressed that their encounters continued to bother them, but that dwelling on the experience was not beneficial as they moved forward to new clinical placements. They understood it was important to not allow past experiences to influence future clinical experiences. One student observed:

> *Because it's a new area. It's a new instructor. And I try to take, like every time I meet a new instructor or have a new instructor I try to take them for face value and not let past experiences influence my opinions towards them. Because if you continue to let it bother you everyday then you're going to drive yourself crazy. But I certainly still think about it. And I still think about future students who have to deal with the same instructor...*

Exploring the Lived Experience

When students experienced "good" clinical placements following incidents of inter-colleague violence they also expressed feeling a sense of recovery from their experiences. Good clinical placements were described by the students as having instructors and staff that were "supportive," "helpful," and eager to "teach" the students. One student who spoke of feeling "belittled" and "ignored" throughout her previous clinical placement described how her new instructor and clinical placement "redeemed" her previous experience. That recovery was especially important for the students who considered leaving the program after their experience of inter-colleague violence.

Chapter 5

Discussion

The findings of my study provide a rich and detailed description of 8 students' experiences of inter-colleague violence during clinical placements. Though each experience was unique, commonalities emerged between the students' stories. The experiences revealed that the students encountered a variety of negative interactions with registered nurses in various roles. Interactions consistent with inter-colleague violence profoundly shaped the students' clinical placement experience. The encounters not only influenced their clinical learning and engagement but affected the students on a personal level. Their stories exposed the complexity of the inter-colleague violence, and suggest that the challenges inherent of the phenomenon extend beyond the immediate clinical practice area.

The main purpose of this chapter is to discuss the findings of this study as they relate to, and extend existing literature on students' experiences of inter-colleague-violence. For this reason each theme will be discussed in detail. An additional purpose is to discuss the themes as they relate to each other. The connectedness of the themes creates the fundamental essence of the students' lived experience in such a way that to minimize or eliminate one theme or another would alter the understanding of the experience. While similarities were noted with other research on the subject, this thesis offers some new perspectives that have not been extensively explored in existing

literature. The addition of such knowledge contributes to a greater understanding of the students' experience, and indicates potential areas for further inquiry.

A strength of this study is that eight participants revealed experiences spanning three programs at two different sites, indicating that experiences of inter-colleague violence were not exclusive to any one particular program or site. As well, this study contributes relevant knowledge to a subject that has, compared to the international literature, not been examined as extensively in Canada.

A Sense of Foreboding

A sense of foreboding is an interesting theme because it reflects the influence that stories, rumors, and first impressions can have on the students' perceptions of interpersonal relationships, and their understanding of inter-colleague violence in the clinical area. It also demonstrates the students' subjective preference to accept such information as trustworthy and credible, which was demonstrated on a continuum of pre-clinical foreboding that ranged from mild "discomfort" to being "terrified." That the students attributed some element of truthfulness to the stories and warnings may be indicative of the close knit ties and sense of comradery also conveyed by students in the theme *we are all in this together.* Even when students tried to remain objective, as in giving "the benefit of the doubt," the stories and warnings from peers maintained a subtle presence. There was no evidence to support that peer exchanges prior to the start of clinical placements were perceived as malicious in nature. Instead there was a sense that information was merely passed along from one student to another as a type of obligatory

warning. That notion also applies to students who experienced warnings from clinical instructors about the prevailing negative atmosphere in certain clinical areas.

The acquisition of that knowledge precipitated a sense of foreboding and effectively prevented students from entering a new clinical experience free of preconceptions and uncertainty. Once the information was acquired it was apparent they were unable to forget it entirely. Even when encounters of inter-colleague violence occurred well into the placement students reflected on their recollections of stories and first impressions prior to the start of clinical. An interesting consequence of that knowledge and sense of anticipation was that the students appeared to become hyper vigilant. Specifically, they were acutely observant for behaviours and/or cues that would give the warnings credibility and thus legitimize their anticipation and concerns. The students also described vigilant behaviours like trying to prepare for clinical more than usual, decreased sleep, and trying to be aware of the perpetrators whereabouts at all times.

This theme is particularly interesting because I was unable to find anything in the literature related to student foreboding associated with peer interactions prior to the start of clinical placements. Specifically how those interactions influence students' anticipation of interpersonal conflict, their behaviours, and perceptions of inter-colleague violence. Stress related to feelings of anticipation prior to the start of clinical practice was observed in the literature but was related to concerns about being prepared and to poor sleep (Chernomas & Shapiro, 2013). Nervousness prior to clinical placement related to the anticipation of more independent practice was also observed in a study by Morrell and Ridgway (2014).

One piece of literature related to word-of-mouth communications and registered nurses was found. Wolfe (2014) suggested word-of-mouth communication about clinical work experiences amongst nephrology nurses should be considered as a contributing factor to the nursing shortage in that area. Specifically, in those circumstances where word-of-mouth communication is used to relate unsatisfactory or poor working experiences and practice environments on nephrology units. He further suggests that word-of-mouth communication is a powerful information tool that can profoundly influence the actions and attitudes of individuals (Wolfe, 2014).

It was apparent that word-of-mouth stories and warnings did influence the behaviours and attitudes of the students in this study. It is also likely that those verbal interactions are commonplace in programs where a limited number of students work together in close proximity for several years. Given the abundance of literature on the importance and benefits of peer interaction and support in nursing education, the absence of research examining the potentially negative side of student communications and interactions is interesting. It is difficult to know to what degree the acquisition of such knowledge influenced the students' perceptions of inter-colleague violence, particularly the severity of the encounter. I believe the findings provided here and the apparent lack of research on the verbal exchange of negative experiences implies a need for further inquiry.

Playing Hide and Seek

The purposeful use of avoidance in the clinical area was a behaviour utilized by students following an encounter of inter-colleague violence. It was a deliberate behaviour that required a level of strategy and timing on the students' part. Successful use of avoidance ensured that students minimized interactions with individuals perceived as threatening, intimidating, and unapproachable. It is apparent the use of avoidance is significantly intertwined with the theme *I had no options*, indicative of the students' sense of powerlessness in the clinical area. They also perceived a lack of control over the actions of perpetrators and clinical contexts. I believe the students' sense of powerlessness and control precipitated their use of avoidance in the clinical area. It was a passive yet tactical self preservation strategy employed to minimize interactions and distress.

The students described feelings indicative of emotional and psychological distress. Those feelings included fear, anger, frustration, and embarrassment. The use of avoidance by nursing students as an emotionally based and negative coping mechanism verses more problem based coping strategies has also been discussed by Chan, So, and Fong (2009), and Gibbons, Dempster, and Moutray (2011). Additionally, it has been suggested that behaviours such as avoidance are more likely used in the face of situations or stressors perceived to be uncontrollable, thus amending emotions rather than stressors (Wang & Chang Yeh, 2005). Given their perception of having no options and control during clinical encounters, avoidance provided students with what they perceived as an avenue to minimize further emotional or psychological distress.

The students were aware that engaging in avoidance was not without concern. Specifically, the use of avoidance was more difficult for the students when the perpetrator was also an evaluator. Availing of learning opportunities, practicing skills, and providing necessary care in the absence of the perpetrator/evaluator required some strategic planning on the students' part. It required that students find a way to complete the care and skills expected of them, but with someone who they perceived as helpful and supportive. Though avoidance reduced interactions with the perpetrator, the strategies and planning required to avoid were challenging and time consuming. Engaging in avoidance therefore created an additional stressor for the students as they manipulated their day to minimize interactions with specific individuals. Gibbons (2010) and Gibbons et al. (2011) also found that even the occasional use of avoidance coping was a strong predictor of unfavourable health and well-being amongst nursing students during their nursing education.

The use of avoidance is not specific to students in the clinical area. It is also suggested that registered nurses purposefully engage in avoidance and withdrawal tactics when faced with conflict and other morally distressing issues (Bartholomew, 2006; Begley & Glacken, 2004). Avoidance was also found to be a conflict resolution strategy between nurses in both the academic and clinical settings (Losa Iglesias & Becerro De Bengoa Vallejo, 2012). Taylor (2013) found that nurses physically removed themselves from the presence of other nurses who were perceived as abusers, and identified themselves as "conflict-avoidant" (pg. 74). Like their registered nurse peers, students in this study also utilized similar behaviours to protect themselves. Nursing students' use of avoidance in the clinical area, when the stressor was correlated to interpersonal

relationships and conflict has been discussed in other studies (Chan, So, & Fong, 2009; Mahat, 1998; Pines et al., 2012). Other researchers have found adverse but significant correlations between students' use of avoidance coping in nursing education and lower satisfaction, well-being (Gibbons, Dempster, & Moutray, 2011), feelings of alienation, and potential burn-out (Gibbons, 2010).

The students I interviewed described feeling humiliated, embarrassed, and useless following their encounters with inter-colleague violence. Those feelings thus perpetuated the students' use of avoidance following an incident of inter-colleague violence. Bond (2009) suggests that such feelings are highly associated with the perception of shame. In the context of the clinical education area it is suggested that feelings of shame may not only cause students to withdraw and avoid instructors and peers, but may also interfere with the professional socialization process and clinical learning (Bond, 2009). Therefore it is plausible that the students felt compelled to avoid or even hide in an effort to conceal those feelings from their instructors and peers.

I Had No Options

I had no options is reflective of the students' perceived sense of powerlessness in the clinical area. It is also worthy to note that this theme was the most obvious and pervasive throughout the interviews. While I have done my best to capture the experience of students' sense of powerlessness as verbalized during interviews, it is challenging to convey and appreciate the students' sense of frustration and anger evidenced in their non verbal communication during our interactions. The most

significant manifestation of their perceived sense of powerlessness was their inability to report the incidents, or confront their perpetrators. The students did not feel they were in a position to effectively and safely negotiate their situations in the clinical area or at the administrative level. Even though students recognized the behaviours as inappropriate they felt compelled to acquiesce. It suggests that the students experienced a significant degree of compliance, and a sense of defeat regarding their reporting options. Those feelings were especially evident where encounters occurred between students and nurses in evaluator roles. With the exception of seeking and receiving support from other students, they purposefully and systematically chose to remain silent about their experiences.

Powerlessness is a persistent theme in much of the research conducted on violence and nursing students. Similar to the findings of this study other researchers have identified that nursing students are aware of their own sense of powerlessness, and that it is a significant barrier to reporting and confronting negative behaviours in learning environments (Clark, 2008; Curtis et al., 2006; Ferns & Merrabeau, 2009; Hinchberger, 2009; Magnavita & Heponiemi, 2011; Randle, 2003; Stevenson et al., 2006; Thomas & Burk, 2009). The students in this study felt powerless to report the behaviours without fear of negative repercussions. Also present was a daunting sense of uncertainty about the reporting process. They perceived low organizational support from both academic administration and from within the clinical context itself. This is further supported by the fact that not one of the participants formally reported their encounters with inter-colleague violence.

It was apparent that the students' sense of powerlessness was most acutely felt when violent encounters involved nurses in evaluator roles verses staff nurses on the units. There was a sense that the students felt particularly victimized when encounters involved clinical instructors. In this study, all of the students reported at least one incident with a nursing instructor or nurse preceptor. In a study by Clarke, Kane, Rajachich, and Lafreniere (2012) students identified clinical faculty as the greatest perpetrators of bullying behaviours that included criticizing, intimidation, and threatening behaviours. Likewise, Unal et al. (2012) found that students were most often exposed to verbal violence from teachers in the clinical area. Additionally, fears of failing or receiving a poor evaluation was a significant factor contributing to the students' silence and inaction following a violent encounter with clinical evaluators. Support of those findings was found in other studies by Celik and Bayraktar (2004) and Stevenson et al. (2006). That understanding was compounded by the students' perception that nurses in evaluator roles could unduly fail them without consequence. An ever present fear of poor evaluation resulted in a consensus amongst the students of "having to take it." Clarke (2008) similarly found that students who encountered incivility perpetrated by nursing faculty were challenged by the prospect of confronting untoward behaviours, and instead felt compelled to "play the game" (p. 287).

The students in this study also expressed a fear of creating additional tension between themselves and their perpetrators should they report incidents of inter-colleague violence. They also perceived the work associated with reporting incidents as taxing and time consuming. They conveyed a sense of importance and urgency to just get through the clinical placement and move on with the program. The students' sense of

powerlessness compelled them to minimize interpersonal contact with their perpetrator(s) through the use of avoidance. Avoidance was perceived by the students as a way to safely reach the end of the placement. Retreat and silence in the face of conflict during clinical training and preceptorship to "survive the experience" (p.12) has also been discussed by Myrick et al. (2006).

Clinical faculty and preceptors were perceived by the students as individuals responsible for facilitating positive learning experiences. As such they were seen as having the most significant influence in the clinical environment and on the clinical learning process. The value of positive clinical relationships and support on student learning has been previously discussed in the literature (Atack et al., 2000; Dunn & Hansford, 1997; Levett-Jones et al., 2007). The students expressed how they expected faculty to be both supportive, and even protective of students in the clinical area. It was apparent that the students understood the negative behaviour and communication of faculty was not only inappropriate and stressful, but also unprofessional, uncaring, and unsupportive. It dampened their confidence and they conveyed feeling useless and inadequate, and ultimately disempowered. Lasiter et al. (2012) reported similar findings in a study of students' experiences with faculty incivility. As such the students also experienced a greater sense of injustice, and that seemed to amplify the feelings of anger and frustration associated with their perceived powerlessness. They professed a strong desire for the clinical placement to end, and a discontent with the clinical learning experience because of those encounters. Similar findings were discussed by Marchiondo et al. (2010) who reported a significant relationship between students' perceptions of faculty incivility and lower levels of satisfaction in the nursing program.

We Are All in This Together

Students who experienced inter-colleague violence during clinical placements felt powerless and expressed having no options. As a result they frequently relied on avoidance tactics in the clinical area to minimize interactions with perpetrators. Students did however employ peer support as a coping behaviour following their encounters. None of the students reported an incident of inter-colleague violence from a fellow classmate. Peer support was perceived as cathartic. A reciprocal process of verbal and emotional support and reassurance was often perceived as the only positive coping behaviour.

Students felt the most comfortable speaking to their peers following their encounters because they felt they could strongly relate to each other. Peer interaction as a supportive coping behaviour was also found in studies by Gibbons et al. (2011), Jackson et al. (2011), and Shipton (2002). The nature of the nursing program, the small clinical education groups, and frequent contact with each other contributed to a strong sense of comradery and togetherness. It was apparent the support the students received from other students in their clinical groups was important. Levett-Jones et al. (2007) also suggest that being part of a group is important as it contributes to a sense of belonging and connectedness. Additionally peer relationships and support have been identified by students as fundamental to the construction of professional identity (Walker et al., 2014).

The students in this study admitting talking to family and friends outside of nursing, but greater satisfaction came from the verbal support of other students who were having or observing similar experiences. The ability of the students to relate on a similar

and familiar level allowed them to more freely vent their frustration, and solicit and give support. Additionally when the students were able to hear about the experiences of other students they were able to depersonalize their own experiences. They were able to view the encounters in a different context, specifically one in which they were not alone or singled out. Depersonalizing the experience was also important to the students as they confessed their self-esteem and clinical confidence was negatively affecting following an encounter of inter-colleague violence. While there was limited discussion of students' abilities to depersonalize violence in the literature, Griffin (2004) noted that new graduates were better able to depersonalize negative behaviours once they understood the origins and constructs of lateral violence.

Studies on nursing students' responses to various stressors in the clinical area have demonstrated some variability in their coping methods (Chan, So, & Fong, 2009; Gibbons et al., 2011; Mahat, 1998). However for the students in this study, verbal peer support was the most frequent coping behaviour. Hakojarvi, Salminen, and Suhonen (2014) also noted the most frequent student interactions following a bullying incident were with peers. Talking to classmates was also frequently employed by students who experienced faculty incivility in a study by Marchiondo et al. (2010). The students also lent support to each other when they helped each other out with care and assisted fellow students who were being questioned by instructors. The students also supported each other by sharing information about what might be asked of them in the clinical area. Additionally when the students recognized that they were all experiencing similar encounters, they worked together and supported each other. Jackson et al. (2011) described such "joint advocacy" (p.106) as a form of resistance against oppression in the clinical area. Certainly for the

students in this study such acts were often perceived as one of the few positive ways they had to cope, and assist each other following encounters with perpetrators.

There is a significant body of work to support the benefits of facilitated peer support and mentoring amongst nursing students in the literature. However literature specific to peer interactions as a coping behaviour following an encounter of inter-colleague violence was not abundant. This was also noted by Hakojarvi et al. (2014) who suggest a knowledge gap regarding how students cope with bullying during clinical practice. A dearth of information in this particular area was surprising given the frequent use of supportive peer interactions in this study as a coping behaviour. Therefore, this study makes an important contribution to the literature by identifying the theme *We are all in this Together* as a coping style for inter-colleague violence during clinical placements.

Letting Go, Moving On

The experience of letting go and moving on from clinical experiences of inter-colleague violence was perceived as important by the students. They felt it was important to their confidence and progression in the nursing program to leave bad experiences behind to focus on future experiences once the clinical placement was over. Some of the students reflected on positive past experiences, and all of the students expressed hope that the next clinical experience would be better. While there was evidence that their encounters with inter-colleague violence would not be forgotten, they were eager to put the experiences behind them and move onward.

Exploring the Lived Experience

As previously discussed, the students felt powerless to confront and report incidents of inter-colleague violence. Following an encounter of inter-colleague violence they compensated by focusing on getting it done and "over with." They recognized that their time in the clinical placement was limited and focused on the idea that they would not likely be returning to the same clinical area or have the same clinical instructor or nurses in the future. In this sense the students understood that their time in a particular placement was fixed. There was a perception that if they could just make it through that particular clinical placement their experiences would improve. Rationalizing the experience in such a manner helped facilitate a perception of letting go and moving on.

The behaviours, attitudes and personalities of nurses and instructors have been described by students as stressful and oppressive in several studies (Clark, 2008; Jackson et al., 2011; Shipton, 2002). The students I interviewed commonly attributed the actions, behaviours, and interactions of their perpetrators to an element of their personality, character, or "style." They also attributed the negative behaviours of staff nurses to the context of the clinical placement area. Contextual and interpersonal characteristics have also been identified as precursors to intra-group conflict amongst registered nurses (Almost, Doran, McGillis Hall, & Spence Laschinger, 2010). Attributing the actions and behaviours of the perpetrators to personality or clinical context is likely indicative of the students' perceived lack of control over incidents of inter-colleague violence. Therefore accommodating incidents of inter-colleague violence based on personal attributes or context allowed the students to rationalize they were not to blame for the encounters. Personality and clinical context were variables they understood as beyond their control.

Similarly in a study by Anthony and Yastik (2011), nursing students recognized nurses' hostile behaviours as personal issues rather than student issues.

Acceptance or accommodation of encounters helped the students rationalize their experiences, but at the same time it also minimized the experience. Minimizing the experience was evidenced by the students' perception that not everyone in their clinical placements was going to "be very nice," or that you "just accept" and "deal" with it. Curtis et al. (2006) noted similar student awareness and accommodation in a study on student experiences of horizontal violence. Likewise, Kiger (1993) observed that nursing students who experienced unwelcoming staff accommodated the discrepancy in their image of nursing by resigning and accepting that behaviour as a reality of nursing.

Students perceived a negative impact on their self-esteem and confidence following an encounter of inter-colleague violence. The experience of letting go and moving on was therefore important to the students' sense of recovery in the nursing program. Although several students questioned continuing with the program they were able to find ways to remain hopeful. Recalling positive past clinical experiences and hearing about other students' positive experiences provided encouragement to move on. They expressed their belief that good learning experiences, instructors and nurses were available. The students also demonstrated a sense of awareness and hope that their negative experiences in the nursing program were the exception. That awareness and hope contributed to a sense of persistence and resilience, and compelled them to move on.

While the eight students in this study all discussed the importance of letting go and moving on, and their strategies for doing this, it is likely that not all students are able to do this. In these cases, it is likely that negative outcomes such as leaving nursing

school or leaving nursing after graduation occur. In addition, long-term feelings of shame and/or anger may persist which may lead to negative health outcomes. There was significant evidence in this study to indicate that students are not likely to forget their encounters or the clinical contexts in which they occurred. Even when encounters involved an instructor the students frequently professed a desire to never return to the clinical context in which the incident occurred. That is a significant concern given that several of the participants were within months of graduation and employment. Therefore, it is challenging to ignore the potential consequences that inter-colleague violence may also have on employment choices following graduation.

Chapter 6

Limitations, Nursing Implications, and Summary

Limitations

This study describes the experiences of 8 nursing students who encountered inter-colleague violence during their clinical placements. Though many similarities were noted between the experiences of the students in this study and experiences of students in other studies on the subject, it is not improbable that another phenomenological study of this nature might render different findings. Accounts and impressions of inter-colleague violence may differ based on a multitude of variables that include but are not limited to culture, age, personality, and experience. The students in this particular study represented a largely homogenous group of Canadian students within a defined age group, with a similar amount of clinical experience. The participants in this study could be considered senior nursing students as they were closer to the end of their program and had the most clinical experience. Therefore it is also difficult to account for differences or similarities in experiences that may occur among more junior undergraduate nursing students with less clinical experience.

Another potential limitation of this study is that only three of the participants were available for second interviews. Three of the participants replied to electronic mails and agreed to brief telephone interviews to review the themes. While those individuals provided feedback and agreed with the study findings, I cannot be certain that the remaining participants would be of the same opinion.

Phenomenology relies on the ability of the participants to subjectively describe their lived experience. While capturing the essence of that experience is the foundational tenet of the methodology, I am aware that it is also one of the greatest challenges. In this sense I am relying on the ability of the participant to describe as fully and completely as possible their lived experience. Thus my ability to capture the experience is based the participants' ability to effectively convey their recollections of the experience.

Nursing Implications

The participants in this study were still in the educational and clinical training aspects of the nursing profession. While an abundance of research exists on the subject of violence in nursing, there is very limited information on the experiences of nursing students in Atlantic Canada. Based on the findings of this study there are several implications for nurse educators and other nursing professionals who work with students during their clinical training. Implications for nursing education, administration, and research will be discussed in more detail.

Nursing Education

It has been suggested that the clinical component of nursing education is the most challenging and stressful for nursing students (Chan et al., 2009; Chernomas & Shapiro, 2013; Shipton, 2002). It is also suggested that stressful events in the clinical area including negative interpersonal encounters negatively affect student learning (Ferns &

Merrabeau, 2009), professional socialization (Atack et al.), satisfaction with the nursing program (Clark, 2008), and student self-esteem (Randle, 2003). The students in this study reported increased stress that manifested as mental and emotional distress, eagerness for the clinical placement to be over, and disengagement from the clinical learning process following inter-colleague violence. Where incidents of inter-colleague violence involved clinical nursing instructors the effects were even more profound. It was evident that the students' expectations of how they should have been treated in the clinical area were substantially different from the reality. Preparing students to identify and deal with inter-colleague violence begins at the undergraduate level of their nursing education.

Inter-colleague violence in nursing is no longer a clandestine subject but it does remain a complex, challenging problem, and an unfortunate reality of current nursing practice. For that reason students' formal introduction to inter-colleague violence in nursing should not be an encounter of inter-colleague violence in the clinical area. Discussions regarding the potential for violence in the clinical setting should not be minimized and withheld from students in the classroom. It has been found that the cycle of violence starts during nursing education, therefore students need to be well-informed about what constitutes violence in the healthcare setting at the academic level (Celebioglu et al., 2010; Curtis et al., 2006; Randle, 2003). The responsibility of conveying that knowledge falls squarely on the shoulders of nurse educators. The students in this study knew what was happening to them was wrong but were often challenged to label the behaviour. I believe that indicates that students are not fully aware of the wide range of behaviours that constitute inter-colleague violence. More importantly, while they knew it

was wrong, there was an expectation they had no other alternative but to accept the behaviour. I suggest that the students' lack of explicit understanding about inter-colleague violence is indicative of a knowledge gap that transverses the academic and practice settings.

The issue of inter-colleague violence in nursing is not a subject that can be ignored or avoided at the undergraduate level of nursing. Nurse educators have a responsibility to inform students of what behaviours are inclusive of inter-colleague violence in nursing practice. Additionally I believe that nursing students need a sound understanding of traditional theories, and other suggested variables that help explain inter-colleague violence in nursing. Students also need to be aware of workplace violence policies in their clinical areas and their rights as students. Education about inter-colleague violence cannot be a onetime deal, or passing conversation in the nursing program. As the component of clinical practice is ongoing in the undergraduate nursing program, education and awareness of inter-colleague violence must be ongoing as well.

One of the more disturbing findings of this study was the "warnings" that students received from instructors about the prevailing atmosphere of a particular clinical area. Specifically, warnings that alluded to the idea that staff nurses in those clinical areas may not be as welcoming or accepting of students. Another disturbing finding is that students were also encouraged not to confront their abusers and instead approach their instructors. Although this practice might be perceived as beneficial conflict avoidance for the student, it did not change the negative outcomes of the encounters for students. While clinical placements may be limited in some nursing programs, any indication that students are being placed in environments where they are knowingly exposed to, or the targets of such

behaviour needs to be addressed by nurse educators in those clinical areas. The perception of a positive learning experience offered in a specific clinical area has to be carefully weighed against potentially negative outcomes on student safety, well-being, and learning. Nurse educators need to be observant of those prevailing atmospheres and report or address where those behaviours are the norm rather than the exception.

Nursing educators need to embrace a leadership role and collaborate with unit staff, management, and administration to ensure that the expectations and abilities of students and staff are clearly outlined prior to the start of clinical placements. Shipton (2002) suggests that nursing educators are in a position to "bridge the gap" between those individuals involved in the clinical learning process, including registered nurses and nursing managers (p.254). Bridging the gap between academics and clinical practice includes providing knowledge to all the individuals involved in the student learning process and making explicit the expectations and abilities of nursing students in the clinical area. Such collaboration must also involve upfront and direct discussions about the appropriate and collegial treatment of students in the clinical area. Leadership and collaboration also includes a commitment to addressing those behaviours when they occur in the clinical area to facilitate positive learning experiences for students.

Disrupting longstanding and negative workplace practices is a daunting task. Thomas and Burk (2009) suggest interventions that are preventative in nature are needed to reduce and stop violence. Griffin (2004) found that new graduates benefitted from enhanced knowledge of lateral violence and the use of behavioural interventions like confrontation to reduce violent encounters. Additionally when the new nurses were more knowledgeable about lateral violence they were better equipped to depersonalize the

experience (Griffin, 2004). I believe an upstream approach to confront inter-colleague violence should begin even earlier while students are still in training. Preventative interventions and strategies for students including assertiveness training and conflict resolution have been suggested by several researchers (Begley & Glacken, 2004; Curtis et al., 2006; Thomas & Burk, 2009; Unal et al., 2012), and could be implemented at the undergraduate level of nursing. Violence education and training that includes role play, cognitive strategies, and simulation of encounters with nurse peers could be easily implemented into the nursing curriculum and taught by nurse educators.

Clinical educators ideally strive to provide students with positive and educational practice experiences in complex, and often fast-paced health care environments. However professional socialization is also an important aspect of the clinical education process (Atack et al., 2000). It is an important opportunity for educators to demonstrate positive role modelling and support for students. Educators need to be advocates and role models in both academic and clinical settings (Dunn & Hansford, 1997), therefore their contribution to the socialization of nursing students in both academic and clinical arenas should be one of example and realistic of concerns within the profession, such as the possibility of inter-colleague violence. Longo (2007) suggests that educators should create supportive environments where students are able to discuss experiences and seek direction following violent encounters. Clinical educators must also ensure to the best of their ability that the socialization process is reflective of the caring principles that guide nursing practice. Educator inaction in the clinical area along with inadequate student education and preparedness effectively prevents students from confronting inter-colleague violence, and further socializes students into a culture of inaction and silence. The

inability of students to proactively cope with those interactions leaves them unprepared for encounters of inter-colleague violence as new graduate nurses. Being encouraged to ignore and avoid conflict in current nursing practice is not a viable solution for students who encounter inter-colleague violence. Most concerning is the possibility that students may conform and utilize some of those behaviours themselves to survive the clinical experience (Randle, 2003), thus perpetuating the problem for future generations of nurses.

Nursing Administration

Based on the findings of this study there are implications for nursing administration in both the academic and healthcare areas. Students expressed a great deal of reluctance to report their encounters based on their fears of further straining their clinical relationships, poor evaluation, and failure. They viewed the process of reporting as time consuming, stressful, burdensome, and futile. When encounters of inter-colleague violence involved nursing instructors the students felt especially powerless and were conflicted about the reporting process. While it was beyond the scope of this study to explore students' feelings and experiences with reporting practices and policies, there was some indication that students are not familiar with existing workplace violence initiatives.

Students felt they were in a vulnerable position regarding reporting because they were usually being evaluated. They also perceived a power differential between themselves and registered nurse peers. All of the students expressed the absence of any viable options to confront inter-colleague violence. That perception made reporting encounters of inter-colleague violence exceptionally challenging for students.

Compounding the situation in this study was that students were often not sure of appropriate avenues for reporting incidents, especially those involving clinical instructors. Only one of the students in this study expressed that maybe they should have spoken to a school councillor about the incident. I believe that implies a need for greater academic and healthcare administrative visibility and support for students to report unprofessional and abusive behaviours. Specifically that visibility includes a well defined avenue for students to formally, safely, and confidentially report incidents of inter-colleague violence perpetrated by instructors and nurse peers.

Students need to be supported at the administrative level, particularly at the academic level. The fact that students often perceived reporting inter-colleague violence as punitive could either imply a significant misunderstanding of the reporting process, or that reporting practices and anti-violence initiatives are perceived by students to be negligible at best. Policies and programs addressing inter-colleague violence need to include students in the clinical area. Clark (2008) suggests that students should be involved in the dialogue at the academic level to facilitate better teaching and learning experiences. Therefore, I believe that where there are discussions on workplace violence programs, student representatives should to be included. This would provide an opportunity for students to verbalize their concerns and experiences, and also provide peer support contacts or representatives for students who have questions about their experiences or the reporting process. Students need to know and be reassured that reporting practices are not only available to them, but that they are viable options.

Nursing Research

A significant amount of international nursing research has been conducted on the experiences of nursing students and violence in the clinical setting. However, there is a limited amount of research on the experiences of Canadian nursing students, and even less information is available on the experiences of nursing students in this particular region of the country. Based on the findings of my literature review this is the first phenomenological study that explored the experiences of students in this region. For that reason I believe further nursing research studies utilizing qualitative and quantitative methodologies are needed to gain further understanding of students' experiences of inter-colleague violence. Additionally nursing research in this area could influence informed decision-making regarding any changes in practice or policy to address this issue.

Because little is known about student experiences in this geographical area, quantitative research methodologies that yield valuable information on the actual occurrence of inter-colleague violence involving students is recommended. Nurse researchers could specifically explore the types of behaviours that students encounter as well as the frequency of their experiences spanning the entire nursing program. Those studies could also include student and clinical area characteristics that might reveal associational data. Studies that clearly identify the most prevalent types of behaviours, most common perpetrators, and the frequency or consistency at which they occur could provide a detailed perspective of student experiences.

Qualitative studies that are exploratory and descriptive to examine students' perceived powerlessness, coping, and resilience in the clinical area would be beneficial.

Based on the findings of this study other pertinent questions were identified that could be addressed in more depth. Do undergraduate students feel they are knowledgeable of and prepared to deal with inter-colleague violence? Do students feel confident in their ability to confront inter-colleague violence? Finally, what are the students' perceptions of support following an incident of inter-colleague violence? Particularly important is students' perceptions of support from clinical educators, nurse preceptors, managers, and administration. Qualitative research methodologies could provide a deeper understanding of these questions, and help guide discussions to address student needs in the clinical area.

On a broader scale there are implications for further studies that challenge the long-standing view that nurses perpetuate violence against each other exclusively as a result of oppressed group behaviour. Oppression theory, in current healthcare contexts, does not provide an all inclusive answer, much the same way as violent behaviours cannot be explained exclusively as a result of one's personality. Farrell (2001) suggests that interpersonal conflict and violence has been observed throughout other healthcare groups and disciplines, not all of which are predominately female or considered oppressed. So to imply that inter-colleague violence is simply the result of either feminist oppression or personality potentially excludes other significant variables at play in current clinical contexts. Studies to determine the effects of other variables alone or in combination with each other would undoubtedly enhance our understanding of this phenomenon.

Conclusion

Inter-colleague violence in nursing is a pervasive and disturbing phenomenon. It defies the key principal of our profession, one of caring. It has become abundantly clear that students are also vulnerable to this phenomenon during their clinical placements. A phenomenological study using the approach of van Manen (1990) was designed to explore the lived experience of nursing students who encounter inter-colleague violence during clinical placements. This study is significant because to the best of my knowledge, it is the first in depth qualitative study to address the subject in Atlantic Canada. Inherently, this addresses a gap in knowledge that will permit the comparison of students' experiences in this region to those in other areas of Canada and other countries. Additionally, it is hoped the information in this study will generate dialogue, within and between the areas of nursing education and administration, about how to better support nursing students in the clinical area.

It is apparent from this study's findings that nursing students are indeed affected by encounters of inter-colleague violence during their clinical training. Those encounters negatively influenced nursing students' perceptions of their nurse colleagues, clinical contexts, nursing education, and their confidence. Clinical learning and engagement were also disrupted when the nursing students experienced inter-colleague violence during clinical placements. Those findings are considerable given the importance of the clinical placement process in nursing education. Placements ideally provide students with the opportunity to practice what they have learned in classroom and lab settings. However when the process of practical or clinical training is interrupted by encounters of inter-

colleague violence, as demonstrated in this study, there are significant and negative consequences on student well-being and learning.

The findings of this study support previous findings by other researchers. A pervasive sense of powerlessness was experienced by the students, perpetuated by their belief of having no options. Additionally the students frequently availed of avoidance behaviours in the clinical area to minimize interactions with perpetrators and reduce emotional and psychological distress. Peer support was also commonly availed of and provided by the students following encounters of inter-colleague violence.

Areas worthy of future investigation and research were identified. Notably absent from the existing literature was information about student interactions, specifically word-of-mouth communication prior to the start of clinical placements. This is an intriguing finding and worthy of further investigation, as those interactions appeared to influence the students' attitudes and actions prior to and during the clinical placement. Moving on from the experience of inter-colleague violence was also important for the students in this study. However there was evidence to suggest that moving on did not imply forgetting about the experiences. Future research is needed to investigate if and how students' memories of their inter-colleague violence impact their future health or how they will treat other nurses.

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Appendix A

Recruitment Flyer for Participants

ATTENTION 3rd, 4th, and 2nd year Fast-Track BN STUDENTS!

Do you have one hour to share your experiences related to how you feel respected during clinical placements?

If so, your participation in this study which I am doing to complete my MN degree at Memorial University School of Nursing would be greatly appreciated! The study is about inter-colleague violence in the clinical setting. This includes acts of incivility, hostility, attempted or actual acts of verbal, physical, psychological (including bullying), and sexual abuse between members of the nursing profession or academic faculty belonging to that profession. Your undergraduate nursing experience is important, and I am interested in hearing about your experiences during clinical placements!

WHY? **Little research has been done on Canadian students experience related to inter-colleague violence.**

WHO? 3rd and 4th year students enrolled in the BN program, including fast-track. Minimum of 2 years in program completed, or 1 in fast-track. Any age or gender. Any student who has been treated with a lack of respect or experienced inter-colleague incivility or violence in the clinical setting within the last 12 months.

HOW? If you are interested or have questions please contact **Natasha Churchill BN RN**, Principal researcher at [redacted] or by phone at [redacted] or my thesis supervisor Alice Gaudine, PhD, RN, at [redacted]

This research is approved by [redacted]

Appendix B

Cover Letter to Participants

Cover Letter to Participants

Dear Sir/Madame, June 2012

Thank you for taking the time to read the enclosed information regarding my research study entitled: "Exploring the Lived Experiences of Nursing Students who Encounter Inter-Colleague Violence during Clinical Placements: A Phenomenological Study". Clinical placements are an important part of your nursing education. Inter-colleague violence includes attempted or actual acts of verbal, physical, psychological (including bullying), and sexual abuse between members of the nursing profession. That includes staff nurses, nurse managers, nurse educators, and fellow nursing students. The purpose of this study is to understand your experience with, and interpretations of inter-colleague violence during those rotations. If you agree to participate in this study, I will conduct one interview with you to explore your experience, thoughts and feelings about inter-colleague violence. The interview will be held privately at either [redacted] or [redacted] and at a time convenient for you. Several months later I will send you a brief copy of the study's findings and we will have a short meeting (by telephone or in person) to discuss the findings.

Please find enclosed a summary of the study and a consent form to review at your convenience. I will contact you within two weeks to ask if you are agreeable to participate in this study. Written, formal consent will be reviewed with you and signed at the start of the interview. Please know that your confidentiality is integral to this study and there is no penalty should you choose at any time to discontinue participation. If you require any further information or have any questions, please feel free to contact me, Natasha Churchill BN, RN, at [redacted], or my thesis supervisor Alice Gaudine PhD, RN, at [redacted]

Sincerely,

Appendix C

Consent Signature Page and Checklist

Signature Page

Study title: Exploring the Lived Experience of Nursing Students who Encounter Inter-Colleague Violence during Clinical Placements: A Phenomenological Study

Name of principal investigator: Natasha Churchill BN RN

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent and cover letter. Yes { } No { }

I have had the opportunity to ask questions/to discuss this study. Yes { } No { }

I have received satisfactory answers to all of my questions. Yes { } No { }

I have received enough information about the study. Yes { } No { }

I have spoken to Natasha Churchill and she has answered my questions Yes { }No { }

I understand that I am free to withdraw from the study Yes { }No { }

- at any time
- without having to give a reason
- without affecting my status as a student

I understand that it is my choice to be in the study and that I may not benefit. Yes { } No { }

I understand how my privacy is protected and my records kept confidential Yes { } No { }

I agree to be audio taped Yes { } No { }

I agree to take part in this study. Yes { } No { }

_____ _____ _____

Signature of participant Name printed Year Month Day

02/28/13 Subject's Initials:

Exploring the Lived Experience of Students who Encounter Inter-Colleague Violence during Clinical Placements

Appendix D

Questions for Participants

Exploring the Lived Experience

1) Tell me about your experience with inter-colleague violence during clinical placement

Prompts:

1) How did this experience make you feel?

2) How did you react to this experience?

3) Describe the circumstances surrounding the incident

4) How would you describe your confidence following the incident?

5) What was it like having to return to the clinical setting following the incident?

6) How has this affected your opinion of the clinical experience?

7) How did you feel when you returned home?

8) How did you cope with the experience?