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# Nursing students' experiences of workplace violence and aggression: Making sense of the phenomenon for educators

Bonnie Jean Beardsley

# Nursing Students' Experiences of Workplace Violence and Aggression: Making Sense of the Phenomenon for Educators

by

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MSN, Lewis University, 1996
BSN, Olivet University, 1993

Dissertation Submitted in Partial Fulfillment
Of the Requirement for the Degree of
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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2003

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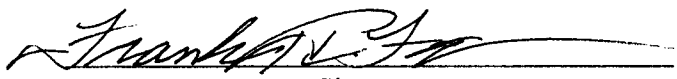

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ABSTRACT

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ABSTRACT

This phenomenological study explored female nursing students' perceptions of their experiences of workplace violence and aggression, their methods for coping with and adjusting to the violence, and the implications for nursing education.

A notice soliciting volunteers was posted on student bulletin boards in multiple schools of nursing throughout Illinois. Ten participants were selected from a pool of volunteers who met predetermined criteria. Open-ended interviews each lasting approximately 60 minutes were conducted and tape-recorded. Four interview questions that guided the process changed as the narrative unfolded, and in some cases, probing became necessary to gain a rich description. Data analysis was completed using Colaizzi's Seven-Step Model.

The results of this study suggested nursing students may experience some form of workplace violence during their nursing education. Once exposed the nursing student may become a silent victim, afraid to report the incident, fearing she will be expelled from nursing school. As a silent victim, the student lacks the ability to cope with the situation partly because of the limited nursing curriculum on workplace violence. This may lead to anger, fear, multiple stress responses, and a distorted perception of caring in the nursing profession. In the end, the nursing student may enter the workplace as a nurse perpetuating the cycle of silent victim of violence, or take on the challenge to break the cycle, opening the way for improving the nursing profession.

# DEDICATION

This thesis is dedicated to the 10 brave nursing students who participated in the study. It is through their dedication, expressed experiences, and hope that the path is now illuminated allowing those alike to find their way.

ACKNOWLEDGMENTS

First and foremost, I would like to express my appreciation to the 10 brave nursing students who participated in this study. They willingly shared their personal experiences, many of which were deeply painful to embrace. Sharing their experience has given me a sense of hope for the future.

Second, I would like to thank my committee members: Dr. David Stein, chairperson; Dr. Linda Crawford; Professor Harry Coblentz; and Dr. Frank Fox. Their words of encouragement, support, and examples of scholarship have contributed to the success of this journey in my life.

Next, my husband Jacques, who has made relentless, sacrifices over the past several years so I might be allowed the opportunity to live out my dream.

My parents, Pete and Betty Thomson, for the values they instilled in me. In particular, my father, a WWII POW, who for me exemplifies courage, pride, and endurance after surviving torture and pain beyond my comprehension. My mother Betty, who was willing to listen when I cried, offering reassurance each time another roadblock was met obstructing my goal.

My children, Christopher and Ryan, without whom a valuable piece of my life would be missing, I love you both! Also, my precious grandchildren, Allison, McKenzie, Steven, and Dallas, your beautiful smiles inspired me to push forward, hoping somehow I might improve the world I will pass on for you to live and grow in. I love you!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

# CHAPTER 1: INTRODUCTION TO THE STUDY

## *Introduction*

On September 11, 2001, terrorist attacks were inflicted against the United States. The immediate consequences of these horrifying acts included death, destruction, and financial and emotional devastation. At this point, it is too early to fully comprehend the magnitude these violent acts will have on the future of our society. However, those who watched the media coverage not only observed an entire nation become a victim but also personally experienced what it feels like to be that victim. Once exposed to such an experience it should become easier to have empathy with "victimization." Therefore, the reader is encouraged to reflect on the extraordinary events of 9/11 while reading the stories of nursing students who too have become victims--"workplace violence victims."

Not only has violence been identified as a public health concern, it has expanded globally. Violence no longer has distinctive boundaries, but crosses over multiple occupational group work settings, affecting all ages, races, socio-economical status, and religions. Furthermore, violence has been identified as the main cause of morbidity and premature mortality worldwide (International Council of Nurses, 2001).

Media tend to focus on extraordinary episodes of violence, such as homicidal acts of a disgruntled employee "going postal," which has distorted the breadth of the phenomenon (White, 1996). Homicide, the extreme form of workplace violence (Occupational Safety and Health Administration, 2000) is ranked the third leading cause of fatal occupational injuries. The Bureau of Labor Statistics (2001) reports of 5,915 fatal

work injuries reported in the year 2000, 674 of those included homicides in the United States workplace. Occupational Safety and Health Administration (OSHA) (2000) reported that for the first time in 6 years homicides were on the rise from 651 cases in 1999 to 677 in 2000. These findings suggest the potential for becoming a victim is on the rise and suggest the nature of the perpetrator may become more aggressive and violent.

In the workplace, violence has been described as "poison" (ICN, 2001) causing negative impact on both the observers and the victims often resulting in evidence of multiple stress reactions. According to reports from the International Council of Nursing (ICN) (2001), 95% of nurses around the world are women who are vulnerable victims because of gender and also because of societal tolerance of violence. Further, they report that health care workers in general are more likely to be attacked at work than all prison guards or police officers.

Historically, the most frequent location cited for nursing assaults has been the psychiatric unit; this, however, is no longer the case (Lanza, 1996). According to research conducted by the International Association for Health Care Security and Safety, 42% of reported assaults occurred in the emergency department, and only 23% occurred in psychiatric units (Drury, 1999). A follow up to the same study confirmed that general medical surgical areas have since become the second most frequent site for nursing assaults (Drury). More recently, the International Council of Nurses (2001) reported that general patients' rooms have become the highest risk areas, with the patient most often the actual perpetrator. These findings suggest the "typical perpetrator stereotype" may not be easily identified, and may in fact no longer exist as once thought.

There is a greater risk in the American workplace of the nurse becoming the victim of a nonfatal violent act than of homicide. The International Council of Nursing (2001) reported 72% of all nurses do not feel safe from assault in their workplace, 95% reported having been bullied, and over 75% reported sexual harassment at work. While homicide is the most devastating conclusion for a victim of workplace violence, exposure to nonfatal assaults are clearly more prominent. There is a sense of finality with a fatal assault of violence. The media present it to the public, then once the initial shock is over, the incident is often forgotten. However, with a nonfatal assault often the victim lives on to deal with the consequences of the experience. Year after year the experience may impact their life and often the victim never reaches any personal resolution to the crisis.

The media naturally focus on those extraordinary incidences of workplace violence rather than the nonfatal episodes. As a result, little or no attention has been directed at those incidences of nonfatal violence in the workplace (White, 1996). The Bureau of Labor Statistics' Survey of Occupational Injuries and Illnesses reported 16,664 nonfatal workplace assaults occurred in 1999. This is a crucial report regarding nonfatal attacks and further demonstrates a neglected concern in the workplace. The groups reported as being the highest risk include: social services with 14 assaults per 100 full time workers, and health services providers with 9 assaults per 100 full time workers.

Not only have the media focused attention away from this concern, so have researchers. Not until the 1980s did any research studies on nonfatal assaults become evident in reported findings (Hales, Seligman, Newman, & Timbrook, 1988). Since that

period of neglect more focus has been directed at trying to understand the nature of the workplace and nonfatal workplace assaults. However, the breadth of workplace violence is so complex there still remains limited information concerning causes, correlating factors, and consequences (Leather, Cox, & Farnsworth, 1990). Ongoing research into the phenomenon of workplace violence should be a priority for those who share an interest in human value and social change. Basic human rights in the workplace should also be a priority for all occupational groups who are noted to be at such high risk, along with employees and employers in general.

In the health profession, violence in the workplace should be a major concern for every individual due to the direct implications to the delivery of health care services. Nurses have direct contact with not only the victims of violence but also the perpetrators of violence, yet they are bound by professional standards to provide health care service in a caring, nonjudgmental manner. The irony of this situation occurs when the health care provider becomes the victim of the very person for whom they are providing care. Further, this raises both ethical and moral considerations for the health care provider who is now in a "catch 22." Research has shown that most often the nurse will not press charges or even report the incident to a supervisor. According to DiBenedetto (1999), the president of the American Association of Occupational Health, "Nurses do not learn to be cognizant of safety in the workplace. The ingrained message nurses get is to keep taking care of their patient, so we keep taking care of others without taking care of ourselves" (p. 3).

Nurse educators are in the best position to influence change in the nature of the workplace environment by preparing future nurses for the risks. This can only happen with a better understanding of the phenomenon and the implications to health professionals. Through this knowledge, comprehensive ideas for improving the situation can become a focus and lead toward enhanced educational preparation for nurses. Nursing education should take on the challenge of educating the nursing student about the potential for violence. First, with faculty developing a comprehensive knowledge of workplace violence, and secondly, using that knowledge to better prepare the nursing student for the complexity of the workplace they will enter.

Therefore, this study addressed the nursing student as a workplace violence victim, posing two questions: (a) What is it like to be a nursing student exposed to workplace violence and aggression, and (b) how might nurse education respond? The results of this study are expressed through this researcher but are derived directly from the lived experiences of 10 female nursing students who were the victims of workplace violence and aggression.

Narratives from the interviewed participants reflect the experience, their personal meaning, and stress outcomes each encountered as a result of being victimized. Various expressions of emotion are evident in the reported encounters and explicit to the derived meaning. The reported coping and adjustment by the participants further added to the personal construct of their violence experience, not only as a nursing student, but also a victim. Further, the participants expressed concern regarding their educational preparation and knowledge related to workplace violence. Last, they discussed what it

was like to participate in this study, expressing their hopes and dreams for the future. Overall, each expressed a similar dream of a safe productive delivery of health care service, ultimately leading to a better world in which to live and work, not only for themselves, but also for future generations of nurses and humankind.

### *Background of the Study*

Workplace violence has been declared a national epidemic by the Center for Disease Control (CDC) (1992). Furthermore, the Justice Department labeled the workplace as the most dangerous place to be (Anfuso, 1994). The Australian Institute of Criminology (2001) labeled nursing as the second worst occupation and the most violent workplace setting in the country (Zin, 2001). More recently, workplace violence has been termed a neglected global epidemic in which society responds by reacting rather then by preventing (ICN, 2001).

In *Report to the Nation Workplace Violence* (Merchant & Lundell, 2001), the University of Iowa Injury Prevention Research Center examined issues of workplace violence and needed research for the future. In their report, they stated, "Our understanding of workplace violence is still in its infancy...much remains to be done in this area of research, particularly data collection and interventions" (p. 3). Accordingly, they suggest the extent of workplace violence and the number of actual victims are not fully documented or well understood.

Lanza (1999) reported assaults an epidemic against the 2.5 million registered nurses (RN) in this country. Further Lanza stated that over 80% of the assaults against

nurses go unreported. Carroll (1999) agreed that the frequency of assaults on nurses is inaccurate. Other researchers support these studies citing several factors associated with under reporting of assaults in the workplace. First, according to Carroll (1999), there are misperceptions on the nurses' part regarding what defines violence and violent actions. Second, nurses downplay the abuse (Carroll, 1999). Third, typical socialization of the female gender into the profession of nursing continues to hold on to old traditional subservient attitudes (Antai-Otong, 1999). Lastly, nursing education has been identified as the perpetrator of this gender stereotype (DiBenedetto, 1999). No matter the reason, the lack of accurate statistical data on the number of assaults on nurses suggests the magnitude of the problem is highly underestimated and is supported by the above research findings.

Workplace violence is financially costly and still rising for organizations as well as for the victims. For example, in one study conducted by Bachman (1994) between 1987 and 1992, workplace violence resulted in $55 million in lost wages per year. In comparison, 1999 calculations estimate workplace violence costing employers $4.2 billion annually with one episode costing $250,000 in working hours lost, medical benefits, and legal expenses (Gardner, 1999). In another report, over $750,000 from 134 assaults was paid to health care victims in single worker's compensation carrier, totaling $84 million (McGovern, 2000). This progressive gain in financial loss is clearly demonstrated in the longitudinal pattern researched and identified in studies. However, according to some, these research studies still do not reflect an accurate picture of the true

losses sustained financially (Anderson & Stamper, 2001; Barling, 1996; ICN, 2001; Lanza, 2001).

The magnitude of workplace violence was underestimated and so the actual financial loss remains unknown simply due to the underreporting or the lack of reporting incidences (ICN, 2001). According to Barling (1996), five unreported incidents of workplace violence occur for every episode reported. Lanza (2001) suggested the reasons hospitals with reports of nursing assaults attempt to protect their interest. For example, with high report of incidences, costs in insurance rates will rise; worker's compensation claims will become more evident which will lead to raised questions and risk to the reputation of the organization. Therefore, the impetus was to refrain from not only reporting incidences, but also to ignore incidences for several reasons. According to Lanza (2001) the biggest reason identified in the research as to why the victim did not report an incident was fear of being blamed, losing their job, and in some cases, nurses referred to violence as being part of the job.

To date, researchers continue to claim workplace violence goes unreported because it is not consistently defined (Report to the Nation, 2001). Historically, Barling (1996) and Seger (1993) reported definitional discrepancies as the reason identified most often why violence was under reported. Further, they suggest this is a reflection of an ongoing debate concerning what behaviors should be included in an operational definition of workplace violence. Based on their research, workplace violence was recognized as having two classifications: physical acts and nonphysical acts. Physical acts included a physical assault (e.g., hitting, stabbing, biting, and shoving). Nonphysical

assaults include direct assault for the purpose of harm or instilling fear (e.g., threatening, cursing). OSHA (1996) proposed the following definition of workplace violence:

> The commission of prescribed criminal acts of coercive behavior that occurs in the workplace setting that includes, but is not limited to, homicides, forcible sex offenses, kidnapping, assaults, robbery, menacing, reckless endangerment, harassment, and disorderly conduct. The term coercive behavior is intended to convey the sense that workplace violence may take many forms in addition to the use force. The aggressor may use berating language, physical or verbal threats, or damage personal property. (p. 1)

Is there a safe place free from violence? Not likely; however, workplace violence poses a particular concern for nurses. During the last decade, the health care industry has experienced a significant increase in workplace violence (International Council of Nurses, 2001; Reich & Dear, 1996). Today, health care workers experience more assaults than workers in any other industry (Boyd, 1995; International Council of Nurses, 2001; Reich & Dear, 1996).

Rising patterns of increasing incidences of violence against nurses have been evidenced since the 1970s according to Lanza (1996), and currently stand at an all-time high (Reiss-Konar, 2001). Today the health care worker shares responsibility to protect his or her client from harm. While this is not a new task the job has become difficult with more than one third of all nurses in the workplace reporting assaults (Reiss-Konar, 1999; Carroll 1999).

In one survey conducted by the Colorado Nurses Association Violence Task Force (1999), 30% of all nurses surveyed in seven different states reported being a victim of verbal threats, sexual assaults, or physical violence. The survey identified the perpetrators most often were the patients and the assault weapons most often used were

guns, knives, flare guns or chairs. Other incidences reported by the nurses in this survey included being kicked, slapped, and pushed. Furthermore, 98% of the assaults were nonfatal.

Another survey, conducted by the Idaho Emergency Nurses Association (2001), found 63% of emergency department staff claimed to have been assaulted anywhere from one to three times while working. Interestingly, the victims also reported they did not file any documentation on the incident, thereby supporting the idea that was previously cited in multiple studies; the magnitude of the problem is limited as a result of underreporting by nurses.

Lanza (1999) reports nurses are confronted every day by patients who use violence as their way to deal with anger and conflict. In addition, Giarrusso (1998) estimated that 60% of all workplace violence occurs in health care settings. In conducting a survey on incidences of violence in the hospital setting, Giarrusso (1998) reported 32% of the hospitals surveyed had reported at least one verbal threat to employees daily, 18% reported weapons were used to threaten staff at least one a month, and 43% had one or more physical assaults toward a staff member each month. Of all health care professionals, nurses have the largest number and the highest rate of nonfatal workplace violence (McGovern 2000; United American Nurses, 2000).

Those who provide direct patient care activities are high-risk targets of workplace violence. OSHA (2001) confirms rising rates of assaults and higher risks of violence against health care and social workers more then any other professional field. However, the Bureau of Labor Statistics (1999) shows assaults against nurses in the workplace have

remained steady over the last decade. A concern identified with these statistics is the data reported only include reported incidences when the nurses were off work as a result sustained injury; nurses who did not miss work were not included in this report.

Throughout the world countries are beginning to react to the rise in assaults against health care providers. The International Council of Nurses (1998) conducted a study throughout the world trying to determine incidences and types of violence nurses are exposed to. Ninety-seven percent of United Kingdom's nurses reported exposure to workplace violence, with 47% reporting attacks either by being punched or slapped. Eighty-five percent reported a desire to leave the profession of nursing; in Canada over half of the nurses reported they would not recommend the nursing profession to anyone with an expressed interest. In Austria, 80% of nurses surveyed reported added stress because of unsafe conditions at work and further reported a direct correlation to their personal and social lives. Further, 60% expressed fear from getting injured at work was the primary stressor.

Whittington (1997) conducted a study in the UK by mailing a survey to 5,000 health occupational groups in multiple settings across five different geographical areas. In the survey the participants were asked to respond to the types and frequency of workplace violence exposure. The study yielded that of all health professions surveyed, nursing students were at greatest risk of being the victim of a work related violent incident. More recently the International Council of Nurses (2001) reported that among health personnel, nursing staff are most at risk for workplace violence. However, more likely to become a victim of actual violence was the nursing student (p. 17).

In Scotland, the Occupational Safety and Health Database (1995) reported that of 1,000 nursing students who had been surveyed, 372 had been assaulted. A physical assault to nursing students was found to be higher then assaults to the regular staff nurses--even those who worked in higher risk areas such as psychiatric hospitals. The study also reported that the female gender experienced more attacks than male. However, if a male was a victim of an assault the act was more violent than the assault against the female.

These findings suggest workplace violence is indeed a global problem threatening the nature of health care delivery throughout the world. Furthermore, these studies suggest financial devastation, unsafe work environment, and a society that is becoming increasingly violent with targets being health care workers (Boyd, 1995; International Council of Nurses, 2001; Lanza, 1996; Occupational Safety and Health Administration, 1999; Reich & Dear, 1996;).

Obviously, the most effective way to reduce the impact of workplace violence/aggression is to prevent its occurrence. However, until that time the phenomenon remains a real concern and nurses remain high-risk targets of that violence.

Not clear in research was the effect workplace violence/aggression has on nursing students and how education should respond to this phenomenon. Therefore, the research questions this study posed to investigate included (a) What is it like to be a nursing student exposed to workplace violence and aggression? and (b) How might nurse education respond?

### *Purpose of the Study*

The purpose of this study was twofold: (a) to document and explore the perceptions of female nursing students' lived experiences of workplace violence and aggression, and (b) to gain a clearer understanding of the implications for nursing education. Ascertaining the perceptions from the nursing students exposed to workplace violence and aggression have provided new insight into understanding things that are hidden to the outsider by helping to raise consciousness (Munhall, 1994). Furthermore, the results of this study have provided a catalyst to examine both the context of workplace violence and aggression toward the nursing student and the implications for nursing education.

The specific objectives that gave shape to this study centered primarily on the participants as they expressed the meaning of their lived experience with workplace violence. It was not the intent of this researcher to advocate or defend any current theories of workplace violence. It was the intent to discover the meaning reported through the lived experiences of the victims, expressed through their own words, using a phenomenological approach to raise consciousness (Munhall, 1994; Polkinghorne, 1989).

### *Conceptual Framework*

Since the intent of this study was to capture the nursing students' workplace violence experience as perceived by each participant, combinations of phenomenological and feminist methodologies were utilized. This method encourages subjective interpretations from each participant allowing free flowing expression through the eyes of the individual.

In part, a theoretical model guided one aspect of this study as a conceptual framework to assist this researchers understanding of the coping and adjustment descriptors used by each participant. The psychological stress model adapted from Lazarus's (1966) theory of stress response became the framework in the analysis of how participants described their coping and adjustment associated with workplace violence and aggression.

According to Lazarus (1966) psychological stress follows an environmental stimulus and through that stimulus an individual will appraise (cognitively) whether the event is a threat or not. How individuals perceive the threat is based on their personal goals, values, beliefs, and/or commitments. The power of the threat is determined mainly by how much harm is perceived (Folkman, 1984). Preexisting ideas an individual has about the event preform the reality a threat has to the well being of the individual (Lazarus & Folkman, 1984). Furthermore, to adequately appraise the event the person must have previous knowledge or a similar experience to an associated reference (Lazarus & Folkman).

As previously mentioned, Lazarus and Folkman's (1986) model provided a conceptual framework for part of the analysis in this study. In particular, how the nursing students adjusted or coped with the experiences they described as they presented their personal experiences, how they appraised the threat and how they coped became evident in the descriptive language they used. Common themes surfaced with coping and adjustment strategies used by the participants. During each interview the participant was asked, "Tell me about your experience with workplace violence aggression." This led to

the question, "How did you adjust or cope to the experience you just described?" This method of questioning and probing allowed for a rich description and surfacing of common verbs used by the participants.

According to the Lazarus model, the perceived threat (cognitive) has implications as to how the victim will respond (cope or react). Lazarus (1984) described these categories of victims' reactions as (a) emotional, (b) social, (c) biophysical, and (d) cognitive. Using these four categories as a framework, deeper understanding of the victims' reactions provided more meaning to the description of the experience. This further helped to determine if any commonalties in stress reactions, coping, or adjustment occurred with nursing students who had been victims of workplace violence and aggression.

### *Problem Statement*

The research on workplace violence clearly demonstrates the increasing risk of health care providers becoming a victim of physical and nonphysical acts of violence. Most significant were recent studies citing the nursing student at a higher risk for being assaulted while providing care than a regular staff nurse (ICN, 2001; OSHA, 1995). Multiple studies clearly support the allegation that research on workplace violence is still in its infancy (Merchant & Lundell, 2001) and more research is needed that focuses directly on health care providers (ICN, 2001).

Barling (1996) reported victimization can result in negative outcomes, including mood changes, paranoia, cognitive distraction, fatigue, and psychosomatic complaints.

Furthermore, in response to stress reactions victims report anxiety, nervousness, posttraumatic stress disorder, sleep disturbance, and tension (Baron, 1993; Braverman, 1992; Henderson & Bostock, 1977; McCaffry, 1989; Northwestern National Life, 1993; Wykes & Whittington, 1991).

Many of the studies identified by this researcher on workplace violence were conducted using quantitative methodology. These studies described stress experienced by victims. Most of these studies used a survey that provided the participant with predetermined verbs to choose from, not allowing the participant to respond subjectively or use their own descriptors.

In conducting a review of the literature, no phenomenological studies were identified by this researcher on the lived experience of nursing students' exposure to workplace violence and aggression while in the health care setting. While there may have been some this researcher did not identify any studies.

Therefore, this gap identified in the research became the focus of this dissertation, beginning with an in-depth understanding of what nursing students' experienced when exposed to workplace violence and aggression, how they adjusted or coped, and finally what educational considerations were evident. The stories came directly from the victims who lived the experience of violence, offering data for researchers who share an interest in better understanding this phenomenon. Furthermore, this study addressed another research gap by using a method never used before to study workplace violence and aggression on a specific typology--the nursing student. The use of phenomenology as a methodological approach encouraged a deeper understanding into meaning of this

phenomenon. In doing so, it moved to raise consciousness through findings regarding the specific cultural typology (nursing student) never studied before in the context of workplace violence and aggression.

Barling (1996) concluded that most studies on workplace violence have failed to examine an individual's subjective interpretation of the event. However, an abundance of research was noted on stress reactions of workplace violence victims using quantitative approaches. Few studies provided subjective interpretations of what it was like to be the victim of workplace violence experiences. Further, no studies were identified that addressed the nursing student as a victim, or mentioned educational considerations.

Consequently, very little was known about the nursing students' experience of workplace violence and aggression. These gaps made it impossible to know how to prepare the nursing student from an educational perspective for the likelihood of becoming a victim. In order to determine what might be done, it was essential first to understand the meaning the experience had from the perspective of the victims. This would facilitate going deep into the meaning of workplace violence through the victims' own words making sense of the situation.

In order to develop effective interventions beneficial for victims of workplace violence, research investigating the subjective experiences was necessary. Consequently, this study was intended to bridge gaps in the existing workplace violence literature building on understanding the subjective interpretation of 10 nursing students' lived experience of workplace violence and aggression. In doing so, this would provide an opportunity to examine the implications this held for nursing education.

### *Research Questions*

To address this problem the following research questions were posed:

1. What is it like to be a nursing student exposed to workplace violence and aggression?

2. How might education respond?

### *Significance of the Study*

At the investigative stage, this study was among only three studies identified by this researcher investigating the effects on nurse victims' subjective interpretations of their experiences of exposure to workplace violence. Designing the study, this researcher considered the apparent gaps and themes that existed in workplace violence literature. Those identified included a paradigm shift to help conceptualize workplace violence, the need to conduct qualitative research to allow for subjective interpretation, and finally the need to focus on the nursing student as a specific typology never studied before.

In consideration of the paradigm shift for conceptualizing acts of violence, this study examined violence and aggression from the perspective of the nursing student as victims. This was accomplished by interviewing nursing students with mixed ethnic backgrounds and gender specific samples of victims who would formulate their own meaning of workplace violence. This provided answers directly from the victims allowing this researcher to gain a deeper understanding of workplace violence and aggression, coping, adjustment, and implications for nursing education.

The use of phenomenological methodology allowed this researcher to derive answers from the questions posed in order to accomplish the specific aims of the study (see Appendix G). In particular, the aim was to better understand workplace violence experienced by nursing students, how they perceive the experience, and to make sense of the entire situation for nurse educators alike, thereby adding a new dimension directed at understanding workplace violence and aggression through the lived experiences of nursing students. To accomplish this a combination of feminist and phenomenological philosophy became the methodological approach. This encouraged the philosophy that women (nursing students) are experts in their own experiences and active participants in the research process (co-participants) (Harding, 1987; Rubin & Rubin, 1995).

This study offered insight into the process associated with violence and aggression perpetrated against the nursing student in the workplace. Further, the data revealed the importance of identifying behaviors seen in nursing students who are or have been victims. Overall, this study provided an impetus for policy and curriculum changes in transforming nursing education.

In conclusion, this study explored some of the questions left unanswered in the literature relating to nursing students as victims of workplace violence and the implications for nursing education by asking what it means to be a victim, providing answers coming directly from the victim. In this way, the researcher was able to gain a clearer and more profound understanding of the phenomenon and the meaning attributed to this experience through the victim. This new knowledge opens the way to improving

and redesigning nursing education to meet the particular needs of this newly identified and growing victim population.

### *Assumptions and Limitations of Study*

A limitation to this study stemmed from the sampling strategy. The process began by posting a request soliciting for nursing students as volunteer participants (Appendix F). The request was placed in multiple schools of nursing and outlined the pre-determining criteria the nursing student had to meet in order to be a participant in the study. Within 2 weeks of posting the invitation to volunteer, 45 nursing students telephoned this researcher requesting participation in the study. Of these 45 requests, 42 actually met the predetermining criteria.

Based on the amount of interest expressed, the sampling process became unwieldy. In phenomenology, a usual number of participants range from 6-12. The targeted sample sought prior to beginning the study was 10. The decision to target 10 as the sample number was based on an assumption by this researcher that *maybe* 10 nursing students would volunteer. The response rate was well beyond expectation and thus the task was to narrow down 42 possible participants to a manageable number--which was 10 as decided by this researcher, a fair range in phenomenological studies. This was accomplished in the following manner.

Based on the demographic information obtained during the preliminary telephone conversation held with each nursing student, the 42 prequalified participants were sorted into four categories: (a) geographical location of the nursing school attended: north,

south, east, or west in the State of Illinois; (b) the culture reported: Black, White, Hispanic, Multi-ethnic/other; (c) the type of experience they described-- physical act, aggressive act or both; and (d) the year in school during the time of the assault, whether a junior or senior level nursing student. Numbers were assigned to each of the 42 possible participants, 1-42. Ten numbers were blindly drawn from a container and then matched to the prenumbered sample pool. This matched number became the 10 participants for the study.

It was not until reviewing the sample strategy that this researcher realized that sorting the 42 possible participants was not necessary and served no purpose. The selection was random from a purposive group of volunteers. Each volunteer had already met the predetermined criteria and no specific samples were taken from any category created in the sorting sequence.

In the end, the purposive sampling of participants was still the approach yet exemplified by mixing and sorting. Ultimately, this was accomplished through randomly assigning numbers and randomly selecting 10 participants.

Exclusion of males was also a limitation in that the results are not pertinent to male nurses. The decision to limit the respondents to women was based on the fact that this population's circumstances were unique in comparison to their male counterparts. Secondly, the culture of the nurse profession is predominately female, 96.4% (ANA 1998).

Another limitation, paradoxical as it may seem, came from the exclusive use of qualitative methodologies. No matter how carefully one designs and implements any

research methodology there is always a potential for interpretative error (Rubin & Rubin, 1995). In an effort to reduce chance for this type of error, numerous, diverse sources were used in validating findings of this study. This was accomplished by relying on the participants for verifying and validating the results, and working closely with university colleagues and members of the research committee who have conducted and are familiar with qualitative studies, including phenomenological research approaches. Discussion occurred on a number of occasions regarding themes and subthemes during the actual data analysis.

Finally, limitations from the actual interviewing process made it important to tailor the interview questioning for each participant. Some needed probing to get a rich description (Rubin & Rubin, 1995). This researcher followed the model for qualitative interviewing designed by Rubin and Rubin. This model closely resembles the chosen methodology of phenomenology employed in this study. This researcher allowed the ideas to materialize through interviews, yet remained aware of the fact that total neutrality was not possible if a thick description was to be gained. Taking an empathetic approach to the participants allowed for a personal relationship to develop between this researcher and the participants. This comfort level encouraged a free, honest flow of descriptions and ideas to surface from the participants.

Feminist methods support the idea that a woman interviewing another woman reduces cultural barriers to communication. This philosophy enhanced data collection. This researcher is a woman, a nurse, someone who has witnessed workplace violence and

aggression, and too has experienced the phenomenon many times in a 20-year nursing career.

In one interview, the participant had been a nursing student of this researcher. The fact this researcher interviewed a personal nursing student may have created a bias; however, the nursing student denied concerns and responded openly, without any hesitation, presenting her story. This researcher assured the nursing student that her involvement was voluntary and in no instance would have any repercussions in her educational pursuit. During the interview process this researcher approached each participant from an empathetic position without allowing personal bias to enter the relationship (Rubin & Rubin, 1995). This was accomplished by bracketing personal experiences, setting them aside during the interview process, but at times allowing for wisdom to guide the interview process going deep into the experience together with the participants.

A particular strength of this study came from the fact that the sample included only female nursing students who had been directly exposed to an act of workplace violence and aggression. This calculated effort facilitated the process of revealing how unique the experiences are when investigating a specific typology of victim, namely, the female nursing student cultural group.

*Definition of Terms*

Definitions of workplace violence and aggression were critical to the phenomenon studied. In the literature for workplace violence and aggression, multiple descriptors were found. Some included both physical and psychological acts, while others only one or the other. No matter what the exposure to violence, in order to arrive at meaning, the findings must evolve from the human being who has lived the experience. Meaning may be expressed through descriptors or personal definition provided from the victim, derived directly from their own interpretation, an important concept in phenomenological study. According to Munhall (1994), this is accomplished with respecting each individual's interpretation of an event as his or her own truth or reality. With this in mind, the following definitions of workplace violence and aggression were used as the predetermining selection criteria when soliciting for sample participants.

Domestic violence: For the purposes of this study, domestic violence was not considered a portion of workplace violence or workplace aggression. The distinction being violence experienced by the participants was associated with their role as nursing students.

Workplace violence: The commission of prescribed criminal acts of coercive behavior that occurs in the workplace setting. It includes, but is not limited to homicides, forcible sex offense, kidnapping, assault, robbery, menacing, reckless endangerment, harassment, and disorderly conduct. The term coercive behavior is intended to convey the sense that workplace violence may take many forms in

addition to the use of force. The aggressor may use berating language, physical or verbal threats, or damage personal property (OSHA, 1996) (p. 1).

Workplace aggression: Bullying, mobbing, victimizing, intimidation, threats, ostracism, sending offensive messages, aggressive posturing, rude gestures, interfering with work equipment, hostile behavior, homicide, rape, wounding, battering, physical attacks, kicking, biting, punching, spitting, squeezing, pinching, stalking, and harassment including sexual or racial (International Council of Nurses, 2001)

*Summary*

Given that violence is a genuine concern across the nation and the public is subjected to the extreme examples portrayed in the media, along with confusing definitions, it was imperative to gain a better understanding of this phenomenon. Health care providers, along with other occupations, have been found at risk for workplace violence and aggression, and would therefore benefit from a better comprehension of the phenomenon.

Of major concern to this researcher were the reports that nursing students had recently been identified in two surveys as being most likely to become victims of workplace violence and aggression (ICN, 2001). Based on these new findings, further research would raise consciousness not only to the risk of workplace violence and aggression toward the nursing student, but also provide a sense of meaning this experience held for the victim helping educators address this newly identified concern.

In chapter 2, an in-depth review of the literature examined concepts related to the nursing student, health care, and education within the context of workplace violence and aggression.

In chapter 3, the nature of the methodology is described including the phenomenological research design used by this researcher to conduct the study. Furthermore, the sample selection, data collection, and analysis using Colaizzi's Seven Step Method are explained along with quality indicators.

In chapter 4, highlighted excerpts of each interview sessions are presented. The chapter concludes with an explanatory section on the themes that were revealed comparing the findings to current literature.

In chapter 5, an overall summary of the research findings, conclusions drawn, and recommendations for further research are presented along with this researcher's reflexivity journaling.

# CHAPTER 2: REVIEW OF THE LITERATURE

## *Description of the Literature Search*

Workplace violence literature appeared in publication between 1980 and 2002, first sparingly, and then with an increasing predominance over the span of several years. The purpose of scanning through the research during this time frame was to provide a background on what knowledge and gaps existed chronologically. This formula also offered this researcher the opportunity to evaluate the internal and external social factors that have implications for workplace violence incidences. During the reviewing process, this researcher uncovered presuppositions in areas of health care, education, and nursing students relating to workplace violence and aggression. Uncovering presuppositions is an essential process for a researcher when using phenomenological and feminist methodologies (Colaizzi, 1978; Fonow & Cook, 1991; Munhall, 1994; Reinharz, 1983).

A computerized search was conducted using the following databases: Cumulative Index of Nursing and Allied Health Literature (CINHAL), PsychINFO, Social and Behavioral Sciences Index (SBSI), Wilson Social Sciences Index (WSSI), ABI, and Medline. Between 1987 and 2002, 275 articles identified by this researcher had some related workplace violence focus. Many workplace violence publications occurred between 1994 and 1996. Using the same keyword search of the World Wide Web and Yahoo search engine, there were approximately 3,500 entries. Further review revealed approximately 100 books written with a focus on workplace violence from 1986 to 2002. Other interesting findings included several instructional video courses offered as training

seminars. These video courses described the nature of workplace violence and strategies for the prevention of violence in the workplace. However, these training seminars focused specifically on sexual harassment as the main cause for workplace violence and aggression, not presenting other potential behaviors that lead to violence and aggression in the workplace.

Most of the databases initially and primarily used employed combinations of the keywords *workplace violence*, *nursing students*, and *nurse education*. These keywords were searched for in title, abstracts, or descriptors of books and periodicals. Care was taken to include the asterisk function that allowed for plural forms of these descriptors. Combinations of parenthetical functions such as *workplace violence* and *nursing students* were used with Boolean operators to further narrow the search results.

Other keyword descriptors used in the literature search within all databases included *phenomenology* and *feminist theories*. Many of these keywords were coupled with terms describing educational delivery systems in nursing such as curriculum and instruction. Finally, keyword searches and background selection focused on accomplished authors recognized as experts in workplace violence research and methodology. Names such as Barling, Lanza, Mullen, Woodtli, Breslin, and Munhall appeared as the most significant authors in the focus of this research.

The central theme identified in all studies follow: (a) the workplace is a violent place; (b) there are high-risk populations in the service sectors; (c) definitional issues have influenced data analysis in a negative fashion; and (d) physical acts are reported more in the media but are actually less likely to occur in comparison to nonphysical acts.

Finally, there was a call to arms by national organizations for nursing: "We need to do something" (American Nurses Association, 1998; International Council of Nurses 2001; Woodtli, 1997). The researcher recognized violence as a major concern; the problem was how to address it. Further adding to the confusion were the multiple definitions and lack of understanding of what actually constituted violence. The call to arms by national nursing organizations was the first step to raising consciousness to the magnitude of this phenomenon.

The outline format in articles and studies flowed like a cookbook recipe for identifying and curbing violence in the workplace. This was presented by telling the reader first how to recognize the signs of a problem, then how one might move to solve it. Placing the studies in a chronological sequence allowed this researcher to identify gaps in the research and patterns that had developed over time. The influences of social change in the business world provided further comprehension for this investigator to go deeper into the phenomenon of workplace violence by understanding organizational change. The next task was to narrow down the focus because volumes of information and research became evident on workplace environment. The task was to focus on workplace violence and aggression in the field of health care, more specifically, nursing.

### *Framework of the Literature Review*

Narrowing the focus, the literature review structure began by tracing the general development and specific application of workplace violence research within the field of nursing education. The selection of empirical research to critique and synthesized was

minimal, narrowed down by three fundamental characteristics: (a) the theoretical base, (b) the participants, and (c) the methodology. It was the purpose of this researcher to identify qualitative studies that addressed nursing students exposed to workplace violence. Furthermore, this researcher sought educational studies that focused on the workplace or violence in general.

This researcher attempted to move from the complexity of workplace violence into the specific nature of violence in nursing. Studies addressing definition concerns and education were also included. The researcher paid close attention to concepts, research designs, sample characteristics, settings, and measurement approaches moving toward those studies that were specific to nursing students, health care, and education in the context of workplace violence. At this point it became clear there were variances in the definitions of workplace violence, making this the beginning point for this researcher.

### *Definitions of Workplace Violence and Aggression*

The term workplace violence had many definitions in existing literature (Barling, 1996; Bulatao & Vadenbos, 1996; Lanza, 1991; McPhail, 1996; Mullen, 1997; O'Leary-Kelly, 1996). Two confusing issues that became evident to this researcher included (a) violence and aggression organizationally motivated, and (b) distinguishing between violence and aggression as an operational definition. Some studies reviewed included domestic violence as part of the concept workplace violence. A rationale for this was presented by an example of a case where the woman had been assaulted while in the

workplace by a spouse or significant other. Therefore, it became obvious that blurring between the boundaries of organizational and nonorganizational violence would further add to the confusion of this phenomenon.

One study, cited by Barling (1996), defined human aggression as any act an individual intentionally attempts that harms another. According to this definition any acts of intentional harm in any organization could qualify as workplace aggression as long as the individual deems the act harmful. In the literature, violence alone seemed to denote some form of physical assault on an individual making nonphysical acts less researched. Barling opened the door to the idea that violence and aggression were two distinctly different terms and should be identified as such.

Multiple studies examined the prevalence in various forms of workplace aggression while also trying to identify the typologies evident in aggressive behaviors (Baron & Newman, 1996; Geddes, 1994; Geddes & Baron, 1997; Newman & Baron, 1997). In one such study (Baron & Newman), 452 full time employees rated the frequency with which they experienced 40 different forms of aggressive behavior. Exploratory factor analysis of the data revealed 33 variables in three dimensions (a) expressions of hostility, (b) obstructionism, and (c) overt aggression. How aggression is expressed is important in determining descriptors that researchers might use in order to study the aggressive behaviors exchanged in the workplace. Often, individuals may not consider certain acts as forms of aggression; therefore, incidents may be dismissed by the parties involved minimizing statistics by underreported episodes.

As early as 1878 research studies used different words to express the term aggressive behavior including 'obstruction.' Indicating that aggressive behaviors were not easily measurable due to the multiple interpretations of meaning. During this period of time, the literature described work slowdown as a form of an obstructing aggressive behavior that was directed toward management. Research conducted during this time further described workplace violence as acts of sabotage conducted by an employee. In one study conducted by Giacalone and Rosenfeld (1987), of the 29 employee sabotage behaviors identified, eight involved work slowdowns where the individuals acted "as a group slowing down production in order to get the foreman in trouble, fired, or transferred" (p. 372) also consider aggressive behavior.

With respect to obstructionism, the literature reflected this type of aggressive behavior as malicious, motivated by intent to cause damage to either an individual or an entire organization. In later studies the term sabotage become more predominant. Research conducted by Greenberg and Scott (1996) suggested that many individuals do not consider theft or damage to company property an act of sabotage. The workers considered this an act of getting what they deserve in exchange for their hard work.

The term violence has taken multiple presentations in the literature. In most studies, the researcher defined the term for the participant. In doing so, a laundry list of options was provided in a survey format attempting to elicit some meaning. Ninety articles published between 1987 and 1995 addressed workplace violence. The reported incidents involved homicides that had occurred in the workplace along with other crimes,

such as robberies and not necessarily by a worker. These could have included a walk-in robbery in which a worker was murdered. During this period, the term workplace violence was defined as any physical act directed against another individual that resulted in harm. Also during this period nonphysical elements were not addressed as a distinct definition. Nonphysical assaults were mentioned only as secondary to the primary physical act being perpetrated.

During the late 1980s the topic of workplace violence took on a renewed interest by researchers (Hales, Seligman, Newman, & Timbrook, 1988). However, the definition discrepancies continue, and the focus changed to researching social determinants as causes for workplace violence.

Studies have since separated descriptors of violence into acts of physical violence and nonphysical violence. For example, over 80% of the cases of workplace homicide studied involved employees who wanted to get even for what they perceived as (their) organization's unfair or unjust treatment of them. (Baron, Neuman & Geddes, 1997; Brockner, Konovsky, Cooper-Schneiger, Folger, Martin & Bies, 1994; Greenberg, 1990, 1993, 1994; Hoad, 1993). When asked to describe situations that made them angry, most people referred to something that another person said or did; something that made them angry (Harris, 1993). Terms used period to describe workplace violence included unfair treatment, frustration, diversity of the workforce, and organizational climate (e.g., dog-eat-dog).

Organizational and management change theory was evident throughout the literature during the early 1980's to the late 1990's focusing on issues of how managers should manage. For example, it was quite fashionable for a CEO of a corporation to brag about the number of employees they had terminated or operations they excised (Dumaine, 1993; Loeb, 1996).

The health care environment as a business endured the same changes as the business organizational climate. In the 1980s, nurses were abundant in the profession, making the job market more complex. The nature of the health care workplace was congruent with organizational redesign, downsizing, and moving from the idea of a team approach to more a business focus with the nurse being the primary care provider. Two factors driving this change in the country included government and competitive free market forces (Zerwekh & Claborn, 2000).

Research studies during the late 1980s and early 1990s reflected the changes of the modern workplace. For example, the survivors as well as the victims of workplace violence reported experiences of considerable frustration and stress (Brockner, 1994), and depression, resentment, and hostility (Catalano, 1993; Novaco & McConnell, 1997). Workforce reductions led to declining morale and distrust of management (Brockner, 1988; Cascio, 1993). Workers having to cope with increased workloads became the impetus for the increased aggression in the workplace. Further studies conducted by Tomasko (1990) indicated a correlation between downsizing, layoffs, budget cuts, and pay freezes with raised hostility and obstructionism in the workplace.

In summary, it is important to note during this period workplace violence researchers did not provide a comprehensive view of the phenomenon associated with workplace violence and aggression. In the preceding paragraphs, the studies revealed the perceptions of workplace violence and aggression were clearly noticed in the work environment but not defined in terms that might have allowed for a complex analysis. Because of these definitional problems, there are aspects not yet studied.

### *Education and Workplace Violence and Aggression*

Workplace violence studies did not capture this evolving phenomenon over time, but at a single point throughout the past several years of research. Among some longitudinal studies identified, few investigated patterns; instead, they looked at factors that would predict possible stress variables of victims.

No phenomenological and only two qualitative studies were found, neither of which were specific to workplace violence and aggression with nursing students or nursing education. The two qualitative studies presented below actually opened the door to concerns about workplace violence regarding nurses and education. However, to date none has subjectively addressed nursing students who have experienced workplace violence and aggression while in the role of a nursing student. Furthermore, no studies have considered how education is or is not meeting the needs of this new victim population.

The Woodtli and Breslin (1996) study was significant in that it drew public attention to the issues related not only to violence in the United States, but to the

escalating incidences of violence against women and the need for related content in nursing curriculum. In this study, a descriptive survey design was used to collect information from schools of nursing related to curriculum content that focused on violence against women, children, and elders. A mailed questionnaire was sent to the deans of all baccalaureate and higher degree nursing programs accredited by the National League for Nursing (NLN). The total number of nursing programs that were surveyed was 622. Of the 622 mailed questionnaires, 306 (49%) were returned. The findings were similar to those found by Hoff and Ross (1995) in their survey of nursing schools in the Province of Ontario. For example, they found that child abuse content commanded the most hours, elder abuse had the least coverage, and the content was assigned in reading assignments only. The nursing student experience did not include any deliberate effort by the nursing educator to provide actual human patient contact as part of their learning.

Both surveys concluded that content related to woman abuse/battering was addressed in psychiatric and mental health courses. The topics received between 2 and 4 hours of classroom instruction. No direct patient exposure was planned specifically to provide the nursing student with an opportunity to care for these victims. If the opportunity was available it was purely chance. Most clinical instructors preferred not to assign these types of patients to nursing students. Of the 53 U.S. educators who responded, all believed that violence content was adequately addressed; however, only 30% of Canadian educators agreed. Canadian educators (90%) seemed more interested in curriculum development workshops or seminars than did U.S. educators (67%), thus

showing a better comprehension of the problem by the Canadian nurse educators of the need in the curriculum to address violence.

The above studies demonstrate a need to address more research specific to workplace violence and aggression in education. For example, no patterns have been determined due to a lack of longitudinal studies on workplace violence. However, several studies have been conducted on the outcomes of stress- related factors and workplace violence. Research gaps identified demonstrated the need for more qualitative studies. The studies need to focus on specific cultural groups allowing the victim an opportunity to express the meaning this experience holds for them. Therefore, researchers may gain knowledge from personal stories and be able to respond to educational needs through an in-depth appreciation of what it means to be the victim and how it has affected their lives.

Education has clearly focused away from providing adequate instructional content for nursing students regarding violence, both in the classroom and through clinical experience. No clinical experience or specific violence content occurred that would have allowed a nursing student to comprehend violent and aggressive behaviors to protect her from harm through a learned experience. In the study previously conducted by Woodtil and Breslin (1996) more than half of U.S. educators surveyed reported being satisfied with the content of violence contained in the nursing students' curriculum. This may have indicated either a lack of understanding or uncertainty regarding the problem of workplace violence. Either way nursing students are unprepared to protect themselves or others when exposed to workplace violence situations they are confronted with.

The survey also indicated the major reason for inadequate attention to the content was insufficient time considering the necessary curriculum requirements facing nursing students prior to graduation.

### *Health Care and Workplace Violence and Aggression*

In sample selection, most studies focusing on health care did not discriminate between settings. The majority of studies crossed over different health care environments including psychiatric settings, emergency departments, home and community health, and also addressed different educational levels (Whitley, Jacobson, & Gawrys 1996; Woodtli & Breslin, 1995, 1996, 2000).

The research conducted on stress coping in the workplace used almost exclusively quantitative measurement approaches. Standardized measurement tools were either adapted or developed specifically for the purpose of measuring stress related outcomes in nurses exposed to workplace violence (Baron, 1993; Braverman, 1992; Henderson & Bostock, 1977; McCaffry, 1989; Northwestern National Life, 1993; Wykes & Wittington, 1991). It is worth noting that no longitudinal design studies were noted that focused on the actual long term outcomes, only predictors of potential stress outcomes.

Based on studies reported by Lazarus and Folkman (1986), there are four categories of reactions that victims expressed (a) emotional, (b) social, (c) biophysical, and (d) cognitive. In this theory, potential outcome reactions to stressors are divided within these four categories. In the stress outcomes studies, nurses used verbs that described emotional reactions such as anger, guilt, insecurity, hate, or hopelessness. In

the social categories, nurses described social reactions to being a victim as a loss of respect, loss of security, and a lack of caring. In the biophysical category many nurses reported headaches and stomach pains. Finally, nurses exposed to workplace violence and aggression reported the following cognitive reactions, they lacked interest in people and the profession, felt burned out, and wished they could leave the profession altogether.

These reported reaction studies of nurses demonstrated how the victim suffered from the experience itself. However these studies directly addressed the reactions to being a victim only in staff nurses not nursing students.

Whitley, Jacobson, and Gawrys (1996) conducted a study on the impact of violence in the health care setting. In this study, the researchers reviewed violence in various health care settings and suggested approaches to prepare nurses to effectively respond to these challenges. A survey was sent to various health care settings in order to determine the incidence of violent and assault behaviors. In the psychiatric setting, the authors indicated that rates might be higher in the United States than in any other nation. Emergency department incidences were reported to be on the rise with 49% of assaults taking place in the emergency department versus 23% in psychiatric settings. In long-term settings, findings reported included both verbal and physical abuse elicited from interviews and focus group meetings with staff. The home care provider reported increased numbers of weapons, drug dealing, and violence incidences during times when they were providing care for residents. Based on statistics of increasing violence in multiple health care settings, nursing students must be prepared to deal with these issues, both as nursing students and as future practicing nurses (OSHA, 1998).

Woodtli and Breslin (1997) conducted further investigations into the nature of violence and the nursing curriculum. The major question confronting nursing educators was whether their own preparation gave them the ability to provide nursing students with the knowledge and skills to function effectively in violence prevention and care of violence victims.

Of major concern was the fact that many educators did not feel they had the confidence to teach workplace violence prevention or any content of violence other than domestic violence, child abuse, or elderly abuse.

As a follow up to the survey conducted in 1996, the same researchers attempted to determine the implications of violence for nursing education programs, as perceived by nurse educators. During the National League for Nursing (NLN) biennial convention in June 1995, held in Chicago, these researchers and 100 nurse educators engaged in dialogue about the implications of violence and abuse for nursing curriculum. Both Woodtli and Breslin presented the survey previously conducted on content in nursing curriculum related to violence against women, children, and elderly. The conference participants discussed the findings during a short question and answer breakout period.

Following the focus group discussion, a general discussion took place with all in attendance. Five violence related topics of concern, as a result of the presented survey, were identified as (a) the lack of faculty expertise to educate nursing students about violence, (b) the lack of learning experiences for hands on approach to learning, (c) nursing student personal issues, (d) the determination of what content to include and how

it should be placed in the curriculum, and (e) determining the expected learning outcomes. During focus group discussions, the educators recorded their comments, thoughts, and suggestions. Issues of special and immediate concern were highlighted and each topic was prioritized into categories.

Findings reported from the focus groups include: (a) the faculty lack expertise about violence in special populations, (b) the faculty lack expertise in violence assessment and intervention, (c) the faculty defined the problem of violence in multiple inconsistent ways, (d) the faculty lack concepts of victimization, and (e) the faculty lack expertise in conflict resolution, debriefing, and crisis intervention.

The focus groups recommended the faculty, as the priority, must develop personal expertise in violence assessment, specific to elders, children, and women. They also recommended violence prevention and care of victims be placed in the curriculum. Again, the focus of concern was directed at a target population and did not address the larger scope of workplace violence and aggression.

At the end of this convention, Woodtli and Breslin (1997) conducted another survey with seven items that addressed nursing student knowledge and learning experiences. The response format was on a 5-point Likert scale. The surveys were placed on a table at the registration desk with a small poster explaining the purpose of the study. There were 107 surveys completed. Of 107 participants, only two identified themselves as not being currently in faculty positions. According to Woodtli and Breslin (1997), 46 (43%) respondents indicated that they taught primarily in baccalaureate nursing

programs; 41 (38%) in associate degree programs; 20 (19%) in graduate programs; 5 (5%) in diploma nursing programs; and 2 in practical nurse programs.

The responses pertaining to curriculum indicated that:

1. Eighty-six percent preferred the integration of violence content into current curriculum. The specific content named was domestic violence, and elder and child abuse.

2. Sixteen percent preferred an elective course.

3. Seventy-five percent disagreed strongly with the adequacy of violence related content currently included in nursing curriculum.

4. Thirteen percent indicated that nursing already have adequate content related to violence.

5. Nearly half reported learning resources were not available to teach.

6. Thirty-three percent indicated that resources were available

7. Twenty percent had no opinion.

Under the survey heading faculty knowledge and development, the following results were calculated.

1. Ninety-eight percent believed that faculty has a responsibility to report abuse in the clinical setting when identified.

2. Fifteen percent expressed adequate knowledge to teach nursing students content on violence and abuse.

3. Ninety-three percent determined additional knowledge for faculty was needed before teaching the content on violence.

4. Four percent felt at this time it was not necessary for nursing students to have any educational component on violence.

Under nursing student knowledge and learning activities,

1. Ninety-six percent of faculty surveyed stated assessment skills for violence are essential for all nursing students.

2. One hundred percent agreed that nursing students must be educated to recognize signs of physical, emotional, and sexual abuse.

3. Ninety percent indicated nursing students have a responsibility to deal with violence in the clinical setting.

4. Ninety-four percent agreed conflict resolution skills must be taught to nursing students.

5. Eighty-seven percent of respondents indicated that primary prevention community educational activities related to violence should be required learning for basic nursing students.

6. Forty-nine percent agreed that nursing students should have planned clinical learning with abused women while the rest of the respondents either disagreed or disagreed strongly.

These research studies have significant findings for this researcher in that several conclusions can be drawn. This sample of educators agreed that content on violence is not currently a focus in nursing curriculum. These findings are contradictory to a previous survey reported by Woodtli & Breslin (1996). In that study faculty reported the content on violence was adequate. However, findings in this current study support a study

conducted by Hoff and Ross (1993, 1995) with nurse educators in Ontario, Canada. The study reported 30% satisfaction with the content on violence currently being presented in nursing schools in Ontario, Canada.

These studies clearly demonstrate an alarming view of faculty knowledge and skills related to violence assessment and intervention. Certainly the dialogue of these nurse educators provides beginning evidence that violence, if addressed at all in nursing education, is sparse and focuses mainly on the victims of domestic violence, and child and elder abuse. Nowhere was there evidence in the literature that nursing students know how to respond to exposure to being victims themselves.

A further follow-up study conducted by Woodtli (2000) identified and described essential knowledge and skills needed by nurses in order to provide competent, sensitive care. This qualitative study was conducted with 13 informants who were considered experts in violence related care. The purpose of this study was to provide data that could form the empirical basis for content revision and serve as a framework for future curriculum development on violence. Seven questions emerged out of the two previous studies focusing on educational dimensions of violence and abuse conducted by the investigator (Woodtli & Breslin, 1996; 1997). The seven questions were:

1. What are your experiences with domestic violence?
2. How do you feel about domestic violence?
3. What do nurses need to know about domestic violence?
4. What skills do nurses need to provide appropriate care for domestic violence clients?

5. What attitudes do nurses have about the victim/survivor?
6. What attitudes do nurses have about the perpetrator?
7. What do you see as the outcomes of nursing care?

A final question was open-ended and simply asked: Would you like to add anything else?

In the analysis, the transcripts were analyzed for significant statements, categories, and themes. The results indicated content on violence needed to be a priority in nursing curriculum. They further suggest nurses' tune into their personal feelings and attitudes about violence. Suggestions for curriculum integration included desirable accomplished skills at five levels: personal, interpersonal, institutional, community, and public policy when confronted with violence.

In summary, according to this most recent survey nurse educators now have an understanding of the importance of addressing violence related issues in the curriculum. The concern remains the content focuses on targeted populations and not on the nursing student as a potential victim herself. Furthermore, the faculty surveyed expressed a need to incorporated strategies for understanding facts and skills for nursing student learning, but not how to address nursing students' needs as victims. No evidence exists in the literature, or in this researchers' general discussion with colleagues, that violence education is being comprehensively addressed for nursing students. There is however evidence that areas of child abuse, domestic violence, and elderly abuse are being "touched on" at various times through the nursing student's educational path.

*Nursing Students and Workplace Violence and Aggression*

No studies that focused on nursing students as victims of workplace violence and aggression were found by this researcher of this date, although it is possible some may exist. In fact, only two surveys found in the research focused a deliberate attempt to delineate the problem of workplace violence and the nursing student. The first survey was conducted in Scotland and reported by the Scotland Occupational Safety and Health Database (1995). In that survey of 1,000 nursing students, 372 reported being assaulted. The second survey, conducted by the International Council of Nurses (2001), reported nursing staff was most at risk, but the more likely victims were nursing students.

Many studies on workplace violence and nurses focused on mixed gender. This research approach missed important considerations for understanding workplace violence, namely a particular typology. Further, no studies were identified that used gender specific nursing students or nurse educators in the context of workplace violence. This supported the need for further research using specific gender and typology.

According to McCoy and Smith (2001), "Nursing has historically been a female profession. Consequently, a primary reason that nurses may face difficulty in taking action when becoming victims of workplace violence incidences is due to the patriarchy ideology of the role socialization of women" (p. 5). McCoy and Smith suggested there are acceptable behaviors for females in the workplace that have been perpetuated as traditionally acceptable. These behaviors consist of skills of listening, nurturing, affiliating, and being sensitive to the needs of others. The authors further pointed out,

"Nurses are socialized into the role of 'nurse'" (p. 5). During the interview process in this study, participants clearly demonstrated how this idea might, in fact, be validated. For example, the nursing students often referred to what nursing "is suppose to be" or how "nursing is caring"; conceptualizing what they perceived to be the essence of nursing. Whether these ideas are perpetuated by society, gender factors, or educational preparation is not determined by this study but clearly identified as a contributing factor to the phenomenon of workplace violence and aggression.

In summary, the findings of this researcher's investigation clearly correlated to what McCoy and Smith (2001) suggested, in that gender issues have in fact perpetuated female workplace behaviors in nursing. Further adding to this phenomenon is the inconsistent management philosophy altering the workplace personalities.

According to Duten (2002), the past management credo--"Shut up and be glad you have a job"--has now returned as the new philosophy because of a poor economic situation in our country. What is perceived as desirable characteristics in an employee are outlined by the Illinois Professional Development Partnership (2002). In this report, the desirable characteristics a doctor or lawyer should have in terms of professionalism were noted as caring, listening, good humor, knowledge, competency, genuine concern, and very approachable. Although the nursing profession was not addressed, one might draw an association between what individuals perceive acceptable for a doctor would most likely transfer to a nurse being part of the medical profession.

In the 1950s, what constituted acceptable behaviors included formality in the workplace and conforming to the rules. The problem of professional behaviors warrants

further investigation by research into patterns of correlation with management philosophy and economics. For example, is someone really unprofessional if they are perceived to be uncaring, stern, less competent or unapproachable? Or might it be the return of the 1950s formality of the workplace that mandates the change in behaviors only to be misinterpreted as negative behaviors.

Dauten (2002) suggests in 2002 individuals in the workplace are required to conform to acceptable workplace behaviors which have throughout the years gone from formal to informal and back to formal, no creativity to creative thinking back to no creativity, out-of-the-box thinking back to in-the-box thinking with management controlling all decision making factors.

Nursing is a profession and therefore nursing students are encouraged to act in a professional manner. What is perceived as professional and unprofessional by a patient may in fact be reflective of the changing nature of the workplace. This formal approach may further lead to a patient who in turn responds violently to what he or she misinterprets as an unapproachable nurse who is uncaring, unprofessional, incompetent, and rigid. As previously discussed, the nature of the workplace milieu might very well lead to misperceptions and higher statistics of assaults against nurses in the future.

According to Lazarus and Folkman (1986), reaction to a stressor may be affected by how one perceives the stressor. In the current study, this researcher noted each victim did present with specific gender bias regarding what the role of a nursing student should be. For example, many participants saw themselves as caring and nurturing in the

traditional sense, without realizing they had choices that may have altered their experience of workplace violence and aggression.

Many participants were bias toward the traditional workplace formality and acceptable educational expectations, such as, the "fear of being kicked out of school if they questioned a faculty, who are the authority." Ironically, this correlates with the research study on staff nurses who fail to report incidences of violence against themselves for "fear of losing their job, or being blamed for the incident" (Lanza, 2001).

No research was located that specifically addressed differences in the male and female nursing students' responses to incidences of violence. However, research did address how female nurses' behaviors reflected the social bias against women in our society. In these studies, Ashley (1995) describes the hospital as "a patriarchal family where nurses' responsibilities encompass all "family" members including patients and physicians. Within this framework, feminine virtues--motherliness, femininity, service, and efficiency--are valued and perpetuated by society and those providing nursing education" (p. 19).

Heim (1995) suggested gender socialization begins at birth, continues through life, and influences careers. This is perpetrated right from the start, at birth when the newborns are wrapped in a blue blanket for a male and a pink blanket for a female. In education, gender socialization is further perpetuated in the hierarchical position of the faculty and the nursing student. This is further carried over in the hospital setting during internships in which the nursing student is introduced deeper into the hierarchy structure

by adding the physicians who command obedience in addition to the educator (Cumming, 1995).

In evaluating health care environments, McCarthy (1995) described them as being traditional in the organization using the analogy of a family. The male in this tradition is responsible to the social norms that suggest he issue orders, assign tasks, and provide leadership. On the other hand, females are not to be assertive but passive, almost subservient.

According to Cummings (1995), men comprised 4% of the nursing profession and were therefore stereotyped as "womanly." Cummings further suggested that this led to the male nurse trying to prove his masculinity by asserting more power and control or working in isolation disassociating from the female nurse. Unfortunately, Cummings further suggested that female nurses added to this gender bias by turning to the male nurse when assistance was needed with tasks requiring more strength, such as moving a heavy patient or conducting invasive procedures on a male patient. By the workday end, the female nurse would become territorial in her behavior, excluding the male from social activities within a group of female nurses no matter how cooperative he was to her requests during the workday.

Cummings (1995) raised another concern by suggesting that most nursing instructors preferred a male nursing student, and may actually have given them preferential treatment. Heim (1995) concluded male and female genders viewed each other through "gender culture lenses" and saw each other's behaviors as problematic

given the world in which he or she grew up (p. 7). This premise substantiates that in the workplace men and women do not follow the same rules, nor do they understand the rules in the same way. Heim described this as "men are competitive and focus on the goal line, while women have a best friend and learn to avoid conflict, to get along, and be nice... men tend to go for the jugular, enjoy a heated argument, and then have a beer afterwards with the enemy" (p. 7).

In comparison, Heim (1995) concluded women would do the opposite of a man--that is, they would avoid the situation, but damage the work environment. Heim described the work environment of female nurses as "going to mama, the sniper" (p. 17). The example provided by Heim suggested two women who were friends with each other had a conflict and as one turned to leave, the other woman turned to another colleague and called the first woman an inappropriate name. This example supports Heim's idea that women would avoid conflict rather than face it.

In summary, men and women have been socialized differently, not only in gender roles, but also workplace roles. Gender specific workplace issues further add to workplace stress and promote the role of victim. In this study the female nursing students raised several questions regarding gender and culture specific biases among nurses in the workplace. Further discussion on this topic is provided in chapter 5.

*Alternative Paradigm for Workplace Violence Research*

This research study on workplace violence and aggression as it relates to nursing students and nurse education is a paradigm shift. The intended purpose in this approach was to introduce researchers to the existentialist framework that includes a key concept: finding meaning through lived experience. By successfully presenting this paradigm, this researcher has provided advanced research on workplace violence and aggression research through an in-depth look at nursing students' as victims.

In addition, this approach further broadens the research because existentialism philosophically supports knowing may come through intuition and interpretation of the phenomena through individual perspectives.

Research expansion through this qualitative approach offered defining aspects of meaning that the victims created and discovered. It was through the process of interviewing and defining aspects of nurse victims of violence and aggression that meaning will now be reflected in qualitative literature.

Further, prior to this study, no studies were found that specifically focused on the nursing student exclusively as the victim of workplace violence and aggression. As previously mentioned, quantitative studies related to coping and stress outcome indicators had been researched, along with studies of the magnitude. This paradigm shift in this study provided qualitative research on nursing students as victims of workplace violence and aggression providing further research into the realm of this phenomenon.

One goal of this research study was to provide an opportunity for nursing students who had experienced workplace violence and aggression to tell their stories. Further, to address a group never before studied (nursing student victim), employing a methodology that had not been used (phenomenology), and provide nurse educators thought provoking ideas on the role nurse education must play in altering this phenomenon.

### *Summary*

In summary, the literature on workplace violence and aggression provided research on outcomes variables of stress reactions derived from quantitative survey studies. This provides researchers with a foundation for studies on psychological factors related to workplace violence. More studies clearly are needed that address specific cultural groups and focus on methods not only to decrease the incidences of workplace violence, but also to better prepare the worker to function in this environment.

This phenomenological study offered an opportunity for the victim to express the meaning of the experience, thereby raising consciousness and opening doors to further inquiry into the nature of workplace violence and aggression. By focusing strictly on nursing students' this new knowledge has provided a sense of meaning to that of being a victim, in what is termed a caring profession.

In the following chapters, phenomenological methodology will be described as the approach used by this researcher to discover the meaning workplace violence and aggression exposure had on nursing students who experienced being a victim first hand.

This researcher further discusses the nature of the study, the method of research, the particulars of phenomenology, techniques for data collection and analysis, and then concludes with a summary of findings and recommendations for future research.

# CHAPTER 3: THE PHENOMENOLOGICAL METHOD

## *Introduction*

Phenomenology is a philosophy that seeks to answer the question, "What is the meaning?" In caring professions, it becomes necessary to support and assist people to reach their personal goals through the study of what it is like (Munhall, 1994). Therefore, how can we attach meaning to an experience unless we know how the person interprets the meaning by personally living the experience? Through the meaning the person attaches to their experience comes "their perception." The important thing about perception is one must have respect for each individual's interpretation of the events as his or her own reality or truth. With this philosophy in mind, the phenomenological design was accomplished as follows.

## *Research Design*

Carefully considered by this researcher were the purpose and specific aims of this study. Critical analyses led to combining both phenomenological and feminist approaches for conducting the study. This approach was based on the need to explore and document lived experiences through the participants' own expressions. By providing this opportunity for the participants, active participation was encouraged leading to the unveiling of meaning. Adding the feminist approach to the phenomenological methodology was drawn from Harding (1987), who suggested research should not be only "*about* women, but also *for* women." Therefore, the women who participated in this

study were approached as co-participants and not passive "subjects," equalizing the research partnership (Campbell & Bunting, 1991; Rubin & Rubin, 1995).

Further, the participants were actively involved in verification of the findings reflecting on what the experience meant to them promoted their awareness as co-participants in the research process (Fonow & Cook, 1991; Rubin & Rubin, 1995). This researcher remained sensitive to potential issues of power relations throughout the entire duration of the investigation. Hierarchical exploitive behaviors were not demonstrated and the nursing students were assured of how their participation in this study would encourage change through having the opportunity to have their stories told (Harding, 1987; Rubin & Rubin 1995).

The combination of phenomenology and feminism are compatible at the epistemological level. While both acknowledge possible existence of more than one truth and emphasize unconventional ways of knowing such as subjectivity and intuition (Fonow & Cook, 1991; Spiegelberg, 1982), this approach was applicable to the research being conducted. Another aspect considered was that phenomenology and feminism accept the participants as legitimate sources of their lives and therefore the most knowledgeable (Campbell & Bunting, 1991; Fonow & Cook, 1991; Giorgi, 1985; Harding, 1987).

Furthermore, the consideration to use phenomenology and feminism was based on the fact they are compatible methodology. In conducting the study, the following descriptors identified in the planning stage became the focus this researcher followed: (a) the lived experience within context, reflection, reflexivity; and (b) research as a socially

constructed, participatory act (Rubin & Rubin, 1995). Living within the context of the research was first suggested in Heidegger's concept of *being-in-the-world* (Spiegelberg, 1982). From this, feminist researchers adopted a similar idea that the humans cannot be removed from their world and only one person can determine meaning.

In this study, the researcher deliberately meant to capture the experience of workplace violence and aggression through the participants' own world as lived and experienced. The interview guide encouraged the participants not only to describe their experiences in detail, but also to elaborate on what meaning they attributed to this experience. Therefore, the flexibility of the design and periodical adjustment of the interview questioning allowed meaning to emerge through the participants (Rubin & Rubin, 1995).

The idea of reflection in research was first noted in the works of Heidegger. Later Colaizzi (1978) and Munhall (1994) suggested reflection as a tool that could be used to uncover presumptions in phenomenon. Feminist methodology drew on this idea and suggested women researchers' experiences could add to the dimensions of this approach through reflexivity. This concept suggested the woman researcher not only reflect on the participants of the study, but also set aside assumptions by reflexive journaling of personal thoughts, feelings, impression, revelations, and intuitions experienced during the research process. Thus, this researcher used reflexivity as a means for critically inspecting the entire research process, "an important procedure for establishing validity through accounts of social phenomena" (Schwandt, 2001).

Colaizzi (1978) treated the participants in studies as equal partners focused on discovery. Further, they were drawn into the verification process of the research results. Feminist methodology also considered the participants as the experts in their own experiences and a natural part of the verification process (Campbell & Bunting, 1991). The difference in feminist thinking is this also is a way to empower and raise consciousness (Anderson, 1991; Gorelick, 1991; Harding, 1987). Therefore, this researcher reflected on personal experiences using that wisdom to design the interview questions, conducted the interviews with an open mind, engaging the co-participant toward finding meaning in their experience of workplace violence and aggression. In addition, this researcher maintained a personal reflexive journal following each interview session.

*Population Sample*

Ten participants were randomly selected from a pool of 45 volunteers of which 42 actually met the predetermined criteria. Numbers were assigned to each of the 42 possible participants, 1-42. Ten numbers were blindly drawn from a container, and then matched to the pre-numbered sample pool to randomly obtain 10 participants. Purposive sampling in phenomenological studies, according to Patton (1990), enables the researcher to locate "information-rich" participants by asking people in key positions for referrals. This researcher made sure that each participant met among predetermined criteria, that of a good informant--as "one who has the knowledge and experience the researcher requires,

has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study" (Morse, 1994) (p. 228).

A criticism of qualitative studies is that sample sizes are generally smaller than in quantitative studies. However, there are no set rules about the necessary sample size in a qualitative study (Sandelowski, 1995). According to Sandelowski, sample sizes for phenomenological studies vary from 6 to 12 participants. This study elected to interview 10 nursing students, each with unique experiences yet representative of various geographical areas, cultures, and levels of education. The sample size adequately provided a rich description evident in the fact the themes became repetitious noting saturation of the phenomenon understudy.

For the purpose of this study, the nursing student was defined as a female student of any race, age, religion, and socioeconomic status, who had experienced an act of workplace violence while in the health care setting, prior to graduation from a four-year nursing school.

The following criteria guided the selection of the 10 participants:

1. Female nursing student.

2. Have experienced some type of violence or aggressive act committed in the health care setting. Specifically, acts of workplace violence and aggression included: (a) physical violence - physical assault with or without a weapon, hitting, shoving, biting, sexual assault, and/or attempted assault; (b) verbal aggression - either in person or by phone/fax/email (e.g., utterance of threats, verbal assault – sworn at/cursed); and (c) aggressive acts - bullying, mobbing, victimizing, intimidation, threats, ostracism, sending

offensive messages, aggressive posturing, rude gestures, interfering with work equipment, hostile behavior, homicide, rape, wounding, battering, physical attacks, kicking, biting, punching, spitting, squeezing, pinching, stalking, and harassment, including sexual or racial.

Selected participants in this study included those who had experienced an act directed against them for the purpose of inflicting harm or instilling fear. The experience may have been committed by numerous individuals, coworkers, supervisors, strangers, patients, spouses, family members, or significant others. Another criterion for participation was that the incident had to occur while the target victim was in the health care setting, which may also have included entering or leaving the site (e.g., in the parking lot).

A notice soliciting for volunteers was posted on nursing student bulletin boards in 25 schools of nursing throughout Illinois (Appendix F). Snowballing (networking), a purposive sampling method that involves the assistance of individuals to help obtain potential subjects was used by this researcher (McMillan, 2000; Patton 1990). This was accomplished by sending a letter to the deans of 25 schools of nursing requesting that the flyer soliciting for volunteers be posted (see Appendix E). Once the volunteers began to contact this researcher, a pool of participants was established based upon their meeting the predetermined criteria.

*Setting*

Once the participants were identified, an appointment was set up at a mutual time and location with each participant. According to Munhall (1984), the location of the interview could be different from individual to individual; however, the choice should be conducive to a conversation and may even include a café. The only place the interview did not occur was this researcher's office because of the position of power that may have influenced the tenor of the interview.

Of the 10 interviews obtained, all except one took place on the various campuses where the student was attending nursing education classes. Various locations on the campuses included the cafeteria, private nook areas, study areas, and libraries. One interview occurred outside a campus setting at the participant's request, because she was no longer a nursing student.

*Data Collection*

At the beginning of each meeting participants were given a chance to ask questions and receive clarification from this researcher. Informed consent was obtained prior to beginning the taped interview, and ample time was allowed for the participant to read and sign the consent form (see Appendix B). Participants were also reminded before starting the taped interview that they could request to stop the interview at anytime, without any repercussions, should they feel uncomfortable.

Each interview was audio tape-recorded, and personal journal entries were made soon after each interview. Journal notes describing the context of the meeting, nonverbal

expressions, and personal impressions were made by this researcher cognitively during the interviewing process and then recorded in a journal within 24 hours after the interview had ended. This was necessary to ensure the interaction could be recalled, both subjectively and objectively, when conducting the data analysis. Further, this researcher moved to a reflexive journal to document thoughts and impressions that would help to bracket assumptions.

This researcher allowed the respondents' as much time as they needed to fully express their stories and experiences of workplace violence and aggression, thus providing a thick description. Further, this researcher allowed 3-7 days of personal time to reflect between interviews, considering for travel time, and wanting to be professional at all times (Rubin & Rubin, 1995). Second interviews were not needed; however, participants were informed should they wish to add any additional information they should contact this researcher by phone.

A researcher who ends an interview with "What was it like for you to participate in this study?" is allowing for a period of debriefing and also offering a time for reflection. It is possible that during the time that follows, more reflection may occur and the person might want to tell more or add more about their experience (Munhall, 1984). Therefore, the participants were informed of this option at the end of the interviewing process and were fully aware of methods in which they could contact this researcher directly.

This researcher transcribed all the audiotapes, waiting no more then 3-5 days after the interview in order to have a clear memory of the verbal exchanges and mental notations made during the interviews.

Each participant was sent a personalized thank- you note within a week of the initial interview (see Appendix H). In this letter gratitude was expressed for her willingness to participate in the study. Further, the letter provided the opportunity for this researcher to remind them the verification summary would be following. There was no monetary compensation provided for participation in this study.

In qualitative research, interviewing begins with the assumption that others' experiences are meaningful and able to be made explicit (Patton, 1990). Other assumptions specific to both phenomenology (Colaizzi, 1978) and feminism (Campbell & Bunting, 1991) are the participants are experts in their own experiences. With this philosophy in mind, the interviews were conducted open-ended and in-depth with each participant guided by a format of questions posed below.

*Interview Protocol*

In a phenomenological study, the process of collecting information involves in-depth interviews (Creswell, 1998; Moustakas, 1994) rooted in questions that provide direction and focus on meaning (Moustakas).

How the participant perceives it, or sees it herself, makes each interview a unique experience. Although the subjects were questioned using the same format, each

individual's perception came through personal reflection of their experiences, the subject's own critical analysis, and expressions (Moustakas, 1994).

The interview questions flowed from the following two research questions posed. First, "What is it like to be a nursing student exposed to workplace violence and aggression?" and second, "How might nurse education respond?"

The first interview question, "Please describe your experience with workplace violence and aggression" was appropriate to ask as a means to draw from the broadest scope of information possible. (Appendix G.) Subsequently, this eventually provided the narrative (Creswell, 1998) and the personal meaning of the experience.

The second interview question, "Talk to me about how you adjust or cope," is a topic subquestion that according to Creswell (1998) helps further investigate the context and perceptions of the experience.

The third interview question, "What kind of educational preparation might improve the situation you describe?" provided the participant with an opportunity to exit from the context of the lived experience outside, reflecting on their educational preparation, further providing information that may be examined by nursing education.

The last interview question, "What was it like for you to participate in this interview?" provided debriefing and the opportunity to reflect once again on the meaning derived not only from the experience as a victim, but also someone who may influence educational change by participating in the study.

In phenomenological research, interviewing techniques require the researcher to "follow the mood of the person being interviewed" (Munhall, 1984). Furthermore, in

phenomenology, listening is described as an art (Munhall, 1984; Rubin & Rubin, 1995). Therefore, modifying the pattern of questioning and remaining flexible encouraged this investigator to truly hear the meaning of what the participants said (Rubin & Rubin, 1995). Accordingly, probes provide three purposes in the interview: (a) improving the depth of the interview, (b) sending a signal to provide more detail to the interviewee, and (c) confirming the interviewer is listening (Rubin & Rubin, 1995). This researcher used probes as means to prompt the interviewee to elaborate, continue a thought, clarify a remark, signal attention, and finally, as a means to complete the interview. In all the interviews, probes were phrased tactfully as the narratives and stories unfolded in an effort to obtain a thick description of the experience (Rubin & Rubin, 1995).

### *Data Analysis*

This researcher transcribed the audiotaped interviews, checking the transcripts against the tapes for accuracy. Parenthetical notations made during the interviews helped to identify when changes in volume, intonation, pauses, voice inflexions, as well as eye contact, gestures, body posture, sighing, crying, and other relevant nonverbal behaviors were noted. The personal journal also provided another source for clarification during the transcribing process.

To analyze data, this researcher used Colaizzi's (1978) seven-step method. Frequently used by other phenomenological studies, this model allows the researcher a method to capture meaning in human experiences (Beck 1994; Streubert & Carpenter, 1995). Phenomenological methods support the idea that through open-ended interviews,

exploration and discovery will occur from a collection of data and further provide information about the phenomenon under study (Moustakas, 1994).

In Colaizzi's (1978) model, the phenomenological data analysis is consistent with what Creswell (1998) describes as, "a search for all possible meanings" (p. 52). Further, the analysis will begin with data collection and end with a narrative account (p. 43). This model allows the researcher to modify the sequence of the steps at anytime the data requires. The following describes the steps as written by Colaizzi (1978).

*Colaizzi's Model of Data Analysis*

1. Read all *descriptions* (protocols) given by participants, become familiarized with the content, get a feel for the entire material, and make sense of it.

2. Extract *significant statements* (SS) pertaining to the phenomenon under study from individuals' protocol and list all of them.

3. *Formulate meaning* for each SS, making sure to remain truthful to the data and allow it to "speak for itself."

4. Organize the formulated meanings into *clusters of themes* (CT) and refer them back to the original protocols for validation. If discrepancies are noted, the procedure must be re-examined and/or conducted again. Refuse the temptation to ignore data or themes that do not seem to fit.

5. Draw a summary of CT.

6. Draw an *exhaustive description* of the topic investigated based on the results so far. Formulate the exhaustive description of the investigated phenomenon as an unequivocal *statement of identification* of its fundamental structure.

7. Return to each participant with the final statement and ask for *validation of findings:* "How do my descriptive results compare with your experience?" Any new relevant data emerging at this point has to be integrated into the final statement.

This model provided a framework for this researcher to conduct the analysis of the transcripts from the 10 participants. It further provided a method of critical analysis through personal reflection and wisdom (intuiting) that is characteristic to both phenomenological and feminist research (Fonow & Cook, 1991; Polkinghorne, 1989). In the analysis this researcher was able to draw from not only her wisdom but also knowledge acquired as a working clinician in the inner-city trauma units of Chicago, Illinois. Finally, this researcher's teaching experience assisted in deriving meaning through significant statements and identifying common themes. The following is a description of the steps this researcher used conducting the data analysis.

This researcher began the process by becoming familiar with the process as outlined by Colaizzi (1978) before beginning the data analysis. Once conceptualized with the steps of the process, this researcher became further immersed in the content of the data by personally transcribing the interview tapes. This allowed for a deeper comprehension of what the participant was truly communicating during the interview process. The personal experience associated with this researcher conducting the transcribing further added to the process of making sense of the data.

Following this first step, which was for the researcher to become thoroughly familiarized with each participant's story, this investigator copied each individual transcript and highlighted what were identified as significant statements.

In Step 3, this researcher began to extract what appeared to be themes from each significant statement identified. Again, carefully reading each statement and trying to capture what the participants were trying to express. At this point, a reverse process occurred. The themes were compared with highlighted statements deemed significant within the whole construct of the interview. This process allowed for verification of whether the identified themes really matched the meaning expressed by the participants during the overall context of the interview.

The fourth step followed and focused on distinguishing major themes that were common among all participants. The subthemes were then grouped within the major themes only as a preliminary version. At this point, this researcher discussed the themes with two educational colleagues. Both possess strong research backgrounds and valued comprehension of phenomenological methodology. They provided feedback and suggestions on the preliminary themes and further made suggestions as to decisions this researcher was proceeding with during the analysis process.

In Step 5, this researcher revisited the themes considering the suggestions from her colleagues, further examining both themes and subthemes while compiling direct quotes from each participant that illustrated particular themes. This was a crucial step and allowed for validation of decision processes this researcher used throughout the analysis.

Each of these quotes and participants were coded as participant 1-10 allowing for easier data tracking.

A summary for each of the major themes was written referencing to the themes, subthemes and illustrative quotes. This was then reference coded having all the data at hand during this process. The challenge to this researcher at the time was to make sure the general and specifics of each participant's interview reflected the true meaning expressed.

During the final phase, this researcher completed summaries, major and minor themes, and again requested of the same two colleagues to provide this researcher with further feedback as to the revision of themes.

After considering their feedback, the final step consisted of the participants' review. At this point, the summaries of themes derived from their experiences were mailed to the participants along with a personal letter requesting the following (see Appendix H). Please examine the draft for accuracy. When you read through the description, please see how your own experiences compares to the themes identified. "Tell me how my descriptive results compare with your experience."

All participants' responded, and only minor changes were suggested. Two participants clarified verbs used in the descriptors of coping, and three added comments regarding how education might respond.

The findings of this study are provided in the following chapter. Narratives include quoted excerpts and summaries of the stories expressed by each participant relating their experience of workplace violence and aggression. All narratives include

specific data and coded illustrative quotes that provided the essence of their experiences. The code *p* defines the participant, and the number corresponds to the number assigned to each participant during analysis.

Creswell (1998) suggests from synthesis of meaning comes the essences of the experience provided for the audience. Creswell further suggests this narrative methodology may include storytelling, chronological reporting, and zooming in and out like a camera lens on a typical day in the life of the subject(s).

Four issues outlined by Creswell (1998) must be addressed in any qualitative report. These are audience, encoding, quotes, and authorial representation (p. 167). The audience of this study may consist of colleagues, participants, policymakers, and the general public. Therefore, it is important to choose words appropriate for the audience. The use of verbatim quotes may help the reader "experience the experience," which is the goal of phenomenological research (Creswell 1998).

In addition to addressing the aim of the research questions, the overall desire of this researcher was to provide an exciting narrative that would evolve from the interviews, unfolding various perceptions of being the victim of workplace violence and aggression while in the role of being a "nursing student."

*Indicators of Quality*

According to Lincoln and Guba (1985), rigor in naturalistic inquiry is established through trustworthiness, a process including attention to the truth-value of the findings and also their applicability, consistency, and neutrality. In addition, Munhall (1994)

warned that meaning could be lost in the method, thus suggesting that phenomenological methods should be derivative rather than prescriptive. Munhall simply defined validity as the "unaltered faithful telling of experience by people" (p. 84). Because quantitative data was not validated the same as qualitative, Creswell (1998) suggested verification and standards were largely related to the "researcher's interpretation of qualitative projects" (p. 207). Moustakas (1994) and Creswell (1998) also suggested methods a researcher might use to validate findings such as the entire data collection process (Moustakas, 1994). One method consisted of eight verification processes that Creswell (1998) cited as (a) prolonged observation, (b) triangulation, (c) peer review, (d) negative case analysis and clarification of researcher bias, (e) informant verification, (f) rich thick description, and (g) external audit (p. 200).

For this dissertation, Colaizzi's method offered a system of going back into the transcripts for verification of the themes (Step 4) and ultimately going back to the participants for verification in the final phases (Step 7). Further, through member checks, the participants were offered a final opportunity to remove any information for future publication. All participants read the draft and agreed to sign the consent to release for future publication form (see Appendix I).

Besides maintaining trustworthiness through member checks, other measures were applied to the phenomenon under study: (a) ample data was collected to gain a "thick description" of the lived experiences; (b) a journal with "an audit trail" of presumptions methodological decisions were maintained (Lincoln & Guba, 1985); (c) contextual field notes were logged, and (d) the advice of two colleagues provided review

of content and methodology—a "peer review" process throughout the entire duration of the investigation (Lincoln & Guba, 1985).

# CHAPTER 4: FINDINGS

## *Overview*

This research project collected data from 10 nursing students who experienced some form of workplace violence while maintaining the role of nursing student. The purpose of the study was to explore the participants' perceptions of their experience of workplace violence to better understand the implications these experiences might have for nursing education. The participants openly shared the stories of their individual experiences (Creswell, 1998). In presenting narrative interviews, the participants lived and reflected on their experiences. This provided for a rich description of the events as they unfolded.

This chapter begins with a reflection of the interview sessions, highlighting findings that became significant in the data collection and ultimately the evolution of themes. Next, the specific characteristics of each participant are presented and identified by coding each participant as P- and corresponding interview number of 1-10. This offers the reader a reference to each participant's experiences and characteristics. Following this section the participants' actual experience with violence is detailed along with the responses to each interview question posed. First, each participant's story is provided so the reader will have an opportunity to "feel what the victim felt." At the conclusion of each interview response section, this researcher presents a personal analysis of the findings. Finally, the chapter will conclude with an explanatory section on the themes that were revealed, supported by excerpts, comparing the findings to current literature.

The process began with interviews consisting of open-ended questioning, in an unstructured format probing when necessary. The questions posed were open ended and broad, a deliberate attempt to ascertain the participant's perception, impression of educational preparation, and support expounding on ideas that would raise consciousness, and thereby lead to improving the situation.

### *Interview Sessions*

The narratives that are presented in the following section were derived from the rich descriptive transcripts obtained from each participant. Using Colaizzi's (1978) seven-step method for data analysis, the first step began with transcribing and reading the narratives trying to "make sense of it." After reading the narratives, significant statements were highlighted and coded using numbers 1-10, corresponding with each participant, thus assuring further confidentiality. From this list of coded statements, clusters of themes were unveiled. A narrative description was then formulated to validate the themes and help this researcher draw conclusions. At this point, each participant was provided with a summary statement asking for validation of the findings. This was accomplished by mailing a letter to each participant with the following, "Tell me how my descriptive results compare with your experience." This resulted in two participants who clarified verbs used in the descriptors of coping, and three other participants adding further suggestions to the research question, "How might education respond?" Possibly this was due to the time frame that occurred between the actual interview and validation, which was approximately 6 months.

Another possibility to consider was that some nursing students graduated since the interview and had entered the actual work environment. In this new role, they may have spoken about their involvement with this research project, or have formulated a different perspective with respect to educational preparation.

In all of the interviews, the participants revealed their personal beliefs and values. This became evident to this researcher when the focus of the interview exchange expanded to include personal viewpoints on issues surrounding their experiences, personal stories, citing personal opinions, and drawing conclusions reflective of their personal beliefs and values.

The participants expounded on their conclusions outside the realm of "nursing student" suggesting macro issues they described as "social barriers and challenges." Thus, they preempted to look toward the future providing exact examples how social barriers might first impact their role as a nursing student, then moving into the future adding thoughts of how this could be a significant factor once they "actually become a nurse."

All of the nursing students expressed the same vision for their profession—the importance of sharing a goal toward enhancing educational preparation of future nurses. While the nursing students' were diverse in their race, year in school, experiences in health care related professions, and expressed different experiences, common themes were identified and analyzed. Three major themes permeated all participants' stories: (a) *personal construct, (b) make sense of the situation,* and *(c) moving toward a better future.*

The major themes and subthemes will be discussed after first introducing the specific characteristic of each of the 10 participants of this study.

### *Participant Characteristics*

Demographic information obtained by this researcher during the preliminary telephone discussion and prior to the interviewing session provided the details of the participant characteristics outlined in Table 1. Through purposive random sampling, the characteristics of the nursing students who participated in this study represent a very diverse group that, although the experiences were unique, themes identified were consistent.

All participants' statements have been transcribed verbatim and have not been modified for grammatical errors.

Table 1

*Participant Characteristics*

| P= Participant | Year of College | Culture/Ethnic | Physical | Nonphysical | Employed in Health care | Area of employment |
|---|---|---|---|---|---|---|
| 1 | Senior | Caucasian | | X | Yes | PCT |
| 2 | Junior | African America | | X | Yes | PCT –ED |
| 3 | Junior | Muslim | X | X | No | None |
| 4 | Senior | Caucasian | X | X | No | None |
| 5 | Senior | Caucasian | | X | Yes | PCT-ICU |
| 6 | Junior | Hispanic | | X | No | None |
| 7 | Junior | Caucasian | | X | No | None |
| 8 | Senior | Caucasian | X | | Yes | PCT-ICU |
| 9 | Junior | Hispanic | X | X | No | None |
| 10 | Junior | Caucasian | X | | Yes | PCT-ED |

*Note:* (PCT) Patient Care Technician, (ED) Emergency Department, (ICU) Intensive Care Unit

## *The Experience*

The initial statement posed to each participant was, "Tell me about your experience with workplace violence." Each participant by reflecting on their unique experiences provided detailed descriptions of the incidences. Excerpts from each participant are provided below, including direct quotes participants expressed regarding lived experiences. All of the interviews occurred between the months of February and June 2002.

*Participant 1*

This Caucasian nursing student was a senior at the time of her experience. She did work part-time as a patient care technician in a hospital. Below are the details of her experience with a physician who was sexually harassing her while she completed clinical internships. She further explains this practice continued into her place of employment. She explained:

> This doctor always seemed to know where I was going to be, whether it was during school hours or when I was going to be at work. At first I thought it was cool a doctor would want to go on a date with me, and then I just got scared. He would just show up in places where I was. The biggest thing was I told him that I did not want to go out with him and he got angry and started to like, stalk me. It actually got worse after I told him that. Then the telephone calls started. He would call sometimes 10 times a night; like he knew I was home but just wasn't answering the telephone.
>
> I was afraid to tell my teacher at the time I didn't think she would believe me. Like everyone else, thinking it was something that I wanted to happen, something I enjoyed. I did tell a few people at work but they laughed at me and said, "What? Are you crazy? Go for it! You might get married and never have to work again."
>
> No one believed me that he was really making me scared; it was like the movie fatal attraction, he was stalking me. All I wanted was to be a nurse, and I thought if I reported him or did anything, I might get fired from my job and kicked out of nursing school. So, I never told anyone not even my parents. He is still around but he doesn't call me anymore. I think he is actually dating one of the nurses where I work at now. I still get scared and he stares at me; those eyes, they are so scary. If I work at the same hospital, and he is there, I bet he tries to get me fired for something. I don't know, but being a new nurse I might make a mistake. Anyway I am going to try and get another job away from him.

*Participant 2*

This participant was an African American, in her junior year of nursing school at the time of the incident. She also worked part time as a patient care technician in the emergency department. She described incidents of bullying, intimidation, and ostracism along with racial discrimination throughout her expressed lived experience. When asked "Tell me about your experience with workplace violence/aggression," she replied:

> I was afraid, you know the people are pretty violent, people are on drugs, and people are drunk. Everyone has their own biases. Well mine is alcohol. This is a real pet peeve of mine. I mentioned this one day and well it seemed like every since I made that statement I have been assigned to patients who are extremely combative.
>
> For example, I had to take care of this older guy maybe around 70. He had swastikas all over his arms and chest. They sent me into his room and he screams at the top of his lungs, "Get this nigger out of here. No nigger is going to touch me."
>
> First, I was really embarrassed that everyone heard him and was coming out into the hall to see what was going on. The nurse said, "You need to go right back in the room and do what you have to do. You should get use to this; it is good experience for you—gives you a chance to experience real nursing." She said, "Someday you might want to work in the emergency room and so now is a good time to get use to it."
>
> People seemed to just make excuses for patients by saying, "Oh, he is just drunk." Or "He is just high; he doesn't know what he is saying."
>
> The biggest problem I have is that nurses seem to think just because I am African American that I can relate to all blacks. Now what does that mean? That is just crazy that people think that way. Some people have really narrow vision. No one should be allowed to treat people this way no matter what race they are. People might think that it's a black thing; that we all cry discrimination, but that's not true. It isn't just black people, it's all minority. It seems to be a universal thing that all minority express they are discriminated against, but that isn't my thing.
>
> People don't get it. They say, "Oh, my husband isn't like that." Or "Not my kids." It doesn't matter. So, everyone just continues to follow through with the same behavior. I thought about it, and it doesn't matter if I am black with a black patient, or white with a white patient. If the patient is going to hit you, they will. No matter what color you are.
>
> When I entered nursing school, I wanted to work with a culture that was diverse. I never wanted to work any where the population was 90% black, or

> white. It seems crazy for nurses and the instructors to think that you could relate better to a patient who is the same race and culture that is really bias on their part. Why would I want to take care of all the black patients? If I were Hispanic would I just take care of Hispanic patients because I speak Spanish? There is real bias in making a student assignment based on this thinking. It really isn't a secret in the hospital where I work, or at my nursing school. I get all black patients, and the Hispanic students get all the Spanish-speaking patients. Why? Why would they want to perpetuate this bias?

*Participant 3*

This nursing student was in her junior year of nursing school. She was a Muslim and reported she experienced both physical and nonphysical acts of violence. Her story reflects racial discrimination, most likely associated with the terrorist attacks of September 11, 2001. This nursing student described incidences of aggressive actions, intimidations, threats, hostile behaviors, and a direct physical attack. At the time of the experience she had never been employed or worked in a health care setting. She reported never having completed nursing school, dropping out near the time this researcher interviewed her. However, at the time of this dissertation writing, about 6 months later, this researcher followed up in order to learn whether she had returned to nursing or to college, and found she never returned to college to pursue any other field, nor did she return to nursing school. Instead, she remains somewhat isolated in the home of her parents, unwilling to participate in any socialization outside the sheltered culture of her immediate family. When asked, "Tell me about your experience," she replied:

> I was born in this country but I am a Muslim. My parents are in this country. My father is a doctor who has been here for several years before I was born. We practice our beliefs, but I do not wear the dress of my country as my mother does. I dress just like everyone else does; like my friends did in high school.

Since the terrorist attacks on September 11th, my friends and the people I walk pass on the street have treated me differently. The worst part of it all was my experience with patients. My instructor assigned me to a patient who was about 50 years old; a white man who had his gallbladder out. It was my surgical experience. I went to his room to take his vital signs and introduce myself. He stared at me and then he said, "Get me my nurse. I don't want no Arab taking care of me. You need to take all your Arab buddies and head back to your own country. Now get out of here." I started crying and turned almost running out of the room. He must have put on his call light to call for the nurse because I passed her as I was running out of the room and she said, "What did you do? What is wrong?" I didn't answer her; I was crying and so afraid. I think he told the nurse the same thing he told me—that he didn't want an Arab.

She never did tell me, she only spoke to my teacher. My teacher, she helped me out by saying, "Don't worry, this will happen to you all the time, just go in the bathroom and get yourself together you can take on a new assignment." I don't know if the teacher did it on purpose but she gave me a new patient that was in a coma. Maybe she was afraid of how people were going to be toward me, or maybe she didn't want to deal with the situation. All I know is, she never tried to talk to me about it, and in fact she just avoided me. This made me feel like I had done something wrong was guilty of something. I did finish the day and went home.

This type of stuff occurred for weeks after, but in more subtle ways. People would stare, students wouldn't invite me to do anything—like eat lunch with them—and my patient assignments, well I really learned how to take care of people who were in a coma, confused, disoriented, and, oh, yeah, I had many patients with Alzheimer's. You see she gave me patients who were out of the state of reality.

Beginning then in November, or I guess you could say December; I dropped out of nursing school. Well, I guess you could say, I flunked out, because I went from being a straight A, honor student to a below average student. I had a hard time concentrating on my studies after that. I don't know really, maybe I was just afraid to take care of patients after that, I was scared.

The students never really treated me the same. They began to talk more to me, but they were only pretending to like me. I don't know why I have to prove that I am an American. I guess they needed me to do that. I couldn't study my reading, well, when I read I didn't remember what I read, my thought would go back to the man who hated me. My parents want me to go back to school but I can't, I just can't.

*Participant 4*

This participant was a Caucasian who around the time of the interview was completing her senior year of nursing school. She had no previous work experience in the health care setting and had not worked but remained a full-time nursing student during her educational pursuit. She told about her experience of sexual assault by a patient, and interestingly, she thought "it was part of being a female nurse." She replied:

> My experience was more of an act of sexual violence. It was my first medical surgical rotation at the hospital; my patient was an 18-year old male. Right from the start that made me a little bit nervous because we were close in our age, but he was paralyzed on his left side and so I really felt bad about that. He seemed angry all the time. He was shot in the back when he was 16 during a gang fight.
>
> So, what happened was I asked him if he was going to need my help with his bath? I asked him, "How much can you do by yourself?" and he replied, "I can do most of my bath, I will need a little help." I left and came back and I noticed out of the corner of my eye he kept sliding down the covers over his private area trying to expose himself. I tried to act like I didn't notice; I just ignored him. I thought maybe I might be imagining it so when his bath was done and it was time to wash his genitals he pulled his privates out and exposed himself to me. He said, "Wash this." I turned away tossing him a wash cloth and towel telling him, "You can wash yourself."
>
> He continued to just lie there exposing himself and staring at me. I told him, "Here are your pants. Please put them on and I will get some help to get you out of bed to the chair." His every look and move was sexual in nature—you know like when they say someone raped you with their eyes? That is how this was.
>
> I didn't want to go into the room but he kept putting on the call light all day. My instructors said, "Go and see what your patient needs." He called me in several times during the day and asked me things like, "Do you have a boyfriend? How serious are you and your boyfriend?" At the time I should have said this isn't any of your concern but I was afraid of getting in trouble with my instructor and I really didn't think I had anything to report, I thought it was just part of nursing. He told me, I love Italians. Too bad you have a boyfriend, you could climb into bed with me and I would show you a good time." He stared at me, I mean up and down with his eyes. Those eyes—I won't ever forget them. Sometimes I wake up and I see those eyes.

> I guess at the time I thought it was my fault. You know, I thought maybe I said something or did something to make him act that way. I thought it was weird but I didn't think it was out of the ordinary, you know? I just thought this was part of nursing because everyone tells stories. You know, the students about male patients who get excited when nurses, insert a Foley or are giving a bed bath.
>
> It wasn't until my friend told me about your study that I thought, gee, maybe my experience wasn't normal. She told me that it wasn't ok for this to happen and that I should have told someone and really should have handled it differently. Sometimes you see cards and movies, you know, that show that sexy nurse and the excited patient? Well, I thought it must be something that I should "expect to happen."

*Participant 5*

This participant was a senior nursing student, a Caucasian who had been working as a patient care technician for 2 years in the intensive care unit at a local hospital. She reported a nonphysical act that included intimidation, bullying, and verbal assaults by a staff nurse while caring for a patient who had a cardiac arrest and was reported to this researcher as "in extreme danger of dying." She replied:

> I was assigned to this lady who was really sick. She had heart failure and she was having all kinds of cardiac problems. I was with her for about an hour before she actually had a cardiac arrest. I knew that something was wrong. I just felt like something was going to happen. She was confused. I couldn't put my finger on it but she looked bad. She was really restless; her oxygen levels were dropping even though she had a facemask on. Her color was changing.
>
> I never really saw anyone get bad right before my eyes. I was nervous that I might miss something so I stayed right at the bedside watching and waiting. I just sensed it you know? I held her hand and tried to orient her, then she stopped breathing and the alarms started ringing. Alarms—all those alarms. They were so loud it was like being in a tunnel and the train whistles sounds.
>
> All the staff came running—doctors and nurses, my preceptor. Everyone started working on her. After 30 minutes they revived her and then they ask that she be transferred to the intensive care unit. We had preceptors and so my instructor was off on another floor and didn't know that my patient had coded. We are suppose to page her if something goes wrong but I was so scared, I forgot to call her, and just followed the preceptor around.

> The doctor was asking me a lot of questions like what I observed in the patient before she coded and things like her state of confusion, her vitals and heart rhythm. That made me nervous because we really hadn't spent much time learning how to read a heart monitor. My preceptor was getting mad that the doctor wasn't asking her questions. She kept trying to butt in and he wouldn't listen to her for some reason.
>
> I helped to get the patient ready to be transferred to the ICU with my preceptor and then it started. I busted out crying. It was my first experience with someone almost dying and it was like a river. My preceptor was furious. "We don't have time for your acting like a baby. Maybe you shouldn't be a nurse because we can't let ourselves get attached to the patient. You just do your job and go home."
>
> I stayed in the ICU for a long time watching the staff get her settled and hooked up to all the monitors. Then my preceptor left because she had to get back and take care of her other patients. While I was in the ICU with my patient she called and said, "Go get the crash cart and take it to pharmacy get it reloaded. You're done with that patient and we have other things to do." I learned one thing that day, one thing that scared me. Nursing might not be "all caring" like our instructors have told us. We are drilled to the idea that nursing is about caring, that it is the "essence of the profession."
>
> When I look around, all I see are nurses who don't seem to care, but just go through the motions of doing, very few talk to their patients for more then a few seconds, few seem to care, this scares me that nurses don't care. I don't mean all nurses, but you know there is more that really don't care then do, from my observations.
>
> Either way, the preceptor and the other nurses all seem to hate each other. They wouldn't help each other and even the doctor didn't want to communicate with the staff. Everyone used threats to get people to do things. Maybe my preceptor used threats just because she thinks that is the way to get people to help.

*Participant 6*

This nursing student was Hispanic and in her junior year of nursing school. She described her experience as one of intimidation, threats, and ostracism by the staff at the clinical site where she was completing her internship. She explained,

> This nurse who worked on the floor where I was assigned for my internship, well, she hated students. In fact, I think she hated everyone, including herself. I was assigned to her for the day to be my preceptor. It was an accident because

normally our teacher didn't assign any student to her. She, the staff nurse, told our teacher, "Don't give me any of those students, they get in my way." Because someone called in sick, the charge nurse moved all the patient assignments around and so I ended up with one of her patients. My instructor came to me and said don't worry about it you already started taking care of the patient and "you will do fine." I don't know if she spoke to the RN or not, I don't think she did. In fact, that nurse scared my instructor, I am sure of it.

I was supposed to give my patient a drug that was order for 7:30 AM. We gave the drug, the instructor, and myself and then around 8 AM she (staff nurse) walks over to me. About half way down the hall, she is yelling, kind of scolding, saying, "We don't give that drug until the breakfast tray is here and that doesn't get here until around eight o'clock." She yelled, "You stupid idiot! Don't you know anything? Your instructor should have known that. Where in the hell is she? I can't be your babysitter. I don't have time for all this shit today."

Well, I just stood there, wondering what I should do. I thought we gave the right drug, at the right time, to the right person, the right dose. You know, exactly what we have learned. My school is crazy about knowing safe drug administration. We are constantly being questioned and tested on drugs.

I didn't respond to her. I didn't make any faces or anything. In fact, my face was just blank. I walked away and avoided her the rest of the day. I cried for about an hour in the bathroom hiding from my instructor. Thank goodness she was busy with another student who had a real sick patient. There were others standing around when she yelled and she kept beating her fist on the medication administration sheet while patient families even came out into the hall to see what the yelling was all about.

We stayed on this unit for 10 more weeks and each week I had to come to the clinical site, I knew that she was talking about students to other staff. She was always in a hurry, always too busy. She made me feel inadequate, unsure of my knowledge, insecure, and often I would second-guess my knowledge. I did tell my instructor, not in so much detail and she replied, "Well, some think students have it too easy. They think it is like a rite of passage getting out of school and into the practice of nursing. They think school is a waste of time, that what you learn doesn't really have anything to do with real nursing."

I don't know why this is. When I become a staff nurse I will remember that incident. If anything, I know the kind of nurse I won't be—and I will welcome students.

*Participant 7*

This participant was a Caucasian junior-level nursing student, with no experience working in the health care field. However, she did work part-time as a waitress while

attending nursing school. She described her experience as one of nonphysical aggressive violence, berating, and intimidation. She described this experience as "dealing with a passive aggressive staff nurse who was friendly to my face but aggressive behind the scene... almost like a psychotic person." Her story was explained as follows:

> My instructor gave my patient assignment to me that morning. I found out later that the staff nurse I was going to work with was really a very incompetent nurse. The assignment wasn't really a difficult one; the patient had pneumonia and was getting antibiotics intravenous. Well, it was time for the medication to be given, and when I went to get it, the medication wasn't in the refrigerator. So, I called the pharmacy and asked them to send it up right away. I waited for 30 minutes and no medication, so I called again. They said, "We have to make it up so it will be another 30 minutes or longer." I went to the staff nurse and I told her that the medication wasn't ready and it was going to be late. Normally, that would not be problem, the schedule would have been adjusted, but this medication had an order for a correlating lab draw. Finally the medication came up and the instructor and myself hung it. Should be the end of the story right? Not so.
>
> Next week when we got to our clinical site the instructor was called into the manager's office. We had made a medication error according to the staff nurse, on that patient we had the week before. She wrote up an incident report and claimed that we did not tell this nurse the medication was hung late, and therefore the lab draw did not correlate with the time the medication was given, or finished. She knew. She outright lied to protect herself. She blamed us when she assured the instructor and me that she had notified lab and rescheduled the times.
>
> In the incident report she noted we were neglectful in letting her know the medication was not available, late to arrive on the unit, and claimed we were incompetent in the care of the patient. Oh, my God! I was so mad! How could she lie to save her own self? Later, I heard that she was on her way to being fired for incompetence herself and this was a way to keep another incident out of her personal file.
>
> My instructor was very supportive of me. She knew the truth, but she said, "We are a guest in this facility and we must not offend anyone. All we can do is learn from the experience." No other students were assigned to work with her again. My instructor carefully watched what her patient assignment was from that point and made sure no student was exposed to her again. But, don't you think that was strange? I mean, she was so nice; like a loving grandmother to my face, but then went behind our back and sabotaged us—lied. I felt like I needed to walk around on my tipsy toes from then on. The fact she was "so nice" made it harder,

and how she lied made all of us students scared that it might happen again with another one of us.

It made learning very difficult. At the time I didn't understand what a passive aggressive person was like. I didn't have any psych nursing; now I do, and I fear these nurses. I fear how they can lie and blame. In fact, I find myself second guessing people and their motives now.

*Participant 8*

This participant was a Caucasian who was in her senior year, who had worked for 3 years as a patient care technician in an intensive care unit, while attending college. Interestingly, this nursing student reported coming from a history of violence exposure, living and growing up in what she termed a "gang-infested" community as a child. She reported witnessing multiple shootings, death and criminal activities as "normal in her neighborhood where she grew up." She explained what her experience was like as follows:

When I was doing my rotation in community health, we reported to the home health office and then we were given an assignment—patients we were to go and see that day. No instructor was around—no preceptor was with us. We were to go in pairs and conduct an assessment and do patient education. The instructor was on a pager if we needed her or we were told call the home health office, or the nursing school, if we had any questions. After all, we were seniors, ready to graduate right? This was our exposure to real nursing, it was really exciting, and this is what happened.

We arrived at this low-income housing area. It was pretty bad, so we called back to the office and the clinical instructor said she didn't know why we had concerns. The man was a young guy who needed to be taught about his newly diagnosed diabetes. Others had visited him and no one reported any concerns. She blew us off, told us to "get the visit done."

We were hesitant about going in, we even wrote in our journals that we feared going on this visit, both of us. We called ahead of time. We had a cell phone and told the guy that we would be coming and gave him a time we would arrive. Going into the apartment it was really freaky. Looking up, he was standing at his door. I thought, gee, that is nice, he is watching out for us.

We went into the living room and sat down. At that time we started doing our assessment, asking him questions about his blood sugar, what he ate. We both were nervous—talking fast now that I think about it. We just wanted to get out of there. Junk was everywhere; bugs, dirt, the smell, it was really bad. Then I noticed a magazine on the table, this gave me the creeps. I learned in school that when you do community nursing, you are not supposed to look at how a person lives, or anything, just stay focused on the person and their needs. So I tried to ignore the pornography that was thrown all around us on the tables.

Right in the middle of all this, he got up and went into his bedroom to get a pad of paper where he was suppose to be writing down all of his blood sugar readings. As he got up and walked out of the room he says, "I had a dream last night." I said, "What was your dream about?" He turns and comes out of the room with this huge long barrel gun and told me, "Well, I don't really remember." He said, "This is a 44," I think. He held the gun up to his head at the temple and said, "I had a dream the police came up to me and put this gun to my head." Then he just sat down next to us holding the gun to his temple.

I said, "Is that a real gun? Is it loaded? What are you doing?" My voice was loud—in fact, I think I was yelling. I hate guns. I looked at the other student and she just sat there, kind of frozen in time. He stood up, and pulled the trigger. It didn't go off, and then he turned and pointed the gun at me and said, "In my dream, they pull the trigger and it doesn't go off."

At that point he turned, and pointed the gun at me. My friend was frozen not doing anything, so I grabbed the gun and wrestled it out of his hand, I opened it and found that the chamber was empty. I think he was going to play Russian roulette or something. I didn't know what was going to happen next. I knew the gun was emptied. But being scared of guns, the way I am, I really didn't know what to do.

By this time, the other student is crying and yelling—she was freaking out at the patient. I thought to myself, "Oh, God, what is he going to do now?" I just wanted her to calm down. It seemed like a long time, but it happened really fast. Then she just starts asking him questions again like nothing is going on. I knew then, I better get her out of there. She kept rambling senseless things. He turns to her and says, "I have more guns you know," and he started to get up and go back to the room where he got the first gun.

I grabbed her by the arm, thinking, "Ok, now he is going to come back with a loaded gun!" I practically had to carry her to the car; she was hysterical by this time. We ran out together. I don't know what I was thinking; she was driving. She sat there unable to start the ignition. I pushed her over and drove us away. We went back to the home health agency first and told our instructor and the staff what happened. This is the best part of this experience! They didn't believe us. In fact, the instructor said, "You both need to go ahead and finish the other two appointments that you have scheduled for today." Guess what? We did!

> I really don't know how, but we finished our appointments and then we both went home. Well, I went home. The other student, she was really shook up. She went to the college and right to the dean to report the incident. The dean called the instructor and they went back to the home health agency. They called the police and they came and took him to the psychiatric unit. They also found several guns, and bullets in the home.
>
> We were really lucky... Crazy how no one really seemed to care, right? No one cared about us or trusted we weren't making up some story.

*Participant 9*

This Hispanic nursing student was a junior at the time of the experience. During her educational path, she did not work and had no previous exposure to working in a health care setting, prior to entering nursing school. She expressed how she was the victim of both physical and nonphysical violence at the hands of another nursing student. Her story represents intimidation, threats, and bullying—just a few of the actions taken toward her by her peer. She explained:

> Right now I am a senior, but this really happened to me when I was starting my junior year of nursing. This other student, she is a bully and unfortunately she has been in every one of the same internship locations that I have been assigned to. She will come right into my patient's rooms and take over, telling me that I am doing something wrong; like she is the teacher or something. She even pushed me out of the way one day. That was scary. The thing is, she never does it in front of anyone, right? She only does these things when no one is around to see her.
>
> I have told her to keep her hands off of me but she just said, "You aren't going to keep us late again today. We are going to leave on time or I'll fix your ass." I am not the most organized person. I am still learning, so I am slower than some of the others who have worked as nurse aides. She is black and she really scares me. I think she is involved with a gang, one that hates Hispanics, because one time she told me that if I caused the group to get out late, her friends were going to have to pay me a visit.
>
> I have told people about it but no one believes me. She is really sweet in front of the instructor. She acts like she knows all the answers, so the teacher likes her. I am quiet, rather shy, I guess. I am too scared to do anything or tell anyone. I tried that once and the instructor didn't believe me. I don't know what to do. I am

> so scared. I asked the dean for a new clinical site but she said no. She told me that "the student is trying to be helpful" teaching me the importance of being done with my work, being organized. She also said, "We all have different personalities and in the real work world this will be true. Now is a good time for you to experience how you will handle different personalities." She (dean) didn't care. I didn't really explain all the details to her. I was too afraid that she would call the student in, and then her gang would get me. I watch my back. I hide. I don't tell anyone about this.

*Participant 10*

This Caucasian student, at the time of her reported experience, was in her junior year of education in nursing. Up to that point, she had worked part-time for 1 year as a patient care technician in an emergency department. She reported an incident of physical assault while caring for a patient, who was, "unresponsive at first, because of a drug overdose, or so we thought." She replied:

> In the emergency department, I really learned a lot. I loved the experience I was getting lots of different patients with different problems. I knew this rotation I would really learn a lot. Not everyone gets a chance to have a rotation in the emergency department; the instructors don't like us to go there. So, when she told me I could go to the emergency department I was so excited.
>
> I was working with one particular nurse he was a male. Seems like there are a lot of male nurses who work in the emergency area, strange isn't it? Well, we got a man by ambulance who was very large. Well, not obese, I mean he was real tall. The paramedic told us that they got a call that he was found unresponsive at home on the floor. They thought a drug overdose, but they weren't sure.
>
> That's the problem you know? You are a detective trying to figure out what is going on with the patient. Sometimes the families can tell you, but not always. So the nurse told me to draw his blood and he was going to get an IV setup. I learned how to assess his level of consciousness doing a sternal rub. When I did that, rubbed on his sternum real hard, he didn't even move. I thought he was in a coma. Maybe I didn't press hard enough.
>
> I put the tourniquet on his arm and started to stick him with the needle and he jumped up in the air. Oh, my God, he was tall. He grabbed me by the neck—his entire hand fit around my throat. He shoved me against the wall, still holding my neck choking me. The problem is, I couldn't yell and when you do treatments

and things, you have to pull the curtain, so people aren't gawking at you since the emergency department is so open. Give privacy to people. So here I am up against the wall, can't yell, and this man is whispering in my ear, "I am going to kill you. Pop your head right off as I squeeze you." My feet weren't even touching the ground.

The next thing I know, I wake up, a patient myself in the hospital. The incident never got written or reported. The instructor said, "That is how the ED is and we're glad you are ok." One staff said, "This happens a lot around here, you just have to watch yourself, you will learn." One of the doctors in the emergency room the one who checked on me said " I bet when you graduate you won't want to work in the emergency department, will you?" Amazing enough to me, it was like no one really cared because this was a typical day in the emergency department, just part of the routine.

### *Summary of Experience*

In completing the analysis of all the participants' descriptions of what the experience was like to be a victim of workplace violence and aggression as a nursing student, the first major theme of personal construct presented. Even though each experience was unique, common findings permeated all participants' experiences whether they were physical or nonphysical experiences. The subthemes fear, anger, stress outcome reactions, coping and adjustment exemplify the personal construct each participant expressed in building their lived experience.

Each participant was asked a subtopic question, "How did you cope or adjust?" The purpose of the question was to encourage the participant not to step out of the lived experience but to plunge deeper into the experience. In this way the researcher forced the participant to remain within the experience before allowing an exit away from their expression of the event. It was through this deliberate action that this researcher was able

to get a richer description and enhance the process of arriving at common themes that would truly express a sense of meaning to this phenomenon.

Below are narratives with excerpts of responses provided by each participant, along with a discussion on commonalities of descriptors identified. Further, these common descriptor verbs, as stated by the participants, were correlated with the four categories of stress reaction outcomes: (a) emotional, (b) social, (c) biophysical, and (d) cognitive as prescribed by Lazarus's (1986) model of stress reaction outcomes.

### *Coping and Adjustment*

The subtopic question, "How did you adjust or cope to the experience you just described?" was asked of each of the participants who responses are as follows:

*Participant 1*

> I have almost become paranoid. I try to explain to people that I am scared to death. I lie to make it go away. People don't believe me; they think I make it up. I get angry no one will listen. It's kind of like a paranoid scare that I have, that someone is watching, that he is waiting for me, stalking me, I guess I try and not talk about it hoping that it will go away. You know, you really don't cope; you just deal with it, so I guess adjust.

*Participant 2*

> I don't think you do adjust to the situation of racial bias. I don't have the level of knowledge to challenge some behaviors. I try to confront the situation, I didn't use to, but now I do, especially when they say this is a black person and you are black, so you can relate to each other. I try coping with the ignorance of racial discrimination but it makes me angry, so you adjust to the ignorance of people instead.

*Participant 3*

I hide from people as a way to cope with my experience. I don't leave the house unless I am with my family. I work around the house keeping it clean and baby-sit my little sister. I just hide and try not to think about it. I feel safe in my home. With the war, I am more scared. My uncle was killed, so my family is angry. I exist on hope in a hopeless time and pray for peace to come soon. I flunked out of school, so I guess I didn't cope.

*Participant 4*

I tell people the story of what happened to me. We joke and laugh about it. Lots of time people will say, "So, tell me a funny or gross story about what has happened to you while you are in school." At the time it seems to make light of the situation. Emotionally, it helps me to cope with the situation. I know that it isn't professional to act this way, but it helps me cope, I guess, because people think it is ok. The reassure for me that it is ok, it seems to make me feel other people understand, and that makes it ok.

*Participant 5*

Cope? I never did. I realize that each person adjusts differently to a situation. I try to forget about it, to just act like it never happened, but it is hard to do. I found it hard to concentrate on my goal—my schoolwork.

*Participant 6*

At the time there wasn't much I could do. So I leaned on my instructor and other students who had similar experiences. Talking about it helped me to cope. It impacted my schoolwork because I started to question myself, lacked self-esteem, afraid I might kill someone. I felt inadequate—stayed very close to my instructors for a sense of security. Making these changes I guess that was an adjustment. I had to always plan for it to happen that way, so I did adjust and I guess that was a way I coped.

*Participant 7*

You can't cope. It was hard to go on, to show up at clinical. I was afraid; you never knew what might happen. It gave me a sense of insecurity and anger. There is no way that you can be comfortable with learning. So, you jeopardize your entire career because you are so angry you can't think and your grades suffer.

*Participant 8*

> I think how we are exposed to different things will have an affect on how we deal with them. I adjusted. I think my relationships were different with other students. I tried to avoid them and their questions. It bothered me that too much attention was given by the teachers, almost like they were afraid they might be getting sued. My experience was like another life event for me, nothing new. I have seen people shot in the street, laying dead waiting for someone to show up. My sister was stabbed four times and I drove her to the hospital. When I was 15, my best friend was stabbed. I think more than anything I was angry at all the attention; all I wanted to do was just graduate. The other student had a really bad time dealing with what could have happened. I just think about it like, well, it didn't happen so let's get on with life.

*Participant 9*

> I watch my back. In fact, I adjusted to the situation. I let the staff think that I don't really know what I need to do, and they help me, then this keeps someone nearby all the time, including my instructor. They get nervous; I really do know what I am doing though. It makes me angry that I could get kicked out of school or a gang might attack me, so I hide.

*Participant 10*

> I worry more. I worry about silly things, things that haven't even happen. I try to anticipate what might happen. I think this helps me to deal with situation. Sometimes I wake up re-living the experiences. I can't catch my breath, I really get scared, and have dreams about his hands on my throat. I see a counselor every month still and he is trying to help me cope. He wants me to talk about it.

### *Summary of Coping and Adjustment*

In summary, the subtopic question, "How have you adjusted or coped?" further added to the meaning participants exemplified in their experiences. Verbs used to describe the outcomes of the experiences were coded and placed within the framework of the appropriate four categories identified as victims reported stress reactions, a model developed by Lazarus (1986). Once placed within this model the findings further

supported the major theme, personal construct, and the sub-themes, anger and fear, which permeated the lived experience accurately described by the participants. Further, this process yielded more "essence to meaning" posed in the first research question of this study: "What is it like to be a nursing student exposed to workplace violence and aggression?"

Table 2 represents the victims' stress outcome reactions including the actual descriptors used by each participant as they provided deeper insight into the meaning of this phenomenon. According to Lazarus's model, there are four categories that provide a framework for determining whether the victims' reactions affected them emotionally, socially, biophysically, or cognitively. The findings demonstrate which of the reactions each participant verbalized within each of the four categories. The primary responses of the participants reflected emotional problems. For example, 100% reported anger, 50% reported fear, 20% decrease self-esteem, 10% hopelessness, 10% lack of confidence, and 30% insecurity. In the second most identified category for stress reaction outcomes, nursing students reported social reactions such as avoidance 30%, isolation 10%, and inappropriate humor 10%. The next category included any cognitive reactions. In this category the nursing students cited loss of concentration in schoolwork (30%) and school failure (10%). The least identified category was biophysical stress reactions. In this category only 1 (10%) of the participants reported insomnia as an outcome of their experience. These findings demonstrate the primary stress outcome most often identified was some type of emotional response by the nursing student. While each participant

experienced emotional problems resulting from their personal experience, how they responded had implications on whether or not they reported any social, cognitive, or biophysical findings.

Table 2

*Victim Stress Reaction Outcome Descriptor*

| Emotional | Social | Biophysical | Cognitive |
|---|---|---|---|
| Fear<br>(P 1, 3, 7, 9, 10) | Isolation<br>(P 3) | Insomnia<br>(P 10) | School Failure<br>(P 3) |
| Anger<br>(P 1, 2, 3, 4, 5, 6, 7, 8, 9, 10) | Humor<br>(P 4) | | Loss of Concentration<br>(P 5, 6, 7) |
| Decrease Self Esteem<br>(P 6, 7) | Avoidance<br>(P 1, 3, 7,) | | |
| Hopelessness<br>(P 8) | | | |
| Lack of Confidence<br>(P 6) | | | |
| Insecurity<br>(P 6, 7, 9) | | | |

*Note:* P = participant

None of the 10 participants expressed the ability to cope with the situation. One of the participants (P8) replied she could have coped if other people would have allowed it and not influenced her. Nine of the 10 participants suggested, "You really can't cope, but you do adjust in some ways—you have to."

According to Lazarus's (1986) theory of stress response, when there is an event, an individual will appraise that threat and determine the potential harm. The power of the threat is further dependent on the previous experiences of the individual, their knowledge about the threat, and frequency of past exposure. As a result the individual will then either respond by coping or react to the threat.

In this study, only one participant (P8) reported she had grown up among violence. Her perspective, as compared to the other nursing student, was completely the opposite. The participant in this study expressed emotional reactions that included anger and hopelessness. These emotions did not lead to any other described stress outcome. The anger she described was directed at what she termed as faculty who did not care. She remained angry with those individuals whom she thought had the power to change the situation but failed to act on it.

Before starting this study, this researcher conducted a case study using the same interview questions utilized in this study with the nursing student who shared the experience with participant 8 in this research study. Both nursing students reported being assaulted with a weapon by the same patient.

In the case study, this researcher's findings showed the participant (a) explained the experience with more details; (b) used vivid descriptions that expressed anger, fear, hopelessness, lack of security, and loss of concentration; (c) reported having been diagnosed with Post Traumatic Stress Disorder; and (d) has since moved away to another state.

In comparison, the case study participant was from an upper class neighborhood, had never experienced any situation, or been exposed to violence in the context of her growing up prior to that day. She described the event with more intensity, she expressed more anger, her stress was more intensified in all categories, and she referred to herself as "a victim" of what she asserted was the lack of educational preparation, lack of faculty knowledge, and lack of caring in both the faculty and the administrative personnel. In fact, she blamed the entire fault of the situation on the educational setting, the faculty, and anyone who represented the university she had attended.

Findings from the case study offered an opportunity to compare the perspectives of two nursing students exposed to the same violent incident, and further determine how different the meaning was for each of them. Ultimately, each had completely different perspectives regarding the experience, including how they responded.

In further comparison it was evident the participant in this current study was angry with this other nursing student for how she responded. This was reflected in her comment, "I think how we are exposed to different things will have an affect on how we deal with them." (P8) and "The other student had a really bad time dealing with what could have happened. I just think about it like, well, it didn't happen, so let's get on with life."

In summary, nursing students armed with knowledge about a potential violent incident, or having past exposure, may reduce the stress reaction outcome they experienced. This is a key finding from an educational perspective assuming if the case

study participant had been equipped with the knowledge to anticipate violence she may have felt more support, less anger, and possibly regarded her educational preparation in a more positive manner. While education may not be able to guarantee safety for nursing students, it may be responsible to expose them to the idea, and where better to start then in educational preparation.

The stress outcome reaction findings in this study are supported by those reported by Lazarus's (1986) research. One nursing student had a preexisting, preformed reality about violence before her experience. Thus, she perceived the threat as less traumatic than did her counterpart, as well as some of her peer group. She then appraised the threat differently based on her history of previous exposure to violence citing it as "another life event." (P8).

The four outcome stress reaction categories: *emotional, social, biophysical,* and *cognitive,* provided the framework for responses to the question, "How did you adjust or cope?" The subthemes, *stress reaction* and *coping and adjustment,* became the significant themes, which were further supported by descriptive verbs expressed by the participants.

The descriptor *anger* was the primary reaction reported by all 10 of the participants. Anger was directed at multiple individuals, and the intensity varied for each participant, but each had anger for having been a victim. Also within the same category the second most frequent descriptor utilized was *fear*. All of the participants reported fear

during, after, or beyond the incident. It was evident during the interviews the intensity of the anger each participant expressed enhanced the level of fear they expressed.

The remainder of descriptors under the category of emotion included *lack of self-esteem, hopelessness,* and *lack of confidence*. All resulted from the participants' anger, hence, heightened fear. These findings not only supported the first major theme identified when asked, "What is it like?" but they also correlated to each personal construct, major themes, and subthemes.

It was the intentional aim to use a subtopic question in the interview as a follow-up to the first interview question. The purpose was not only to seek an answer to the second research question posed regarding implications for education, but also to remove the participant out of the "telling" of the lived experience into a reflection stage. In concluding the data analysis, it became apparent that the intentional aim of using the subtopic questions had led to a more intensified expressed meaning.

In further analysis, the social stress reaction descriptors, *avoidance, isolation,* and *inappropriate humor,* were described as outcomes of their experiences and also as suggested coping mechanisms. Within the category of biophysical stress reactions, one participant reported insomnia. The final stress reaction category, cognitive, included three participants who reported *lack of concentration* and one participant *dropping out of school.* Although only three nursing student participants described a lack of concentration, all mentioned that they, (a) had a hard time studying, (b) had grades that

lowered, (c) did not want to come to clinical, and (d) feared being kicked out of the nursing program.

Without specific grade point analysis, it was not possible to determine how much the nursing students were affected cognitively in their educational pursuit. Although three participants reported being affected and the other seven participants alluded to the idea that they had experienced a decrease in their school performance either by grade or clinical performance. Only one participant actually verbalized supporting statements. This may have been because this researcher is a nurse educator and some nursing students may have considered it too embarrassing to reveal their actual grade pattern.

### *Education Suggestions*

During the next phase of the interview process, each nursing student was ask to respond to the question, "What kind of educational preparation might improve the situation that you describe?" The aim was to address the second research question posed by this study, "How might education respond?" The participants replied,

*Participant 1*

> Students need to know about dealing with doctors or male patients who may make sexual advance toward them. There should be some discussion in class at least on how we should respond to this. I don't think we talked about how to deal with inappropriate behaviors toward us at all, in fact we didn't.
>
> Also, I would have felt more confident if I had known someone supported me, and understood what I was going through instead of just laughing it off. No one seems to think this was a serious problem including the teacher. I think role-play might have been a method for teaching us about these situations at least make us aware that it might be a problem. Everyone is not a young nurse who wants to have an affair with a doctor.

*Participant 2*

Don't baby the student. Don't do clinical in settings that are predominately one race, because if a student is from one neighborhood she doesn't know the culture other than her own. I don't mean terrify them, but we should go into inner city hospitals where there is a diverse population. When we graduate we will be dealing with various cultures and why shelter us from that as a student now? I think many students will really be culture shocked when they get into practice. I know that in my nursing program we talked about diversity but teachers must really emphasize the real things that students will have to deal with If they recognize that a student is closed minded in her own world, then they should put them with patients who are different from them. Not do like most instructors do, put the Hispanic student and black student with their same culture. That is more for the convenience of the instructor and the staff, and not really a learning experience.

You cannot change people from their bias the way they were raised and the values they learn. But for students, this is a large piece of the profession. You know how many Hispanics there are getting to be in our area? No matter, we should look at the person beyond the culture and not treat people indifferent, let people know you won't be treated indifferently no matter who it is. Rather than shelter the student, or protect a student, the instructor should find cases that can expose a student not only to culture differences, but also to potential safety issues. Who is going to protect us when the instructor isn't picking our patients for us?

Language barriers are another problem that we don't address in school. Do you think that when the Hispanic nurse is busy with her own patients that she wants to walk around and interpret for all the nurses and doctors? I see that all the time. If I were Hispanic, I would just say, "No! Learn to deal with the language barrier." In fact every nurse, at least in Chicago, should know how to speak Spanish; it should be mandatory in the school curriculum. I plan to take Spanish next year. Otherwise, how can you communicate?

Students need to learn not to stereotype the "black drug addict." I watch nurses withhold pain medications all the time. This makes me really angry. Like the sickle cell patient I had in clinical, he needed his pain medication and the staff wouldn't give it. They said, "He's just a drug addict, he can wait." Nurses control the fate of the patient. That is a scary thought for us students. We can relieve pain or allow pain; we are in control.

I know that you cannot change the older nurses, they come from an entire different world then we are entering. They tell us all the time, "When I was a student, we did this and this." I just smile and try not to be defensive. The older nurses are angry. I don't know why, but they hate to deal with students; some anyway.

I really have seen a lot of social issues in the emergency department. It would help to talk more about that in course work. Like, how do you deal with a homeless person when you have to, if he needs medications, food or even clothes, or just a place to sleep. None of us know how to find answers to social problems, but yet it is a part of the nursing role we are going to enter. Instructors are going to have to put more emphasis on culture and social issues with violence, they have to, there really isn't a choice anymore. The world is getting more violent and so are people, or maybe it just seems that way. Emphasis on safety factors and how to deal with a potential violent situation has to be discussed or pretty soon all the nurses will be off on disability.

*Participant 3*

Teachers need to help others to understand the different cultures, and to help them learn not to be afraid of something they don't understand, or someone who believes differently. If a teacher knows a patient is racially biased, she should not give the student a different patient, but should talk to that patient and maybe we could learn together from each other. When the teacher protects the students she also is creating more racial bias.

All nurses should take care of all patients without prejudice, and patients must learn that also. I think we should have some ads or articles that we can talk about that would help us learn about prejudices, to practice I guess. Students might be assigned to patients who would challenge their personal values and beliefs. I think if I would not have been taken from my patient he might have learned something about me as a person who is good and kind.

There needs to be transcultural nursing courses. I think my friend had that course but she is at a real big college and they have to take that course. More time and practice in problem solving ourselves when we are confronted with issues rather then the instructor who fixes the problem. My instructor didn't even talk to me about the patient refusing my care she just said, "Better get used to it."

I wonder what would happen if every sick person put an order in for the "perfect nurse." Would they order a black nurse if they were black, a white nurse if they were white, a single nurse if they were single, a poor nurse if they were poor, or a rich nurse? How would people place a nurse order? Maybe there would be no nurses then to take care of them, and how would they feel then? Even doctors, what if everyone chose the doctor the same way. People say they love their doctor or they hate their doctor.

*Participant 4*

In class we never talked about the things that could happen to you as a female, like sexual harassment by a patient. In fact, it was never talked about except kind of between some students, but we all laughed about it. Now I feel bad that I had a

misconception of nurses myself. I don't laugh at the funny, sexy nurses on TV anymore; it is really offensive to me now. But, when I started nursing, I laughed about it just like all of my friends.

An overview about the profession of nursing isn't enough. We need to understand the issues that our profession is faced with and not find them out on our own by accident. When I look back on the situation, I didn't know how to communicate, or to express, how I felt to the patient without getting trouble. Students need to be comfortable in saying what they need to patients and instructors.

Students need to know they have options, and it is OK to let them know the boundaries that patients have in interacting with students. Students should learn how to communicate boundaries that are safe with patients to protect themselves from harm, not wait until something happens and learn by fire, so to speak. Case studies might be good or just talking and sharing the experiences and problem solving how to handle a situation.

We spend so much time learning the textbook; realities of nursing issues are lost. All of us can read. Our class time should focus on problem solving and learning how to enter the profession focused and prepared with a knowledge that we anticipate "things might happen, but at the same time be prepared."

*Participant 5*

Learning how to read people. We never spend anytime on that. If we could read people we might know how they will respond to us. When things are stressful, adrenaline is high in everyone; this can lead to major problems. Things get said and the chances of getting hurt get better. I suggest that students be exposed to content on how to handle various types of people, cultural groups, and that we learn better how to prioritize, because sometimes it just appears that we don't care to our patients, but really we have something else we have to do.

Putting priority on what to do next, and why, often doesn't put the patient first. For example, I will do what the instructors tells me to do, and not try and explain why I should do something else first, in my opinion. I guess we learn to just follow someone's orders—the teachers, the preceptor, the doctor—we just follow orders rather than think for ourselves. I see it in nurses all the time. The doctor says go do this and even though a patient needs a pain medication they will follow the command and not prioritize what they should do first. This is when patients and families get mad; they see us as non-caring. Learning how to act professional, well that is part of it. Communicating and know how to say things without being aggressive, that takes more practice then nursing school teaches.

*Participant 6*

I think a class about the violence in the workplace would be good. If there was a class we could learn about the different situations; some exposure before it happens is better then none. We might be better off when we enter the real world that everyone tells us about. My mother is a nurse, and she told me, "It will be quite a shock when you have to enter the working world and deal with all of those personalities." Well, nursing students are sheltered, and that is my opinion, not my mother's. But it is true; when I am in the clinical practice I realize that I really have an unrealistic idea of what nursing really is. I really have mixed thoughts about caring.

Caring, caring. That is all you read about and get tested on, right? I don't see much teamwork; people don't care, right? Nurses don't care about other nurses; some do if they are friends, but just watch them and you see they make faces, laugh, and gossip about each other, but never to the other persons face.

Maybe nurses need more skills—people skills. My mother said all nurses should have to pass personality exams, learn how to be human. How can people care about other people when they don't care about people they work with?

*Participant 7*

I have learned from experience that I would never treat people so bad, especially the way my nurse treated me. So, I guess I would volunteer to mentor another student once I finished school that might help to improve the situation. I learned the hard way and since I am a young nurse, I will help other young nurses, so they don't have to go through what I did.

I think being young students we should all work together and learn from each other. We can learn so much from working together, and especially from people who are kind and willing to help you learn. When I get my first job, I plan to visit the area and all I really care about is how the staff interacts with each other. I am going to ask to observe, you know? If the staffs are all fighting, then I won't go there to work.

We could do so much better if we all were open, honest, and caring. Isn't that what we are supposed to learn? That should be a focus we get told—be caring, be empathetic nurses. I think all of us start out that way because we don't want to be like the nurses we have witnessed in our programs. But, what happens is we really never learned about caring very much.

I won't be sneaky or manipulative when I get into the hospital; instead, I will remember to be caring. You know there is a difference between caring and being cared for. To care for someone is to just go through the motions, meet the needs physically. I think all nurses that I have watched "care for" their patients. What they don't do is provide caring. Maybe education needs to start with practice what you preach.

I think we need more courses on realizing personalities in the workplace; a course to learn about the environment of nursing and what to expect. You walk into a room and you are surrounded with different personalities. It is important to know how to handle yourself. We lack self-confidence because we are students. Learning skills of how to disagree—to compromise.

In the clinical I was in, there were constant ongoing issues. Many of us didn't know what to expect or know what to do about it, and the instructor became our troubleshooter and problems solver. She was our shield from the staff but this took up so much of her time. Very little learning was going on. Let's face it, you cannot learn in that kind of workplace. Here we are on the unit and we are faced with issues that we really have no knowledge of, we aren't prepared for that. Some guidance from instructors, and more instructors who understand the workplace issues at hospitals that support learning for nursing students.

Post conferences we talked about workplace issues because that is all that we were learning about, but the fear factor is so high, that you start to wonder why you want to be a part of this profession. The misconceptions about how great it is going to be—I felt like I let my teacher down sometimes because she was the troubleshooter all the time between the staff and the students. I wouldn't want to be a nursing teacher I know that.

*Participant 8*

Students need to know they have options about their learning. They can say no if they don't feel safe about a situation. No student should be out on a limb by herself. Preceptorships really don't work. Get rid of them. Nurses are not all good teachers; some just do it for the money. At least get good preceptors.

Home health visits should not be the time when students really learn about potential violence. I mean you should already know that you can say no if you think there is a risk to being injured by a patient. But, going into homes, that is a much greater risk, especially without any instructor.

Know about dealing with people, assessment skills that are not physical assessment, but people assessment skills. Maybe some course instruction on how to talk to patients if they get angry or to de-escalate a patient who is violent, even other families. In psych, we didn't learn how to deal with people, we just learned about the different mental illnesses. If someone got "out of control," then the nurse just gave drugs or put them in a quiet room, so you really don't have to make any decisions other than knock them out or lock them up. That isn't going to be the case for us when we aren't working in the psych unit.

*Participant 9*

Instructors need to recognize when a student is faking; I mean her personality. I keep thinking that this student might really hurt somebody when she gets out of

> school, but the instructors think she is the greatest. She might really kill someone. Instructors need to educate themselves first before they can change things for us. When this student gets her degree, she will probably be fired in the first week unless she can hide her true personality from the employer. Instructors put students at risk when they cannot recognize a dangerous student. We never talked about people who are bullies. When a student is bullied, maybe talk about how to handle a bully because teachers don't even recognize it.

*Participant 10*

> For sure we need more time on communication skills development. Also, it would be important to learn about how to calm and soothe a high-risk situation, and maybe some teamwork projects that would teach us how to identify and support each other by at least being alert and aware of someone who is going to be violent. I think practice the motto and learn the motto, be prepared, be prepared. And that comes from learning the risks and using our judgment—that critical thinking thing we hear so much about.

### *Summary of Education Suggestions*

The second research question posed in this study was, "How might education respond?" The theme that was prominent in the responses was, *make sense of the situation.* By making sense of the situation, the participants offered insight into the experience of being a victim and provided examples of where they concluded education had either met or failed to meet the needs of this specific group. Subthemes that were identified included *caring, lack of knowledge, beliefs/values, social-cultural barriers,* and *transformation of education.* Conclusions drawn by this researcher from the participants' responses are as follows.

*Caring.* Participants expressed concerns that nursing may not be a caring profession and also student learning could not occur in a noncaring environment. Further,

they concluded caring was a term that may be taken for granted and in fact it might mean more than the profession has really defined.

*Lack of knowledge.* All participants clearly verbalized they lacked the necessary knowledge in communication areas including language, culture, people skills, and workplace violence.

*Beliefs/value.* Participants expressed the need for instructors to be proficient themselves in people skills, to teach the reality of nursing, not to compromise values but to purposely offer learning opportunities that would challenge nursing student values and beliefs.

*Social-cultural barriers.* Participants reported mandatory classes are necessary in order to break down social and cultural barriers. Courses that address the various issues that are facing health care, and how to problem solve some of these issues on their own. They suggested courses that focus on different languages, especially Spanish, and transcultural nursing to learn about different cultural practices. Although nursing students requested more knowledge on social issues, no specific courses were suggested, nor were there any suggested courses regarding issues facing health care.

*Transformation of education.* Participants suggested major transformation in the educational content their programs were providing. The transformation suggested not only the content, but also the method of delivery, both in courses and clinical education. For example, more knowledge of professional issues, cultural diversity, ethical and social issues, crisis intervention, role of nursing, safety, violence, workplace ethics, workplace

skills, and more. They also wanted more control of their personal learning experience in the clinical setting by having opportunities to work with high-risk populations, thereby allowing more exposure to problem solving.

### *Participation in the Study*

In the final phase of each interview, a debriefing question was posed, "What was it like for you to participate in this study?" Each participant focused on change, and a move toward a better future. Therefore, the third major theme of this study became *move toward a better future.* From this further sub-themes were identified including *improve professional misconceptions, educate society,* and *hope for the future generation.* Below are narrative excerpts of each participant's response to the closing interview question.

*Participant 1*

> It was like a burden was lifted; talking about it and knowing that someone understands. Most people don't understand what it is like to have someone stalk you and not have anyone believe you or think it is a problem. Talking about it really helps when someone listens.
>
> I wish people knew that nurses are professionals and not party dolls. I have hope that all of us younger nurses will help change the negative opinion about nursing and we act and represent the profession in such as way that it will open up more opportunities for us.

*Participant 2*

> I like it. I am glad I participated. It gave me a chance to be heard and have someone to talk to who will listen and doesn't think I am just another black person complaining about racial issues. It was really important to verbalize how I feel and not be judged. I handle race relations well and it is really important to educate people. When people read my story, hopefully they will identify with it and then they will be educated about the issues and maybe think to themselves ...I won't ever be that way.

*Participant 3*

I volunteered for this study and I am glad you let me be part of it. I wanted everyone to know what it is like to be a different culture and to be treated so bad, whether you are a student or not. I wanted people to know that we all must live in peace in this world and stop passing judgment on others for what they are and not who they are. I don't know if I will ever return to school, but I might if I know there are people like you who really want to make learning better for their students; teachers who care about human beings in general.

*Participant 4*

It was OK, I guess. I found it a little awkward to talk about what happen to me, but if I helped any students in the future, then it would make me happy. It did benefit me to revisit the situation and take a good look at how I might have done some things different. I guess the fact that it was so hard to talk about the incident just shows that, as nurses, we have problems talking about things that embarrass us.

In a way I learned something by just thinking about the incident again and that was "How can I teach my patients about embarrassing things if I can't talk about an embarrassing moment?" Thanks for letting me be in the study, maybe other students will read my story and realize they aren't alone.

*Participant 5*

I needed to vent my frustrations and this was a good way to do that. I wanted to know that I didn't do anything wrong and to reassure myself that I would be a good nurse. So, talking about it gave me the opportunity to know that I am going to be a good nurse and that it is going to be ok.

*Participant 6*

Umm, well, old memories and questions were raised in my mind. I know that I will do things different when I enter practice. I plan to listen and support others and act as a mentor to other students, remember where I came from, that I was once a student too. I will encourage learning in students and will teach them not to fear learning, but to ask a lot of questions.

*Participant 7*

I never expected to be in a situation like I was in so it was really hard to talk about it. Even now I realize that it was a learning experience, I guess, but it isn't going to be a lesson easily learned emotionally. It is good to talk about it and to have an

opportunity to get out all those feelings. It is so painful though. The road is hard to complete the schoolwork and the papers, but when I started to question whether I wanted to go to my clinical I knew how bad it really was. I lost the desire to learn and didn't realize it until now. I know that I am going to be a better nurse because of it.

*Participant 8*

It was difficult to re-live the experience of almost getting killed, of course. I really think I just put it aside because I didn't want the attention that everyone was giving me. All the phone calls, the instructors—I just didn't want to really talk about it. I wasn't going to participate at first because of that. I was sick of talking about it; I just wanted to get on with school and graduate. Only a few weeks left and I didn't want anything to get in the way after 4 years. I really feel that if I can make a difference for anyone who reads my story and learns from it, then I am satisfied that I participated.

*Participant 9*

No one really seems to understand much about being bullied, so I hope that when other instructors read my story they will want to learn about it, and help students who are in that situation. I didn't really know there was even such a thing. I thought it was just kids in school who were bullied, but now I am learning more about it and maybe I can make a difference by letting other people know what it is like to be bullied and people will take it more seriously.

*Participant 10*

It was hard for me to talk about my getting attacked. The nightmares started again and then I had trouble getting to sleep. I know that I will be helping someone else and that makes me feel good that I can do that. I still see the counselor about once a month now and that helps too. He tells me that I need to talk about it, so I know that it really wasn't might fault. I think I realize that it wasn't my fault, but still I am scared, and I need to know that my friends are around. When I graduate in May, I don't know how I will be without anyone around that I know, but I really want to be a nurse.

### *Summary of Participation in Study*

For some, the burden of being a victim had been lifted as they told their personal stories, for other it may not have. Overall, there was a sense of relief and expressed hope for the advancement of the profession they were about to enter. The idea their personal experiences might be a forum for educating society about nursing was important to the participants. In the final minutes of analyzing themes, it became clear the nursing students who had experienced victimization still held on to hope for the future of our society, for their chosen career path, and would most likely enter the profession better prepared, ironically the result of a negative learning experience.

### *Major Themes and Subthemes Supportive Findings*

The analysis of this study revealed three major themes and multiple subthemes as characteristic findings that permeated the participants' stories, yielding to the question "What it was like to be a nursing student exposed to workplace violence and aggression?" The three major themes included *personal construct, making sense of the situation,* and *moving toward a better future.* Following is a description of these three major themes and their respective subthemes with supportive excerpts derived from transcribing, sorting, and coding the data.

Figure 1 depicts a model of interactions and the evolution of themes. It begins with the lived experience as the stories unfolded, then moves outside of the experience as the participant reflected on the implications for education. The theme selection process, as Munhall suggests (1994), required this researcher to "dwell with the data"—reading it

over and over to assure what the participant was trying to express was truly being reflected. Colleagues acting as a form of peer review assisted this researcher toward the final decision on themes. However, most important were the participants themselves who reviewed the narratives and preempted themes to determine there was validity to what they had expressed with this researcher. The conclusions drawn by this researcher regarding major and minor themes came from the findings (themes) that permeated the participants' experience.

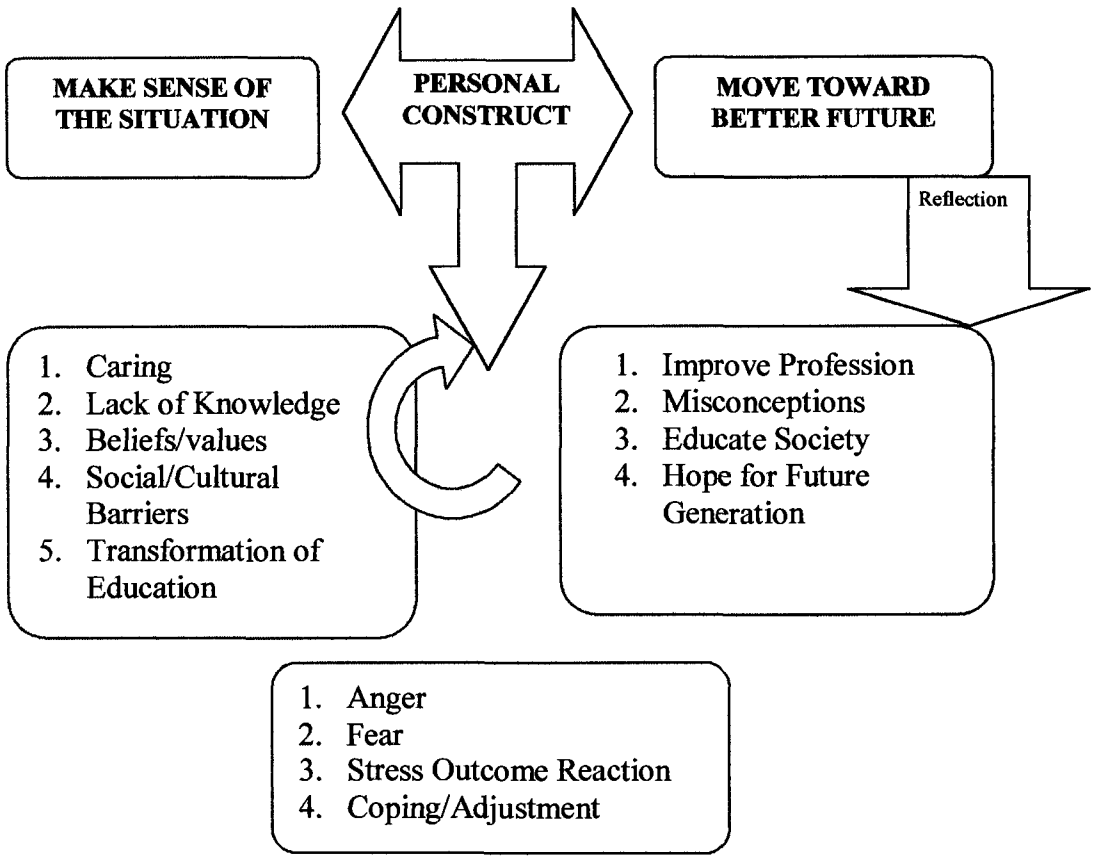


*Figure 1.* Major themes and subthemes.

When placed in the context of the literature available, certain aspects seemed to be universal with the participants' in this study. However, the contributions of this particular study have unveiled some independent characteristics that are the direct result of qualitative research using a phenomenological and feminist approach, inclusive of the specific typology (nursing student). Therefore, four aspects of findings previously discussed in chapter 2 will be compared in light of the major themes and respective sub-themes. Those aspects include definitions of workplace violence and aggression, nursing education and workplace violence, health care setting and workplace violence, and lastly nursing students and workplace violence.

*Personal Construct*

During the interview process, each of the participants constructed an experience hoping whoever read their story might somehow be able to understand "what it is like." This research study attempted to offer the opportunity for the participant to express their lived experience as only they could. Following the philosophy of phenomenology, only "they" know the meaning of the experience. However, others can seek to learn from the meaning expressed through the eyes of that individual.

As van Manen (1990) suggests, this allows for widening of the lens, and therefore raising consciousness to make others aware and deepen understanding (Munhall, 1994). Jean Amery wrote, "Whoever was tortured, stays tortured." Amery was a Holocaust survivor who, along with others, took their own lives years after their experience was over, a victim living the meaning of the experience beyond endless years.

The phenomenon of being a nursing student who experienced workplace violence and aggression cannot be defined in universal ways, only through commonalities found in the construct each victim provided. Therefore, each participant's construct (experience) was unique. Hence, to answer, "What is it like?" an attempt at finding meaning becomes expressed through consistent patterns of themes the participant used in describing the event.

During the chronological advancement of research on workplace violence, studies have revealed multiple definitions and confusion over what should constitute workplace violence aggression (Barling, 1996; Bulatao & Valdenbos, 1996; Lanza 1991; McPhail, 1996; Mullen 1997; O'Leary-Kelly 1996). Further studies attempted to isolate and define specific behaviors that might lead to a more comprehensive definition amendable to future research. A study conducted by Greenberg and Scott (1996) asserted workers would demonstrate behaviors that are the direct result of what they perceived to be an equal exchange for their hard work.

A study conducted by Brockner (1994) found that victims of workplace violence reported considerable frustration and stress, depression, resentment, and hostility. Changes in the workforce and organizational climate were found to have direct implications for increased aggression and deviant behaviors in the workplace.

All of the major themes, *personal construct, make sense of the situation,* and *move toward a better future,* suggest that nursing students who are victims of workplace violence too, are confused about not only how to define it, but how to make sense of it in light of altering the path for the future. Sub-themes such as *anger, fear,* and *stress*

*outcome* correspond to studies conducted on victims by Brockner (1994). Further, the themes of *caring, lack of knowledge,* and *social cultural barriers* exemplify the participants' reported observations of the workplace environment and their perceptions of equal exchange for their hard work, as asserted by Scott (1996).

In light of past research on workplace violence, definitions, and aggressive behaviors, some of the participants in this study were aware of being a victim of some form of workplace violence aggression while others were not. This became evident not from the interviewing process, but during the selection process when this researcher received phone calls from volunteers who stated, "I never thought of it as workplace violence until I read your posting and the definition." In soliciting for volunteers, this researcher used definitions provided by the Occupational Safety and Health Administration (1996) to define workplace violence, and International Council of Nurses (2001) to define workplace aggression. During telephone conversation with the pool of volunteers, not one reported being aware of the defined classifications of workplace violence and aggression.

Therefore, themes found in this study support a continued lack of knowledge as to a universal understanding and definition of the phenomenon workplace violence.

In the following section, this researcher will conclude with excerpts from the participants that became subthemes supporting "meaning" expressed in seeking to answer the question posed by this research study. "What is it like to be a nursing student exposed to workplace violence and aggression?"

*Anger.* The subtheme anger was primarily expressed by all of the 10 participants. The anger was projected at multiple individuals with no consistent patterns noted. For example, levels of anger were detected in intonation changes during the interviewing process, facial expressions, nonverbal, and verbal expressions. All the participants were especially angry. It was unclear sometimes who they were actually angry at during various interviews.

One participant (P1) stated, "The biggest thing was, I told him I didn't want to go out with him and he got angry." Nonverbal facial expressions and hand movements during this time supported that she was angry with the perpetrator being angry with her. Another participant (P2) who nonverbally expressed anger in her tone and expressions did so when stating, "I thought about it and it doesn't matter if I am black with a black patient or white with a white patient. If a person is going to hit you, they will no matter what color you are."

During another interview (P3), anger was expressed also in nonverbal as well as subtle phrases such as "I was born in the country. I am Muslim. I dress like everyone else does. I don't know why I have to prove that I am an American." Further expressed anger was noted in another participant (P4) nonverbally and through statements such as "I turned away and tossed him a wash cloth and towel telling him you can wash yourself. I told him, 'Here are your pants; please put them on.' His every look and move was sexual in nature, like when they say someone raped you with their eyes."

During another interview (P5), again nonverbal expressions were noted that expressed anger along with the statement, "Everyone used threats to get people to do things. Maybe my preceptor used threats just because she thinks that is the way to get people to help." Another example of anger (P6) was expressed by the nursing student who stated, "I don't know why this is. When I become a staff nurse, I will remember that incident. I know the kind of nurse I won't be."

In an interview obtained from participant 7 (P7), the nursing student was extremely angry during the entire interview. She couldn't sit still; she had constant nonverbal expressions of anger. At one point she stood up and stated, "Oh, my God! I was so mad. How could she lie to save her own self?" This nursing student was attempting to gain my support for her anger at the experience and in a sense was projecting that anger toward this researcher who, she was aware, was a nurse and nursing educator. The nursing student was not intimidating to this researcher during that period of time because it was obvious that she herself had no idea that she was projecting that anger directly at this researcher.

The most intensive anger expressed came during the interview with the nursing student who had experienced a patient directing a gun at her along with another nursing student (P8). When telling the story she was calm, her voice was steady, but she expressed anger in her facial expressions and mannerisms. She stated, "My voice was loud. In fact, I was yelling. I hate guns. The best part of the experience—they didn't believe us! In fact, the instructor said, "You both need to go ahead and finish the other

two appointments that you have." Right, no one cared about us or trusted we weren't making up some story."

Another example of anger (P9) was expressed in the statement, "I told her to keep her hands off of me but she just said, 'You aren't going to keep us late again today.'" A final participant (P10) expressed anger in the statement, "Amazing enough to me, it was like no one really cared, like it was a typical day in the emergency department, the routine."

During the interview process the participants would verbalize their experience often presenting with inconsistency in expressions of anger in tone, facial expression, and hand movements. Sometimes the anger was evident through their verbalization of the words, "I am really angry." Although, it was not until completing the data analysis this researcher really identified the extreme changes in levels of anger each participant had expressed. While transcribing the data, reviewing the notations made in journal entries, and reflecting on each interview the actual extent of anger became clear. What continued to remain unclear throughout the study was whom the anger was directed at. During some interviews it appeared to be the situation itself rather than a particular person. At other times, it was many people yet this often changed throughout varied interviews. Constantly reviewing the transcripts offered insight into the realization that not only was there inconsistency in the intensity of anger but also inconsistency in the projection of their anger.

*Fear.* The second subtheme, *fear,* was expressed many times in five of the 10 participants.

*Participant 1* – Then I just got scared, afraid to tell my teacher. He was really making me scared.

*Participant 3* – My parents want me to go back to school, but I can't—I can't.

*Participant 7* – I fear these nurses, I fear how they can lie and blame.

*Participant 9* – I am too scared to do anything or tell anyone. I don't know what to do. I am so scared.

*Participant 10* – He grabbed me by neck. His entire hand fit around my throat. He shoved me against the wall, still holding my neck choking me. I was never this scared.

*Stress Outcome Reactions*

The third subtheme, *stress outcome reaction,* was a significant revelation in that verbs used by each of the participants helped add meaning to understanding the experience for this researcher. The verbs allowed for a common language one this researcher and future readers of this study might apply when trying to attach common identifiers to "what it is like." The reader is referred to Table 2 for specific coding of the verbs expressed by the participants.

The findings demonstrated that all participants primarily experienced some form of emotional stress as a result of their experiences. Five participants also experienced social stress as well as emotional. One participant reported a biophysical reaction as well

as emotional to her experience, and four were affected both cognitively and emotionally. Two others experienced social, emotional, and cognitive stress outcome reactions.

*Coping and adjustment.* The subtheme, *coping and adjustment*, presented as a theme from the subtopic question this researcher used as a method to establish deeper meaning of the lived experience. The purpose of asking the nursing student, "How did you adjust or cope to the experience you described?" was to force the nursing student to stay within their experience as they lived it further by adding descriptors to their narrative story. This forced the nursing student to clarify the experience using words as a way to define it for this researcher. As a result, further meaning was elicited from the nursing students. For example, the participants used some type of clarification to ensure this researcher understood the significance of the experience before addressing the question about coping and adjustment. Further, all 10 participants expressed they did not cope, but might have adjusted to the situation.

Examples from each participant are as follows:

*Participant 1* – I have almost become paranoid hoping it will go away. I don't think you cope.

*Participant 2* – I don't think you do cope with racial bias', it's more like you adjust.

*Participant 3* – I hide from people as a way to cope, but you really don't cope.

*Participant 4* – I tell people the story, we joke, even though it isn't appropriate, it helps work toward coping.

*Participant 5* – I realize each person adjusts differently to situations. Cope? I never did.

*Participant 6* – At the time there wasn't much I could do, making adjustments was a way to cope but I can't say I did cope.

*Participant 7* – It was hard to go on. You don't cope, you can't.

*Participant 8* – How we are exposed to things has a different affect on how we deal with them. I adjust; people won't let me cope.

*Participant 9* – I watch my back so I guess that I adjust in order to cope.

*Participant 10* – I worry more. I still see a counselor monthly to try and cope.

### *Making Sense of the Situation*

The second major theme identified was *making sense of the situation.* In analysis of transcripts it became obvious that not only were the nursing students trying to *make sense* of their experience, but also they began to generalize and rationalize what might be wrong. In trying to express their experience they reflected on the meaning that it also had for them as a nursing student about to become a nurse. The purpose of this study was to derive meaning from the experience that the nursing students all shared, and secondly, to find out how they felt education might respond. The interview question that was asked of the participants, "What kind of educational preparation might improve the situation that you described?" yielded more than this researcher intended. The reason being, the

participants not only had suggestions for education, but also tried to make sense of why things were happening to the profession. The question forced the participants to reflect on the meaning of their experience once again; this time trying to make sense of why it occurred. While it was not the intent of the question, it did provide another forum for expressing, *"What is it like?"* going from past, present, to future.

The second aspect addressed in the literature included studies on education and workplace violence and aggression. No studies identified by this researcher, although there may be some, addressed the nursing student as a victim. One study presented by Woodtli and Breslin (1996) first drew attention to issues of educational content on violence in nursing education, but focused on delivery of care for a victim of violence, not on the provider of care, namely the nursing student. The participants in this study expressed themes that further supported a continuous lack of attention, citing examples of limited content regarding violence in their curriculum.

The themes found that correlated to results of the above study include all the major themes and subthemes. To date, the nursing students expressed they lacked knowledge about violence. This was supported with specific examples cited along with observational experiences. As the nursing students moved through the process of the interview, their goal was to *transform education* as a solution to this phenomenon.

Literature on health care workplace violence and aggression was further substantiated by all the themes and subthemes. For example, Lazarus and Folkman (1986) reported four categories that victims expressed. Within those categories, specific reactions in response to being a victim were reported. The reaction reported by the

participants in this study closely correlated to the reported reactions from Lazarus and Folkman's research findings on stress outcome reactions of nursing staff.

For example, there were similarities in the verbs used by the nursing students that directly correlated to those reported in the original study by Lazarus and Folkman. These included the emotional reactions of anger, social categories, and lack of caring. One difference was noted between cognitive reactions reported by nursing students and those reported by nursing staff. This difference was current practicing nurses focused more on working within the workplace environment, and the nursing students focused more on the workplace as a learning environment. Therefore, cognitive reactions were based on how each individual viewed the health care environment as a "job" or a "place of learning."

All of the themes in the research findings further supported the studies conducted by Woodtli and Breslin (1997). The concerns expressed by the nursing students supported concerns about faculty preparation to instruct nursing students on violence topics. This was exemplified in the participants' "view of educators" knowledge of violence.

Literature reported on nursing students and workplace violence and aggression was substantiated through all the themes identified in the reported findings of this research study. For example, although no studies in the literature addressed the nursing student as a victim, studies have recently identified high risk factors for the nursing student to become a victim of violence. The International Council of Nurses (2001) reported that nursing students are more likely to become a victim in the workplace than staff nurses. This report is timely, supporting the concerns identified prior to conducting

this study and it speaks to the magnitude of the problem. Furthermore, the 45 nursing students who originally volunteered as participants in the study all voiced concerns regarding the growing incidences of violence toward nursing students they had been observing.

McCoy and Smith (2001) presented from their research that nurses are socialized into the role of nurse. Further, they cited misconceptions by individuals regarding what nursing is and the concept of caring in the profession. They suggested possible factors such as, misconceptions of society, gender factors, and lack of education preparation as causes. Throughout this study themes evolved that support this thinking, for example, *caring, beliefs/values, social cultural barriers, misconceptions,* and *educate society.*

*R*ecently the Illinois Professional Development Partnership (2002) presented "desirable professional characteristics" as caring, listening, good humor, knowledge, competency, genuine concern, and very approachable. The participants expressed themes that suggested they too, considered some of the above descriptors of professional characteristics and pointed out how some nurses did not possess professionalism.

In conclusion, although literature is limited on nursing students exposed to workplace violence and aggression, the themes expressed in this study supported what we already knew about the phenomenon.

Following, the subthemes, *caring, lack of knowledge, beliefs/values, social cultural barriers,* and *transformation of nursing,* will be discussed along with the quotes that participants provided.

*Caring.* The nursing student participants expressed no one seemed to care about their personal observations of current staff nurses in practice. Further, they equated this with the overall nursing profession citing rationale through their personal observation of current nurses in practice.

They described staff nurses that did not act in a 'caring manner' toward anyone. One nursing student declared, "There is, in fact, a difference between caring about and caring for someone." They described the staff nurses that were uncaring, "as going through technical procedures in a busy and uncaring manner." Further, the participants suggested, "education itself doesn't practice what it preaches" in terms of caring, taught in their nursing education. Reason being, the instructors did not show any form of caring when it came to addressing the incident of violence/aggression the nursing student was exposed to. A concern about the true meaning of caring was also questioned, as was the term professional nurse. In all, the participants expressed concern the misconception about caring extended beyond the nursing student to patients, families, and other individuals who are recipients of the care provided. The main concern expressed by the nursing students was the lack of caring might perpetuate the idea that nurses are not caring, and this could result in the increase of workplace violence.

Excerpts regarding caring that supported this concept are noted below from the respective participants.

*Participant 1* – I would have felt more confident if I had known someone supported me and understood what I was going through.

*Participant 3* – My instructor didn't even talk to me about the patient who refused my care. She said, "Better get used to it."

*Participant 5* – This is when patients and families get mad; when they see us as non-caring.

*Participant 6* – I really have mixed thoughts about caring. Don't see much caring, or teamwork. Nurses don't care about other nurses. How can people care about people when they don't care about people they work with?

*Participant 7* – We could do better if we were open, honest, and caring. What happens is we really never learn about caring very much. I will remember to be caring. There is a difference between caring and being cared for. All nurses I watch care for their patients. Maybe education needs to start with practice what you preach.

*Lack of knowledge.* The next subtheme of making sense of the situation identified was *lack of knowledge*. Nursing student participants expressed concerns relating to what they should but do not know about workplace violence, aggression, safety, social cultural issues, and how to address prejudice and bias. They felt they could not protect themselves from being harmed. As a result of this knowledge deficit, they lacked confidence in themselves and the profession. Lack of understanding people yet needing to have people assessment skills was mentioned frequently. There was shared concern for not being able to problem solve for patients who presented with social issues due to lack of personal knowledge of potential resources available. Explicitly, the nursing students expressed

concerns about the issues specific to the nursing culture and how they would "fit" into the profession.

Below excerpts are provided that demonstrate the theme expressed as nursing students further "make sense of the situation for educators."

*Participant 1* – Students need to know how we should respond to this; how to deal with inappropriate behaviors.

*Participant 2* - Students need to know not to stereotype. None of us knows the answers to social problems but it is a part of the nursing role we are about to enter. We need more emphasis on culture and social issues with violence.

*Participant 3* – Teachers need to help others understand. There needs to be transcultural nursing courses.

*Participant 4* – In class we never talked about things that could happen to you as a female, like sexual harassment by a patient.

*Participant 8* – Nurses are not all good teachers.

*Beliefs/values.* The third subtheme, *beliefs/values*, resulted when the participants began to express how personal values and beliefs influenced the meaning they held about their experiences. For example, some nursing students believed they are sheltered from the actual reality of nursing as a student by the instructor who they termed as "controlling the exposure to experiences." Further, it was expressed instructors' perpetuated bias in multiple ways regarding nursing students including how they made the clinical

assignments. They shared the belief that staff nurses in general were prejudice and often stereotyped patients. Another concern was the idea of staff nurses who stereotyped patients and held the fate of those patients in their overall control. The reality of nursing, which was termed by the nursing students as "real world nursing," was not taught. From this thinking, they expressed they could possibly change this negative perspective of the profession because they were "young, and would all work together," whereas the "older nurses didn't care and hated everyone." They expressed the belief that educators "do not practice what they preach" and equated that to a noncaring attitude toward students. They believed that a good instructor must have strong knowledge about issues that pertain to nursing in general, including workplace environment issues.

The following excerpts expressed these thoughts.

*Participant 2* – Don't baby the student. Don't do clinical in settings that are predominately one race. Students need to learn not to stereotype. Nurses control the fate of the patient.

*Participant 3* – Nurses should take care of all patients without biases. Nursing students should be assigned to patients that will challenge their personal values and beliefs.

*Participant 4* – The reality of nursing issues are lost. We enter the profession without knowledge. Things might happen...not prepared.

*Participant 6* – I have an unrealistic idea of what nursing really is.

*Participant 7* – What happens, we never really learn about caring. Isn't that what we are suppose to learn? We lack self-confidence because we are students.

*Participant 8* – Students need to know they have options—to say no if they feel unsafe. Nurses are not all good teachers.

*Participant 10* – Instructors need to recognize when a student is faking; I mean her personality. Instructors need to educate themselves before they can educate us. Instructors put students at risk when they cannot recognize a dangerous student.

*Social cultural barriers.* The fourth subtheme, *social cultural barriers*, became evident when nursing students defined the term culture. For example some nursing students spoke about the nurse profession as one culture while some spoke about multiple cultural groups meaning ethnic or racial origin. Others spoke about the social issues that face different cultures. Although the personal definitions of culture may have reflected a different meaning to each participant, it clearly remained a predominant concern of the participants and a significant theme.

An example of different definitions of culture included one nursing student's expression, "students will experience a culture shock" referring to the nursing profession itself. Another example expressed was the idea that the instructors perpetuated bias in assigning patients to nursing students according to ethnic and cultural factors. Language barriers were also mentioned and specifically expressed in one comment, "all nurses need to know how to speak Spanish in this field." Further they referenced social, cultural, and violence content needed to be taught in nursing courses. They spoke about social issues

and mentioned they did not understand how to help patients faced with these types of issues. Further expressing a shared concern this would become worse if the violence trend continued in society.

Below are some of the excerpts cited from the nursing students' interview responses.

*Participant 2* – Students will really be culture shocked when they get into practice. Put the Hispanic student and the black student with their same culture; that is more for the instructor's convenience than for learning. Learn to deal with language barriers; at least in Chicago learn to speak Spanish. It should be mandatory in school. Older nurses are really angry. I don't know why they hate to deal with students—some anyway. I have seen a lot of social issues in the emergency department. It would help to talk about this in a course. None of us know how to find the answers to social problems...more emphasis on learning cultural, social issues, and violence.

*Participant 3* – Teachers need to help us understand the different cultures.

The next theme resulted from the interview question the student was asked originally to answer, "How might education improve the situation that you describe?" While other themes surfaced right away, this became the summation of their thoughts in making sense of the situation for education. The final theme became *transformation of education.*

*Transformation of nursing education.* Overall, the general expressions of the participants were expressed toward what educators should do differently. They

mentioned more personal support from educators as very important. Further, they mentioned several teaching strategies that might be used to educate and prepare a student for potential exposure of violence directed against them. Some ideas mentioned included role playing, prioritizing exercises, problem solving exercises, communication practice, more exposure to clinical experiences that may, in fact, not be safe, teamwork exercises, and challenges to critical thinking. Exposure to multicultural experience in the clinical setting was suggested along with learning about the various personalities they would be to be exposed to, such as the bully. They asked that nurse educators teach the "reality of nursing"—to practice and not shelter them from obvious professional issues. They requested instructors be open and expose nursing students to what issues they should expect to encounter in the workplace and in the culture of the profession. They wanted to improve the relationship between nursing student and instructor, overall with the goal being to enhance learning opportunities. Courses deemed as necessary by the nursing students included transcultural nursing practice issues and Spanish. They further suggested additional content in areas that focused on safety, violence, communication, crisis intervention, and the role of nursing.

The professional image of nursing was also a concern the participants identified. For example, one nursing student stated, "Somehow the idea of caring must be learned and become meaningful." Participants felt strongly nurse educators needed to be current in issues facing the profession and the workplace, such as violence and culture. The

students expressed an interest in having more control over their learning environment by being allowed more decision solving opportunities.

Below is a list of excerpts directly taken from the interviews that supported this call for the transformation of nursing education.

*Participant 1* – Make us aware there might be a problem. (P1)

*Participant 2* – Don't baby the student. Don't do clinical in settings of one race. Why shelter us from that as a student now? Talk about diversity, emphasize real things, and find cases that expose a student not only to culture differences, but also to potential safety issues more emphasis on safety factors.

*Participant 4* – Take care of all patients without prejudices... needs to be a transcultural nursing course. More practice and time with problem solving ourselves rather than the instructor fix it. An overview on the profession of nursing isn't enough. We need to understand the issues our profession is faced with—learn how to communicate boundaries to protect from harm. Just talk and share. Learn to problem solve and handle a situation. Too much time learning the textbook.

*Participant 5* – Students need to be exposed to various types of people, cultural groups, and learn better how to prioritize...priority on what to do next...learning to just follow orders, we just follow orders rather than think for ourselves.

*Participant 6* – I think a class about violence in the workplace would be good. Nursing students are too sheltered.

*Participant 7* – Some guidance from instructors...more instructors who understand the workplace issues...hospital that support learning for nursing students...I wouldn't want to be a nursing teacher, I know that.

*Participant 8* – Know about dealing with people assessment skills that are not physical assessment, but people assessment skills. Learn who is a violent—even family member.

*Participant 9* – We never talked about how to handle a bully. Teachers don't even recognize it.

*Participant 10* – More time on communication skills development. Learn how to calm and soothe a high-risk situation. Learn teamwork through projects. Practice the motto and learn the motto, be prepared, be prepared and that comes from learning the risk and using our judgment; that critical thinking thing we hear so much about.

### *Moving Toward A Better Future*

The final question posed during the interview process was, "What was it like for you to participate in this study?" This question was asked for the purpose of allowing the participants the opportunity to add anything they deemed important but also as a debriefing period for both this researcher and the participant. This resulted in the third and final major theme, *moving toward a better future.* Participants expressed the desire to change the perception of nursing, educate society, and offer hope to a next generation, their generation. As the nursing students spoke on their feelings about participating in the

study some expressed a burden had been lifted, it was a chance to be heard and to educate others who might someday be exposed to a similar experience. During this time, there was reexamining of their own personal feelings and perceptions about how prepared they might actually be to enter practice. They expressed the idea they really had learned from their personal experience with workplace violence. Many did not equate learning to their negative experience until this point of reflecting. Thereby the subthemes include *professional misconceptions, educate society,* and *hope for the future.* Below are excerpts from the participants' interviews that expressed these themes.

*Professional Misconceptions*

*Participant 1* – I wish people knew that nurses were professionals, not party dolls. Younger nurses will help change the negative opinion about nursing.

*Participant 6* – I wanted to know that I didn't do anything wrong and reassure myself that I would be a good nurse...I am a good nurse and that it is going to be ok.

*Participant 9* – No one really seems to understand much about being bullied.

*Participant 10* – I think I realize that it isn't my fault, but I am still scared and I need to know my friends are around.

*Educate Society*

*Participant 1* – That we act and represent the profession in such as way that it will open up more opportunities for us.

*Participant 2* – It gave me a chance to be heard. I handle race relations well and it is really important to educate people. When people read my story, hopefully they might identify and will be educated.

*Participant 3* - ...everyone to know what it is like to be a different culture and be treated so bad...wanted people to know that we must all live in peace and stop passing judgment on others.

*Participant 6* – I will encourage learning in students and will teach not to fear learning to ask a lot of questions.

*Participant 8* – I really feel that if I can make a difference for anyone who reads my story and learns from it, and then I am satisfied.

*Participant 10* – Make a difference by letting other people know what it is like to be bullied.

*Hope for Future Generations*

*Participant 1* – I have hope that all of us...

*Participant 2* – And maybe they will think I won't ever be that way.

*Participant 3* – I would like instructors who care about human beings.

*Participant 4* – Maybe other students will read my story and realize they aren't alone.

*Participant 6* – I plan to listen and support others, mentor other students, remember where I came from—that I once was a student...encourage learning in students.

*Participant 7* – I know that I am going to be a better nurse because of it.

*Participant 9* – I hope that when other instructors read my story, they will want to learn.

*Participant 10* – I will be helping someone else and that makes me feel good.

### *Summary of Theme Analysis*

Although the literature is limited on nursing students exposed to workplace violence and aggression, the themes expressed supported what we already knew about the general phenomenon of workplace violence. The definitions of workplace violence and aggression are multifaceted and therefore led to problems with underreporting and disputable statistics. Secondly, the magnitude of the problem is not truly reflected through underreported findings. Further, nursing students are high-risk targets of violence and aggression in the workplace while in clinical internships and will be faced with the same problem once they become a staff nurse. Further, the necessary educational preparation regarding violence is lacking in nursing education. Consequently, this results in a distorted view of nursing through the eyes of nursing students who, without knowledge, become confused about the phenomenon leading to an ongoing cycle of perpetuated violence and aggression in the nursing profession.

The next chapter will conclude with a detail summary of the findings related to nursing students who have been victims of workplace violence and aggression drawing conclusions and suggesting recommendations based on the findings of this study.

# CHAPTER 5: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

## *Summary of Research Findings*

This chapter provides an overall summary of findings related to the study of nursing students who have been victims of workplace violence and aggression outlining the implications of these results for nursing educators. Common themes expressed by the 10 participants are discussed in relationship to the original research questions posed, "What is it like to be a nursing student exposed to workplace violence and aggression?" and "how might education respond?" Conclusions are then presented, along with recommendations for further research.

## *Relationship of Research Questions to Findings*

### *Research Question 1 – What is it like to be a nursing student exposed to workplace violence and aggression?*

As shown in Figure 1, three major common themes were identified in this study that provided the framework for answering the research questions posed: *personal construct, make sense of the situation,* and *move toward a better future.* Respective subthemes identified flowed from these major themes and provided further clarification for this researcher during analysis of the findings. Discussions regarding the unfolding of this process toward answering the research questions are as follows.

Each of the 10 participants began by building a *personal construct* of their lived experience with workplace violence and aggression. In doing so, they provided a

narrative story about their unique experience, first living within the experience and later, reflecting on the experience. In this way the participants attempted to provide answers to what it is like to be a victim of workplace violence and aggression. The narrative stories were told by each of the participants at which time they expressed themselves to this researcher in the "I" first person. This was assurance to this researcher they were living in the experience as they told their stories. Even though the experiences were unique, all nursing students had some concrete formulation of what it meant to be a victim of workplace violence and aggression.

Every participant primarily expressed anger in terms of "what it is like." This anger was directed at different areas such as the situation, the perpetrator, society, and in one case, directly at this researcher. Overall, all 10 equated anger as the most significant expression of what it means being this victim. Interestingly, that expression of anger took on many forms identified both in verbal and nonverbal notation. The intensity of anger varied with each participant's expression, but it was the most significant meaning attached to the experience by all the nursing students.

Participants secondly expressed *fear* in terms of "what is it like." The fear they experienced focused on multiple situations, such as fear of the perpetrator, fear of the teacher, fear of future, fear of nurses, and fear of the situation.

In their construct, they expressed common descriptor verbs attempting to ensure this researcher was able to understand the "meaning" of "what it is like." The verbs added insight into "meaning" and moved the construct of the lived experience deeper toward clarifying the essence of the experience for this researcher.

Accordingly, nursing students reported a lack of self-esteem and self-confidence that often led to feelings of hopelessness. This was expressed in the idea they saw no way out of their personal experience. This was further extenuated by the idea the group expressed regarding coping and adjustment. They suggested you cannot cope, but you can adjust to the situation. By making adjustments, it might help an individual to cope with their experience. The ways to do that might be to just avoid thinking about the experience, avoid talking about it, and in some cases, it was suggested one might socially isolate away from the situation. This was the most extreme sense of adjustment by one nursing student who became a social isolate, dropped out of school, and withdrew from society.

Overall, nursing students who are victims of workplace violence and aggression primarily experience a sense of anger and fear. The difference was in the intensity of the emotion and the projection of the emotions. Nursing students lacked coping skills attempting to adjust never really resolved the inner personal conflict associated with victimization.

As a result of this inner personal conflict, the students further attempted to reflect on their personal experiences over and over trying to make sense or to place blame in some cases. While placing blame was not a deliberate attempt of the nursing students, in most cases it was the result of trying to find a resolution to their being a victim.

In posing the second research question, "How might education respond?" the nursing students offered the following suggestions for educators of nurses.

*Research Question 2 – How Might Education Respond?*

The idea of reflection on the experience and the emotions that surfaced from the participants moved the nursing students into *making sense of the situation.* Although the nursing students expressed the idea that one cannot make sense of this situation because it does not make any sense, they tried to equate their experiences in such a manner it would make sense for this researcher. The negative experiences shared by the group ironically offered insight into a nursing student's viewpoint of issues in the profession of nursing. These views, although tainted by the experience, offer educators the opportunity to evaluate personal approaches taken when educating nursing students in both theory and application of practice.

First, the nursing students expressed that no one really cared about the situation. In support of this they referred to past experiences, current nurses they have observed in practice, and even suggested, "society doesn't care." The group expressed concerns that this could perpetuate further violence. They compared caring to what they had observed in the clinical setting and determined that what they are taught in the educational setting often was in direct conflict with what they are currently observing. In all they blamed nursing education for "not practicing what they preach." While caring is considered the essence of nursing, nursing students do not see this exemplified in the practice setting. This raises doubts regarding the true meaning of caring, caring concepts, and the intense focus of caring in educational preparation.

In an attempt to further provide education with suggestions to this phenomenon of workplace violence and aggression, nursing students suggest they *lack knowledge* about

violence, listing specific areas of limited educational preparation. For example, content specific to violence was suggested along with more opportunities to develop skills that would prepare them for exposure to various violent situations.

The nursing students discussed how *beliefs/values* might be expressed in education. Suggestions were (a) teaching the reality of nursing, (b) allowing nursing students to be exposed to potential violent situations, and (c) not to shelter them. The nursing students shared a belief that nurses in general were prejudice and held too much control over the fate of patients. There was an expressed opinion that a good instructor of nursing is one who has knowledge about the profession, the workplace, and issues related to nursing in general.

*Social issues* and *barriers* to learning were identified as concerns for education to address. For example, reduce the culture shock for nursing students entering the profession by better exposing them to the nature of the workplace while a nursing student. Provide knowledge in areas that would provide insight to managing social issues that prevail in our society today.

Nursing students moved into *transformation of education,* concluding this might be accomplished with different teaching methods and more curriculum content addressing diversity, culture, ethics, professionalism, workplace transitioning, and professional issues. The courses identified in particular that nursing students see as lacking in their educational preparation included Spanish and transcultural nursing.

Nursing students wanted to re-examine the idea of caring and the meaning it has to the practice of nursing. They want to start with changing the hierarchical position of

educator/student moving out of the traditional gender biases. Further, they wanted more control over their learning experiences, specifically in the clinical setting.

### *Summary How Education Might Respond*

In summary, the question, "How might education respond?" as posed to nursing students who were victims of workplace violence and aggression can be answered in the following manner.

1. Recognize the risk associated with students and workplace violence and aggression. Although not thoroughly researched, recent attention has been drawn to the fact that nursing students are higher risk of being targets of violence than staff nurses. Armed with this information, the nursing student can be better prepared for the likelihood of this occurrence. This could be accomplished with nursing educators evaluating the content that specifically addresses diversity, culture, professionalism, ethics, workplace transitioning, and professional issues.

2. Consider the conflicting idea of caring as seen from the perspective of the nursing student taking time to openly discuss issues that face nurses currently and in the future.

3. Right the wrongs of gender biases in the profession removing hierarchical positioning of educator/student and move toward learning communities.

4. Partner with students and facilitate their personal educational journey by offering flexibility, while still maintaining structure guiding their learning opportunities.

5. Most important, remove traditional gender biases that perpetuates and haunts the profession of nursing. Personally, this researcher (nurse educator) has been guilty of this on a number of occasions without ever having realized it until conducting this study.

In speaking with multiple faculty members, they too admitted they would often "consider what might be best for the patient" and would therefore assign Spanish-speaking nursing students to patients who spoke only Spanish, or even match cultural or ethnic backgrounds. Though not a deliberate attempt to perpetuate bias, this was more likely directed at "what was best for the patients." Nursing students in this study have opened a new perspective regarding what they termed educational bias. Educators must evaluate this in the face of multicultural changes occurring in society today.

Nursing students wanted to *move toward a better future*. As a group they identified professional issues that conflict with the idea of what nursing is and should be. They want to improve the profession, right misconceptions, and in doing so, educate society. The nursing students' spoke from the idea they would do this starting now and would pass on to the next generations a profession they could proudly enter. However, they determined the real future of nursing lay in the hands of nursing educators who were the leaders in transforming the nursing profession.

## *Conclusion*

When placed in the context of existing literature, the themes identified were not new in comparison to what we already knew about workplace violence victims. They are, however, new in the sense that we knew nothing about nursing students who have been

victims of workplace violence and aggression, nor did we know what the implications of this phenomenon would have for nursing education. This study's contributions consisted of unveiling specific aspects not known prior to this study.

One relevant finding was the underreporting of workplace violence and aggression among nursing students and faculty, along with their rationale for not reporting incidences of violence and aggression among nursing students. For example, the nursing students cited fear of getting kicked out of school, no one would believe them, and no one seemed to care. In all of the experiences presented in this study, no one outside of the victim (i.e., faculty, staff, or health care workers) made any attempt to file an incident report. In fact, the incident was accepted as "the way it is in the profession, so get use to it." It is possible that some failures in nursing programs may be the direct result of exposure to unreported workplace violence and aggression or even the trauma associated with the visual observations of incidences. Nursing students equated the consequences of reporting incidences of workplace violence and aggression with dismissal from the nursing program or a misconception they were not going to be a good nurses.

Similarly, literature supported underreporting of workplace assaults by nurses and equated this fact to nurses who "don't want to lose their jobs, fear of being blamed, and refer to violence as part of the job" (Lanza, 1999, 2000; Reiss-Koncar, 2001). While it may not be a new finding, it correlated with the fear expressed by the nursing students and supported the idea of a societal tolerance of violence.

Another finding identified in this study also correlated with the literature on lack of knowledge regarding what actually constitutes forms of workplace violence. Nursing students and volunteers whom this researcher spoke to prior to initiating this study expressed "they had no idea what defined violence and aggression in the workplace." This was also reflected in the literature as an ongoing debate regarding what behaviors constitute an operational definition (Report to The Nation, 2001; Barling, 1996; Bulatao & Vadenbos, 1996; Lanza 1991; McPhail, 1996; Mullen, 1997; O'Leary-Kelly, 1996).

Although not a new finding, this suggested knowledge is imperative regarding types of violence and aggression in the workplace in order to reduce the incidence not only in current practice but in the future.

In looking at stress outcome reactions expressed by the nursing students, the findings also correlated closely to the same reactions as those of staff nurses who cited fear, lack of caring, hopelessness, and anger as outcomes stressors experienced (Lazarus & Folkman, 1986). However, differences were expressed in cognitive reactions. The staff nurse expressed lack of interest in people and the profession, and reported a desire to leave the nursing profession citing "burn out." Nursing students on the other hand reported they could not concentrate, grades declined, and some just simply dropped out of school altogether. These findings have direct implications for nursing education. For example, the nursing students who are better prepared and exposed to the complexities of the workplace may enter the profession with different expectations of their chosen career, thus, reducing the potential for job burnout. In the current state of an extreme nursing shortage it is imperative that nursing students who enter the profession remain in the

profession and not leave because of unrealistic expectations or misconceptions of issues they will be faced with.

While not a new finding, nursing practice concerns should be raised regarding the professional image that nursing students perceived in their learning environment along with the variable findings of the organizational milieu. For example, nursing students expressed a concern that staff nurses are not caring, and further how these perceptions might carry over through their actions, perpetuating more violent response from recipients of care. This study identified that "caring is questionable in what is perceived to be a caring profession." The idea that caring was not exemplified in the nursing staff nor the nursing faculty conflicted with the theoretical basis of nursing education.

Findings reported by Woodtli and Breslin (1997), supported faculty do lack expertise regarding violence in various populations, assessment and interventions, defining problems of violence, concepts of victimization, conflict resolution, debriefing, and crisis intervention. Further, in this study little has changed since that research was presented in 1997, regarding faculty knowledge and violence education. Nursing students need support from faculty when they are recipients of experiences of workplace violence and aggression. Educators need to have expertise in the concepts surrounding violence and aggression in order to provide education direction and support for nursing students.

A surprising finding in this study was the nursing students' perceptions regarding gender stereotyping, which was in direct opposition to what one study by McCoy and Smith (2001), found. For example, according to McCoy and Smith, nurses are socialized in the role of a nurse. Nursing students in this study often referred to nursing as what it

was supposed to be, how "nursing is caring," and what they perceived to be "the essence of nursing." Further, they suggested this misconception might be perpetuated by society, gender factors, or even educational preparation and was a contributing factor to the phenomenon of workplace violence.

In this current study, nursing students recognized and questioned this type of stereotyping. References were made to nurses who did not prioritize care and simply followed the orders of doctors, and further, they questioned following orders of the instructors, doctors, and then even staff. They outlined what they considered to be unprofessional conduct and questioned the actual role of the RN. Based on the conflicting observations of lack of caring and images of what they deemed imperative to professionalism, this was a grand finding for this researcher: that nursing students could have such insight into the profession.

There was a blur between traditional and untraditional thinking in the nursing students. This became obvious when they questioned the hierarchical position of health care providers, faculty, and the implications this had on their learning opportunities.

In one sense the participants in the study were torn between the traditional patriarchal family equated to the health care environment (Ashley 1995) and the desire to rethink this idea on caring. They saw nurses as noncaring, yet they also saw this as an opportunity to examine what the term caring should be in the professional sense.

All in all, the nursing students were moving toward equal playing ground in both education and their future position as staff nurses. Further, they equated this with society, improving misconceptions, and improving the profession as the "young nurses." While

some may consider this an insult, it suggested this generation of nurses has the insight and drive toward changing professional issues as they are confronted.

Of particular concern was the idea that faculty perpetuated bias in the manner in which they assigned patients. Several participants referred to faculty bias directly or indirectly. Nursing students referenced faculty as defending this bias with the idea it was a good learning experience and good for the patient. However, the nursing student equated this to poor learning experiences for the convenience of the instructor and nursing staff. This idea caused this researcher to reflect on these comments and to invite comments from other nursing students in general discussion. Comments made by other nursing students supported the idea that instructors perpetuate bias and assign patients and nursing students based on matched culture, ethnicity, gender, and language skills.

Nursing students suggested all nurses should learn to speak Spanish. This was reported as an important consideration due to the increasing Hispanic population in the area where this study occurred, and has direct implications for curriculum changes.

*Student Meaning of Experience*

Nursing students exposed to workplace violence and aggression uniquely expressed the meaning of the experience; however, there were some commonalities they all shared. The incidences of workplace violence and aggression toward nursing students are prominent, yet ignored. This has certain implications for nursing education and society as a whole.

First, the nursing students who have experienced workplace violence and aggression will react primarily with anger and fear. This anger will be projected in several ways, but mainly at the educational setting and the instructor. The nursing students want someone to intervene and rescue them from the experience yet, they feel trapped and see this as a hopeless situation. They feel that if the incident is brought to the attention of their instructor, nothing would be done, and further, they might be labeled and even kicked out of school. Therefore, the nursing students try to cope with the situation, which may or may not be possible, based on their previous exposure to similar experiences. Some nursing students had more insight into violence while others had little or none. This preempted exposure does have a direct correlation to the intensity of emotions and stress outcomes that nursing students experience. In either manner, the nursing students will not usually cope, but will adjust to the experience. This is accomplished in a manner described as just keep quiet, do not talk about it, and then graduate without any problems getting in the way of their meeting their educational goal. In taking on this burden of silent victims, the nursing students will have decreased self-esteem and often will lack self-confidence. Depending on the nursing student this is the point of failure when they may drop, or flunk, out of their nursing educational program.

The reality of this exposure presents another concern for educators. Nursing students will take on a tainted perspective of nursing and what nursing actually is. They begin to question whether nursing is really about caring. In education we begin with telling students nursing is a caring profession, yet they are confused by what they are told versus what they are seeing. This causes the nursing students to question the knowledge

of the educators, which leads to disrespect and an altered learning environment. The nursing students see the workplace as a noncaring, prejudice, hostile environment in which no one cares. This is further reinforced by the idea that the faculty does not care. Instead the faculty ignores the situation, makes the situation tolerable, or shelters the nursing students. The nursing students respond to this by seeing avoidance in the instructor to address the concerns, and also a lack of knowledge of workplace issues. The nursing students begin to recognize that not only does the faculty lack knowledge in dealing with workplace violence, but they also have no skills to deal with the hostile workplace. This gap has not been addressed in their education.

The observations made by the nursing student are perpetuated with faculty who do not teach the reality of workplace issues. In this sense the nursing student sees the faculty as a bias and prejudice person. Gender bias is viewed as a problem for only the "older nurses." Nursing students recognize and question the idea that the nurses are nurturing, and motherly. In fact the "younger new nurses" expressed a sense of duty to change this gender bias of female motherliness in the profession they were about to enter. The idea of bias was further examined by the nursing students and recognized as prejudice in the faculty.

Nursing students saw barriers both in culture and language among the staff and patients in the workplace. They recognized the need for change in the curriculum that would address this gap. The nursing students do not agree with matching cultures, or common spoken language with staff or nursing students. In fact, they saw it as a

perpetuation of prejudice and bias. The nursing students expressed the idea that education has the responsibility to change this situation.

*Meaning for Education*

Nursing education must recognize there is a problem. The nursing student must be confronted with the reality of the workplace and the issues that continue to plague the profession of nursing. If nursing students enter the profession armed with knowledge, the reaction and the outcomes will be improved. For example, we as educators teach "prevention." The nursing students were able to recognize that the responsibility begins with their education and therefore, the educator must provide the knowledge and skills that the nursing student needs to enter the workplace environment. The current workplace in most cases is exactly as the nursing student views it. Nationally, there is a nursing shortage. Thus staff nurses are faced with issues such as burn out. The trend is to try and "fix it" in the workplace. The focus is on teamwork, in-services on working together, and leadership. The hospitals promote the idea of getting along and working together. Would it not be a better solution to first start with educating the nursing student on the reality of this workplace, arm them with knowledge, and begin with a prevention approach?

This gap could be addressed by (a) recognizing that there is a problem, (b) looking at the personal knowledge the faculty have with which to educate the nursing students on issues of the workplace and violence, (c) teach the nursing students they must take care of themselves prior to taking care of others, and (d) focusing on the health care provider, making their needs the priority.

Education must begin to look at the curriculum and the courses being taught. Does nursing teach courses that are moving with the trends of society? For example, trends such as increase in multicultural, ethnicity, violence, workplace structure, and languages barriers, even an aging population? Nursing students will be confronted with a different workplace based on current trends in our society. Hence, it is imperative that we arm them with the skills preventatively to face these challenges head on.

A reality call for this educator was the idea that faculty perpetuated bias and prejudice. It is crucial faculty evaluates teaching methods used with nursing students and begin to move toward a shared learning. Nursing students today want more control over decisions in their learning. The autocratic hierarchical style of education must be evaluated and nursing students must be allowed to view their personal learning as a shared goal, one with the instructor who facilitates the learning experience yet allows "reality learning."

In the end, the educators of nursing students have the challenge to change the current workplace. The old saying "we eat our young" should not be the rite of passage for the nursing student entering the profession. The goal is to make the profession one that every male or female sees as a desirable lifelong career. The outcome of this change will lead to a better workplace environment, a strong respected professional image, and a commitment to remain and not leave the profession due to burnout.

*Recommendations*

As stated above, recommendations for change must begin at the entry level of education, not at the entry to practice level. The problems identified in the meaning expressed by the nursing students' exposure to workplace violence and aggression can be addressed if nursing faculty first recognizes there is a problem. They will need to evaluate their personal knowledge of workplace milieu, issues in the nursing profession, trends in society, and, finally, match these with an evaluation of the curriculum and content of nursing education.

Nursing students of this study offered suggestion for education that this educator finds appropriate. They suggested courses that addressed trends in social change—Spanish as a mandatory course, along with courses regarding issues in the workplace. They wanted more exercises in critical thinking that addressed teamwork and approaches to managing violence. Courses that addressed transcultural populations and approached to different ethnic groups were important yet lacking in the curriculum. In practicum, exercise scenarios would be helpful to teach communication skills when confronted with violent patients, families, and even peers. From the scenarios, nursing students could learn how to protect themselves and defuse potentially dangerous situations.

Most important, educators should teach the reality of professional problems facing the nursing student. Students may in turn see these problems as challenges and move toward positive change. The nursing students' perspectives of the workplace are reality-based issues we as nursing educators are confronted with. Therefore, we must take on the challenges of nursing education and become the driving force for professional

practice change. Once we as educators conduct analysis regarding the educational preparation currently being provided for nursing students regarding workplace violence and aggression, the need to evoke change will become clearer. Although it may be impossible to stop incidences of violence and aggression against a nursing student, it should be essential to educate them about the possibilities, thus arming them with the knowledge to protect themselves.

In summary, if education address the findings of this study, the experiences of workplace violence and aggression for both nursing students and staff nurses will take on a new meaning. While it is not possible to guarantee that violence or aggression will not occur in the workplace, the intensity of the experience and the meaning may be changed if nursing students and staff view it from the same perspective. One that is colored with the idea they were prepared for the reality of violence, they were educated on the methods to prevent self harm, and they will receive the necessary support from faculty or the employer when reporting the incident knowing the policy is zero tolerance of violence against nurses.

*Contributions of New Knowledge*

This research study has made significant contributions to the literature regarding the nursing students who have experienced workplace violence and aggression. The conclusion made from the analysis of the findings supported the current literature on workplace violence and aggression in general. First, findings supported there is a lack of universal definitions of workplace violence and aggression. Second, they supported the

lack of accurate statistical data in the health care profession regarding actual assaults on nurses. Third, they supported the stress outcomes experienced by nurses, and last, they supported a lack of educational preparation.

New to the knowledge of current literature was the focus on a specific typology, the nursing student who at the time of this dissertation had not been studied in the context of violence in the workplace using a phenomenological and feminist approach. Although there may be some studies on the nursing student and violence, this researcher did not find any prior to conducting this study. The themes that emerged from the participants in this study are new and add to the voluminous research on victimization. Yet in particular they added a new typology and new methodology of qualitative design as a means to study the issues of workplace violence and aggression.

Most significant contributions are in the area of nursing education. The nursing student's experiences of workplace violence raised awareness to the problems of workplace violence and aggression in nursing students, the meaning, and the altered perceptions that result from the negative experiences. Further, the nursing students offered a reality check for nurse educators offering a personal perspective of gaps in education and ideas for improving and changing the future by transformation of education.

Another significant contribution was the addition of information to the health care organizations. From a business perspective, health care environments must address the idea of workplace violence and aggression with zero tolerance. While this may be the

philosophy of business practice, it is not the perspective of the nursing student who cites reported incidences of unreported, look the other way attitudes, in the health care setting.

Nursing students who attend clinical practice in hospitals that demonstrate a lack of concern regarding workplace issues make mental note of that experience and quickly eliminate that organization from a future job selection. In a time of extreme nursing shortage the hospital should be addressing workplace issues with employees and be cognizant to the milieu and the examples that current employees display publicly.

*Implications for Social Change*

The results of this study have direct implications for social change. First, the study provided insight in the entire process of workplace violence and aggression perpetuated against nursing students. Further, the data revealed the meaning attributed to this experience by the nursing students themselves. Through the eyes of the nursing students, the perspectives of professionalism, victimization, behaviors, and educational gaps are presented, which will raise consciousness to a neglected research area.

The nursing students themselves, through their expressed lived experiences, have provided an impetus for social awareness and social change regarding violence and aggression not only in the workplace, but also as a societal tolerance that must not go unchecked. Through their participation and the findings of this study, policy changes are easily identified in areas of violence and aggression tolerance, reporting of violence and aggression incidences, and mandatory educational preparation in violence and aggression issues.

Further, major transformation of education is desired, including changes in policy and procedures for the addition of new content and the methodologies used to gain necessary educational preparation. In conclusion, the new knowledge has opened the way for improving and redesigning education that addresses societal trends.

*Implications for Future Research*

Because of the national shortage of nursing and the need to entice nurses into the profession, further research is necessary that will remove the barriers to this goal. First, one aspect of research should focus on the actual number of nursing students who have experienced workplace violence and aggression to accumulate some actual statistical data. In addition, these data might be compared to those nurses already working in the health care setting. This would lead to better establishing the magnitude of the problem.

Secondly, more research is needed in the area of the actual health care environment. For example, the working milieu and how the negativity seen by the nursing students affects the care they provide, and the public's perception of nursing.

Third, more research is necessary on whether nursing students come to the profession with some previous exposure to violence themselves, and if, so how that affects not only their personal perceptions of workplace violence and aggression, but also their reactions.

Next, more research on nurses educational preparation is needed, including faculty preparation to teaching workplace violence and aggression, faculty personal

belief/values, and variable teaching strategies that will provide how to teach nursing students who will be faced with the changing face of a violent society.

Another area of research might be to determine if the dropout or course failures in nursing education are in any way associated with incidences of unreported violence and aggression. If so, how does that correlate to the burnout of nurses in the profession?

Finally, a longitudinal study may provide a comparison of that nursing student who had little or no violence educational content with those who do. This might also include specific courses such as transcultural nursing, Spanish, issues in health care, and others mentioned by the nursing students in this study. Once integrated into the curriculum, program outcomes could be analyzed and compared for results.

Overall the study has raised consciousness and prompted future studies on issues of workplace violence and aggression in the areas of psychology, sociology, education, economics, and philosophy.

### *Researcher's Experience Reflexivity Journaling*

This section addresses the researcher's personal experiences with conducting this research study it will be written in the first person. The discussion will focus on my experiences in bracketing my assumptions, as written in my journal entries.

In the beginning of this study, my intent was to capture the lived experiences of nursing students who had been exposed to workplace violence/aggression. I chose the method of phenomenology as my approach because I wanted to capture the meaning as

only they could express it. In a sense, I realized that my personal interest in this subject developed years ago when starting my nursing education. Twenty years ago nursing education was an autocratic environment in which a nursing student was at the mercy of the instructor. The methods used to teach were derived from heightened levels of discipline. In some case intimidation and ridicule were used to get this nursing student to meet the expectations of the teacher. Learning for myself was difficult in this environment, but I survived and found it to be one of my more horrifying experiences of my life.

Upon entering the practice of nursing as a novice I realized that the anger and fear I had experienced in obtaining my nursing education had carried over into the health care environment not only for me, but also for everyone I spoke to. The new graduates hated their learning experiences, hated their schools, and more often hated the educators. This became evident to me and was points checked in my journaling as nursing students reflected on their anger, fear, and lack of support, seen mainly as the educators' fault.

Further, the meaning the nursing students attached to the exposure of workplace violence/aggression required me to journal often and stop to reflect on my personal experiences in order to check my assumptions. I captured in my reflexive journal that these nursing students were powerless, they saw the situation as hopeless, and yet expressed a sense of duty toward their chosen profession. Often I would check my own realty as I found myself shaking my head in agreement with comments and situations the nursing students relived.

In one interview, I found it necessary to take a long break before continuing on to the next interview. This interview was with the nursing student who had been assaulted by a patient with a gun. I found myself becoming angry with the nurse educator who sent the nursing students alone into the environment, and who did not seem to care or take the time to respond when they called her for help. It was necessary for me to keep an open mind and allow the participants' own truths to surface; only this way could I capture what they really were trying to share. In doing so my personal thoughts, feelings, beliefs, and values had to be expressed in my journal so as not to express something that reflected my own interpretation of the event.

According to the phenomenological methodology, the investigator has to undercover presuppositions by submitting to a process of self- reflection (Colaizzi, 1978). This is a challenging task. No matter how carefully I tried to acknowledge and displace my personal experiences as a nursing student, a nurse exposed to workplace violence/aggression, and educator, they would resurface and interfere with my interviewing.

Following is a note written in my reflexive journal after listening to an interview with one nursing student. During this interview I lost focus and tried to explain to the nursing student that her experience was really bad, but here is what I experienced. I tried to compare my own experiences as more significant. Below is an excerpt from my journal.

> I am really angry this happened to you. I can't believe that your teacher didn't do something. I would never let this happen to my students. I experienced the same thing as a student and I know how it must feel.

> This was my assumption! You are reinforcing the idea that faculty are bad. Making it seem like I am the expert on teaching and forgetting the student is the expert here not me. Take the time to listen and stop formulating opinions that are personal. You are adding to the negative experience through your own experiences. STOP IT!

After this interview I became more aware of how difficult it was going to be to unlearn (Munhall, 1994) things that I had experienced for years as a nursing student, a nurse in practice, and finally, an educator. My 20-year career and all the wisdom had to be extracted from my mind.

In some ways my clinical expertise was helpful because I could relate to experiences of workplace violence/aggression both from having been a victim in several experiences and also from personal observations of this phenomenon as a nursing educator. In the end, the reflexive journaling became one of my biggest assets in removing myself from the experiences of the nursing students and yet journaling my personal thoughts and feelings, something I should have done twenty years ago. In a sense, it became cathartic for me and allowed the nursing students to express their own meaning without my personal interjections.

In the end, I realized the 20-years of being a nurse, both good and bad, have offered me an opportunity to pass on my wisdom to the next generation of nurses. Through the eyes of these nursing students' experiences surfaced my utmost respect and admiration that they will be the change agents of the future.

*"Walk the path of your destiny with an open mind and heart." (author unknown).*

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*Appendix A*
*Walden University*
*Request to the Institutional Review Board for Approval to Conduct Research*

Walden University
Committee on Ethical Standards in Research
155 Fifth Avenue South
Minneapolis, MN 55401

1. Project Title: (Use same title as Final proposal): Nurse Students' Experiences of Workplace Violence and Aggression: Making Sense of the Situation for Educators.

2. Exemption category claimed: 2 (Insert the category numbers)

3. Principal Investigator: (full name & degree) Bonnie Jean Beardsley MSN RN

   Address: 1840 Deer Run Drive Montgomery, Illinois 60538

   Home Phone: 630-966-9741

   Work Phone: 630-844-5134

   Email: bbeardsl@waldenu.edu

4. Projected inclusive dates of project: Jan 2002-through Nov. 2002

5. Check one: Faculty Research X Student Research (Doctoral)

6. If principal investigator is a student:

   Advisor's Name: Dr. David Stein

   Address: 2180 Bryden Road Bexley Ohio 43209

   Telephone: 614-231-0315

   Email: dstein@waldenu.edu

**Questions must be addressed completely. A request involving a survey or interviews must be accompanied by copies of the instruments which will be used to gather data.**

Research applications must include a consent statement or consent form appropriate to the research questions . (Use the sample form as a guide in preparing forms, letters and oral statements.) Research involving the use of pathological specimens and existing data without identifiers does not require consent from subjects.

7. Abstract/Lay Summary

Describe the research, including research questions, the purpose of the research, and methods to be used (hypothesis and methodology). Describe the task(s) subjects will be asked to complete. **Use lay language (language understood by a person unfamiliar with the area of research). Area-specific jargon should be avoided or explicitly explained.** If using existing data, records or pathological specimens, explain the sources of data, the type of tissue used, and the means of access to data. (Provide attachments as necessary.)

In this qualitative research study, 10 female nursing students who have been victims of workplace violence/aggression will be asked to participate in a 60-minute interview session with this investigator. The following four questions will be the focus of the interview.

(1) Please describe your experience with workplace violence and aggression.
(2) Talk to me about how you adjust or cope.
(3) What kind of educational preparation might improve the situation you describe?
(4) What was it like for you to participate in this interview?

The interviews will be taped and consent obtained prior to the interview and immediately before beginning the interview process.

The purpose of the study is twofold: (a) to document and explore the perceptions of female nursing students lived experiences of workplace violence and aggression, and (b) to gain a clearer understanding of these implications for nursing education.

The methodology to be used includes a combination of phenomenology and feminist approaches which are best suited for exploring and documenting lived experiences and unveiling meaning of the phenomenon from the participants own perspectives.

The 10 participants will be selected through snowballing and purposive sampling. A notice soliciting for volunteers will be posted on nursing student bulletin boards in 25 schools of nursing throughout Illinois.

Interviews will last approximately 60 minutes each and will be tape-recorded. This investigator throughout the study will maintain personal journal notes. The tapes will be transcribed by this investigator and then validated by each participant individually. The method to be used for analysis is the Colaizzi Seven Step Method. This method works well with phenomenology and feminist research

8. Subject Population:

a. Number: Male: 0 Female: 10 Total: 10

b. Age Range: 20 to 40

c. Location of Subjects: (elementary/secondary schools, university, public institution, hospitals and clinics, private institution, other)

____elementary / secondary schools
____outpatients
____hospitals and clinics
_X_university students
_X_other special institutions: specify:

Participants will be located in schools of nursing throughout Illinois in multiple places. Interviews will occur in selected sites by participants. They will attend various schools that will not be identified in the study.

____Other hospitals: specify:

d. Special Characteristics of Subjects (Check all that apply)
____ inpatients

____ prisons/halfway houses

____patient controls

_X_normal volunteers (adults)

e) If research is conducted through community agencies, written documentation of approval/cooperation from such agency (school, etc.) should accompany this application. List the names of any organizations or agencies providing authorization to invite their constituencies to participate in the study.

N/A

f) Describe how subjects will be identified or recruited. Attach recruitment information,

i.e., advertisements, bulletin board notices, recruitment letters, etc.

This study will employ purposeful sampling in the tradition of qualitative research. The participants will be chosen personally after eliciting a pool of volunteers to ensure a selection of information rich cases.

g) If subjects are chosen from records, indicate who gave approval for use of the records. If private medical or student records, provide the protocol for securing consent of the subjects of the records and approval from the custodian of the records.

NA

h) Who will make the initial contact with subjects? Describe how contact is made.

The researcher will make initial contact by phone and then in person and in private at the participants' home of choice meeting site for the interview

i) Will subjects receive inducements before, or rewards after the study? (Note: Include this information in your consent documents.)

The 10 participants will not receive any inducements or rewards before of after the study.

j) If subjects are school children and class time is used to collect data, describe in detail the activity planned for non-participants. Who will supervise those children? (Note: Include this information in your consent documents.)

N/A

9. Confidentiality of Data

Describe provisions made to maintain confidentiality of data. Who will have access to data? Will data be made available to anyone other than the principal investigator? (School officials, medical personnel?) If yes, explain below and in the consent form.

There will be no need to share data with anyone other then the participant/investigator. Ultimately, the study will be submitted to Walden University and copies will be offered to the participants. The consent form attached addresses these concerns.

Where will data be stored and for how long? If tape recordings or videotapes are created, explain who will have access and how long the tapes will be retained. Written consent is required for recordings; the consent form should include this information as well. (Students are expected to retain the original data for at least 5 years after the dissertation is approved).

Tape recordings of the interviews and data will be stored in the personal home of this investigator in a locked file cabinet. No one will have access to the tapes or any data other than this investigator who will destroy the tapes and Transcripted data after the legal limit of five years November 1, 2007.

10. Informed Consent Process

Simply giving a consent form to a subject does not constitute informed consent. Using the sample consent form, prepare and attach a consent form, statement, or letter for review (for exemption categories 1, 2, 3,4, 5, 6.

Note: Researchers are cautioned that consent forms should be written in simple declarative sentences. The forms should be jargon-free. Foreign language versions should be prepared for any applicable research.

--**Consent form:** Signature of subject and/or parent is required for research involving risk, and for research where a permanent record of the results will be retained (including videotapes).

--**Consent Statements/letters to subjects:** Statements read to study subjects or distributed to participants prior to interview or as a cover sheet for a written survey should be modeled after the sample consent form, but do not require signature.

**--No active consent is required for observations of public behavior.** Photos, films, videotaping, etc., require review by the Program Director and written consent of subjects.

**--No active consent is required for review of public records, private records already stripped of identifiers, or research involving pathological specimens that are not identifiable by name or number.**

11. Exempt Category #4: Pathological Specimens

All pathological specimens should be stripped of identifiable information prior to use. Registries or tissue banks where subject's samples are identified or identifiable are *not exempt* from Committee review.

Describe the source of the specimens. How will they be obtained? If not obtained by the principal investigator, then by whom?

12. Exempt Category #5: Public Service Programs

In addition to the information provided under abstract, above, provide documentation of conformity to the requirements for category #5, including written documentation or cooperation from the public agency involved in the research.

13. Exempt Category #6: Taste Testing

To be eligible for this category of research, all food tested must be GRAS (Generally Recognized As Safe) and wholesome. Food ingredients must be at or below the levels found to be safe by federal regulatory agencies. Describe the food to be tested and provide assurance that these conditions are met.

**Applications for compliance with ethical standards in research require the following assurances and signatures:**

(Note: original inked signatures are required; no stamps or "per signatures accepted.)

The signatures below certify that:

The information provided in this application form is correct.
The Principal Investigator will seek and obtain prior written approval from the Program, Director in the event of any substantive modification in the proposal, including, but not limited to changes in cooperating investigators and agencies, as well as changes in procedures.

Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.

Any significant new findings that develop during the course of this study that may affect the risks and benefits to participation will be reported in writing to the Program Director and to the subjects.

The research may not and will not be initiated until final written approval is granted.

This research, once approved, is subject to continuing review and approval by the Committee Chair and AVPAA. The Principal Investigator will maintain complete and accurate records of this research.

If these conditions are not met, approval of this research could be suspended.

Signature of Principal Investigator: Bonnie Beardsley Date: 18 Jan 02

**As Committee Chair, I assume responsibility for ensuring that the student complies with University and federal regulations regarding the use for Human Subjects in research. I acknowledge that this research is in keeping with the standards set by the University and assure that the Principal Investigator has met all the requirements for review and approval of this research.**

Signature of Committee Chair: [signature] Date: 15 Jan 02

**As Associate Vice President for Academic Affairs, or designee, I acknowledge that this research is in keeping with the standards set by the University and assure that the Principal Investigator has met all requirements for review and approval of this research.**

Signature of AVPAA: [signature] Date: 1/28/02

*Appendix B*
*Participant Consent Form*

Nurse Students' Experiences of Workplace Violence and Aggression: Making Sense of the Situation for Educators.

You are invited to participate in a research study consisting of interviews with nursing students who have been victims of workplace violence and aggression. Bonnie Beardsley, nurse instructor at Aurora University and PhD student at Walden University, is conducting this study. You were selected as a possible participant due to your gender, your status as a nursing student, and your personal request to participate in this study based on your experience with workplace violence and aggression.

The purpose of this study is to document and explore the perceptions of female nursing students' experiences of workplace violence and aggression, and to gain a clearer understanding for nurse educators. The overall purpose specifically of the interview is to find out what the experiences of workplace violence and aggression was like for you personally, how you adjusted or coped with the situation you describe and lastly, what your feelings are about participation in a study like this.

The data will provide information that will enhance the field of nursing education and help future generations of nursing students who may be exposed to a similar experience. If you agree to volunteer as a participant in this study, you will be asked to answer four questions related to your workplace violence and aggression experience. The interview will take place in your home or a mutually agreed upon location and will last

no more than 60 minutes. A follow-up contact will be required for verification of the interview data once it has been compiled for accuracy.

As far as can be anticipated, there will be no physical risk to the subjects participating in this study. It is possible to experience some psychological risk while re-living the event for this researcher. The primary benefit for the participants will be the opportunity to tell your story in such a way that others might benefit from reading the lived experiences and to improve the environment for professional nurses to practice in. Participants will not receive any payment or reimbursement for their involvement in this study.

The records of this study will be kept private. In any sort of report that might be published, I will not include information that will make it possible to identify a subject. Research records will be kept in a locked file at my residence and only the researcher will have access to the records. The tape recordings will be erased by November 1, 2007, allowing the 5-year legal term to maintain data. No one but the researcher shall have possession or knowledge of the written or taped data generated by the study.

Your decision whether or not to participate in this study will not affect your current or future relations with Ms. Beardsley, or your status as a student in nursing education. If you decide to participate, you are free to withdraw at any time for any reason without any adverse effect upon you. You are encouraged to ask any questions of Ms. Beardsley before agreeing to participate in this study.

The researcher conducting this study is Bonnie Beardsley. If you have any questions about participation in this study please feel free to contact me at 1840 Deer Run Drive, Montgomery, Illinois 60538, or call me at 630-966-9741.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent to participate in the study entitled "Nurse Students' Experiences of Workplace Violence and Aggression: Making Sense of the Situation for Educators."

Signature_____ Date_____

Print Name_____ Date_____

Signature of Investigator_____ Date_____

*Appendix C*
*Letter Requesting Authorization To Networking*

January 25, 2002

Bonnie Beardsley
1840 Deer Run Drive
Montgomery, Illinois 60538

Maryanne Locklin, Chair

Aurora University School of Nursing

As you know I have reached a point in my doctoral studies where I will begin the process of soliciting for participants. In a previous discussion you informed me that you would provide me with the addresses and names of the deans to the surrounding nursing education programs. Therefore, I am asking for permission to obtain the network list from you at this time. I will then contact each dean by mail and ask for him/her to post an invitation to participate in my study.

An authorization and endorsement of this technique is desirable in order to meet one of the required regulations related to human subject research.

Thank you for your support and time.

Bonnie Beardsley, RN MSN

Aurora University School of Nursing

*Appendix D*
*Endorsement and Authorization of the Study*

January 25, 2002

Bonnie Beardsley

To Whom it May Concern

Bonnie Beardsley is currently employed as a nursing educator at Aurora University School of Nursing. In my capacity as the Chair of the program, I am Ms Beardsley's immediate supervisor.

Ms Beardsley has requested my endorsement and authorization to use a network list of the area schools of nursing deans in order to solicit for participants for her doctoral research project entitled, " Nurse Students Experiences of Workplace Violence and Aggression: Making Sense of the Situation for Educators.

Ms. Beardsley has conferenced with me to explain the details of this research project, and has supplied me copies of all pertinent documents related to it. Ms. Beardsley has reviewed with me the purpose and need for my approval for this project, in regards to human subject research.

I hereby give my full and complete approval and permission to Ms Beardsley to utilize the networking list of deans as a method to obtain participants for her doctoral research.

Sincerely,
Maryanne Locklin, Chairperson

*Appendix E*
*Letter to Network of Deans*

Bonnie Beardsley
1840 Deer Run Drive
Montgomery, Illinois 60538
630-966-9741

(date)

Dear (name)

My name is Bonnie Beardsley; I am a doctoral student at Walden University and also practicing nurse educator at Aurora University. For my dissertation I am conducting a research study consisting of interviews with 10 nursing student who have been victims of workplace violence and aggression while in the role of nursing student.

The overall purpose of this study is to document and explore the perceptions of female nursing students' experiences of workplace violence and aggression, to gain a clearer understanding of this phenomenon for nurse educators like you. The data will provide information that will enhance the field of nursing education helping future generations of nurses and educators.

Enclosed is a posting I hope you will place on the student bulletin board in your department or in a location that students receive information.

Thank you in advance for allowing me to solicit for participants through this network.

Sincerely,

Bonnie Beardsley

*Appendix F*
*Solicitation Posting for Participants*

*FUTURE NURSES*
*YOUR PROFESSION NEEDS YOUR HELP!*

*I am a doctoral student at Walden University and a nurse educator at Aurora University School of Nursing. For my dissertation, I am conducting a research study consisting of interviews with nursing students who have been victims of workplace violence and aggression. I will be interviewing about 10 students.*

In order to participate you must meet the following criteria:

- Be a female nursing student;
- Have experienced some type of violence or aggression in the health care setting as a nursing student;
- Been victimized by either a patient, family member, spouse, peer, staff member, or supervisor;

  Actions may include bullying, mobbing, victimizing, intimidation, threats, ostracism, offensive messages, aggressive posturing, rude gestures, hostile behaviors, battering, physically attacked, kicking, biting, punching, spitting, squeezing, stalking, and harassment.

*Above are just a few examples of actions that constitute both physical and nonphysical acts of violence and aggression you may have others.

Your Participation will provide information about the magnitude of the problem associated with workplace violence and aggression toward nursing students. Furthermore, it will help educators make needed curriculum changes; finally, improve the profession not only for nursing students but also for the entire profession of nursing.

If you or anyone you know might be interested in participating in this study and meets the general criteria please contact

Bonnie Beardsley MSN RN Study Investigator
Aurora University School of Nursing
347 South Gladstone Avenue
Aurora, Illinois 60506-4892
beardsle@aurora.edu
630-844-5134

*Appendix G*

*Interview Questions*

1. Please describe your experience with workplace violence and aggression.
2. Talk to me about how you adjust or cope.
3. What kind of educational preparation might improve the situation you describe?
4. What was it like for you to participate in this interview?

*Appendix H*

*Thank You Letter – Validation Of Themes*

(DATE)

Dear Ms.

I want to thank you for participating in my study and agreeing to provide feedback on my findings. I have finally completed the analysis of the 10 nursing students who have been victims of workplace violence and aggression. Even though each story was different, common themes were found. I attempted to capture commonalities among the 10 stories. As you read the summary you should be able to find some of your experiences.

Enclosed is a description of the experience (1-2 pages), summarizing the themes identified in the study. When you read through the description please see how your own experience compares to the themes that I have identified. Tell me how my descriptive results compare with your experience.

I will follow up with a personal phone call in a week to clarify any questions regarding terms or ideas in the summary that you may not understand. During this conversation I will be asking you to give me feedback so I can readjust any information that is not truly representative of your experience

Sincerely,

Bonnie J. Beardsley RN, MSN

PhD Candidate

*Appendix I*

*Consent to Release Manuscript for Publishing*

(Date)

Dear Ms.

Once again, I wish to thank you for participating in my study. I have completed the writing of the manuscript and would like your permission to release the study for publication. Enclosed is a draft copy of the dissertation that will be released for publication following my oral defense during November 2002. There are minor editing changes needed prior to the release, however, the personal narrative section is verbatim and will appear in the publication as written in the enclosed draft.

As previously discussed during your signing of the original consent form, every effort was made to provide for anonymity and confidentiality. However, there is a risk with narrative interviews that personal identity might be exposed through the very nature of your personal experience. Please review the enclosed draft, focusing in particular on your personal narrative. If, after reviewing the narrative, you agree to the release of the manuscript, please sign below.

I have read the above information. I have asked questions, received answers, and willingly authorize the release of the study "Nurse Students' Experiences of Workplace Violence and Aggression: Making Sense of the Situation for Educators."

Signature _____ Date_____

Print Name _____ Date _____

_____ Date _____

Signature of Investigator

3230 Cremin Lane
Aurora, Illinois 60504
Phone: (630) 966-9748
Fax: (630) 844-5134
E-mail: beardsle@aurora.edu

# *Bonnie Beardsley*

**Formal Education**

| | |
|---|---|
| 2003 | **Doctor of Philosophy Education**<br>Walden University<br>Minneapolis, MN |
| 1996 | **Master of Nursing Education**<br>Lewis University<br>Romeoville, Illinois |
| 1993 | **Bachelor of Science in Nursing**<br>Olivet Nazarene University<br>Bourbonnais, Illinois |
| 1984 | **Associate Degree in Nursing**<br>Illinois Valley Community College<br>Oglesby, Illinois |

**Work Experience**

| | |
|---|---|
| 2000- present | Nursing Educator<br>Aurora University<br>Aurora, Illinois |
| 1996-2000 | Nursing Educator<br>Illinois Valley Community College<br>Oglesby, Illinois |
| 1994-1996 | EMS/Trauma System Director<br>Saint Joseph Provena Corporation<br>Joliet, Illinois |
| 1990-1993 | Trauma ED/ SICU<br>Loyola University Medical Center<br>Maywood, Illinois |
| 1985-1990 | Emergency Trauma Nurse Specialist<br>Morris Hospital<br>Morris, Illinois |
| 1984-1985 | Medical Surgical Nurse<br>Presbyterian Hospital<br>Dallas, Texas |

| | |
|---|---|
| **Certifications** | Trauma Nurse Specialist State of Illinois<br>Advance Cardiac Life Support<br>Certified Emergency Nurse |
| **Awards** | Outstanding Faculty Research Award<br>Illinois League for Nursing<br>October 2002 |
| | Illinois Outstanding Educator<br>May 1998 |
| **Professional Association** | Illinois Nurse Association<br>Sigma Theta Tau<br>Honor Society of Nursing |