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The University of Southern Mississippi

VERTICAL VIOLENCE AND THE STUDENT NURSE: IS THIS TOXIC FOR
PROFESSIONAL IDENTITY DEVELOPMENT?

by

Sherri Williams Cantey

Abstract of a Dissertation
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

December 2012

ABSTRACT

VERTICAL VIOLENCE AND THE STUDENT NURSE: IS THIS TOXIC FOR PROFESSIONAL IDENTITY DEVELOPMENT?

by Sherri Williams Cantey

December 2012

This narrative inquiry centers on student nurses' stories of vertical violence perpetuated by clinical registered nursing staff and the meaning that students associate with this phenomenon. Student nurses are the very young and potentially impressionable members of our profession; therefore, a concern of this study was if vertical violence affects professional identity development for the student nurse. Additionally through stories revealed by these participants, this study attempted to explore whether perceptions of violence are believed to be a rite of passage into the profession. Students are the future of our profession, and it is important that this phenomenon be understood from the students' perspectives.

Nurse leaders must be aware of vertical violence for the very reason that it may be affecting the young of the profession. Students will become the future healthcare workers that care for patients, that become our employees, and that speak for our profession one day. It is important that leaders be aware of what affects them, which can in turn affect our healthcare organizations and the quality of care that patients receive.

Through narrative inquiry, this research was intended to elicit stories as a way to construct meaning of vertical violence from the student nurses' perspectives in order to better understand this phenomenon of interest. The participants in this study were in their final year of nursing education at a university located in the southeast United States and

were subjected to vertical violence in the clinical setting by clinical staff registered nurses. The participant sample size included four registered nursing students from the generic class, and necessary information pertaining to the study was given to each. All four nursing student participants verbally agreed and signed the informed consent for inclusion in the study. Participants were instructed that they may withdraw from the study at any time. Through narrative inquiry, the researcher conducted two 1-hour interviews with each participant. This allowed for collection of data in the initial hour with a follow-up interview for participant check of original data and clarification. It was the aim of this study to attempt to convey the meaning of the students' perspectives of vertical violence and how it affected their professional identity development as the future generation of the profession.

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A Dissertation
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December 2012

DEDICATION

To my children,

Lauren Kathryn, Jamie Michelle, and Zachary Eli Cantey,

who are my life.

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The culmination of this research could not have been accomplished without the support of many colleagues, friends and relatives. Their encouragement has been a sustaining force throughout this journey.

Much appreciation and thanks must be expressed to a wonderful leader and mentor, my dissertation chair, Dr. Janie Butts. She has played a pivotal role in my educational endeavors. Throughout my doctoral career, her patience and guidance have been instrumental, especially in those moments when I was uncertain of the next step. Her wisdom as an experienced researcher in both qualitative and quantitative paradigms has been invaluable to me as a novice researcher. I sincerely appreciate the many hours she has invested in guiding me through this pursuit.

To my dissertation committee, Dr. Karen Saucier-Lundy, Dr. Patsy Anderson, Dr. Susan Hart, and Dr. Robert Newsome, I offer my sincerest thanks for your advice and direction through this process. Dr. Lundy has been a constant guiding force since my master's education, as she served on my thesis committee and has tirelessly continued with me through these last five years. Dr. Anderson challenged me to think on a higher plane and provided for me a spirited debate partner on the topic. Dr. Hart provided knowledge and guidance during my clinical practicum. My love of philosophy has continued to grow and I owe thanks to Dr. Newsome for allowing me to be in his company as he discussed a topic that is dear to him.

Without research participants, there would have been no completed study. Therefore, I cannot forget the four nursing students that shared their stories of vertical violence with me. It was through their willingness to discuss something so personal to

them that has generated the findings contained within this query and for that I am forever grateful.

Lastly, I must acknowledge the undying love and support that my family so graciously gave. My three children, Lauren, Jamie, and Zachary, were always there, cheering me on, no matter what. Even if it meant that I had to miss some type of event for them, they were always telling me that it would be okay. They were my inspiration to move forward with this pursuit and my motivational drive when my perseverance wanted to falter. To my parents, Danny and Sharron Williams, who believe I have become a professional student even though I contend I am a seeker of knowledge, have never once given up on me. They have praised my efforts and supported me through the trials as only parents can do. I could not have accomplished this endeavor without my family's unconditional love and support and for this I am forever thankful.

This journey has not been without obstacles, but nonetheless it has provided me with a constant learning and growing process. Just as a narrative inquiry revolves around experiences in life, this research could not have been accomplished without the support and guidance of all mentioned, because it was through all of those combined experiences that make me who I am today.

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CHAPTER I

INTRODUCTION

For many years in nursing, a negative phrase has been circulated throughout literature to indicate that while we care for patients, we may not care for our new colleagues. This phrase indicates that nursing eats their young. In recent years, other terms have surfaced to describe this cannibalism we perpetrate against those recently added to our ranks. Expressions that are now being used include language that equates to violent behaviors such as horizontal violence, lateral violence, workplace violence, and possibly vertical violence. The focus of this research study was centered on violence that is directed toward our young, the nursing students that will be our future in healthcare, by staff nurses already in practice. This denotes a pattern of behavior from higher level of functioning to a lower level which indicates vertical violence.

In this chapter, I will discuss my personal experience with vertical violence and the influences in my professional life that led to my fascination with this phenomenon that seems to be plaguing the nursing profession. Vertical violence becomes a troublesome menace to the very young of the profession, the nursing student. I have become quite fascinated as to how a profession deemed as caring can commit such acts against our own. As a nurse educator, I have witnessed it first-hand perpetuated by clinical staff registered nurses toward students. Therefore, is this a quandary for nurse leaders? I believe this is a conundrum that cannot be ignored! This research focused on the exploration of vertical violence and the effects this has on our young, in relation to the development of a professional identity. Again, this should be an area of concern for all nurse leaders as this phenomenon can actively influence an organization's ability to employ and retain nurses.

Chapter one will offer a more transparent understanding of this phenomenon, defining characteristics of vertical violence will be presented, including my own personal definition developed through concept analysis. The purpose of the research will be discussed as well as the rationalization for using narrative inquiry. Through this method, it was the aim of this researcher to provide some clarity to the phenomenon of interest through first-hand accounts.

Research Purpose

The specific aims of this research were (a) to have student nurses describe their stories of vertical violence (b) to describe how vertical violence shapes their professional identity as a future nurse, (c) to determine if vertical violence stories as presented by students is believed to be associated as a rite of passage into the nursing profession, and (d) to understand if transformational leadership theory can assist in fostering a positive professional identity. This is a problem that is scourging the profession and all nurse leaders must be aware of this phenomenon and its affects (Thomas & Burk, 2009).

Research has demonstrated a more in-depth knowledge base of horizontal violence, which is also synonymous with lateral violence. Horizontal violence is identified as a pattern of violent behaviors, such as bullying and intimidation, between nurses that are equated at the same status level on the hierarchical ladder (Hinchberger, 2009). This is essentially nurse to nurse violent behaviors, whereas one nurse perpetuates the violence against another nurse that is of equal standing. Horizontal violence and vertical violence are both associated with violent behaviors but there are different connotations for each situation. Vertical violence is a pattern of behaviors that is directed toward a person that functions on a different level of the hierarchical scale, either in an inferior or superior position, but usually directed toward subordinates. This is where

vertical violence truly differs from horizontal violence, but there is a dearth of existing research relating to vertical violence in the United States, but is more noted in other countries (Thomas & Burk, 2009). This research, however, focused solely on vertical violence and the effects associated with the phenomenon.

Personal Experience with Vertical Violence

My own personal experience with vertical violence actually occurred as a graduate nurse in 1990. At that point in the history of the nursing profession, state boards awarded graduate licenses while students awaited board results. I was beginning as a graduate nurse in a local emergency room that was located in a city with a population of approximately 50,000 people. Therefore, the size of this city could easily produce a steady stream of patients for this emergency room, yielding busy periods at times. The emphasis of the size and volume of this emergency room is important because each shift was staffed with three nurses on the day shift and only two nurses on the night shift, illustrating that teamwork was a necessity.

As I began my work as a graduate nurse, I was placed on the night shift with one other nurse, who of course, was the charge nurse. I wanted to learn and do as much as possible. When I graduated from nursing school, I felt as if I was provided with a solid theoretical basis as a beginning nurse generalist. However, I believed that experience would continue to grow my own knowledge and skills. Being inquisitive is part of my nature because I love to learn. Therefore, any time I had a question, I went to the only other person I could, my charge nurse. Needless to say, she did not view my questions as important and basically ignored my questions or snapped very short answers at me.

This vertical violence pattern continued for approximately two months. One morning, the nurse manager came in early to speak with me privately, while the charge

nurse of my shift eased out of the hospital without saying a word. The nurse manager told me that she was moving me to the opposite rotation. Again, my inquisitive nature took over and I wanted to know if there was a problem. She informed me that she had to move me because the charge nurse was not happy with the questions that I was always asking.

To conclude this review of my initiation into the nursing field via vertical violence, the move to the other work rotation was exceptionally positive. My new charge nurse was welcoming and nurturing in my professional growth. This move provided me with the necessary confidence to continue in the nursing profession, which has now yielded an experiential base of 21 years.

Definition of Phenomenon

Much research has been conducted and published about horizontal/lateral violence and workplace violence. All of these behaviors that occur in a work environment can lead to negative effects. Horizontal or lateral violence describes violent behaviors that are committed against one person on the same hierarchical scale as the perpetrator. Workplace violence is essentially the same, but can also be used to describe any violent exchange that occurs in the work setting, regardless of employee status.

Workplace violence in recent years has been shown to escalate from threats to physical abuse, traumatic injuries, and death. Thelen (2009) cited real-life incidents of employees threatening to “go postal” and telling others to “wear bulletproof vests” while in the work environment (para. 7). In a recent publicized workplace event, Army psychiatrist, Major Nidal Malik Hasan killed and wounded many co-workers after going on a shooting frenzy at Fort Hood (Casale, 2009). It was speculated that Major Hasan was upset about his upcoming deployment to Iraq or Afghanistan (CNN, 2009) and this was the result of his anger.

At the University of Alabama in Huntsville, another workplace catastrophe occurred. Biology professor Amy Bishop began a shooting spree aimed at her department chair and other faculty members in February 2010. Allegedly, Bishop had been angered over the denial of tenure and viciously lashed out at those who worked in the biology department with her. She killed the department chair and two other faculty members and wounded three other employees in her brutal attack at the Alabama university (Huffington Post, 2010; Whittington, 2010).

Not only do we as a society have to worry about violence in the workplace, but also in our children, who will grow up to become the future workforce. Bullying and verbal assaults run rampant through the childhood years and can be a learned experience of what may later develop into violent behaviors in the workplace. One such recent event involved teenager, Pheobe Prince, from Massachusetts. She suffered verbal assaults, internet violence via emails and social websites, and physical violence before deciding to take her own life (Lavoie, 2010; Reitz, 2010). The district attorney filed charges against all nine teenagers involved in the bullying incidents and additional indictments of civil rights violations and criminal harassment were added for some of the teenagers (Goldman, 2010).

With these events and many others like them that continue to surface leaders in all arenas must be aware of the possibility of violent acts. Nursing is viewed as a caring profession (Jasmine, 2009) and because society has this perception, nurse leaders must also be concerned and actively engaged in preventing any type of violence in our ranks. Behaviors of a violent nature lead to undue stress in the nurse and leaders must initiate interventions that will assist in decreasing and/or eliminating this pressure (Hamaideh, Mrayyan, Mudallal, Faouri, & Khasawneh, 2008). Briles (2005) believes that staff morale

is negatively affected by violent behaviors and when leaders ignore this phenomenon, a loss of nursing staff may be the result. Not only do organizations need to worry about the loss of staff but the overall productivity of the facility can be affected (Kerfoot, 2007). This emphasizes an immediate need for nurse leaders to be aware and vigorously prevent violent behaviors in the organization.

The effects of violence in nursing are numerous. Many for the victim, but still the perpetrator is plagued by feelings of low self-esteem (Hastie, 2006), which carry forth as a menacing presence during the victimization of others. Absences, tardies, and decreased retention can be the effects of violence for healthcare organizations when nurses suffer violent behaviors (Baltimore, 2006; Hurley, 2006). Additionally, for the victim, it has been demonstrated through research and will be further discussed in Chapter Two that numerous physical and emotional manifestations occur (Kivimäki et al., 2003; McKenna, Smith, Poole, & Coverdale, 2003; Öztunç, 2006).

Incidents of workplace violence have spurred a need for reporting mechanisms for employees and prevention through development of zero-tolerance policies by some institutions. In a report by the United States Department of Labor, Bureau of Labor Statistics (2006), it was identified that greater than five percent in both public and private facilities, reported an incidence of vertical violence in the over seven million establishments identified. Of the establishments surveyed in this report, 29.1% of employers had instituted some type of documentation mechanism for all types of violent behaviors. Of the 350,000 employers that reported violence to the Bureau of Labor Statistics, only 10% of facilities actually instituted a program to combat destructive behaviors while over 80% of those facilities did nothing. According to the Bureau of Labor Statistics (2006), over 43% of industries evaluated expenses related to violent acts

in the work setting and more than 35% of organizations reported that workplace violence does have negative effects on the individuals that have been victimized. In addition, The Centers for Disease Control and Prevention (CDC) (2006) stressed the need for workplace strategies to avoid deaths and physical injuries. However, the question is, are non-physical threats ignored, while only physical threats take precedence in the workplace? Employers and leaders must not ignore violent behaviors in the workplace because it does occur and ‘burying their heads in the sand’ to pretend that it cannot happen in their organization can be a dangerous assumption (Wolf & Neuharth, 2009).

For this study, the purpose was to solely investigate vertical violence propagated by staff nurses against student nurses. Vertical violence indicates that the perpetrator is operating at a different level of the hierarchical ladder than the victim (Thomas & Burk, 2009). Further clarification of this phenomenon and the definition that will be utilized in this study is that “Vertical violence is defined as any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment” (Cantey, in press).

As Hutchinson, Vickers, Jackson, and Wilkes (2006) indicated, a great deal of research has been published on bullying and horizontal violence. However, a dearth of research exists on the phenomenon of vertical violence. Therefore, throughout Chapter Two of the literature review, more research publications on horizontal/lateral violence and workplace violence, which indicates that the perpetrator and victim are functioning on the same status level, have been presented as much is lacking on the phenomenon of vertical violence. This indicates that more research must be undertaken to fully

understand the nature of vertical violence, indicating that the perpetrator and victim are on different hierarchical planes.

Professional Identity

Identity development is shaped by a multitude of events and experiences in our daily lives. Both positive and negative experiences play a large role on how a person views their personal and professional roles (Lipscomb, 2010). As nursing students engage in the learning process that leads down the path of joining the professional ranks, many experiences influence the growth of a professional identity for students. Through classroom and clinical activities, students encounter many day-to-day events that can influence their development (Milisen, De Busser, Kayaert, Abraham, & Dierckx de Casterle, 2010).

Nursing is a challenging profession, engaging in complex relationships with patients and multiple disciplines. Nursing students must function in their practicum with clinical staff registered nurses of varying experiential backgrounds as well as nursing faculty. These relationships can produce multiple experiences for the student nurse to draw upon while developing a professional self-image. Positive and negative experiences can affect employment success and fulfillment, which consequently can influence professional identity development (Milisen et al., 2010). If positive experiences occur, the student may excel in a professional identity development. However, if negative relationships develop such as with vertical violence, what type of professional identity is cultivated?

Conceptual Relationship

The nursing profession is largely a female dominated profession. Women have always been placed in a subservient position in the male dominated workforce, which is

the case with some healthcare organizations. Administrative positions, as well as many physicians, are usually driven by a strong male presence, which can lead to feelings of oppression from the male dominated population in healthcare. Women have typically held lower roles on the hierarchical ladder in healthcare resulting in powerlessness, beginning with director of nursing, nurse managers, charge nurses, and staff nurses. Through this power differential, a feeling of oppression can often emerge, thus creating oppressors within the nursing regime (Farrell, 2001; Lee & Saeed, 2001).

Throughout history, women have been viewed as the weaker sex biologically, while men have been portrayed as the more powerful and aggressive gender. By means of the natural reproductive process and responsibility of the household, women have been deemed the more fragile sex, lacking the assertive abilities needed for the working world versus their male counterparts. Oppression then becomes a powerful force used to instill compliance in the weaker being (Brittan & Maynard, 1984).

Bosmajian (1983) believed that a language of oppression existed. In society, the ability to control the names given to individuals or groups demonstrated power. This can prove true for women as well as nurses through the naming of nurses as “handmaidens” of physicians (Munhall, 2007c, p. 40). The word maid is indicative of the female persona and thus characterized as the more feeble gender in society. Bosmajian would argue that the basic meaning of a word could relegate a negative or weaker position to a member of society.

Oppression is a dangerous trend in society that leads to learned behaviors as it is continually witnessed. Beginning with the ignorant and uneducated of society, Freire (1968/1974) first discussed his theory as a means for those in society who were oppressed to take control of their situation and become more productive. He likened this feat as a

means of being reborn as a new being, taking new measures to overcome oppression and moving toward independence.

Freire (1968/1974) further hypothesized that if oppression was not halted violence from the oppressor would erupt. Feelings of exhilaration develop within the perpetrator and the need to continue oppressive behaviors and violence toward the victim and others becomes a powerful enticement for the tormenter; an adoration for their total being as the mocker in control of the situation. This sense of elation is perceived as power to the tyrant. Therefore, the proliferation of the cycle of oppression and violence ensues from one generation to another.

For the victim of oppression and violence, feelings of degradation, worthlessness, and powerlessness may develop. As negative behaviors continue to be encountered, especially if the oppressor is of a higher status level, victims may assume a position of wanting to lash out at others within their own group. This type of behavior prefaces the vicious cycle that can arise through continued oppression. If the original victim begins to oppress another victim within the culture group then horizontal violence occurs (Roberts, DeMarco, & Griffin, 2009).

Oppression and violence occur synonymously and must be stopped to promote true freedom. To begin the necessary action of liberation, the oppressed must reflect upon the experience itself and begin to identify the true meaning. Once the victim has an idea of what has been occurring, then steps may be taken to correct such pathology. The oppressed are barred from an autonomous lifestyle due to the actions of the oppressor. To correct the violent behaviors, the exploited person involved must be an active participant for eliminating said behaviors of oppression and violence. (Freire, 1968/1974).

Method

To accomplish this research, it was this researcher's desire to understand (a) the experiences and feelings of the victims in response to vertical violence, (b) if nursing students believe this is a rite of passage into the profession, (c) whether violent acts influence a professional identity of those that will be the future of the profession, and (d) if transformational leadership effect this phenomenon. Since a deficit of knowledge exists regarding vertical violence, especially in the student nurse population, a qualitative approach was utilized to understand the inner experiences associated with growing as a new nurse in the face of violence.

Qualitative methods follow an inductive path of reasoning by generating meanings from patterns, behaviors, and experiences of the human and social condition. Collection of data occurs through the senses and is expressed in words that produce themes of the phenomena of interest. Findings provide detailed descriptions of themes with words, phrases, or sentences by participants that demonstrate the nature of the phenomena more clearly. Utilizing a qualitative approach to research with inductive processes assists in the possible generation of new knowledge (Brink & Wood, 1998; Creswell, 2009).

Through a narrative approach, much can be learned about how a person copes with various social issues, which shape the overall person. Different situations, events, and issues arise and influence the way a person views his/her own life. If domineering forces are present, these forces can even begin to shape one's life story to an existence that could change a person's individuality (Duffy, 2007). Does the experience of vertical violence affect student nurses in this way? Do they begin to believe that vertical violence

behaviors are an initiation into the profession of nursing, that all must be forced to endure?

From stories elicited, themes were extracted and an analysis of these themes took place. According to Duffy (2007) a type of thematic narrative analysis is that of identity development, in which a person's experiences shape their inner self. It is further suggested that this inner self may be created by another authoritative figure (Duffy, 2007). If an authoritative figure can structure another's own self-perception, then can vertical violence from a clinical staff registered nurse form a student nurse's self-identity toward nursing and the profession? Can this phenomenon of vertical violence shape the student nurse to an alternate identity? Through stories of vertical violence, it was the hope of this researcher to understand some of these questions.

Therefore, a story with thematic analysis accomplished the means for this research. The qualitative method of narrative inquiry was instituted to generate stories associated with the questions posed. Narrative inquiry focuses on a person's perceptions and experiences through the story told, which is then generated by the researcher into words whereby meaning can be understood. One particular phenomenon with single or multiple occurrences can be the concentration of the study or it can be an entire life history (Creswell, 2007). Therefore, narrative inquiry can utilize a narrow or broad focus, but the center of narrative inquiry is the story and meaning that is embedded.

CHAPTER II

REVIEW OF PERTINENT LITERATURE

Introduction

An epidemic is spreading through the nursing profession as if a rampant and devastating illness were attacking the body. This epidemic is not new to nursing, but open dialogue is more widespread than in years past. What has been termed as nurses eating their young is now termed either vertical, lateral, or horizontal violence (Baltimore, 2006; Fudge, 2006; Lubejko, 2009) and is affecting recruitment and retention of nurses for organizations and also the profession as a whole (Berry, Gillespie, Gates, & Schafer, 2012; Cho, Lee, Mark, & Yun, 2012; Hurley, 2006; Longo & Sherman, 2007; Meissner, 1999). The presence of this problem in nursing can lead to increased organizational cost related to turnover and even affect patient care if turnover is great.

Nursing students are not exempt from these negative behaviors (Leiper, 2005; Hinchberger, 2009). During their clinical placements, students are at increased risk for experiencing vertical violence from staff nurses (Curtis, Bowen, & Reid, 2007; Hinchberger, 2009). This can include any number of negative behaviors that may be a detriment to a student's learning. Student nurses feel powerless at the bottom of the hierarchical chain (Stevenson, Randle, & Grayling, 2006) and these events leave them with a sense of doom, wanting to never go back to the clinical area or leave the profession all together. Staff nurses that practice violent behaviors toward student nurses endanger recruitment and retention efforts by healthcare organizations and the nursing profession (Beech & Leather, 2003; Curtis, Bowen, & Reid, 2007). The focus of this literature review and research will be on the phenomenon of vertical violence perpetuated by staff nurses toward student nurses and how this affects a student's professional

identity development, as well as whether this phenomenon is viewed as a rite of passage into the nursing profession.

If vertical violence affects professional identity and is a rite of passage, transformational leadership might be a counteractive force to the phenomenon of vertical violence or might explain how some new nurses and student nurses can transform, even negatively. Transformational leadership theory offers a theory that can alter the way people think and act, seeing each individual as solely human and treating them as such (Northouse, 2007). Utilizing a nurturing leader, student nurses could develop a positive professional identity, diminishing the incidence of vertical violence. Transactional leadership mainly uses rewards for positive behaviors or punitive measures with negative behaviors, but lacks the encouraging components of transformational leadership to foster a change in the subordinate (Northouse, 2007). Thus, a transactional leader functions on a lower plane of morality development in contrast to the transformational leader that uses the four identified behaviors in the theory to encourage subordinates to transform to a higher level of thinking and character. Therefore, if a leader or a registered staff nurse in a senior position does not yield a caring attitude and chooses to provide guidance only through management-by-exception as identified in transactional leadership, the student or new nurse could develop a negative professional identity.

To conduct this research, a qualitative design using narrative inquiry was utilized. A narrative method provides a storied approach that illicit personal experiences in a chronological order (Riessman, 2008) of the student nurse's history with vertical violence and how this affects professional identity. Additionally, it is the hope of this researcher that these stories may provide an insight as to whether students view violent patterns as a rite of passage. Therefore, this literature review focused on the phenomenon of vertical

violence, professional identity development, rites of passage or initiations into nursing, transformational leadership theory and how this can relate to positive professional identity development, and details on the narrative method and how narrative methods have been utilized to conduct other research queries.

A literature search was performed on CINAHL and a separate library source through The University of Southern Mississippi, Metasearch. CINAHL proved to provide more references related to violent behaviors. Several of the articles found were very similar between the search terms of horizontal violence and lateral violence. Horizontal violence yielded 25 articles whereas lateral violence generated 16 entries. For the search of vertical violence on CINAHL, there were only three articles found. When using several terms that have been described in definitions of these terms, bullying proved to be the term that produced the most sources with intimidation and verbal abuse following. This indicates a dearth amount of research focused on vertical violence. Several research studies also included violent behaviors that were perpetrated by patients, families, and visitors. However, for this research focus, vertical violence was examined in relation to staff nurses perpetrating violent behaviors against student nurses and how this affected professional identity development as well as rite of passage into the profession.

The purpose of the qualitative research study was to illicit stories via a narrative methodology of student nurses' experiences with vertical violence. Four specific aims were (a) to describe student nurses stories of vertical violence, (b) to describe how vertical violence shapes or transforms their professional identity as a future nurse, (c) to determine if vertical violence stories as presented by students are believed to be associated as a rite of passage into the nursing profession, and (d) to understand if transformational leadership theory can assist in fostering a positive professional identity.

To conduct this research, questions were used to guide the telling of narratives instead of forming a hypothesis. Questions allowed the participants a medium for freely expressing stories so that insight could be gained into this phenomenon of interest. The research questions addressed in this study included

1. What stories are conveyed by student nurses about vertical violence?
2. What do the stories reveal about the effects of vertical violence on these student nurses' professional identity development?
3. Do these stories indicate that students believe that vertical violence patterns are associated with a rite of passage into the profession of nursing?
4. Given a brief description of transformational leadership theory, could this be a theory that could be utilized to nurture a positive professional identity and decrease vertical violence?

These research questions were used only as a guide to allow students to voice their stories using their own words and feelings.

Nursing is a profession that many chose, but then many leave for one reason or another. If nursing is deemed a caring profession, should we not care for our colleagues as well? The relevance of this study for nursing leadership was to understand the concept of vertical violence and the effects this caused to professional identity development. Nurse leaders should also be aware of this phenomenon and whether it is perceived to be a rite of passage into the professional ranks. If vertical violence affects professional identity as well as being a rite of passage, this could influence nursing practice as well as recruitment and retention.

Literature Review

Vertical Violence

A multitude of behaviors can be evident with vertical violence. As Cantey (in press) identified, “Vertical violence is defined as any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment.” Furthermore, behaviors such as bullying, sabotage, and intimidation have been associated with the term vertical violence (Briles, 2005; Fudge, 2006; Pietruczuk & Philipsen, 2009). Violent behaviors can be an obvious act or a covert act, such as denying requests or overloading assignments (Fudge, 2006). Meissner (1999) further classified these acts as a “kind of genocide” that is occurring in the profession (p. 43). As Taylor (2001) discussed horizontal violence, she eluded to violent behaviors usually occurring from an upper level to a lower level of staff. However, horizontal violence has been defined to occur between nurses on the same level, whereas, vertical violence is identified as superior to subordinate level. Many terms can be utilized to describe violent behaviors, but for this research vertical violence focused on behaviors that stem from a superior to subordinate level, which limits performance and satisfaction of work for the victim (Cantey, in press).

Several studies have reflected the prevalence of workplace violence with most reports focusing on horizontal violence or lateral violence instead of vertical violence. A study conducted in Turkey on the frequency of verbal abuse revealed that 80.3% of nurses had been victimized in this manner (Oztunc, 2006). In the southeast United States, Stanley, Martin, Michel, Welton, and Nemeth (2007) reported findings of lateral violence

and that 65% of nurses in the study witnessed violent behaviors. McKenna, Smith, Poole, and Coverdale (2003) found that greater than 40% of newly registered nurses experienced rude and humiliating behaviors in their initial year of practice. Related to vertical violence, Leiper (2005) described a study that included over 500 nursing students with 34% being subjected to rude and humiliating situations by nurses (p. 44). In another study from the United Kingdom, verbal abuse was experienced by 90% of nursing students that was perpetrated by healthcare employees (Ferns & Meerabeau, 2008). These research studies indicate that workplace violence is a detriment to the nursing profession and healthcare organizations; therefore, theories behind vertical violence must be understood.

Theories Associated with Vertical Violence

One of the most widely recognized theories noted in the literature review associated with violent behaviors is one of oppression (Farrell, 2001). A female dominated profession, nursing, is often presided over by male management/administrators. Stereotypical roles of the female include being a weaker and more emotional gender (Farrell, 2001). Freire (1968/1974) inferred that the oppressed are dominated by a force and struggle to overcome this force, but in turn the oppressed can become the oppressor. As a nurse feeling a sense of oppression, reactions to the oppression lead the nurse to become the oppressor (Lee & Saeed, 2001) to those working below, such as the nursing student. This reactive behavior becomes the controlling factor in a nurse perpetrating violent behaviors directed at the student nurse.

Another related cause of vertical violence can be seen through generational/hierarchical abuse and observational practices of nurses (Farrell, 2001). Bullying has been shown to occur more frequently on different levels with the perpetrator being higher up the chain of command (Olender-Russo, 2009), which emphasizes

hierarchical abuse. As nurses enter the workforce, experienced nurses are assigned as preceptors to show them the routines of the working environment. These veteran nurses may have encountered violent behaviors when they were students or new nurses and have considered this to be a rite of passage. Therefore, the initiation of nursing students and new nurses are considered necessary by the skilled practitioner. Vertical violence is then proliferated as a cycle of negative behaviors from one generation of nurses to the next (Farrell, 2001; Griffin, 2004; Stevens, 2002).

Low-self esteem in veteran staff nurses may be a link to vertical violence perpetuated against student nurses. Nurses that have experienced some type of professional sabotage during their tenure may have developed problems with self-esteem and therefore, may revert back to an oppressive nature and a need to regain some power and self esteem by having someone lower on the hierarchical chain to direct. Vertical violence behaviors can be manifested from a low self-esteem or lack thereof in staff nurses, who then tries to exert power over student nurses (Farrell, 2001).

Effects of Vertical Violence

To first discuss the effects of vertical violence in victims, organizations, and the profession, violent behaviors begin with the perpetrator. Those who practice violent behaviors are thought to have low-self esteem, feel powerless over work and personal situations, and/or dealing with stress in the workplace, such as staffing shortages and complex patients (Farrell, 1997; Stanley, 2007). This lashing out at others lower on the hierarchical ladder is considered a rite of passage by perpetrators. Considered an initiation into nursing practice, it is assumed that all newcomers must endure this ritual. A sense of power over work situations and increased self-esteem is garnered by the person responsible for the violence. This cycle of vertical violence perpetuates a continual

process that can be propagated to new generations of nurses, beginning with nursing students (Hutchinson, Vickers, Jackson, & Wilkes, 2006).

Student nurses and new nurses who are exposed to vertical violence may experience physical and psychological effects. Feelings of self-doubt, inadequacies, depression, increased stress and anger can surface in the victim after just one received violent behavior (Edward & Hercelinskyj, 2007). With increased stress, chronic disease patterns such as hypertension and cardiac problems may arise (Kivimäki et al., 2003). Physical manifestations have been described to include headaches, fatigue, body aches, and insomnia. Additionally, nausea and weight loss have been reported by victims following perpetuation of vertical violence (Jackson, Clare, & Mannix, 2002; McKenna, Smith, Poole, & Coverdale, 2003). Students and new nurses have reported tearfulness and irritability associated with violent episodes (Hastie, 2006). Effects of vertical violence can lead to widespread chaos not only for students and new nurses, but also for healthcare organizations.

Healthcare organizations that allow vertical violence to permeate between staff members are at a greater risk for decreased recruitment and retention. Stroud (2010) analyzed turnover reasons at the healthcare facility where she was employed and found that declining recruitment and retention were associated with acts of lateral violence. In a qualitative study by Curtis, Bowen, and Reid (2007), violent behaviors were found to influence 90% of respondents in deciding which organization they would join. Student nurses that are subjected to violent behaviors during their clinical rotations would therefore be hesitant to seek employment at such an agency where these behaviors were prevalent. A study conducted in Australia on workplace violence demonstrated that approximately 19% of nurse resignations in healthcare organizations were related to

violent behaviors (Hegney, Eley, Plank, Buikstra, & Parker, 2006). Nurses that remain in their positions despite victimization may exhibit higher absenteeism (Longo & Sherman, 2007), which in turn costs healthcare organizations in productivity.

Increased healthcare costs may be incurred at facilities in which vertical violence takes place. These costs may be in the form of paying other nurses overtime to cover shifts of those who are absent or for resignations. Excessive orientation costs may be related with increased turnover of staff that resigns shortly after assuming a position with a facility. A decrease in quality patient care has been cited as a possible result of workplace violence through increased stress, absenteeism, and turnover (“Personal & Financial,” 2008), as well as mistakes in nursing care and inadequate nursing performance (Stroud, 2010). According to The Joint Commission (2009) on nurse staffing issues, workplace violence can lead to dissatisfaction among nurses thus affecting communication regarding patient care. Wise (2008) speaking for The Joint Commission has further declared that a culture for patient safety must be maintained to ensure quality patient care. Furthermore, the legal aspect of allowing vertical violence behaviors must be considered. As cited by Martin (2008), when hospitals have knowingly allowed physician harassment monetary judgments have been awarded to victims. Vertical violence is behaviors that occur from superior to subordinate, which means that the superior has power over the subordinate’s position. This in turn could be indicative that nursing superiors could be held accountable for harassment of those in lower positions. Therefore, organizations must understand the costs associated with and take necessary measures to halt vertical violence and maintain strength in the nursing profession.

Retaining and recruiting nurses into the profession is a must for the future healthcare needs of our nation and world. Recurrent cycles of shortages have been noted throughout the profession's history (Green, Hatmaker, & Tabone, 2008). According to Johnson and Johnson's (2006) website our nation will be 800,000 nurses short by 2020. According to The Council on Physician and Nurse Supply (2008) the need for nurses will continue to be an ongoing issue due to the healthcare needs of society. Patients in today's society have more complex healthcare problems but are living longer, which increases the nurse acuity mix for patient care. New nurses are being placed in an independent nursing role faster than ever before, which compounds their stress levels to care for patients without a needed experience base (Reinsvold, 2008). Therefore, stress level and job satisfaction have been shown to be a result of why some nurses leave the profession altogether (Reinsvold, 2008). Findings in several research studies have reflected an aim of participants to vacate their current positions as well as the nursing profession altogether after experiencing workplace violence (McKenna, Smith, Poole, & Coverdale, 2003; Sofield & Salmond, 2003). With vertical violence impacting stress levels and job satisfaction, this provides an indication that this phenomenon can cause nurses to leave the profession (Longo & Sherman, 2007).

Another issue for the profession is having a unifying voice for nursing. In a section regarding nursing news from the *American Journal of Nursing*, Foley (2009), the senior editor, discussed how several affiliations have been broken. Foley spoke of how several state associations have disbanded from the American Nurses Association (ANA). There have also been some state associations that have cited harassment and other violent behaviors from other nursing organizations. Foley's (2009) concern for the profession is who will be the voice for nursing and why can we all not work together. If there is unrest

in the profession that is characterized by power struggles between associations, the phenomenon of workplace violence does exist and must be confronted to improve working relations for all nurses.

Vertical violence in nursing can lead to mass detrimental effects. As the effects of this phenomenon spread rampantly through the profession, a solution must be discovered to maintain recruitment and retention for healthcare organizations and the profession as a whole. First, to address the problem, a theory must be identified to manifest a change.

Professional Identity Development

From noted psychologist, Erik Erikson an individual's identity is developed in stages of development, mainly in the adolescent years where an individual is beginning to become a socialized being within and out of peer groups. Adolescents begin to know what is socially acceptable and grow also through life experiences. However, each of Erikson's developmental stages has milestones that must be accomplished so therefore, identity can continue to develop with each stage (Weiland, 1993). So if identity continues to develop over the course of a lifetime, how does a professional identity develop?

Munhall (2007c) suggests that before we as beings can ever speak, we learn through our surroundings and how to express our own self wishes. As our vocal abilities develop, we continue to articulate who our individual self is at present and thus becoming. Munhall (2007c) further believes that in the profession of nursing, nurses continue to shape their own individual selves and make their identities known through actions and verbalizations.

Clough (2010) described identity development as an ongoing process that occurs between our personal and professional lives. He has utilized narrative research to discern a level of knowledge and teach school age children about the effects of globalization on

the environment. Through his research, he found that even when he encountered something in his personal life, it weighed in on his professional area of responsibilities. Clough used an example of going into a café that promoted a “green” lifestyle where labeling occurred throughout to inform customers of the ownerships intention to promote a healthier environment (p. 112). This made him wonder if he promoted a caring worldview attitude in his teaching profession as these restaurateurs and if not how could he make an impact. Clough further emphasized that while today his story may be presented in one way, tomorrow is a new day that will yield new experiences that may produce a change in self and identity.

New experiences, positive and negative, occur every day that can produce a change in beliefs and self identity. Halse (2010) believes that personal and professional identities are intermingled and the journey is met by daily obstacles. A narrative inquiry conducted by Halse involved a colleague, Sue, who was a teacher in Australia. Halse details Sue’s life story from her humble beginnings as a child belonging to a working class family to adulthood as she began her own family, deciding that she needed to do more with her life. After Sue completed her education, she began teaching in a school that was populated by a variety of cultures. Throughout Sue’s tenure, she attempted to develop a cultural awareness curriculum but was plagued by resistance from other faculty. Sue’s desire for a cultural awareness program in the educational system stemmed from past experiences in childhood when her father had firm opinions of the Japanese culture, but yet at various times, several Japanese students were allowed to live with Sue’s family. The research narrative and findings detail Sue’s difficulties and transitions that occurred and how her professional identity evolved from the encounters that

transpired. Halse thus considers personal identity and professional identity to be connected by all of our daily experiences.

An overall sense of identity can be developed and then evolve into a new identity, later in life according to Waller (2010). Waller conducted a narrative study on two female non-traditional students in the United Kingdom. Both women had very different lives, but their commonality existed in their educational pursuits. This study emphasized that their familial background and environment, as well as their educational endeavors influenced and then redirected their personal and professional identity.

How then is a professional identity in nursing developed? A study conducted in Australia of undergraduate nursing students and students in a midwifery program revealed several factors that the authors believed prohibited a complete development of professional identity. The lack of instruction in nursing history and how that history affects our practice to this very day was a defining factor. The authors believed that students had no sense of where the profession had come from and therefore, lacked a true understanding of what it meant to be a nurse. Data were collected by interviewing several students, but also nursing faculty. Continued deduction of historical components from academic curriculum was felt to be the leading cause of the debilitating professional identity development in new nurses by nursing faculty in this study (Madsen, McAllister, Godden, Greenhill, & Reed, 2009).

Shaw and Timmons (2010) conducted a qualitative research directed at whether nursing uniforms influenced professional identity development for student nurses. Through 14 interviews of both male and female participants, the researchers found that there was some link between the development of a professional identity and the nursing uniform. Participants believed that the nursing uniform conveyed professionalism and

was an expression of pride in the role as a nurse. While the authors did not differentiate the percentage of the sample according to gender, several female participants believed the traditional nursing uniform was better for the nursing image than the current uniform of scrubs, but all of the males in this study opted for scrubs. Even though there was a divided opinion of traditional versus present day nursing uniform, the findings still confirmed that the uniform positively influenced professional identity development.

Another study investigated professional identity in newly registered nurses from year one to year three. Deppoliti (2008) found several factors that she believed were associated with professional identity development. Finding an environment that was a good fit, being matched with a nurturing preceptor, successful completion of the licensure examination, undertaking a charge nurse responsibility, and continuing with educational endeavors were the factors that the author found beneficial to professional identity development after analysis of the qualitative data. If any of these areas were not accomplished, feelings of anxiety or dissatisfaction were noted to occur. The new nurses in this study differentiated between “good” and “bad” preceptors. If a positive preceptorship occurred, then the new nurse was likely to feel good about the profession and positive identity development was facilitated. If there was a negative experience that was encountered, this would likely influence the nurse to leave the facility and possibly the profession. Deppoliti (2008) believed that further research in these areas were needed as well as distinguishing level of education, age, gender, and race in order to avoid premature losses and engage others to enter the profession.

A positive professional identity is necessary, whether it be as a student or experienced nurse. It fosters a sense of providing competent care to all clientele. In a cross-sectional survey of students completing their last semester in a baccalaureate

program in Belgium conducted by Milisen et al. (2010), it was found that competence in nursing was necessary to promote a professional self-image. The study found that these students felt competent in certain skill areas of nursing based on the survey instrument that was used, but not others. Areas of perceived competence were physical nursing skills, such as communication and professional relationships with patients. However, areas that students believed they were less than competent in were operating medical equipment, delegation, and administrative skills. The authors believed that organizations should continue to foster competence in new nurses in order to further promote a positive professional self-image.

Does vertical violence affect professional identity development and if so are these continued acts of violence considered to be a rite of passage into the profession of nursing that may possibly affect identity development? If vertical violence is indeed engrained in the nursing profession, as a rite of passage, students may believe that this practice must continue to occur, when it is not needed.

Rite of Passage into the Professional Realm

Is the practice of vertical violence behaviors thought to be a passage into the nursing profession? Do nurses who experience this phenomenon believe that since they had to endure, so must others? The search for rite of passage did not reveal anything about a link between violent behaviors and rite of passage; however, entry into the profession and initiation searches provided some insight into joining the ranks of nursing.

Upon finishing nursing school, new nurses enter the workforce and can be greeted by many challenges. To counteract the learning curve in a new facility, new nurses are placed with a preceptor. This should be a nurturing relationship into nursing, but sometimes can prove disastrous and deleterious for neophyte nurses if the preceptor is not

supportive (Gerrish, 2000; Moore, 2006; Stacey & Hardy, 2011). Pearson (2009) discussed her experience as a student nurse being placed in clinical rotations with preceptors, some that fostered her development and others that were sabotaging her very existence in nursing. Prior to Pearson's last placement, she once again was placed with a preceptor who continued to degrade her developing professional self and she decided to leave nursing school. However, she wanted to finish out the semester and with the last placement, the preceptor was everything that Pearson needed to restore her professional ideal of nursing. The preceptor nurtured Pearson to provide her with a renewed passion for nursing, thus inspiring her to finish the program and ultimately begin a career as a nurse.

Becoming familiar with an institution's policies and procedures as well as the unspoken rules can be challenging for the neophyte nurse. Each facility has its own culture and traversing this path alone is daunting, but with a receptive preceptor, this is an easier path. Stacey and Hardy (2011) conducted a study where new nurses reflected on both positive and negative experiences, including horizontal violence. Through storytelling, the authors found that these novice nurses could be transformed into nurses that would be better equipped to deal with the shock of a new facility and profession thus easing their process into the world of nursing.

Once again, several studies have continued to emphasize the necessity of a nurturing preceptorship for students and new nurses to become acculturated into the professional realm of nursing. Rush, McCracken, and Talley (2009) found that nursing students' exemplified a greater self understanding of nursing when there was an encouraging figurehead present in the clinical setting. Levett-Jones and Lathlean (2008) in another study found that a feeling of belonging was crucial to learning and growing in

the nursing profession. These students were always looking for the end of the clinical day and had little to no motivation to complete clinical tasks or learn anything further. Once belonging was accomplished, students were inclined to work hard, learn, and remain optimistic in the clinical setting. On the contrary, it was determined that if students and new nurses do not feel welcome in the nursing environment, professional growth is doomed. Again, both of these research studies believed that a nurturing preceptorship was a key element to finding a place in the nursing world.

Transformational Leadership Concepts

Professional identity development is equated to socialization with attitudes and moral views of a profession (Faulk, Parker, & Morris, 2010). Therefore, student nurses must become social beings within the professional environment in which they wish to participate. Many factors, including vertical violence, can influence their identity development. This is an important concept to explore when considering how nurses view their identity. Student nurses that are exposed to violent behaviors may develop an identity that believes violence is an acceptable practice for the profession. However, with good role models, students may realize that the violent cycle can be broken. Transformational leadership theory provides insight into how this phenomenon of interest can impact professional identity development and how the theory can transform a student nurse who has been exposed to vertical violence.

Transformational leadership theory could be utilized to halt vertical violence in nursing schools and healthcare organizations, that overall would produce changes in the profession. To comprehend how this theory could prevent violent behaviors, the theoretical concepts must be understood. Transformational leadership has been used in many organizational settings to provide guidance for leaders to influence, motivate,

support, and stimulate growth in subordinates. This is a theory that centers on how the leader can move the subordinate to a higher level of thinking and performance in the organizational system (Bass, 2008; Jung, Wu, & Chow, 2008; Northouse, 2007; Pounder, 2008). Bass (2008) and Burns (2003) examined transformational leadership theory to Maslow's Hierarchy of Needs and believed that in transforming followers, they would leave the lower self needs and move toward self-actualization and concerns for group or organizational goals. Transforming leaders should have high moral character with strong values that correspond to that of general society and should rally followers to adapt strong character and values to work for the greater good (Burns, 2003). Numerous research studies have been utilized with transformational leadership theory with many citing improved organizational performance (Northouse, 2007; Pounder, 2008; Vecchio, Justin, & Pearce, 2008). This theory focuses on the relationship between the leader and his/her subordinates.

To fully understand the theory, the concepts that comprise transformational leadership must be explored. Within the framework of this leadership theory are four identified behaviors, which are referred to as idealized influence, individualized consideration, inspirational motivation, and intellectual stimulation (Bass, 2008; Northouse, 2007). While some authors refer to transactional leadership as part or completely separate to transformational leadership, this paper will address it as an adjunct to transformational leadership theory. Transactional leadership focuses on an exchange or reward system for completion of specified role performance and/or behaviors exhibited for the organization. The concepts identified with transactional leadership are contingent reward and active or passive management by exception (Bass, 2008; Northouse, 2007; Yukl, 2006). Therefore, transformational leadership will support the change in followers'

behaviors and transactional leadership will demonstrate the reward to followers for the noted change in performance.

Idealized influence or charisma is the first factor of transformational leadership. This describes the ability of the leader to inspire the follower to greater heights or abilities in their current performance. A leader can influence and inspire followers by being a role model in their present position of professional responsibility. Influence is important in the transformational leadership scheme because it advances the followers' trust in the leader and therefore, the follower desires to emulate the leader in organizational responsibilities (Northouse, 2007).

Inspirational motivation deals with how the leader encourages a subordinate or follower to act in a different way than what the follower has been achieving. This factor deals with how leaders effectively communicate change to subordinates (Northouse 2007; Yukl, 2006). Being able to communicate with subordinates and being sensitive to their needs and dreams allows the leader to connect with subordinates and the potential to motivate them to a higher level (Maxwell, 2008). Communication with subordinates is a must for the leader to be able to discuss issues that are important to the subordinate, but also the goals for the task at hand and for the organization. A leader aiming to motivate and inspire followers must be able to enthusiastically articulate goals, foster confidence in subordinates, encourage collaboration, and provide positive feedback as necessary (Burns, 2003). As the leader works toward inspirational motivation, followers feel that the leader is truly concerned with their well-being and trust in the leader's ability develops (Northouse, 2007).

Providing a creative and stimulating achievement environment defines the third factor which is referred to as intellectual stimulation. To accomplish this concept, leaders

must encourage followers to strive for a higher level of achievement. This means that the leader wants subordinates to think outside of the box and challenge themselves to develop new ways to deal with organizational issues (Bass, 2008; Northouse, 2007; Yukl, 2006). Interaction between followers to generate ideas is encouraged and leaders that intellectually stimulate should avoid public condemnation for mistakes that followers may make (Bass, 2008). Leaders can also delegate to subordinates or give them autonomy with certain projects that accentuates the achievement environment. Subordinates will feel a sense of empowerment and more like a key stake holder in the organization (Jung, Wu, & Chow, 2008).

Consideration of the individual in the transformational leadership model deals with treating everyone with respect and as human beings that have the ability to live a satisfying life. This factor is important for the transformational leader to accomplish because the subordinate will sense that they are cared about in the grand scheme of the organizational structure. Followers need to be listened to, tutored, and advised for development of individual consideration to occur (Northouse, 2007). Encouraging achievement, advancement, and learning opportunities for subordinates' professional needs promotes consideration by leaders and can play an important role in stimulating followers to work toward organizational goals (Bass, 2008). Leaders may also provide challenging tasks to subordinates in this phase which again promotes a sense that the leader considers the subordinate as a significant contributor to the organization (Northouse, 2007; Yukl, 2006).

Transactional leadership has two components, which are contingent reward and management-by-exception. Contingent reward is what the leader provides for the subordinate for a proposed change or task completion. This can be in the form of

monetary worth, organizational recognition, or a professional promotion. If this approach is utilized before transformational leadership principles are applied or as a standalone theory, the transformation of subordinates will not occur. In other words, the subordinate may not feel a part of the organization and does not think on a higher level about organizational improvements, but instead focuses on their individual needs and desires and what the organization can do for them (Northouse, 2007; Yukl, 2006). Therefore, Bass (2008) concludes that contingent reward in the form of recognition and praise fosters the psychological nature of a human being and supports transformation more so than monetary rewards. Significance of a follower's contributions to the organization can be confirmed by contingent reward if used appropriately.

Management-by-exception can be classified as either active or passive, but basically utilizes a pattern of negative reinforcement, unlike the contingent reward factor. With active reinforcement, the leader watches employees every move for possible infractions and quickly points out these to the subordinate and expects immediate action to correct the violation. Passive management-by-exception refers to a leader who will sit back and allow infractions to occur, but will only address the infractions when a serious problem due to multiple infractions has come to light. The subordinate will not have been counseled previously about the issue; therefore, this leader fails to document behaviors that are a detriment to the organization (Northouse, 2007). Leaders that use this approach will not increase motivation or transform subordinates to a higher level of cognition.

Halting Vertical Violence through Transformational Leadership

Does vertical violence discourage positive professional identity development in the student nurse? This research surmises that vertical violence may inhibit identity development and therefore, the progression of violent patterns must be halted for the

good of the profession. This would thus prove beneficial to recruitment and retention of nursing students into the profession and in healthcare organizations. Knowledge of vertical violence for nursing leaders is a must so that solutions for this deadly problem can be identified. As Ferns and Meerabeau (2008) determined, violent behaviors must be addressed jointly by nursing education and healthcare facilities. Additionally, the entire nursing profession must embrace this change, which includes all nursing associations and organizations.

To begin transforming our workforce comprehension that vertical violence should not be tolerated; nursing faculty must convey positive messages and encouragement to nursing students. Nursing is a caring profession and for nurses to be so unkind to those entering the profession does not exhibit the basis for which the profession is known (Fudge, 2006; Hinchberger, 2009; Leiper, 2005). This can be conveyed to students using the four concepts of transformational leadership. Promoting a caring profession, nursing faculty must emanate this concept by becoming a role model for students and promoting an influence for students to reach a higher level of moral and ethical behavior. This caring attitude emphasizes what students idealize as the nursing profession (Wade & Kasper, 2006). Consideration of each student's strengths and weaknesses along with personal characteristics allows students to begin to feel accepted into the profession. When nursing faculty convey idealized influence and individualized consideration for students, this can promote motivation and intellectual stimulation in students, thereby promoting creditable professional identity development. The goal for students should be to learn in a caring and non-threatening atmosphere, which has been shown to improve learning (Clark, 2008; Curtis, Bowen, & Reid, 2007).

Through the education of nursing students, Martin and Stanley (2011) initiated an inquiry in their own program of nursing to understand violent behaviors that students encountered. Confidentially, students conveyed acts of violence that were either witnessed in the clinical setting or were victims of the act. Through stories of violence, the authors integrated lateral and vertical violence concepts into their school curriculum and also began teaching it with professional behaviors. Emphasis on the nurse leader's role in understanding these concepts, identification of violent behaviors, and how to intervene are discussed and believed to be of extreme importance to begin the process of eliminating this phenomenon from the profession.

To initiate a beginning appreciation of the significance of vertical violence to student nurses, this research was accomplished through the qualitative method of narrative inquiry. The research aims were to understand if this phenomenon of interest impacts professional identity development, whether nursing students associate vertical violence with a rite of passage into the nursing profession, and if transformational leadership theory could be used to curb violence in the profession.

Qualitative Paradigm

Qualitative research refers to what many consider a "lived experience" (Munhall, 2007c, p. 39). As Munhall (2007c) noted many definitions exist and if only a few were considered, much understanding of this paradigm could be limited or lost; therefore, she cautions to avoid restrictions placed on the meaning and structure of a research study using a qualitative method. For the qualitative researcher, the participant's experience in its entirety is the focus; a holistic process. Another means of association for qualitative research is that the whole individual interacting in a given social context is important because the experiences are directly influenced by the person and the social situation. To

dissect the experience into parts might lead to misconstrued meaning of the research findings. Therefore, from the qualitative perspective all elements of the lived experience contribute to the inquiry (Munhall, 2007c).

Qualitative methods follow an inductive path of reasoning by generating meanings from patterns, behaviors, and experiences of the human and social condition. Collection of data occurs through the senses and is expressed in words that produce themes of the phenomenon of interest. Findings provide detailed descriptions of themes with words, phrases, or sentences by participants that demonstrate the nature of the phenomenon more clearly. Utilizing a qualitative approach to research with inductive processes assists in the possible generation of new nursing theories (Brink & Wood, 1998; Creswell, 2009).

There are several approaches that can be utilized for qualitative research. With the growing interest in the narrative paradigm from the scientific community, more disciplines are realizing that this approach may be useful for investigation of their phenomenon of interest.

Narrative Inquiry

Narrative inquiry is a qualitative method used to explore life stories of a particular phenomenon or to connect several events together (Riessman, 2008). The particular focus of this research was to procure stories of vertical violence from student nurses. Through thematic analysis, words and phrases were identified through the time sequenced events of the narratives to assist in determining the research aims.

Professional identity development for nursing students begins in both the classroom and clinical settings as they witness nursing instructors and clinical staff registered nurses interact with each other. Both positive and negative experiences can

shape the professional identity. Therefore, a concern is how do negative experiences such as vertical violence perpetrated by a clinical staff registered nurse, who is in an authoritative position, affect identity development? With the narrative process, students were able to openly identify stories of vertical violence and how they felt this affected their professional identity development.

Understanding if nursing students believed vertical violence behaviors were a rite of passage into the professional ranks was also explored through narrative inquiry. Stories of experiences that illustrated violence were analyzed to comprehend if students believed that violence was attributed to a passage into the nursing profession. If violence is seen as a rite of passage, does this instill a belief in the nursing student that the cycle must continue?

Narrative Inquiry Background

Narrative inquiry is a qualitative research method that has been based in the social sciences, history, and education but has become more popular in other research arenas (Creswell, 2007; De Fina, 2009). The process utilizes stories of the research participant to gain insight into a specific phenomenon, not only through the story itself, but also through the analysis of what is said and how it is said (Bleakley, 2005; De Fina, 2009). Healthcare researchers are beginning to utilize the narrative inquiry approach more frequently to understand patients' feelings and stories of varied phenomena (Bleakley, 2005).

An initial insight into the background of narrative inquiry is that the terms, narrative and stories, are used synonymously. Narratives illustrate experiences from the participants' lives. Denzin and Lincoln (2005) view narrative inquiry as if observing an acting performance of a given social circumstance. Polkinghorne (1998) stated that

narrative inquiry “is the scheme that displays purpose and direction in human affairs and makes individual human lives comprehensible as wholes” (p. 18). Through this research method, experiences were conveyed in association with a particular social situation and thus, meaning was inferred by both the participant and the researcher.

Just as a fiction or non-fiction story, a narrative holds the same elements.

Narrative inquiry utilizes stories to emphasize a person’s life experiences and takes a particular tone, whether it is drama, romance, or tragedy. Each narrative begins with an introduction or abstract that briefly describes how the experience or phenomenon became important to the subject. The research subject continues into the story by providing the setting or settings where the experiences occur and the other characters involved. Once the demographics are detailed, the person of interest directs the narrative to the emphasis or plot of the experiences. The plot provides the essence of what will be studied in the inquiry. When the story or experience has been completely unearthed, the participant may culminate the narrative by inferring the meaning of the experience to him/her. Just as a published book or novel contains a story, a narrative provides a story and through this storied experience, meaning can be extracted through the voiced events (Duffy, 2007).

Storytelling is a unique way in which lived experiences can be communicated.

Life experiences lead each person to a place where an identity is created and continuously evolves. This continual evolution occurs through one experience after another in various social situations. It is the actual experiences that shape an individual’s perception and identity (Clandinin & Connelly, 2000). Research conducted utilizing the narrative approach demonstrates how participants’ identities are shaped through the culmination of life events (Duffy, 2007; Riessman, 2008). Polit and Beck (2008) viewed narrative inquiry as an ability for a person to extract meaning of the internalized experience with

the outward occurring action that surrounded the experience. Lindsay (2006) suggests that in the course of reliving an experience through storytelling, new meaning may be discovered that was previously unidentified. Through experiences, those explaining the narrative become a part of the context and their own personal identity can be developed or transformed (Riessman, 2008).

Duffy (2007) further believes that narrative research is an active process involving both the researcher and the participant. Guidance through research questions during the interview process can assist the participant to identify issues in the story that are significant. This type of inquiry is more than a means of soliciting a story, but instead an encounter where meaning may be cultivated from certain experiences for both the participant and the researcher.

Experiences occur in the context of the social world in which we live. It is these life experiences that can be explored for meaning through narrative research. Harling-Stalker (2009) believed that there are two types of narratives that can benefit the qualitative research paradigm, ontological and epistemological narratives. Ontological narratives are stories presented by the actual person conveying the experience whereas epistemological narratives are the analyzed component from the researchers perspective of the conveyed experience. Both approaches were utilized in this research study as it is the stories from the actual person that yielded the analyzed results.

Types of Narrative Inquiry

Even though narrative research is still considered somewhat young in the field of methods, there are several distinct types of narratives that have been identified. Research can be crafted as a biographical or autobiographical study through a life or oral history narrative approach, and a personal experience story. These types demonstrate that

narratives can be accomplished through verbal and/or written word, but all narratives are retrospective in nature revealing life's past events and actions as portrayed by those involved. Narratives may also be guided by theoretical perspectives such as oppression of groups and the phenomenon of violence (Creswell, 2007). According to Riessman (2008), visual arts can be considered as a narrative method through expression of feelings and thoughts via images. Each type serves a useful purpose in narrative research.

Life history. Many variations exist in the description of life histories as to how this type of narrative inquiry can be accomplished as well as the extent of content covered. A life history can be biographical, meaning that the researcher collects the stories from the individual being studied and then writes the research. This requires the researcher to collect, analyze, and interpret the data that is then made available in a report. However, the researcher can have the individual who is the study participant write the life history making it an autobiography. A first-hand experience can be presented from this type of life history, which in true narrative form provides the feelings of the study participant. The differences in who actually tells the story provides an understanding of the point of view, but the content that is expressed also provides a distinction in the life histories (Creswell, 2007).

Personal experience narratives. This type of narrative deals with specific experiences from a given time. It may be from a single event or several occurrences that exhibit similar experiences and generate comparable themes to the researcher. Quite similar to personal experience narratives are those that reflect upon a specific phenomenon of interest; meaning that the researcher may gather narratives from a common group to solicit stories for an understanding of the phenomenon (Creswell,

2007). This type of narrative can be associated with vertical violence in nursing students and how it influences professional identity development.

Descriptive. Polkinghorne (1998) suggests that the types of narrative accounts are descriptive and explanatory. Descriptive inquiry actually looks at the meaning of persons' narratives that occurred in a specific social setting; it describes the account and what meaning can be derived. For the interview, narratives are reconstructed by the interviewee or participant collaborator in a chronological order, while following those ideals of a true story with setting and plot as well as details. As the story evolves, meaning can be understood and this type of inquiry can give light to the participant's view of their own self-identity.

Explanatory. Explanatory narrative inquiry seeks to understand why something has happened. Through stories, the researcher can possibly determine a causal relationship between similar narratives and why certain outcomes occur. As in all narratives, these stories are past accounts and through analysis, commonalities are identified. Once the similarities are identified, they can be merged to reveal how the relationship from one event to the next leads to the explanation of the phenomenon of interest.

Analysis of Narratives

Labov and Waletzky (1967) discussed narrative inquiry analysis as a process of beginning with the simplest of narrative elements and understanding how they are directly linked to the situational context in which they occur. Attempts at analysis of large complex folklores should be avoided because the researcher must begin with the basic unit to provide better insight. Further, they emphasized that the basic elements are

those pieces or concepts that are being studied and must first be comprehended in order to analyze the composition and meaning of the themes that emerge.

Creswell (2007) believed that analysis occurs through a restructuring of the story, called a restorying process. Participants in a narrative research study often convey stories that may not represent the true order of the experience. They may begin with the basic element that is the focus of the research, but then reverts back and forth with details from the past to present. Thus the researcher must place these events in a chronological order to comprehend the entire story of the experience; building the story around the phenomenon of interest. Furthermore, Creswell (2007) emphasizes that as the stories evolve, we as researchers observe and hear additional information that shapes the questions that are asked and that analysis can be an ongoing process throughout the inquiry.

Narrative Inquiry in Action

Narrative inquiry has been popular in the social sciences arena for years and is now branching out into multiple disciplines. Researchers have utilized study conclusions to convey meaning from learned experiences in the classroom; whereas, the healthcare disciplines are beginning to use narrative findings to understand feelings associated with various disease states or even care that was provided.

Education. Teachers in all areas become privy to experiences from students, families, and co-workers. When reviewed in research, these life stories provided insight into the meaning of teaching and relationships. Through reflection, these stories have helped researchers understand their culture, professions, and relationships with those that were present in the interactions.

All of our experiences are stories that have been told or are waiting to be told. Clandinin (1993) pondered on how teachers' educational programs and curriculum for higher education programs in university settings were developed and whether dialogue of classroom experiences led to or assisted in the development of said programs. Through the course of exploring ways that the educational programs could be developed using the narrative inquiry approach, Clandinin discovered that encounters with other teachers/student teachers, parents, and students generate new ways of educating future generations possibly via stories of instruction or classroom experiences. This means that with each group, everyone sees every learning opportunity differently and unique meaning for each learning experience occurs. Each group could share an experience in which learning occurred and this could generate new ways of knowing or methods that could be researched using the narrative approach, leading to the discovery of new ways to produce educational programs for instruction. Essentially what Clandinin is inferring is that if several people experience the same method of instruction or learning, each person can convey different meaning from the experience. Thus a new path of knowledge may begin with each possible experience and starting point. Each beginning story can take the research query in new directions but similar commonalities could be demonstrated. With narrative inquiry, Clandinin believed that there is always new learning that occurs with each person's experience.

Healthcare. Formal narrative inquiries have been undertaken less in healthcare, but in recent years seems to be gaining interest by the healthcare researcher. However, the stories told in formal education to illustrate learning are just that, narratives that produce knowledge for the next generation of healthcare professionals (Bleakley, 2005).

Through these narratives, we gain evidence-based practice of the benefits of care that has and will be provided.

Just within recent years, nursing has started utilizing the narrative method in research. Ayres (2007) studied caregiving and the meaning of the effects on lives of those involved. Participants in the study who shared their stories of caregiving were both male and female, were from various races, and had provided care to family members with multiple diagnoses. Interviews were the medium for collecting the stories from participants and yielded four groups of meanings for caregiving. These narratives led researchers to understand that caregiving from these different groups were defined in degrees of joy, responsibility, guilt, and ambiguity. Certain caregivers believed that their lives were better for providing care to their loved ones, while another group considered caregiving as a normal family process, a responsibility of living. While yet another group felt a sense of guilt for being the person in the relationship who was healthy, while the recipient of care was ill. The last group that related ambiguity was caregivers who had recently been placed in this role associated with a new debilitating diagnosis and was having difficulty conveying their thoughts and feelings about caregiving. This research demonstrates that persons providing care for family members in need are affected in different ways according to how they view their individual situation.

Research findings on caregiving yielded recommendations for additional research. In the group that viewed caregiving as enhancing their lives, the two caregivers were African American males. In previous research, Ayres (2007) had found that usually African American females were the caregivers who claimed that caregiving provided betterment to their lives. Therefore, Ayres believed that further research needed to be conducted on African American males' feelings as the primary caregiver. Additionally,

the group who expressed ambiguity was uncertain of their feelings and Ayres wondered if this was related to the newness of the caregiving role and the inability to fully explore their feelings toward this phenomenon. Even though the narrative method is new on the horizon of research in nursing, this study alone produced two potential research queries.

Another narrative research query conducted by Overcash (2003) involved utilizing the narrative method to enhance care and hopefully improve patient outcomes. She emphasized how narrative research allowed women who had been diagnosed with breast cancer to discuss the significance of this diagnosis, how they dealt with the fears associated with cancer, and the effects on their daily lives. The process of being able to tell their story was equated to a purging of the physical and emotional turmoil that the person had experienced. Conveying some of these burdens to healthcare providers was the clinical implication for this research to improve quality patient outcomes.

Anthropology. Narrative inquiry has been combined with other qualitative research methods to produce results. Angrosino (1994) conducted a narrative life history incorporating ethnography with a mentally handicapped man who had lived through multiple struggles. The life history reviews this man's struggles as a child growing up on the streets and how his sisters and he were sexually abused by several of their mother's boyfriends. It detailed the unstable nature of his childhood, moving from place to place to live before ending up on the street with an older man. After years of hardships during childhood to young adulthood and ending up in several psychiatric facilities and homes for assisted living, the man was given a place of his own as well as gainful employment, but would be required to take the city bus from his apartment to his job. Angrosino was responsible for showing this man the bus routes which required several transitions from one point to the other. Angrosino noted that the prospect of a job or place to live was not

a focal point of excitement for this man, but instead it was riding the bus to and from work. A central theme that emerged from the life history was that this man experienced so much poverty and struggles over the course of his life where he lived and walked on the streets, that he viewed being able to ride the bus as a status elevation in society. By conducting narrative inquiry in the setting that this man was most comfortable, Angrosino, through direct observation and interviews, was able to extrapolate the significant meaning in this man's life.

Narrative method is the re-creation of lived experiences through stories as conveyed by the individual participant. These stories, in turn, produce meaning as seen by both the participant and the researcher. Through narrative inquiry, new learning can be gleaned from various phenomena of interest and disseminated to improve scientific knowledge.

Summary

Vertical violence can include any type of negative behavior used by a person in a superior position that somehow causes feelings of degradation in another person that is in an inferior position in the organizational hierarchical chain. This phenomenon is plaguing the nursing profession and has been around more years than many of us care to admit, but has been referred to by many in the profession as "nurses eating their young." Other more widely recognized terms associated with vertical violence include horizontal/lateral violence, which infer that the perpetrator of violence and the victim are on the same hierarchical level; and workplace violence, which is violence that can essentially happen anywhere in the work environment between any levels.

Utilizing narrative inquiry to accomplish this research, it was this researcher's aim (a) to describe student nurses stories of vertical violence, (b) to describe how vertical

violence shapes or transforms their professional identity as a future nurse, (c) to determine if vertical violence stories as presented by students are believed to be associated as a rite of passage into the nursing profession, and (d) if transformational leadership could curb this phenomenon.

As Martin and Stanley (2011) inferred, nurse leaders must be aware of violent behaviors and take a chief position in leading the efforts to reduce the incidence of vertical violence. Transformational leadership theory is one such theory that can promote higher levels of moral and ethical behaviors in followers as well as functioning and an individual desire to succeed for self and organization (Northouse, 2007). Therefore, if nursing leadership is positive, it is believed that this theory can assist student nurses as well as neophyte nurses in the development of positive professional identity.

CHAPTER III

METHODOLOGY

Introduction

Violent behaviors in nursing present a quandary for all in the profession and prevent cohesion within the ranks. Horizontal/lateral violence and workplace violence have received much more attention than vertical violence. Horizontal/lateral violence indicates the violence occurs between equal level employees. Whereas, vertical violence infers that the actions transpire between staff members on different hierarchical planes. In an attempt to understand the phenomena of vertical violence more completely, a narrative approach was utilized to elicit stories of vertical violence from nursing students to determine if this influenced a professional identity development and if nursing students believed that a rite of passage existed only through enduring the ritual of violent behaviors.

Many types of violent behaviors exist in the workplace. Behaviors can include yelling, snide comments, humiliation, and withholding necessary information (Cantey, in press) that impedes workforce performance and satisfaction. Other acts can include bullying, incivility, and aggression (Wilkinson, 2011), but overall, violence can be any type of behavior that leaves the victim with feelings of degradation and worthlessness. Therefore, a narrative method produced experiences of the phenomenon of interest that were incurred by the participant.

This chapter will focus on the methodology that was used to conduct this research. It was the intention of this researcher to provide a clear description of the research process that was utilized, including the role of the researcher, review of research questions, an interview guide that facilitated initial data collection (see Appendix A), and

how stories provided by participants guided development of potential subquestions throughout the process. Philosophical assumptions, data collection process, criteria for subject participation, participants' role as interviewee and the relationship between researcher and participant are discussed, as well as the maintenance of an ethical study. Additionally, measures used to analyze narratives in understanding the meaning of stories with generation of themes are discussed. Overall, it was the goal of this researcher to maintain a theoretical balance with the focus of the research to produce research knowledge that would benefit the nursing profession.

Review of Research Questions

Using a narrative approach provided stories of the phenomenon of interest and how those attempting to negotiate passage into the profession felt about their own professional identity development. Using a narrative approach allowed for exploration of a problem that has not been explored in research or very little research knowledge has been generated (Creswell, 2007). As previously discussed and as nursing history has revealed nurses eat their young, but still there remains a scarcity of adequate nursing knowledge on the phenomenon of vertical violence. There is a lack of knowledge on vertical violence experienced by student nurses and the effect of this phenomenon on professional identity development. Additionally, there is lack of knowledge as to whether student nurses, who are our most vulnerable population in this profession, view this phenomenon as a rite of passage that they must endure to become a member of the profession. This narrative inquiry was used to generate stories of nursing students'

perceptions of vertical violence and the influence that this experience had on their professional lives and was therefore, guided by the following research questions:

1. What stories are conveyed by student nurses about vertical violence?
2. What do the stories reveal about the effects of vertical violence on these student nurses' professional identity development?
3. Do these stories indicate that students believe that vertical violence patterns are associated with a rite of passage into the profession of nursing?
4. Given a brief description of transformational leadership theory, could this be a theory that could be utilized to nurture a positive professional identity and decrease vertical violence?

Identified Assumptions

Narrative inquiry is a method that exists in the qualitative research paradigm. Both qualitative research and the narrative method have their own assumptions. All qualitative research studies utilize words, rather than statistical methods, to convey plausible research data. In our path to discovery, qualitative researchers rely on basic philosophical assumptions, ontology and epistemology. Although the narrative method leans on assumptions to guide a given study, Clandinin and Connelly (2000) believe that the narrative process is a "fluid approach" (p. 184). Therefore, the assumptions of a qualitative research will be briefly discussed as well as those that are basic to the narrative process.

For individuals that encounter similar situations, there will be multiple interpretations and multiple realities that are produced. In qualitative research, ontologically, the focus is on reality, the unique ideals of the experience (Creswell, 2007). This reality is specific to the individual being, as meaning varies (Munhall,

2007c). Therefore, the reality of vertical violence and the effects on professional identity development will be distinct, but may produce certain similarities, which emphasizes the need for a qualitative approach.

The epistemological assumption means that the researcher attempts to understand the true meaning of the phenomenon of interest. In this way, the researcher gains entry into the setting with the participant. While maintaining objectivity, the researcher becomes ‘close’ to the study participant through interviews in the field, allowing for a more in-depth look at the essence of the study (Creswell, 2007; Denzin & Lincoln, 2005; Munhall, 2007a). Through the use of narrative inquiry, true meaning of experiences of vertical violence by student nurses was understood.

Within the narrative framework, Clandinin and Connelly (2000) identified the “three-dimensional narrative inquiry space that guides inquiry: interaction, continuity, and situation” (p. 50). With the first dimension, interaction, this emphasizes the personal aspect of a narrative and how meaning is derived. As Polkinghorne (1988) believed, personal significance and meaning are derived from all life experiences. With meaning attached to experiences, Duffy (2007) noted,

In other words, narrative inquiry functions at the interface of personal and social identity and of the very social world, which is constitutive of such identities.

Narratives reveal, sometimes consciously and often unconsciously, the meanings, conventions, dominant beliefs and values of the time and place in which a person lives and develops an identity. (pp. 401-402)

Even as the same experience is re-enacted through our memories and further told to others, the meaning may continue to transform (Polkinghorne, 1988). These views

emphasize that each experience with associated meanings can influence and thus modify personal identity throughout the course of life.

Continuity, the second dimension, emphasizes temporality. Assumptions involving this dimension infer that knowledge, learning, experiences, and meaning are in a constant evolution; we as humans are always discovering and realizing the essence of life (Spenceley, 2004). Clandinin and Connelly (2000) stated with narrative inquiry and the dimension of continuity the “past, present, and future” must be considered and in a continual search for meaning the narrative must be viewed from “inward and outward, backward and forward” (p. 50). The inward movement emphasizes that meaning from an experience is affected by our beliefs, values, and morals that we have already established and the outward looks toward the surroundings where the event occurred. Temporality is further implied when Clandinin and Connelly (2000) inferred “that to experience and experience... is to experience it simultaneously” by looking at the meaning of the past, current relevance of the meaning, and the meaning of the experience for the future (p. 50). Polkinghorne (1998) stated,

Narrative ordering makes individual events comprehensible by identifying the whole to which they contribute. The ordering process operates by linking diverse happenings along a temporal dimension and by identifying the effect one event has on another, and it serves to cohere human actions and the events that affect human life into a temporal gestalt. (p. 18)

The third dimension that Clandinin and Connelly (2000) discussed as an essential understanding for a narrative inquiry is situation, otherwise known as the setting, where the experience discussed in the narrative took place. Situations can include the social or cultural context in which the experience occurred or give the actual location (Duffy,

2007), such as a specific floor in a healthcare agency, or as Clandinin and Connelly (2000) later identified as the location within “the inquiry landscapes” (p. 51). All three of the dimensions are assumed to be true of a narrative inquiry as Duffy (2007) stated

It is not possible to tell about a life without talking about the people, the place, the time, and the events that were going on during the time of that life and ordering those elements into something that makes sense – a story. (p. 419)

Therefore, all three assumed dimensions will have a necessary position in each narrative revealed in the research query.

Vertical violence and the meaning it produces for the victim is specific and different for each individual. For this research, the focus was vertical violence perpetuated by clinical registered nursing staff against our most vulnerable ranks, the student nurse. The meaning was what the student nurses deemed the meaning from the experience to be and how it affected their professional identity development. To reveal the meaning through narrative inquiry, student nurses told their stories of vertical violence, which were recent past events in a clinical setting during their educational pursuits for a nursing degree. These elements mirror the assumptions of a narrative inquiry, and how open ended questions from the researcher guided this process in finding meaning associated with vertical violence and professional identity development.

Role of the Researcher

Prior to research analysis or identification of themes, stories must be told and narratives must be constructed. Before this can happen according to Clandinin and Connelly (2000), the researcher must explore his/her own meaning of experiences that may have led to the inquiry for the particular phenomenon of interest being studied. Therefore, the relevance of this phenomenon of interest began years ago when I first

embarked on my journey in nursing as a graduate nurse. As discussed in Chapter I, I encountered an episode of vertical violence that I have replayed over and over. Initially, there was much pain, both emotional and physical that I experienced anytime I had to go to work and sometimes when I was not at work. What did the experience really mean to me? With each recollection and as I grew in nursing, the meanings changed. As Clandinin and Connelley (2000) noted, “This task of composing our own narratives of experience is central to narrative inquiry” and hence, is the starting point for the researcher (p. 70).

After exploring meaning within, the researcher must become the “instrument” for the research (Munhall, 2007a, p. 179). According to Mishler (as cited in Neander & Skott, 2006), “narratives are not found, but instead, the researcher is an active contributor in the creation of a narrative” (p. 297). The researcher allows for this collaboration by utilizing open-ended questions that allow the narrative to take shape by the participant, who is the actual narrator of the event. Chase (2005) emphasizes that the researcher must be intent with active listening during the narration and must listen to the “voices” or context within each narrative (p. 663). Chase (2005) described the narratives from a research study on women superintendents as professionals, but also as a woman dealing with other barriers in the workplace. Chase (2005) stated,

But I soon found that it was difficult to separate a woman’s talk about work and her talk about inequality. Finally it dawned on me that there was a connection between a woman’s construction of self in one story (e.g., about her individual strength as a competent leader) and her construction of self in other stories (e.g., about her individual strength in fighting discrimination). (p. 663)

Therefore, the researcher must listen attentively as the narrative unfolds.

Maintaining an objective, but close relationship to the participant is necessary, but can pose difficulties for the relationship. The researcher wants to be able to establish a trusting relationship but be capable of backing away when needing to maintain objectivity in the research process. Clandinin and Connelly (2000) believe this occurs as the researcher “experiences the experience” by being able to understand the narrative and the emotions associated with the experience (p. 81). This is a connection that occurs, but to maintain objectivity by backing away, field texts are created (Clandinin & Connelly, 2000).

The researcher must also construct field text from the recorded narrative and from direct observations of the field experience. During the interview process, participants may move from recent events to experiences from the past that influence the phenomenon being studied. This emphasizes the backward and forward movement that the researcher and the participant enter in together. Therefore, the researcher’s responsibility for active listening and observation is a must as narratives must be pieced together in chronological order to create a reliable picture of the experience. Additionally, the researcher must be aware of narrative threads that may surface with each passing conversation (Clandinin & Connelly, 2000).

As the narrative process begins and continues until culmination of the research study, it is the researcher’s responsibility to maintain active listening, an open mind for awareness of emerging threads, and continually negotiating the relationship with the participants in the study. Not only is it important to gain entrance with the participant, but it is also crucial that the researcher sustain the connection. Accomplishing this meant that participants in this research query were willing to continue through two 1-hour interviews and understood the meaning of the study. At the culmination of the research process, the

researcher and participant had developed an understanding that all things that are temporary have an ending point, but also from the relationship an understanding of the phenomenon had occurred (Clandinin & Connelly, 2000).

Role of the Participant/Narrator

Narrative inquiry is a research methodology that is based on acquiring stories from individuals that have experienced a particular phenomenon that is being investigated. These stories are told by the participant, who is also considered the narrator of the account being told. Participants are responsible for the narratives identified in the research process and much can be ascertained about the social and cultural aspects of the experience during the interview, including the setting and demographics of those involved. Meaning from the experience may also be conveyed by the participant (Hardy, Gregory, & Ramjeet, 2009; Polkinghorne, 1988). Therefore, much of what the researcher learns is provided by the participant/narrator.

Another role of the participant/narrator is to review field text notes to ensure accuracy. Clandinin and Connelly (2000) refer to this review as a “participant signature” (p. 148). They infer that this process is more than just making sure that the notes accurately relate what was told, but more so that the central character of the story, the participant, is portrayed correctly according to their own experience and meaning (Clandinin & Connelly, 2000). Wiles (2003) further stressed the need to confirm the final interpretation of themes as well as findings from the research study with participants (p. 193). This provides for a way of ensuring reliability but also emphasizing that the participant is as much of a stakeholder in the research process as the inquirer (Clandinin & Connelly, 2000).

Protection of Human Participants

Much of qualitative research is conducted through one-on-one contact with human participants. As with any research query, the lives touched by the research process must be protected. Narrative research is focused on stories from participants related to personal experiences of a particular phenomenon. Reliving experiences can provide relief to the participant by being able to discuss the event with an outsider, such as purging feelings of regret or discontent. Although, sometimes discussing past lived experiences can produce feelings of distress. Therefore, participants that encounter feelings of distress and require the need to speak to an outside counseling service, contact information was provided (see Appendix B) and the participant was informed that they could withdraw at any time. Even though there is a possibility of distressful feelings, the participant may gain new insight from being able to recount the experience to the researcher. Through re-examination of personal experiences, participants may have a shift in their identity (Duffy, 2007). How vertical violence affected professional identity development in student nurses who have experienced violent behaviors was the phenomenon investigated in this research query. Therefore, ethical guidelines for the protection of human subjects were upheld.

Institutional Review Board

Institutional Review Boards (IRBs) are organizations that ensure ethical and moral treatment of human subjects participating in research studies. IRBs follow the three principles that were identified in the Belmont Report as requirements for any research study: “respect for persons, beneficence, and justice” (Christians, 2005, p. 146). These principles ensure that researchers maintain independence, lessen risks, and provide fair treatment to participants. Prior to any contact with participants, the proposal for the

research was submitted to the IRB at The University of Southern Mississippi. This proposal was reviewed to ensure that these three principles were met prior to approval from IRB to conduct research was granted (see Appendix C).

Gaining Access

Participants in this study were nursing students who have met certain criteria for inclusion in the study, one being that they encountered vertical violence by a clinical staff registered nurse during their clinical experiences. The researcher initially contacted the nurse administrator for a baccalaureate nursing program at a university located in the southeast United States to inquire about requirements for access into the institution and if there were suitable candidates for participation in the study.

To demonstrate a potential subject pool and interest in the need for conducting this research, I sought permission from this university's college of nursing (see Appendix D) to solicit participants from the senior level of the generic baccalaureate nursing class contingent upon IRB approval. Once approval was granted (see Appendix C), a flyer (see Appendix E) seeking participation was placed on the bulletin board with the researcher's contact number so students could initiate contact.

Once students initiated contact and expressed an interest in participation, a full explanation of the study was included and the concern that discussing feelings associated with vertical violence could bring up feelings of distress or ambivalence might occur. Students were also informed that at any time they could withdraw from the study if they felt distraught or just unable to continue. This is the reason that in narrative research, not only must the researcher gain access, but also must maintain the relationship to ascertain the participant's willingness to continue throughout the process (Clandinin & Connelly, 2000). At the initial contact, with a participant, a full explanation was provided and an

informed consent (see Appendix F) for participation in the study was secured. At the follow-up or second interview, students were also asked if they were willing to continue with the research process and were asked to once again sign the informed consent to ensure autonomy of the research participant. All four participants remained in the study through its entirety. Students were compensated for their time with \$20 for each interview. Students were informed that they would not be denied compensation should they have decided to terminate their research participation at any time.

Informed Consent

The researcher obtained informed consent from all persons identified to participate in the study prior to the collection of any data. The process of informed consent meant that individuals were advised of all study details, which included but were not limited to title and focus of the study, method of data collection, duration of study, along with risk and benefits. Participants also understood that they could voice any questions or concerns at any time. Additionally, an agreement to participate in the study was freely made, without any type of coercion (Christians, 2005; Munhall, 2007b). I provided a full explanation of the research query and then when participants were willing to participate, an informed consent was signed.

Narrative research brings stories of human experiences to light; these moments of reliving past events may be ones of enlightenment or regret. At any point and for whatever reason during the research study, participants were aware that they could decide that continuation in the research study was not feasible. For this reason, renegotiation of consent to participate in the study was ongoing. This allowed for study participants to opt out if necessary (Clandinin & Connelly, 2000; Hardy, Gregory, & Ramjeet, 2009; Munhall, 2007b).

Protection of Anonymity

Confidentiality and anonymity was maintained to provide protection for the participants in the study. In doing so, participants were allowed to pick a pseudonym to protect their identity within the research study. Interviews were taped recorded and then transcribed; therefore, the pseudonym was used in all of these research documents. The pseudonym was recorded on the demographics page that included data that could identify the participant; however, only the researcher has access to these data files with identifying demographics. Additionally, these items have been protected in a secure location by the researcher during the study and will remain for at least five years following the completion of the research.

Interviews and Follow-up

Interviews were the source of data collection for this research query. To accomplish a storied approach and collect data for the research aims, two 1-hour interviews from each participant occurred for data collection. During the interview process and with follow-up, participant checking of data occurred to allow the participants to be a part of the research process and ensure that their stories were recorded correctly. This process also allowed participants to corroborate the analyzed data and themes that were identified by the researcher, which leads to valid picture for the aims of the research study.

Study Design

Research Setting

The aims of this research study were to obtain stories from student nurses who experienced vertical violence perpetuated by clinical staff registered nurses during their clinical component of their nursing education and how these experiences shaped their

professional identity development. Four participants from a baccalaureate nursing program at a university located in the southeast United States agreed to participate in the inquiry in order to understand if and how vertical violence affects professional identity development and if nursing students view this phenomenon as a rite of passage into the ranks of nursing. As previously identified, the study utilized a narrative approach and focused on analysis of content from the data collected.

Sample Selection

Sample selection in a qualitative study is often smaller than its counterpart, quantitative research. The goal of ensuring an appropriate sample size in qualitative research is to have saturation of the topic, illustrating that the focus is on meaning and not a rate of occurrence or randomization (Morse, 2007; Zuzelo, 2007). Therefore, the researcher aimed to find a sample that would address the needs of the study, participants that had experience with the phenomenon, which is also known as purposive sampling (Creswell, 2007; Morse, 2007).

For this research study, purposive sampling was utilized. Participants were sought from a generic baccalaureate nursing program in their final year of nursing education and had encountered violent behaviors from a clinical staff registered nurse during their clinical rotations. Data saturation determined the sample size, which occurred with four participants. Therefore, following these sample guidelines and securing the sample during the final year allowed students a better understanding of whether vertical violence affected professional identity development and rite of passage into the profession.

Instrumentation

Qualitative research methodology mainly employs the researcher as the instrument and this is no different for the narrative method. However, a demographic tool

(see Appendix G) was utilized to maintain anonymity with research participants' code name as well as other demographics. Additionally, distinguishing the final year of nursing school and the acknowledgement of at least one actual encounter of vertical violence was necessary. The demographic tool assisted the researcher by providing evidence of vertical violence encounters perpetuated by a clinical staff registered nurse in the student nurse sample.

The main instrumentation for narrative inquiry was the researcher-participant relationship. Narrative data existed based on stories of experiences from participants. These data can also be seen in visual, oral, or written sources provided by participants, but the stories were told to understand the full meaning (Riessman, 2008). This research was conducted using the narrative approach via interviews allowing the participants to tell their own stories of vertical violence. An interview guide was utilized to facilitate the process (see Appendix A). From the interviews, a transcript was produced and analyzed and this data was checked with participants to ensure accurate meaning of interviews.

Validity and Reliability

Establishing validity and reliability within the qualitative paradigm is much different than statistical analysis in the quantitative framework. Every researcher must be concerned with these issues and constantly strive to understand whether the research is valid to the profession and if the research findings paint an accurate and reliable picture. Even though there are differences that exist between the paradigms, there are still many different facets to explore in narrative research to ensure valid and reliable findings.

With narrative inquiry research, participants share their stories of the phenomenon of interest with the researcher. The researcher must then reconstruct the narrative and analyze the contents of the data, prior to reporting the findings. Hence, the concern with

validity using the narrative methodology is two-fold. Initially, the first concern of validity for the researcher is the story of the experience told by the participant. These data provided is first-hand knowledge to the participant only (Riessman, 2008). Therefore, the researcher must be an active and avid listener and ask for clarification as needed. The second issue with validity lies in reconstructing the interview data into transcribed narratives. To ensure that the transcribed data are clear, input was verified with the participant, which further produced validity for the study. This verification of data with participants is referred to as member checks and is regarded as the most substantial method for determining legitimacy by Lincoln and Guba (as cited in Polit & Hungler, 1995).

Reliability of the study was justified through intercoder agreement. Intercoder agreement occurs when other researchers review transcribed data and concur with the stipulated meanings procured from the data (Creswell, 2007). Therefore, to ensure intercoder reliability for this research study, data was transcribed and the dissertation chair reviewed the transcriptions for consistency of findings.

Data Analysis

To conduct data analysis for this study, there were several issues that had to be considered. The research questions directed the interview process, but also guided the analysis process. Data was produced from tape-recorded interviews and analyzed for structure and themes. Examining stories of vertical violence, how vertical violence affected professional identity development in student nurses, and what students believed about violent behaviors as a rite of passage was accomplished by structural and thematic analysis.

Structure and theme are a part of all narratives. Narratives are stories that capture experiences of everyday life as occurring in a given social situation (Labov & Waletzky, 1967) and analysis of these experiences can yield new knowledge. According to Labov and Waletzky (1967), “. . . the basic unit for analysis has been a substantial piece of thematic material, defined at various levels of abstraction by the type of action referred to” (p. 13). Both structure and theme are intertwined. Structural analysis for the researcher began by examining the simplest of elements, the narrative clauses and the temporal sequencing. As participants conveyed their stories, embellishment and extraneous details were included that interrupted the temporal sequence, but during data analysis as the researcher reviewed transcripts, the sequence was identified. According to Duffy (2007) when reviewing structural analysis proposed by Labov and Waletzky,

. . . narrative data are coded by examining the narrative line by line and identifying the abstract, which introduces and summarizes the story; the orientation, which provides contextual details of character, time, and place; the complication, which describes critical events in the story; the evaluation, which outlines the meaning and implications of the narrative; the result, which provides the outcome or resolution of the story; and the coda, which describes how the storyteller brings the events and meanings of the story back into the present. The researcher then fashions a new story emphasizing the key structural elements of the narrative and how they have come together to form a particular story with a particular meaning pattern. (p. 413)

It is through this structural analysis that content of vertical violence narratives was analyzed and themes identified.

Limitations

Conducting a narrative inquiry requires the researcher to trust solely on what the participants convey in interviews on the phenomenon of interest. This required each individual participant to look back on experiences of vertical violence and discuss possibly painful and/or demeaning experiences with the researcher, which could have been a limiting factor. Students were at times hesitant to provide all details of the experience, but were allowed to express each occurrence at their own rate and in their own words. An additional limitation was the sample size. The sample was limited to four participants. Therefore, a larger sample size might have produced more definitive findings.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Introduction

Nursing is a caring profession but unfortunately is plagued with a disease that can spread throughout the ranks and produce vile effects. This disease is known as vertical violence and can affect the very young of the profession, student nurses. This study has been conducted to understand certain effects of the phenomenon of vertical violence on our student nurses. The specific aims of this research are (a) to have student nurses describe their stories of vertical violence (b) to describe how vertical violence shapes their professional identity as a future nurse, (c) to determine if vertical violence stories as presented by students is believed to be associated as a rite of passage into the nursing profession, and (d) to understand if transformational leadership theory can assist in fostering a positive professional identity.

Data Collection

Data collection occurred on the campus of a university located in the southeast United States. Participants for the study were enrolled in their senior year of the generic Bachelor of Science in Nursing program. Four participants consented to the research study, completed the demographic questionnaire, and selected a pseudonym so that confidentiality could be maintained. Two 1-hour interviews were then conducted with each participant and were recorded to ensure accurate collection of stories associated with vertical violence. The interviews were then transcribed and analyzed by the researcher for common themes. Validity of original interview was performed by checking data through the follow-up interview with each participant. Reliability was accomplished through intercoder agreement with the dissertation chair.

Participants' Stories

Harry

Harry is a 21-year-old male nursing student who experienced vertical violence on at least three different occasions throughout his clinical rotations from a clinical staff registered nurse. His very first clinical experience was plagued with degrading remarks that left him feeling belittled and doubtful. His self-esteem and confidence took a blow as he experienced vertical violence one semester after the next. This is Harry's story of those three encounters, which he experienced verbal abuse, along with ignoring, rude, and humiliating behaviors.

The first time was the very first day of clinicals. We were all really, really nervous because that was our very first day and there was ten of us. We each had one patient to help and then at the end of the day, I guess she was charge nurse, we were all in a huddle getting ready to leave, and she leaned over and told her coworker, "Out of the ten of these, zero are going to make it." I thought that was just one of the most rude statements you could say just because it was our very first day there and we were already uneasy and not really confident because it was our first day on the floor. You know we had only been at nursing school for a probably a month, and I just thought it was really, really unprofessional and rude.

We each get one rotation in second semester to go to the operating room, and, so we all get to go to surgery. It was my day to go. Our very first semester we were all at hospital A, and then second semester there was a group of ten that had to stay at hospital A, while everybody else could go to hospital B. The clinical instructor who taught us worked at hospital A, so she had to just do her stuff at hospital A I guess. So it's the first day of OR (operating room), and it was

my time to go. I went down there, and it was like nobody wanted to help at all. I said, "I'm here with Southern to job shadow" and the guy literally said, "We don't like student nurses." I was like "Okay." I then said, "Well, you know, I'm going to be with you all day." He said as he called another nurse over, "He's going to be with you today." That nurse said, "Ugh, why?" I was thinking they do not want me here and it's so apparent. There was all these opportunities that I wanted to get to see and it's like none of them wanted to be involved in helping me whatsoever. I felt like more of a burden. I get back to Southern and I get to talk to everybody else who was at the other hospital, hospital B, and I got to hear their experiences and they just loved it. Some are even thinking about "Oh I want to be an OR nurse" and I so wanted to be an OR nurse so bad and I hate it. I tell everybody that was one of the worst experiences in nursing school, like I absolutely hated it. I don't want anything to do with OR now because of the way they treated me; I just couldn't stand it.

We were on the floor and it was kind of a slow day. There were a lot of discharged patients and we were kind of just looking for something to do at this point. I know me; my patient was discharged so I wanted to help all the other nurses with their patients just because I didn't have anything to do. So, I went up to one nurse and I said, "Do you need any help doing anything?" She said, "I don't want your damn help." I was so taken aback that I said, "Okay," and I walked off. I was so insulted. Even if you don't want my help, there are so many nicer ways to go about it than that.

After Harry discussed his actual experiences with vertical violence, he shared with me how these occurrences made him feel. Not only did he question his abilities, but he lacked the desire to go to clinical and was overcome with fear.

Well the first one, the one when she leaned over and said none of us are going to make it, that broke my confidence completely and my confidence already was really low just because we were all really scared. It was our very first day and so to hear that and for somebody you know to say that they're not going to make it and they're not good enough, it gives you a thought of what if I'm not good enough, what if she sees something that's not good enough. So that broke my confidence, which now I look back and think it's ridiculous because I know I'm competent in what I do but I just felt like it was a comment that was so unnecessary. At that point in time, my first experience going to the hospital, I completely lacked any confidence in myself and for the next few times we went to the hospital, I second guessed everything I did because I wondered if this is what I should be doing? I was just nervous, really nervous to go to the hospital because I was afraid everything I was doing was just wrong because of her comment about none of us making it. When the woman told me that she didn't want my damn help, well, that was just so offensive. That made me look at nurses in a different light because we're supposed to be this caring profession, we're supposed to be this nurturing profession, and she is going to use profanity when all I'm asking is if she needs any help or if she needed me to do anything. That just made me think she was miserable in what she was doing, like she absolutely hated nursing. She was always just so rude about stuff and finally for her to use profanity against me it was just like you treat me like crap I wouldn't want you to be a nurse to my

mom knowing you're going to come out of the room using profanity against a student nurse. I wouldn't want you to be a nurse to my family member more less me. It kind of made me look at nurses in a different light because in this caring profession you're dealing with vulnerable people, so what do the nurses do when they walk out.

My first semester with the woman who told us that none of us were going to make it, every Thursday, which is the day we have clinical, I did not want to wake up & go to clinical. It was a nightmare, more than anything just because I was afraid. I always had to second guess myself. I was afraid of doing something wrong, because I don't want people to think that I'm not competent or I'm not going to make it. So, I always feel like I have to prove to people that I am competent; it is so stressful to go to clinical and to think that I have these nurses breathing down my back and judging every single thing I do. So for the first few weeks, we went to the hospital, I completely dreaded it.

One of the major concerns of this research is to understand if vertical violence has an effect on professional identity development in student nurses. Harry and I discussed his eventual return to a more determined state to accomplish his goal to become a nurse.

Well like I said, in the beginning, I had really low self-confidence & yes I gained it back. I think about those times I was in first semester, like the really, really low points and they say what doesn't kill you makes you stronger, but it just makes me want to be the nurse that they aren't. When I become a registered nurse, get my license, and go to work, I want to always remember what I went through. I don't want somebody to go through an initiation phase. I don't want us to have a student nurse be treated like crap and I just know that when I become a nurse, that

it's made me realize that I'm going to always remember where I started and I'm going to always remember that first semester of nursing school when I felt so low. I have always told myself that I will never ever make someone feel like that when I'm a nurse. I want to be the nurse that the student nurses say that they like to have, that they want to work with, and that teaches them. I want them to say that he is the nurse that I want to work with that day and he is the nurse that I want to be one day. I don't want, in the future, for student nurses to say he's negative and we don't want to be with him or work with him because I'll always remember that first semester of nursing school and how low I felt.

Harry mentioned an initiation into the professional ranks of nursing. An additional research aim for this study was if student nurses believed that vertical violence could be seen as a rite of passage into the career path.

I believe that some nurses definitely treat it that way, like it's a rite of passage. There are some nurses out there that think of it that way, which is awful, because I don't think of it like that at all. As I'm going to be a future nurse, I'm not going to think of it that way at all. So, it's sad that some nurses feel like it's a rite of passage, but they feel that way. I feel like there are some nurses that will pick their favorites and people that aren't their favorites, they will treat like it's a rite of passage, like it is initiation. They will treat them badly.

Harry held firm opinions regarding care to family and friends by nurses who victimized others through vertical violence. He expressed his beliefs that vertical violence can have negative effects on recruitment and retention into healthcare organizations as well as the nursing profession and why he considered it necessary for nurse leaders to be aware of this phenomenon.

As a student nurse, I have to think when I graduate, where am I going to get a job? I know that I'm not going to apply to hospital A, because I know how those nurses are; how some of the nurses are. It's sad that certain groups of nurses can ruin a whole facility in somebody's eyes; just by the way they treat people. I just wouldn't want to be associated with people that are so negative. They say birds of a feather flock together; well, I wouldn't want to be in that flock. I wouldn't want to have to go to work with people who treat student nurses and patients in ways that I don't think is really right. So, I do think it does affect recruitment & retention.

When discussing the necessity for nursing leadership awareness of this phenomenon, Harry strongly agrees in the need and to possibly improve recruitment and retention.

It needs to be made aware! One hundred percent needs to be aware! There needs to be an end to this or there needs to be repercussions for nurses who do it. There needs to be awareness to the fact that it is happening. It's so unfair for people higher up in power to feel like they can treat people who are on the lower end of the totem pole badly. That is not right. They should be the ones helping us and who are weaning us into these positions, instead of treating us so badly. Like I said, I go to the point that it completely broke my confidence and I know that I am going to be an incredible nurse. I know I'm going to be awesome at it and I'm 100% confident in that. It would have been sad if I would have quit just because I felt I wasn't good enough because of that one nurse. If that would have been the case, the world would have been missing out on one awesome nurse. I feel like it should be 100% made aware of because of situations like I went through because I almost quit! I almost said I don't want to do this anymore because of the way

she made me feel and if that was the case then I wouldn't have been a nurse and I know I'm really good at it.

Most definitely, it should be a concern! For future customers/co-workers, just like I said, I would never want to go work at a hospital where I have seen nurses treat people badly. I don't want to toot my own whistle, but I'm a really good nurse and I know that hospital A, that facility that may be treating people badly, but I won't put an application in there. It is unfortunate for them because I know that I'm really competent and really good at what I do and I know I am not the only one out there that feels that way. If they aren't made aware of it, they could be missing out on some really good nurses/future employees. This needs to be made aware of for this reason as well.

Believing that nurse leaders must be aware of vertical violence, Harry was asked to describe characteristics that he felt would be most beneficial for a nurse leader or a positive professional role model to possess.

Respectful would be a good one. Nurturing is another one. I would say, just having a will to teach and having the will to really just show us the ropes.

Harry was asked to clarify what he meant to have a will; would he classify that as a spirit/passion?

A Passion! Yes, being passionate about just what you do. We look up to nurses as what we will be one day. As a student nurse, we see a nurse and we realize this is going to be our job one day. It's really unfortunate when we have these nurses who feel miserable about what they do. When you have those nurses that are passionate and they love what they are doing, you can just tell when they go into to work. This is just what they want to do and they want to be there; that is a

really good thing for student nurses to see. On the other spectrum, if you have a nurse that comes in and she is miserable and obviously doesn't want to be there, then it makes you feel like nursing is a job that you wouldn't want to go in to. So, definitely passion, but respect is huge as well, because you want them to respect their co-workers, patients, student nurses; you want them to be respectful and an all-around good person.

After many difficult semesters of being a victim of vertical violence, Harry finally started to believe in himself once again. His confidence began to resurface in his senior year and he once again felt as if he was competent. Harry realized that while vertical violence remains a part of the profession at present, it does not have to be that way. With awareness of the phenomenon by nurses and nurse leaders alike, we possibly could decrease the occurrence of violent behaviors.

Princess

Vertical violence behaviors that were described by Princess included ignoring behaviors, rude and humiliating comments, and withholding necessary patient information that was essential for patient care. Princess completed the demographic questionnaire noting that she had on at least four different times been the victim of vertical violence. She described incidents where nurses were not helpful and basically ignored her existence.

I guess really the first times I ever experienced anything like that was my first semester in nursing and maybe it was because I was new to it and really didn't speak up. We were at a different hospital at that time than where I have worked at since that rotation. We were at hospital A and now we are at hospital B. The first semester there, all of the nurses were not very helpful. They knew you were

waiting on them, but they're still not going to give you the time of day because they're busy, so you're not their number one priority. The same thing with charts; they know you are waiting on a chart, and yet they're not really doing anything with it, but they're not trying to help you get any information. If you have to go pick up information, you're going to be there for hours when it should take really like 30 min to an hour. I think they definitely could have been a lot more helpful. They could have done more if they wanted to help you. I mean if they were trying to be, they weren't going out of their way to help you out; they knew that you were waiting. They were not in any hurry to do anything, so yes that would be withholding information. It's the same thing as when you go into get patient information. They are like "I don't know what patients you need," because I guess that takes time out of their day. A lot of the ignoring occurs like the fact that they knew we're there; they just kind of act like you're in the way.

Princess continued to identify other rude and humiliating experiences in her clinical rotations. She witnessed non-verbal body language that made her believe that clinical staff registered nurses wanted nothing to do with her. All the while, she was a student trying to learn and grow in the profession, but had limited knowledge of facility policies and layout; all she wanted was to be of help and receive help as she learned.

My third semester, I was working my peds rotation, and it was my first time being on the floor. We had kind of viewed it before, but we didn't know where anything was. I walk on the floor and I meet my nurse and everything seems fine. Nothing really jumped out at me; she wasn't really mean. I've never really had a nurse be just mean. I asked her "what can I do" and "was there anything I could do for the patient?" I was trying to discuss with her about the patient. I was discussing what

was wrong with him and she just doesn't seem interested in talking & is kind of stand offish. I was just like, ok you know I won't bother her that much, but I was like "are there any meds that I can give" and she just like gave me a whole list of things to do and was pretty much just go do it. We're not allowed to do all that stuff by ourselves. She was just like go get this antibiotic, go get these meds. I don't know where any of this stuff is. I don't know any of the codes for the med room. So, I was asking her questions and she was just acting like oh can't you do anything on your own and giving me like a lot of attitude.

While she described this incident along with all of the non-verbal body language she received, Princess' vocal tone took on one of complete and utter disgust for her attacker.

I could just tell all of the kind of gestures she was giving me, all of the body language was pretty much saying, "I'm annoyed with you," and "can't you do anything on your own." Like I said, I didn't know where anything was and I had never given some of the antibiotics she was telling me to. She walks in there because I was looking for things and there's like 50 million drawers in there. I had pulled them all open and she's like "Here," and "here is this," and then she says "Did you look in the fridge." I was thinking how am I supposed to know where anything is and I had never been here before in my life and she was pretty much condescending, and acting like, "you should know this."

During the above interaction, Princess did report that the nurse did not yell when she said "here," but did say there was a difference in her vocal tone.

There was a different inflection, almost like "are you stupid" or like I was dumb or should have known all of this stuff. I went with my instructor to go give the

meds and I remember her telling me what to do. My instructor was giving me step by step instructions and it should have caught in my head that I was supposed to flush before. I was just listening to her and not really thinking like I should have been and it was a screaming 2 year old, screaming, flailing, and the nurse wasn't even in there to help. We were holding her down. The students were holding the child down. The nurse gave no instruction, she just said go in there and change the dressing. Well, what did she want me to do and what should I use? It was like pulling nails. I would go in there and ask her a question every five seconds, because she never really gave me any instructions. She just said "go change that dressing" and "get someone to help you hold the child down." So, it took me like multiple times to go in there and ask where all of the supplies are, she said "it's supposed to be in the room." I go look in the room. There's nothing in the room. She then says, "Well, it should be in the supply room." So, then I have to go find someone to give me the code to the supply room. You know it just went on and on. I could have been done with it a lot sooner if she had been like "ok, I need you to go change this dressing, all of the supplies are right here." You know what I mean, if she could have given me some type of direction.

After the nurse refused to come in and provide assistance with the care of this child, she finally entered the room only to criticize what had been done by Princess.

After we gave the antibiotic, we went in there because it was like a little bit wet underneath (the IV site) or something and so she wanted to change the dressing. I knew she was mad at me and I came in there to help her. She said, "Did you flush," and blah, blah, blah. While we're in there with another nursing student, and I didn't do this because I was the afternoon shift, but the morning shift of

nursing students from the same school, had changed the linen and they had piled it high in the room. We're supposed to take the linens out. If I was to do it, I would take all the linens to the dirty linen; I'd go ahead and do that at the time, but it was piled high out of the dirty linen cart. While I was helping her change his dressing, in front of the family and everyone in there, she was like "That is ridiculous, that is unacceptable, and you need to take that out." She was like really condescending, putting me down, like humiliating me in front of the family. I thought I'm here to help you, not for you to feel free to talk down to me and like give little things for me to do. I hadn't even been in there much. I gave the antibiotics and then went to go do other things like change the dressing. I hadn't even addressed that and hadn't even been there that long and she was like you need to get to that right now. It was like I couldn't do the thinking on my own kind of thing. Then when we had to stop the antibiotics and flush again, it was like a blatant statement in my mind because I had brought everything I needed to flush and she left a thing to flush right there. I knew it was her like don't forget.

After this encounter with the nurse, Princess spoke with her classmates in the hall about the experience and realized that the other students had similar experiences with this same nurse.

I was talking in the hall to the other students and she was doing the same thing to them. She was treating them like they should know it and that they're just stupid for not knowing it, and being condescending. So, it was not just me, it was all the other students.

Princess referred to this experience on her care plan, when she was completing her clinical paperwork. During the interview, Princess confided in me that her clinical

instructor and this nurse were friends and also that this nurse served as a preceptor for the college.

She was an experienced nurse, from what I heard she was actually a preceptor for our school. I talked to another instructor about her and she said, "Oh, well she's a preceptor for our school; we use her." Well, I said, "I would not put any students with her, she's not helpful." I would never want to work for her. She ruined peds for me. I would never work peds. It's not like I would have chosen it before, but it ruined my peds experience. I didn't enjoy it at all, because of that one bad experience and I wrote it in my care plan. When I wrote my care plan, I wrote "I do not suggest that any students work with this nurse. This was an awful experience and she was condescending and not helpful." My teacher didn't really address it. I really don't think, but she said, "I'm sorry if you didn't have people being nice to you." I mean she wasn't like rude about it or anything. She was just kind of like, "I hope you got a nice nurse this week," but that's really all she said.

As Princess finished this statement, she was tearful and her voice was quivering.

I was really angry, because I've had lots of great experiences with other nurses like on other floors in past semesters. Most of the time I run into nurses that want to help you and want you to watch, want to let you learn & that's what I usually run into. I've never experienced someone that was blatantly being condescending and didn't want to help at all. I've just never run into that, so I was just kind of taken aback and didn't expect it. I didn't know how to take it.

I mean I felt humiliated; especially when it was like in front of other nursing students and the family. So, she put me down because I'm like someone who is supposed to do the lower work because she knows what she's talking

about. I'm like if you gave me any direction and real instruction on how to do something, I would do it on my own.

Princess never really said anything aloud to this nurse, but only had these thoughts to in her mind. Although, she did say that she mumbled several things under her breath, but saying nothing to the staff, as she walked down the hallway to re-join her classmates.

Oh trust me; I went down the hall saying some inappropriate things to some other students for sure. I never, I'm the kind of person who never, even if I don't like what someone does, I'm kind of like level headed and the person doesn't bother me, but she made me really mad. I was definitely going down the hall saying, "She does not need to be working with kids." How does she work on the peds floor; she does not have a caring bone in the body.

While these were the major incidents with vertical violence, Princess recorded on the demographic that she had been privy to approximately four occurrences. When asked to describe the other experiences, Princess stated that these were the ones that were most prevalent, but the others were basically comprised of overall rude and ignoring behaviors.

Like I said when I first started, those were like the ignoring and stuff and that was really at a different hospital on the floor that I worked at all the time. So, it was kind of like multiple experiences of the ignoring and not being helpful, but those kind of glaze over in my mind. This is the experience that sticks out in my mind that has ruined it.

Princess continued to focus on this incident, because this seemed to leave the largest impression on her. Therefore, we re-visited her comment of "not having a caring

bone in her body” with relation to the fact that nursing is thought of being a kind, caring, and compassionate profession.

Well that’s what doesn’t make sense to me; why wouldn’t you want to make better nurses? The way I look at it is we’re the future. I’m not here to take your job; I’m just here to learn. If this was you, wouldn’t you want to treat other nursing students how you would want to be treated? I for one would never treat someone like that. I don’t want to make someone feel bad. I know it’s hard as a student now. I know it’s difficult when you don’t know what to do or haven’t done something before. I know how important it is for the nurse to make you feel better about things you do right. It empowers you (the student), but instead I don’t know why they want to make you feel like you are lower. I don’t see what that does for them. I don’t know if it’s like a power drive like I’m just above you and I don’t have to give you the time of day. I don’t know if it’s that, but when she was interacting with patients she was not super friendly. I’m not saying she wasn’t or didn’t do what she needed to do, but she didn’t take any extra time out. I mean, I could see it reflected in her work, I think anyone could tell that she wasn’t like the nurturing type just from watching her with other people too. I think you could tell it’s not just with nursing students; she didn’t seem like the nurturing type in general.

Princess mentioned a “power drive” as a possible notion of how this nurse could treat her and others in this violent manner. I explained the theory of oppression as a potential mechanism of violence and queried Princess as to whether she believed this was pertinent as a causative factor in vertical violence.

Yes, I could see that. I mean she obviously did it to other students. Well I mean I had other students the same day that were also with her, had another patient with her, and she was the same way to them; same condescending way. So, I just don't know how she could be a preceptor and nobody ever noticed that she was like that. If I probably had to deal with her again, I probably would have taken further action. I'm the kind of person who if you make me mad or kind of rub me the wrong way the first time, I'll take it. I'll take that one thing and I might give you a second chance or see how we interact the next time, but I didn't have her again. So, I mean I think she was there, but I never had her again, so I never really pursued anything.

Avoiding this nurse would have been the path that Princess would have chosen, but each time she returned to clinical, she stated she felt fortunate that she was not the nurse assigned to her patient.

It was kind of the luck of the draw but at the same time, we would try and think will she be on today? It was the other weeks that we had the chance, but we worked with partners a lot of the time because there were never any patients really on the peds floor, but I just happened to not get here the other two times. I just didn't get her, but I probably would have switched patients or I probably would have said something like I don't want to work with her. I just can't believe that she doesn't have any complaints as nasty as she was.

It was very apparent that Princess was bothered by her encounters with vertical violence. She expressed anger which was an emotional response of the attack and one that is understood given the circumstances. However, Princess described several other physical and emotional effects of the vertical violence.

I had some headaches. I mean she definitely stressed me out a lot more because she felt like I should be on this higher level or that I should know a whole lot more than I did. So, definitely increased stress, but it definitely made it stressful and I was just intimidated. I was just waiting to make the wrong move; waiting for her to be like oh, you're doing this wrong; be unhappy with something I did or criticize something I did. I felt like questioning myself such as, "Do I know what I'm doing" and "can I do this?" It didn't really make me question nursing, but It definitely ruined my peds experience. I definitely didn't want to go back to that floor. The first week and another week I ended up in the NICU so I didn't have to deal with it at all. So, the first week on the floor, luckily I only had one other week on the floor, so I'm sure if I had gone more often I would have had her again. Like I said, questioning myself, maybe like questioning my self-confidence was what she did. If I had the confidence to initiate or really do those tasks by myself, she made me feel like I didn't know what I was doing.

Vertical violence plagued Princess's clinical experiences from the very beginning and seemed to be worse in third semester. Therefore, to be subjected to such negativity over the course of her learning, could her professional identity development have been affected? Princess detailed how she began to question herself all of the time and she expressed wonderment of how a caring profession can expose others in our ranks to such behaviors.

Well it made me question myself more than what I was before, because in third semester, I was doing really well. I mean good grades, probably the best I've done in nursing school. So, I thought everything was going great and then that put a big dent in things. You know, I was thinking am I really ready to go out into the real

world? Can I deal with all this stuff? Like I said, it ruined peds for me. It definitely did. Not like I would have ever worked in that, but it made me hate peds over all. I would have never said I hated it, maybe it wasn't my favorite, but it put like this negative connotation with my pediatric classes. It definitely made me not like that it all. We should be helping each other. We are working in the same profession. Why are you trying to hurt the people that are going to be taking care of your family or you one day? Why do you want to stop them and cripple them from learning to be the best that they can be? Why don't you want to encourage them and teach them the best that you can? That's the only way that you get better, by learning from other people and if you're hindering that, what are you really doing? You're not just hurting them, you're hurting other people that they are going to take care of. It might not be the best that they can be. I definitely know that when you feel like you lack confidence, you question yourself such as what if you make the wrong decision or don't make the decision quick enough. That's kind of how I feel about it. I wouldn't want someone to go through what I went through. That's the way I think about things. With a negative experience or when someone's really mean to me, I want to shelter other people. I don't want that to happen to them. I want to be the opposite of that. I want to make things better. I mean that's my take on it. I wouldn't want to be that person. I wouldn't want to be viewed like that, like I viewed her.

Another area of concern regarding the phenomenon of vertical violence was if Princess believed her story was indicative of a potential rite of passage into the profession and whether she believed that this particular nurse in the pediatric rotation was practicing this rite. Princess also believed that many nurses practice this belief.

I think that maybe she thinks that nursing students are below her. I definitely think that she thinks that. I think that she thinks that we are definitely not of the same playing field and that we're not on the same level as her. I definitely believe that there are a good many out there. You know there is probably someone on every floor that does that to somebody. There's always going to be that one person; you know the one bad egg. I know it probably happens a lot; it's just not talked about as much or there's that person who just deals with it every day. They just keep their tail between their legs and will just do their work the best they can.

The disillusionment continued for Princess as she talked about the past and present events of her educational life and how it has affected her and her current beliefs on the healthcare system. Princess expressed that the impact on healthcare and the profession of nursing with recruitment and retention could be detrimental if the progression of this disease is not altered.

It definitely affects recruitment and retention! If I had to deal with that every day, I could see people who don't brush it off as easily as me or weaker than me, I would quit if I wasn't as motivated. After I went through all this school, I could definitely see losing a lot of nurses to this for sure. Like I said, if someone treated me like this all the time, I wouldn't want to go to work. I wouldn't want to there anymore. If it kept happening in different places that I went, I would quit. I understand and I'm sure that people get fed up with it and feel like they can't do anything right and maybe made the wrong decision. I mean, if those people who have those bad experiences tell other people, who would want to be a nurse? Who would want to be a nurse if you thought that all you were going into was people putting you down, just because you were new? I don't think that's right. I didn't

plan on working at the hospital where I was. I wasn't planning on working there in the first place, but yes it is definitely not on the top of my list. It dropped a little bit after the experience! I probably wouldn't want to work there and I definitely wouldn't work on that unit. It would definitely be lower on my list. If I had the choice between two hospitals and they were both about the same, then, yes that experience would weigh on my decision. I would put that one below whatever else I was deciding between.

As Princess continued about recruitment and retention, she continued to focus on the nursing profession. She conveyed that nursing is a very rewarding profession, but requires an extensive commitment.

Nursing is already a hard profession as it is. You're already looking at the daunting task of finishing school and they know that the money is not going to outweigh all those bad things that they have to deal with such as vertical violence and someone putting you down every day. The long hours, it's not easy work, and it's a profession where you do all of this stuff and nobody really realizes it; you're under appreciated. Add on top of that, the work place is miserable and nobody's going to want to go do that. Everybody always says to me, "Oh gosh, nursing school is so hard. I could never do that." That's just about school and I could see people getting into to school and saying nursing school is already hard, why do I want to deal with this for the rest of my life? Why do I want to go into this and deal with being unhappy for the rest of my life?

The halting of vertical violence must begin somewhere and as we talked about this topic, our concern was where it must start to be recognized as a significant problem

for the nursing profession. Princess shared her opinion as to why she believes that it is a necessity for nurse leaders to be aware of this phenomenon.

I feel like a confident happy nurse is going to do a better job than someone that is miserable at work who doesn't want to be there. Just in that sense and then in the turnover, you're going to be getting new nurses in all the time. If there is one nurse making every new nurse miserable, you're not going to be retaining those nurses. Better patient care, being more pleasant to patients and more pleasant to one another leads to a better job for all, because they may be miserable and making someone else miserable. You know the oppressed person could be doing that to someone else such as another new nurse coming in. When you feel like you're friends with everyone and everything is happy, you're happy to be there. I would like to work there. I would love going to work if I had friends and we were all close. It sounds like definitely a better place to work.

As we discussed a happy work environment, I asked Princess to describe an ideal mentor who would be a positive profession role model. Princess provided characteristics that she believed would foster a confident and optimistic professional identity development.

I guess her loving her job. I love meeting nurses that love their job because that makes you feel like, "Oh this is what I want to do." They love their job. It makes you feel empowered and encouraged; somebody who respects everyone whether they are there as lowest on the totum pole or not. I mean I respect someone who respects other people. Also, caring is important. If I see them working with patients, being nurturing and caring to the patient, which makes me want to do the same thing. I see them in a positive light, knowing they're going to do the right

thing and have integrity. This is just what I like to see in a good person, if they are trustworthy & dependable. I expect them to have good qualities as a person and professionally, to do their job correctly and be good. Also, to lead by example because if I see you doing something right then, I want to do it because you can't cut corners. I've experienced that in high school. There would be four managers and they would do everything that the nurses do. This shows you that they don't think they're above anything. They're not above doing all the things that just the floor nurses do. They'll go in there and pick up something off the floor. They'll go in there and do the smaller stuff like help you change linens. When you see them like that it tells you that they care about the job. It's not just about a title to them. It means that they are still the same person that they were when they started. They still respect and know that your job is hard too. They love their job, they love other nurses. They want to empower everyone else to make them better.

Episodes of vertical violence hampered the learning environment for Princess.

Her perpetrators were mainly rude and withholding of information, but during the third semester this last episode of vertical violence seemed to cripple her. She would only remember her pediatric clinical rotation negatively, because the violence overshadowed anything that she took away. However, in the end, she persevered in her beliefs in the profession of nursing and remained in her nursing program as her confidence began to improve once again.

Kelsey

In completing the demographic questionnaire, Kelsey indicated that throughout her clinical rotations, she had experienced greater than five episodes of vertical violence perpetuated by a clinical staff registered nurse. Each hospital that she attended for clinical

employed registered nurses that were hostile in one way or another. The violent behaviors that she encountered were ignoring behaviors, withholding necessary patient information for nursing care, and one nurse yelling.

Initially, I asked Kelsey to describe her story of vertical violence that she experienced in two hospitals that she referred to as Hospital A and Hospital B. While the first clinical experience is always scary for beginning nursing students, when it is coupled with a behavior that is consistent with vertical violence, the fear is amplified. The following story is exactly what happened to Kelsey on her very first clinical experience.

I would say we've been at two separate hospitals recently, but at Hospital A this is where my first clinical experience ever happened. The first day we were there gathering information, which is the day before we actually go. It took probably 45 minutes for us to be able to go and actually access records and look into things. Nobody was really helpful; our instructor was even there trying to help us get patient assignments. It took, and I understand it was busy, but we were there I'd say, between 3 and 6 and or 3 and 5. We got there at 3 o'clock. All of us got there early, really bright eyed and bushy tailed and we didn't get anything done or we didn't even start until 3:45. They withheld charts from us for hours on end. We had to start partnering up because we knew we wouldn't have enough time to deal with waiting on patient information. So, our clinical instructor had to put up with us not having enough information to do post conference. The next day we showed up and I know blood pressure cuffs are kind of scarce so you have to wait on them. We let the actual registered nurses use them first if they wanted to and then we would take them. There was always somebody, one of the nurses, complaining about not having blood pressure cuffs because the students were using them. My

clinical instructor, she goes to the same floor like twice a week and her other clinical group had an incident happen where the chief nurse for the floor got really upset, so my instructor had to write up every nurse on the floor that day. So we come back the next week and they aren't very kind to us anymore. We aren't allowed to do anything besides check vital signs; otherwise, we really wouldn't have learned much that semester. We had to tread really lightly, so it wasn't really a learning environment. It was very hostile. We would have to try to go to lunch early and leave early. We would stay extra-long in pre-conference and post-conference so we would learn something. We weren't allowed to assist with meds. I don't think we did anything that semester besides vital signs and bed baths. They wouldn't even let us shadow them.

This violent behavior toward Kelsey and her classmates occurred the entire semester during every clinical rotation. Kelsey expressed true disappointment of the lack of a true learning environment.

The next semester, Kelsey went to a different facility, which she labeled as Hospital B. Once again, she experienced rude and ignoring behaviors from the clinical registered nursing staff.

We would show up right on time and wait for people to get off the phone so we could get a list from them. It took a very long time. Our whole clinical group would be standing around the nurses' station and they wouldn't try to assist us until at least 30 minutes later. That's probably our biggest issue was having people ignoring us. We even would say "excuse me" and tell them what we were doing and it still took a very long time to start. And then they gave us a list, and they would tell us which patients they thought we should get because it would

either be a good learning experience. They were more helpful than the last place anyway. Then we would go get charts.

Even though Hospital B had some nurses that would eventually be more helpful than Hospital A, there was one a nurse that Kelsey remembers vividly, which was because she yelled at her while she was standing at the other end of the hall.

There was one nurse in particular we had issues with on that floor. We would look and see who the nurse was assigned to on our room that day and if we had her we were kind of upset. Our clinical instructor would even try to talk us into getting another patient that morning and trying to work around it. I was one of those kids who believes I can work around it. I can do this. I'll deal with her today. It's good experience to help with the work place environment. In the future, you're not always going to get along with everyone. I guess there was a lack of tech nurses on the floor that day and vital signs weren't getting to the nurses as soon as they wanted them. We had the computer system there that tells us what time to do certain things and so we were waiting on our next time to check vital signs. We try to follow the schedule as best we can. It's there for a reason. This nurse just yelled down the hallway that she didn't have her vital signs for her meds that she was giving at the time. She started yelling down the hallway about how somebody needs to get on top of things, so instead of actually taking vitals herself, she decided to scream about it. This was my nurse. It wasn't my patient, but it was my nurse for the day, so we had to be cautious around her. I also had this same nurse on another day and she was in a little bit better mood, but she had some IV fluids to hang and we're not allowed to do anything unless our instructor or the registered nurse is in the room with us. I told her this. So, I went and got the IV

fluids for the patient. It was an antibiotic. I went into the room and the nurse had walked down the hallway. I went to go to talk her and I told her that I couldn't do this unless she was in the room or I could go get my instructor. It's really fine; I just need to double check the MAR against the physicians orders. Well she completely ignored me. She didn't let me look at the MAR even on the computer. She didn't check it against the physicians orders in front of me because that's acceptable too. So, I had to go get my instructor to give these meds and she had to go somehow and find a way we could check it against the MAR, so we could make sure it's what we were supposed to be giving. The 6 rights of medication are so important. We did that. I knew I wasn't going to sit there and try to figure out how to hang an IV fluid on my own. It was my first time hanging IV fluids so my instructor helped me through that. I don't know what possesses people to leave somebody stranded when they know that they can't do things. So that was an issue.

These were the stories of vertical violence that Kelsey was subjected to over and over during her clinical experiences. From these violent experiences, Kelsey suffered several physical and emotional manifestations.

We really did fear going every week. We all carpooled together, so we would always talk about the worst case scenario and how we could get through the day. Nursing school in general is pretty stressful, but you want your learning environment to not be so stressful. I had my childhood asthma come back because I was so stressed. The clinic here saw me a lot. I'm not on birth control, but I didn't have a period for 6 months and it was very traumatizing. I think those were the two most crazy stress things I had, but they were pretty crazy. I went to the

clinic just because one night I was laying in my bed, this was so upsetting, and I just couldn't breathe. I had to miss class the next day. It was first semester. I had to miss and I had to go to the actually clinic to get it taken care of. I saw a doctor and she told me that it was my childhood asthma. I'd thought I had overcome it, but it's mostly like stress and exercise induced. I hadn't been running that week so it was pretty crazy. I have my inhaler on me at all times now, but before this year, I didn't have any asthma issues at all.

These were significant manifestations that Kelsey suffered. She conveyed that they finally lessened when she left these clinical settings and only required her rescue inhaler if she exercised.

Kelsey faced considerable violence that resulted in multiple stress induced effects. Therefore, one of the specific aims of this research was how vertical violence affected professional identity development. Kelsey thought that it did affect her in certain ways.

I would say definitely so. First of all I don't think we learned much professionalism in those instances to mirror. We didn't learn any skills or anything and I don't think that is a very good learning environment. That's no way to train future nurses to be afraid of what you're going to be doing for the rest of your life. We should be excited to go to these places and we're just now feeling that now. I would say it has definitely taught me what not to do in the future! I think we are missing out on a lot, like learning a lot of diversity in nursing, how different nurses do different things. I think we have missed out on a lot, but at the same time, people also need to learn how to deal with conflict. I think that is something that our generation is really bad at. So, it's helped us in that sense but in terms of learning, I don't think it has helped us at all.

Kelsey voiced that she and others in her clinical group were fearful that they could have been missing out on better clinical experiences and this could have a negative impact on them.

While she sensed that she and her classmates in the clinical group were lacking in clinical learning, we continued to discuss professional identity development to identify any decrease in self-esteem. This process brought on several responses that reflected emotional issues associated with effects of vertical violence.

It makes you feel really dumb when people treat you like that, even though you don't deserve it, but at that moment you're not really thinking straight. We always felt really dumb and we would always huddle together for a team huddle to pep us through the rest of the day. In those little huddles, we would talk about how a lot of people would say that they just didn't know if they were going to be able to do this in the future. All of these things that these nurses are doing right, we are made to feel like we aren't apparently doing them right. Reason would then take over and we would realize that they were just being mean. I didn't doubt myself, but it's still pretty upsetting to feel like you are dumb per se when you know that you know the material. You know that you have studied up. You looked up the night before everything about your patient, all of his medicines and then out of nowhere, one thing happens and you just feel unprepared. I'd say as a student, it made me angry, because there was nothing I could have done to change anything that could have happened.

These emotional responses made Kelsey pause, but in the same moment, one could see that she was angry over being made to feel inferior in her clinical setting.

Just as Kelsey believed that her professional identity development might have been affected from vertical violence, she also stated that some clinical staff registered nurses believe that this phenomenon should be practiced as a rite of passage into the profession. She said that even her nursing instructor warned them that some nurses would be less than helpful.

I think some nurses expect it to occur, like just the way we were told before we started going to the hospital. We had a few of our clinical days on campus to kind of prepare us for clinical and one of the instructors kept repeating, “You know not all of the nurses will be nice to you.” It’s something I think some nurses expect that we are supposed to go through that because maybe they experienced it in the past. I think some think it is ridiculous too. I know a lot of the ones at Hospital B were new nurses, so they would understand. They would help us and say, “This is something I learned, so let me teach you this.” They’re kind of in the same stage that we are in so they kind of understood. The other place kind of had older nurses there or people who have been nurses for a very long time. I don’t know if it is a generational thing or what, but I do believe that some nurses think this.

With the many physical and emotional manifestations that Kelsey endured, we moved on to discuss if she believed that vertical violence would affect recruitment and retention for the profession or for healthcare organizations. Another issue that we explored was if she herself would consider working for an organization if she knew vertical violence was rampant in the facility.

I definitely think so; at least for our select ten that it affects recruitment and retention. I know just because of my experience with Hospital A, I will never look for employment there, even if it is the best offer. I know that probably sounds

irrational because it was just that floor, but a facility that allows that to occur consistently is not where I will work. It was not just my clinical group, but it occurred with multiple clinical groups, like mine & our instructor's other clinical group. It is still happening. I don't have a lot of respect for a facility like that, even if they are top-notch. As far as the profession, for me, I just know, nursing is what I want to do. If I don't like one place, I'm going to find another place to work, whether it is at a hospital or somewhere else.

Recruitment and retention could possibly be improved if vertical violence was halted or curbed in some way. We discussed whether there was an importance for nurse leaders to be aware of this phenomenon. Kelsey believed that it was a definite need for leaders to understand vertical violence.

I do and I think with Hospital A we had an issue with a nurse leader. I think it would make people a little more conscientious about how they treat others and how their student nurses perceive their facilities because you might be well staffed now, but in the future they are going to consistently need an influx of nurses. I do believe that it is going to be very important in keeping a facility well-staffed. I've done a lot of research recently on nursing burnout. I was in the honor's college for a little while. I just know that a lot of burnout issues happen because of a place's lack of staff and I think it would really help out with retaining people.

Kelsey stated that facilities were going to need an influx of nurses because, as she pointed out, unless vertical violence decreases or ceases all together, organizations will have difficulty providing staff for the population that it serves.

For facilities, word of mouth can be a powerful marketing tool, but also bring about detrimental effects to the organization if negative. Kelsey emphasized that nurse leaders needed to be aware of the effects of word of mouth as related to the phenomenon of vertical violence. Everyone is a potential customer for a healthcare organization, but negative comments can spread like wildfire and affect the facilities bottom line.

That's for sure. I know that again from personal experience. I've been known to be the person that people call when they need to be taken to the emergency room here on campus. I know that every time, I will take them to Hospital B instead of Hospital A unless they are really strongly against going to Hospital B. I know that I've told everybody about my experience with Hospital A. The word has gotten around and I just know that whenever someone has had that kind of experience, they tell all their friends, they tell their family, the family tells all their friends and word spreads.

An experience, whether positive or negative, can lead people to share those accounts with others and that end result can affect a facility.

Next, as we examined the effects of vertical violence on healthcare organizations and the nurse leaders' awareness, the conversation moved to the positive characteristics of a nurse leader. Kelsey explained qualities she believed would be beneficial for a positive professional role model; that the positive individual could nurture her as she grew in the profession of nursing.

I think that someone who has a willingness to teach. Maybe not to be a teacher, but someone that is willing to explain. Don't take on a role as a mentor if you're not willing to do this. I know that my best experiences have been with mentors, who not only talk through what they are doing, but someone that is going to ask

you questions. It is not to make you feel dumb, but to see if you understand if there is a lack of understanding and then explain it. We definitely don't need to be babied, but we don't need to be abused as well. Somebody that's willing to let you do things. I know that one of our favorite nurses on the floor; he's probably just been there for a year now, but he would explain things out loud. He would let us do certain things or if he was afraid of us messing up, he would do it, but tell us, "Hey I'm about to do that NG tube. Do you want to watch?" He would also be respectful, because if it was an NG tube which is obviously something traumatic, he's not going to invite the entire class in there. He would just allow couple of us in there. He was respectful of the patient, but also of us. Another quality is somebody who is not going to forget the little details.

A leader with these characteristics would be someone that could provide guidance to Kelsey in her necessary transition from student nurse to neophyte nurse.

Kelsey's journey through her clinical rotations was filled with occurrences of vertical violence perpetuated by clinical staff registered nurses. Through her stories, Kelsey shared both her physical and emotional ailments that she suffered as well as life lessons that she learned about herself. She realized a spirit within her inner being that was a driving force that would not let her stop pursuing her goal of nursing.

Rachel

Rachel encountered vertical violence perpetuated by clinical staff registered nurses beginning in her first semester of nursing school as well. Rude and ignoring behaviors occurred at both healthcare facilities that Rachel attended for her clinical rotations. She also was victim to non-verbal insults, such as loud sighs and rolling eyes. One episode that Rachel identified yielded a direct conflict in patient care as the patient

would suffer approximately an hour longer because the nurse ignored her completely. Overall, Rachel said that she faced three episodes of vertical violence by a clinical staff registered nurse, while she participated in clinical rotations. The following story reflects her experience at Hospitals A and B.

During her first semester, from the very first clinical day, Rachel seemed to always be the one student nurse in her entire clinical group that was subjected to work with one particular nurse every week. Therefore, every day that Rachel went to clinical, she was always under the tyranny of this one nurse.

First semester, I was working on the TCU floor, of Hospital A. We were on that floor and there was a staff nurse. I was assigned a patient and every time we are assigned a patient, we go and check in with the nurse that is responsible for that patient. Well for some reason, I always had this particular nurse and I don't know if she just didn't like students or what, but I would go to give her information and she would completely ignore me. One time when I went to go on the day before clinical, I found my patient information and I was going to introduce myself to the patient. When I was in there and I had just gotten in there to talk to her, that same nurse came busting in the door and she just completely cut me off. She didn't say anything to me. She just completely acted like I wasn't there. I had my clipboard sitting on the patient's table and I stepped back and was quiet. She took my clipboard and kind of like threw it to me. The patient was just looking at me. She wasn't going to say anything, but she knew it was kind of rude the way the nurse was acting. I was just quiet and was not going to talk bad about the nurse to the patient or anything, so I just let her do her business. She just walked out when she finished talking to the patient. I mean she was nice to the patient. She was just

always mean like anytime I had to go and tell her something or ask her where the chart was or ask her a question about the patient, she would not answer me or if she did it was really snooty or really short. She would just say “What?” She wouldn’t be nice at all.

Rachel said that the nurse would either sigh loudly or roll her eyes when a student asked a question. This sort of occurrence happened over a 7-week period during her entire first semester of clinical rotations in nursing school.

With each passing week, Rachel continued to experience violent behaviors.

Rachel’s next words reflect that violence.

It was terrible! All the nursing students would laugh because I would go out and check on the dry erase board to see who the nurse was and it was always her. She couldn’t stand me and I didn’t like being around her. It starts to interfere with the patient care when she’s not communicating with me or what’s special to know about that patient. It made me nervous. You know how you’re always supposed to lower the bed every time you work with them? Well she went into the patient’s room and did something and the bed was in the highest position when I walked back in there to go check on the patient. I was like “Oh my goodness” so I put it all the way down. I walked out there to the nurses’ station and I told her “I think you might have accidentally left the bed up, so I put it all the way down just so you know.” She didn’t like that at all. She didn’t say anything when I told her. She was just sighing and rolling her eyes. She was acting like she would never do something like that because she was the staff nurse.

One time and this was kind of funny, but there was a lady in the hospital and one of the patient’s family members was asking that same staff nurse a

question. She told the family member whatever it was but was answering the question and the family member said, “Oh, well you’re just a staff nurse, I want to talk to the doctor.” The nurse flipped out and was screaming toward the patient’s family. After the family member left, she was screaming to the other nurses that the lady insulted her calling her “just a staff nurse.” She was red in the face because she was so mad. I mean you are like a step above the regular nurses, but that doesn’t mean you have to act unprofessional. She just had a temper on her. That happened multiple times with her being rude, like every time I went pretty much.

Rachel did smile and laugh when she was telling me about how mad this nurse acted after the incident with the family member.

Her story continued into the second semester of nursing school, when Rachel’s clinical rotations moved to Hospital B. Again, she was ignored at this facility by clinical staff registered nurses, but one instance of being ignored actually affected a patient’s care.

At Hospital B, which we were at second semester, I just see more and more of the older nurses or those that have been around longer who don’t care at all to help or to give information to student nurses. They really ignored us. Multiple times, I have asked, because we were standing there half the time and would say, “Is there anything I can do or can I come and follow you with this?” I don’t know if it’s because they are just watching their back or what, but they just don’t want us to do anything. I think it’s just frustrating, because we’re there to help the patients as well. They’re not helping the patients by not letting us help the patients. Things that they don’t do, they don’t let us do. Well most of the time we do baths, but

this one time I had a patient at Hospital B and he was in there for sinus bradycardia. He was feeling really dizzy like the whole time. He was throwing up constantly. I was worried. I went to go tell his nurse. I told her. I had to go out there 4 times and ask her, because he had gotten it in his nasal cannula, so I needed to get another one of those. I was asking if she could call the doctor to ask for Phenergan or something to settle his stomach because he was gagging. She didn't do that for an hour and a half. I had to go out and ask her and she said, "Oh he's fine, just take his blood pressure." He didn't have anything ordered for nausea. That's why I was asking her to call. Just to see if he could have something. She finally did call two hours later. At least an hour and a half later she finally gave me the nasal cannula, because the other one was just nasty. This affected patient care and she didn't take the time. Whatever she was doing, she didn't leave that nurses' station to go in and even check on him to verify what I was telling her or anything. She did not even go in there to check on him. I left that day pretty mad!

This example of ignoring behavior actually illustrated how vertical violence can negatively affect patient care. Choosing to ignore Rachel in this instance meant the patient suffered for an hour and a half longer than he had to suffer, because she could have called the physician and secured an order for an antiemetic.

Another episode of vertical violence came while Rachel and her classmates, as well as her clinical instructor, were trying to find a location to discuss the day's happenings. Rude comments and yelling were the root of this occurrence, as Rachel begins first with a description of the perpetrator.

She is just this short, little fire-ball of a lady. One day there wasn't enough patients for us to all get a patient, so half of us got a patient the day before, while the other half had to wait. I was in the other half that had to wait. So, we were trying to get all of our patient information and we were using the little conference/luncheon area to type up our care plans. She came in there and said, "Ya'll need to get out! We're having a meeting and ya'll don't need to be in her!" Even my teacher didn't want to deal with her.

This was a brief encounter, but nonetheless, not something easily forgotten by Rachel.

Stress alone can be the result of any traumatic event, but usually other ailments arise. From her experiences, Rachel also experienced several physical and emotional episodes.

Well I have headaches all the time. I don't know if that's from all of that or not. They have gotten worse. Definitely the stress of it, because you are frustrated that they are not listening to you, not taking you seriously. They had 2 different rotations and one with the bad section of nurses that would be on one Friday and then we had the good set the next. So every time that next Friday rolled around, I knew there were really unpleasant people to work with. It makes the day long and you dread that Friday. The bad group of nurses! That is really how we referred to them, the bad group & the good group, our entire clinical group including my teacher.

Rachel did not experience major or long-term physical or emotional symptoms. However, she dreaded the long day of an inhibited learning environment in the clinical setting.

With nursing having an image of caring, why would some nurses inflict potential harm on the very young ones in the profession? Do some nurses believe that a rite of

passage must be accomplished to gain entry into our way of life? Rachel believed that rite of passage is a generational issue, meaning that some of the more experienced nurses deem a rite of passage necessary, whereas the younger, newer nurses do not.

I guess some of the older nurses might think that but I think our generation, those close to mine don't think that. I guess just because of the time difference, how far apart we are, may be the reason. I just think that people in general feel like they have to knock other people down in order to gain from it & it just happens to be more in the nursing field.

I asked Rachel if anyone had ever said to her, "I've paid my dues, so you have to now" or if she had ever heard the expression.

No. I have heard that expression, but no one has ever said that to me. I can see how some people say or think that way only because it had been done to them. It's why they feel that way, but I just don't think it is necessary to be mean to anybody. We're all trying to help people and do the same job. We're not against each other; there shouldn't be any competition between nurses on the floor.

Rachel views perpetrators of violent behaviors as the seasoned nurses of the profession.

These are nurses that should be passing on a wealth of information to students and nurturing them in their career path. Her stories in her clinical rotations illustrate vertical violence. Our dialogue then turned to how experiences affect her professional identity development.

I know how I do not want to come off to people or my co-workers or patients. No, I never felt like I wanted to quit the profession. It did make me a little bit uneasy. In certain people's eyes, there is a right way to do something, like to change a dressing or whatever, so that made me a little uneasy or low self-esteem or self-

confidence in my abilities to do things. You're trying to do good and someone is there to knock you down as you try to crawl up. It hurt my feelings but it didn't make me not want to be a nurse. Even though it may hurt your feelings, it shouldn't affect you that much because I know that in any job there is going to be situations like that.

Rachel personifies experienced nurses as culprits of vertical violence, so how would she view the phenomenon of vertical violence in terms of recruitment and retention for nurses and other staff in healthcare organizations. Rachel expressed that word of mouth is a strong influencer, both positive and negative.

If it happens to somebody and the word spreads, no one is going to want to have a job there or they won't be there long, if that's what they are going to experience. I think some people even though they hear about it, they have to experience it themselves to know that you were telling the truth. That definitely could hurt them. Yes, if I knew that there was vertical violence at a facility, it would lessen my desire to work there. If you already know about it before you even apply there, you just automatically knock that one out of the pool. The vertical violence might be going on, but if it's going on enough to where you hear about it then you know it's pretty bad. If Hospital A and Hospital B have problems like that but you heard about it with Hospital A, then I would be much less likely to apply there or want to work there.

Rachel stated that she would probably eliminate a facility from her potential employment prospects if she indeed was aware that vertical violence was occurring in that particular work environment.

Recognizing the impact that this phenomenon could have on healthcare organizations and the nursing profession, Rachel explained why she believed it was imperative for nurse leaders to be mindful of this problem. Not only is it forcing one person to deal with unpleasant behaviors in the work setting, but also patient care and the image of a facility and the profession can be affected.

If they are so adamant about quality patient care, it would be stupid for them not to want to learn ways to go around the vertical violence. If it's affecting their patient care, then why wouldn't they want to know about it and try to fix it. Well not only do you want to make it a better work environment for yourself, but why would you want to go to work every day and work with rude people? Like I said it really does affect patient care. Every hospital is always talking about quality patient care. I just think it is kind of like a reality check because they could be acting terribly and not even be aware of it or they could really help themselves to be a better leader. They could be completely rude and then when you brought this up to them, it is more like a reality check. I would think they would know how they were acting but some people are like that and just don't know, but if it is addressed like it obviously needs to be it would help. The staff nurses are the ones that I have come in contact with, having bad attitudes, and then they are acting as a role model to the other nurses. If those nurses can't think for themselves and start acting like the bad group then I'm sure that bringing the subject to them will help fix more than one personality. I think it would be helpful for them to know.

Rachel and I discussed how vertical violence could affect the organization and why it is necessary for the nurse leader to be aware of the signs. I posed this question,

could word of mouth of vertical violence affect the customer base for a healthcare facility?

Yes. I've heard quite often, like just from family members that I have been hospitalized, who had terrible nurses and they will never go back there. Even though it could have only been one nurse that ruined the entire experience. I wouldn't take my family there. It's just bad, because they are already sick and vulnerable and then they have to deal with rude nurses. That is not what you want to have to deal with when you're sick. I'm sure half those nurses that work there wouldn't want to be a patient there because they know what they deal with and what kind of people are going to be taking care of them.

Although formal nurse leaders and mentors must be aware of a plethora of issues in healthcare, other nurse leaders can emerge in various roles that may not be formal nurse leader positions. Rachel shared the characteristics that she believed would be most beneficial for a positive professional role model or leader.

I think they need to have good communication skills, for sure. Like know how to talk to you, explain things, willing to teach but not being frustrated if you don't understand things the first time and be organized. They need to brighten up a room, make people feel, the patients feel like everything is going to be ok and that they're going to be taken care of to put them at ease. They need to be caring and down to earth. They need to respect others. Respect covers a lot of it. Respect as a person and their religion. I think being passionate about what they're doing, not just being there, but being there because that's what they want to be doing and that they enjoy what they're doing, not just because they are making the money. It's not just a job.

As with the other participants, Rachel was the victim of vertical violence for much of her nursing education clinical rotations. Instead of being seen as nurturing and providing knowledge to the new members of the profession, experienced registered nurses were seen negatively. It was these nurses who committed these heinous acts of violence against her and her classmates. Even though Rachel had bouts of low self-esteem, she preserved in her belief to continue in her chosen path of nursing.

Professional Identity Development

Vertical violence, as evidenced by the participants' stories, is present in the nursing education's clinical rotations and in student nurses who are victimized by clinical staff registered nurses. Munhall (2007c) suggested that before we as beings can ever speak, we learn through our surroundings and how to express our own self wishes. Therefore, what happens to each person, our environment and encounters, helps define who we become. Clough (2010) described identity development as an ongoing process that occurs between our personal and professional lives. If identity development is in a state of constant evolution, then each experience can continue to mold our identity or send it in a different direction.

Through data collection and analysis, several themes emerged while attempting to understand how vertical violence affected professional identity development. Participants involved were all senior level nursing students who encountered vertical violence while attending clinical rotations at a healthcare organization. Each participant had experienced vertical violence from a clinical staff registered nurse, beginning in the first semester of nursing school. All participants conveyed an excitement for nursing but were soon dismayed by the treatment that ensued. Feelings of self-doubt and low self-esteem materialized. This is indicative of a broken confidence that each faced. Somehow in the

midst of their continued struggles, a pattern of resiliency surfaced within each of them that would not let them quit nursing school; they would not be broken. This pattern of resiliency illustrated the theme of restoring confidence.

Broken Confidence

A sense of excitement met with anticipation of something new is how participants felt when they were embarking on a new journey in their nursing education. However, this exhilaration was soon met with uncertainty and feelings of inadequacy as these nursing students entered their first semester's clinical rotations. Surrounded by vertical violence, each one began to question themselves in one way or another.

Harry. In his own words, Harry had his confidence broken on his very first clinical experience when the staff nurses looked at them all and inferred that none of them would be successful. From the initial moment he stepped into the hospital, he had an uphill battle with his confidence.

Hearing that really shatters what little confidence anyone has. You know as a student nurse, you don't have much confidence going into the hospital setting as it is because it's new and it's a scary situation and then hearing stuff like that, it just lowers what little self-confidence you already had. Then it comes to every time you go to the hospital, if you have low self-esteem and you have little confidence, you second guess the littlest things like giving bed baths. You second guess yourself in doing that and just every little thing you have to constantly think, am I doing this right? Even though you know you are doing it right, that broken confidence is the reason that you have to second guess every little thing you do.

Not only did Harry emphasize the broken confidence that was within his own being, but also he expressed a broken confidence in the profession overall. He believed this to be an area of concern related to nursing's purpose; a caring profession.

When you think nursing, you think caring; out to help people. When you have vertical violence in situations, you have nurses who are on a higher hierarchy than you and they make it known that you are inferior. It really does break your confidence in the profession, which is sad that such few people can do that, but words can hurt. It's the stuff they say and they know they are superior. They have a higher ranking than us and for them to say stuff that is unnecessary, is like kicking us when we are down. It really does make you second guess the confidence and the profession you are entering.

Harry's confidence was broken and he struggled to make sense of the attacks he suffered at the hands of what he presumed was caring individuals.

Princess. As she was subjected to violent behaviors, Princess experienced self-doubt in her abilities and knowledge. She knew she wanted to be a nurse, but those questions kept surfacing as to whether she would be capable to reach that goal.

They definitely make you feel less than what you thought you were. You feel like you are doing well and you are accelerating through the program. You gain more and more knowledge every semester and then run into someone who just cuts you down. It definitely makes you question yourself. Do I know enough? Can I do this? Can I stand up against this kind of thing? I don't consider myself to have a lot of confidence but I guess I have thicker skin. Maybe it doesn't bother me as much, but it definitely does take a blow to your confidence. It makes you feel like you don't know what you're doing. They make you feel like you are definitely

below them. Like I said, if I had to deal with that all of the time, I don't know if I could have much self-esteem or confidence. I mean, people say a lot of things. Nurses eat their young, so it's kind of a little widely known that you might run into that.

Kelsey. Kelsey seemed to have the strongest sense of self out of all the participants. While they all knew that they wanted to be a nurse and overcame the violence, Kelsey did not feel it affected her confidence greatly, but she did express a broken confidence in the profession.

I don't think it broke my confidence, but you could see that other people's confidence was broken. It does kind of break a little bit of my confidence in the nursing profession, in the sense that these people are meant to be helpful. This is something that my parents have always told me, but if I can't even be nice to the people around me, how am I supposed to be nice to other people. Like, if I can't be nice to my own family, how am I supposed to be nice to strangers? In the sense, you are a unit, you are a team, and so if you can't be nice to your own teammates, how are you supposed to be nice to your patients? That's just how I view it.

Kelsey stated that she feared and dreaded the clinical days, because she felt victimized but realized that her manifestations were of a physical nature, such as the exacerbation of her childhood asthma and amenorrhea.

Rachel. Rachel also agreed that there was a broken confidence within her as well as in the profession.

It breaks you down enough to where it affects your work performance and then maybe your caring abilities for the patients. I think that's right. It's definitely a

cycle kind of thing, but for the entire nursing field as a whole. I think that everyone individually has experienced that coming into being a new nurse. Just the fact that they don't take your abilities and your knowledge seriously, they just kind of brush it off. Even sometimes when you make a suggestion, they will take it as their own. They don't think you're up to par with their position.

Her broken confidence in the profession was basically limited to her concern that nurses in general doubted her skills as a student nurse and that she believed some nurses used the superiority factor when dealing with students.

Restoring Confidence

Restoring confidence was not an instantaneous resurgence. Participants were subjected to at least two or more instances of vertical violence and at least one participant encountered violent behaviors every week when she attended her clinical rotation. Each participant had a will to succeed; a pattern of resiliency was seen in each one of them and the stories that they shared. From this resiliency, confidence was restored, which may have been assisted by patients and their comments or positive nursing role models in nursing.

Harry. From the very beginning of his confidence return, Harry attributed the resurgence to his patients. He said that they were always very complimentary of his professionalism and the quality of care that he provided; praising him for his efforts.

I knew all along that I was going to be a good nurse and I would be good at what I did. It's hard though when you have nurses that make comments that are just unnecessary, but at the end of the day, it's about our patients and not about the other nurses that I'll be working with. Patients are not afraid to tell you how well you did or how bad you did and so it's been nice to have positive feedback from

the patients. To me, that positive feedback from the patient weighs a whole lot more than the negative feedback that the nurses give. When we first went to the hospital in our first encounters, we didn't get to work with a whole lot of patients very much. You're with a partner, so you're never one on one with a patient in first semester. You're pretty much with an instructor all the time. As they give us more and more responsibility, we're able to be with the patient on our own. When that patient tells you that you did a great job, that's all the confidence you need. At the end of the day, that's all that matters. That's who we're working for. We're working for the patient. We want the patient to have the best customer service there is and not the nurse. So I would definitely say that my patients restored my confidence throughout the semesters I have been here.

Princess. Realizing that there will be some negative experiences in life, Princess tried to focus on the positive aspects. She gave credit to her patients for helping to restore her confidence, but she also praised her nursing faculty for their assistance.

I just think about the positive experiences that I have had the whole time because I can't let one small negative thing ruin all of the positive great nurses that I have had, all of the great patients that I have had, and all of the great nursing instructors that I have had. I can't let one person, who has tainted nursing as a negative thing and then having to deal with someone that's condescending and doesn't care about whether you succeed or not, do that. I can't let one person who doesn't even know me or doesn't know where I am in life, ruin it for me. I can't let her make me mad or feel bad about this because that's just giving her more power; that's letting her put me down more. When I can move past this, I can be happy and I can feel more confident. I'm just letting her bring me down more the longer I

dwelling on this and the longer I question myself. The longer I feel like that, the longer I'm going to sit in that rut. When I got past this, I guess I felt empowered again. I felt like I could take hold of my life, my nursing education, and do with it what I want, because she doesn't have any hold on that. So I guess empowered; taking my life in my hands again, taking it back, and getting my confidence back. Princess recognized that many people helped her to restore her confidence, but overall, she had the drive and refused to let the violent attacks on her bring her down.

Kelsey. While Kelsey did not think her confidence in herself was broken, she did fear and dread clinical days. Kelsey admired the nursing profession for being a true caring profession and she believed that this ideal was shattered when a few nurses during her clinical rotations perpetuated violent attacks upon her. However, her confidence was restored in the profession by the camaraderie of her clinical group and through the positive role model of her clinical instructor.

My clinical instructor definitely helped. We always get together & talk every time. I told you before that our clinical group is like a bunch of best friends now. I honestly don't think I would have made it through the first semester if it weren't for the clinical instructor I had. We were just lucky enough to have her for the second semester. She was always there and if the nurses acted up, she always made sure she documented it and it was taken care of. She would always just tell us, "I'm proud of you. You're doing what you're supposed to be doing." She also tried to protect us from that first facility when she said, "Ok, I know you want to do more, but right now we should probably just do vital signs, bed baths, & just help." She was our mediator and someone that would build us up after we had a hard day.

There were several positive and encouraging clinical staff registered nurses that were nurturing with Kelsey.

We had a certain three nurses that we could go to and ask if we could do anything for them and they would let us. They would tell us that we were doing a great job. They would be there right by our side. One even was telling us that there was an elderly patient that needed an IV and said that I could help and he let me do it! He was beside me the entire time and talking through the steps and making sure I knew what I was doing. I would say he was definitely a big help. He's one of the nurses that we always go to. He's actually just out of nursing school. He's an older guy but he knows where we're coming from.

Rachel. Among the people that Rachel credited for restoring her confidence was her patients, their families, and her nursing faculty. She also believed in the resiliency within herself.

It's just when you start the nursing program and then you experience someone being hateful or whatever it may be, it does break you down. You have to understand if this is where you want to be though. Like I said before, in any profession, you're going to experience people, whether they don't like you or whatever. Your confidence is then shattered, but it does take a resilient person to understand that you can come back from that. Like, if you have made mistakes and then they were rude to you or something, you learn from that. I think I said before that the patients are what keeps you coming back or makes you want to stay in the program or with nursing. Those other nurses who choose to act like that towards new nurses or student nurses shouldn't be able to have that power to run people off. It's kind of like understanding yourself and what you want. You

need to understand that when you experience these kind of things, not to let it break you down. You just have to be strong. The patients and their family members help. You could just go in there to check on them and they would just be so grateful for you caring for them. Even sometimes your peers would help. If I saw a nurse being rude to one of my peers, I would say encouraging words like, “Don’t let that person get you down. You’re doing great.” I think throughout I was able to gain confidence back because other people were helpful.

Rite of Passage

Caring, compassionate, and helpful are just a few adjectives used to describe the profession of nursing. How then do we as a profession not adhere to those words when we deal with our next generation of nurses? Why does violence plague the profession? This was the concern of the participants as we discussed vertical violence and whether some nurses view a rite of passage as a necessary initiation practice into the profession of nursing.

Each participant thought that vertical violence was definitely a problem for nursing and believed that some nurses initiate student nurses and new nurses into professional practice in this manner. In this study, participants identified offenders of violence as experienced or seasoned nurses. In contrast, they were able to identify with nurses who had recently joined the professional ranks and did not think it possible for these newer nurses to practice a rite of passage.

Endangering the Future Practice of Nursing

An additional finding from participants’ interviews was the overwhelming affirmation that every nurse leader must be aware that vertical violence occurs as a rite of passage. Negatively affecting recruitment and retention of quality nursing staff was seen

as the largest concern by participants. Refusing to consider employment opportunities at healthcare organizations where vertical violence is allowed to occur was a common pattern throughout the narratives. Identification of this theme, which seemed to repeat with each participant, was endangering the future practice of nursing. These nursing students believed that if nurse leaders were not aware or chose not to acknowledge vertical violence, recruitment and retention would negatively be affected for healthcare organizations allowing vertical violence, as well as the nursing profession as a whole potentially. Participants not only would reject employment opportunities at these facilities, but they also adamantly refused to seek healthcare for them or their families. Understanding that word of mouth can be a powerful marketing tool, either positive or negative, these participants have already told family and friends of their harsh treatment and have encouraged their loved ones to avoid these places. Nurse leaders must be aware of vertical violence because vertical violence can negatively affect recruitment and retention as well as the potential influx of patients into the healthcare facility.

Harry. After Harry's first experience with vertical violence, he informed his family members of the violent behaviors at Hospital A so they would not seek care there. As a future nurse, he adamantly refused to ever work at that facility or any other facility that allowed vertical violence.

I think word of mouth travels faster than most anything around. If somebody hears something bad about a certain thing then they're going to tell someone and then they're going to tell someone else. Knowing the vertical violence that I have received, I wouldn't want my family or myself to be nursed by those particular nurses. I just know how they are outside of the patients' rooms and how they treat student nurses and how they treat people who are inferior to them. That is just not

a person that I would want working on my mom or step dad or my grandmother or me or anybody. Anybody can walk into a patient's room and smile and say, "Hi, how are you doing," but it takes a lot more to treat student nurses better.

Princess. Princess is convinced that violence starts on a small scale, possibly only one occurrence, but if allowed to grow, it can become like a wildfire and cause negative repercussions for the profession. At first, she believed that it is damaging to the profession, as a whole, but then she came to believe that it affects both the healthcare organization and profession equally.

You know it starts on a smaller level, it maybe just that floor that people don't won't to work on and then people just make those big associations of not going to work at that hospital. No, I wouldn't be likely to work there. The more you let it grow and those people who do vertical violence keeps it going all of the time.

When people feel down on themselves, then they become a nurse and they can do that to other people and so it does grow and if it continues to grow it could hurt nursing a lot. People already say those who aren't even in nursing, that nurses eat their young. If you look at it on a bigger scale, then it does hurt nursing to have that kind of reputation. It's not most nurses, but word of mouth hurts. This is true. It really hurts everything to do with the hospital. I know hospitals around here that have a bad rep for nurses that aren't helpful and for nurses that aren't as caring, so people don't won't to even go there as patients. The hospital is viewed as negative, along with the nurses and other nurses avoid working there. It hurts the hospital as a whole.

Kelsey. Kelsey was determined not to succumb to vertical violence. Several times during the interviews, she was unwavering in her desire to become a nurse. She believed

that there are certain people that will become a nurse regardless of their victimization by vertical violence. Kelsey indicated that not all people are as resolute as she is in her determination and that violence could endanger the future practice of nursing.

I think it does to an extent cause endangerment. Of course, you have a lot of students, like me, who aren't going to not be nurses. I guess it is kind of like a weeding out thing, but you have some people who can't handle the weeding out, who would be wonderful nurses. I think that is endangering staffing at least. I believe that you won't be able to have quality care. I think you will have more decubitus ulcers, more infections, and more little things that can turn into big issues, just from not having enough staff because of the violence. Patients just aren't comfortable in these facilities.

Rachel. Rachel described vertical violence as starting as a small problem but growing into one of greater proportions that endangers the future practice of nursing. She remains firm in her belief that nurse leaders must be aware of this practice and attempt to decrease the violence in healthcare facilities. Her opinion, similar to other participants, is that word of mouth is a powerful instrument that can affect the healthcare organization in a negative manner.

Like I said people talk all of the time, even if they didn't experience violence, they can hear it from someone else and already not want to be a part of it. I just think that violence is present and that people need to be aware and it needs to be addressed or else nothing will ever come of it. It could possibly elevate. I don't know if it could possibly be extinct, just lessening what is going on. I feel like both the organization and the profession is affected, but I feel like it's kind of tied

into one. I think it definitely affects the organization. I feel like it can start small in the organization like one unit and then spread.

Perpetrator Characteristics

Another theme identified with the phenomenon of vertical violence and rite of passage was perpetrator characteristics. The perpetrators are those nurses that commit these violent acts. Each encounter they incurred was perpetrated by an experienced nurse, which they defined as someone who had been in nursing for a while. The participants never offered information on the number of years that was considered to be experienced, but indicated that the perpetrators had been in nursing for a while and newer nurses of just a few years were less likely to commit these violent acts. Not only did the pattern of experience arise with perpetrator characteristics, participants also expressed the belief that at they believed that these nurses who were practicing vertical violence were miserable.

Harry. All nurses have one thing in common; each of them was a nursing student at one time. Harry believed the more experienced nurses, who have been out of nursing school longer than newer nurses, may not have remembered what it was like to be a student.

Yes, these nurses were miserable! When it has come to my situation, it has always been the more experienced nurses. In fact, the nurse that I was talking about that we have confided in, she was a newly graduated nurse. So she kind of understood where we were coming from when it came to other nurses not treating us right because she said she experienced the same thing when she went through nursing school. She knew what we were going through. It's been the more experienced nurses that have been cruel and I don't really know why that is. With that whole

professional identity, it makes you feel like nursing did that to them because it is the more experienced people and maybe it is because they have been nursing so long that it just makes them cruel people. I think that's what makes us real nervous is you see these experienced people versus the new graduates and the experienced people seem crueler. They've been nursing a whole lot longer, so maybe nursing drove them crazy or mean or something.

Princess. Similarly, Princess conveyed the same sentiments as the other participants seeing the experienced nurses as the predators who were in some way miserable.

I mean she had obviously been working there a long time in the same unit and she is a preceptor. I mean she was probably in her upper 30s, but she had obviously been there in that same unit for a while from the sound of it. I think that maybe they forget what it is like to be a nursing student or a new nurse. I think the new nurse is more likely to remember and want to help nursing students out because they remember how it was to be in clinicals. Maybe they see us as a burden, because that's what we feel like to them. I think that people who victimize other people and who would commit vertical violence are not happy with themselves. They're not happy about something. That's why they are acting on other people to make themselves feel better. That's just what people say about those who pick on others. The nurse that did this to me, I don't think she was happy with her job. She didn't make me feel like it was a happy place to be. I feel like she was miserable.

Kelsey. Kelsey also illustrated the patterns previously identified with perpetrator characteristics that experienced nurses are miserable in some way. She discussed the specifics with two of the nurses she encountered.

Yes, more experienced nurses are the perpetrators as far as my experience with vertical violence. The ones that were at the first facility, the one that I will never work at, they were miserable! There were never any smiles. There was never any laughing. They just didn't seem happy. At the second facility, one of the other nurses started talking to her and said, "Oh, I heard your husband is back home." Then my nurse, the one that was violent towards us said, "Is that all you have to talk about on this floor is my personal life?" You could obviously sense unhappiness with these people. We had talked about how you have to drop what is going on with you at home when you come in to care for other people, but there was obviously something going on with her life. She obviously didn't have any real friends on the floor at the time. She didn't make any friends with the other nurses. She was always by herself.

Rachel. Again the patterns of experienced and miserable were used to describe the nurses who propagated vertical violence.

They were both experienced nurses and charge nurses. They don't want to take the time out of whatever they are doing to have to teach you or worry about you. Yes, they seemed miserable, probably with their personal life and a lot of times people will take their personal problems and bring it to work. They then take it out on somebody else. Both of the nurses that I had pointed out, they both were not pleasant people. So I don't know if they had a position and wanted to get a better position and that wasn't happening. Like as a staff nurse, they wanted to

move up and that wasn't happening or it could be a number of things, but I do remember that their personalities were not friendly. They were more loners. They would approach people if something needed to be communicated, but really they were just kind of short. They didn't greet people; they just kind of said "Hey" if they even said anything.

Characteristics of a Positive Professional Role Model

A positive professional role model in this study was equated to a person who could nurture nursing students into the profession of nursing, while assisting them in the development of a positive professional identity. One of the specific aims of this study was to understand if transformational leadership theory could foster a positive professional identity. Participants were asked to identify characteristics that they thought would be beneficial for a nurse leader to possess and then to list the characteristics that embody a transformational leader. While most of the characteristics that each participant listed were similar, there were some differences. Students were asked how their list compared to that of a transformational leader. They all agreed that many of the listed characteristics compared to those associated with a transformational leader. Building the future is the label for this transformational leadership theme.

Building the Future

Tomorrow is the future and while nurses are uncertain as to what will happen, they must continue to care for patients. In this study, participants expressed the need to halt or lessen vertical violence in the clinical settings. Seen as a rite of passage, these nursing students believed that nurse leaders must be aware of the phenomenon and take action against this negative practice in order to preserve nurses and other staff at

healthcare facilities. Participants believed that positive professional role models were needed to nurture them and others just like them into the professional ranks of nursing.

Harry. When Harry discussed a positive professional role model, he compared his description to a nurse who was willing to teach them and explain various nursing procedures. She allowed them to perform skills in clinical and would suggest which patients would provide them with an optimal learning experience. Harry believed she was truly caring and supportive.

Those nurses that we encounter at the hospital, they are the people that we are going to be in five years, ten years. That's going to be the positions that we are in, so they are kind of setting the foundation of our career because we are student nurses and they are setting the glue into our foundation. If all the nurses on the floor were like that one nurse that we could confide in then I think that we, all of the students on that floor would have such a better outcome, such a more positive look on nursing. Not to say that we necessarily have a negative look, it's just if we had more receptive nurses to work with, people would have a more positive outlook on nursing. Having nurses that say stuff out of context and say really snide remarks and say stuff that is unnecessary is like tearing that foundation down, when instead they should be building it.

Princess. Princess believed that the profession would grow with more professional role models. She believed a nurse mentor should be one that respected others, was encouraging, demonstrated great integrity, empowering, and inspired excellence.

I feel like the more nurses that we have like that, the more people you're going to get in the profession. Just interacting with patients and other nurses, they're going

to want to do more, they're going to want to excel, and they are going to want to go back to school. When someone feels empowered and encouraged, they're going to reach their maximum potential. We need a lot more nurses like that. I've encountered a couple on floors and you can tell the morale is higher than other floors. You can tell that all those nurses are doing all that they can and staying on top of their game, like cleaning everything up and getting everything done, when other floors have people that aren't as encouraged and people are slacking. You can definitely see a big difference whenever you have someone like that leading other nurses, when others want to follow and that they believe in. They really believe that person is what it means to be a nurse. That caring person respects everyone and they do stuff whether it is below their pay grade or not. They're still going to do it because they care and because they can remember when they were the staff nurse versus whatever position they are in now. They can remember being at the bottom of everything and they're willing to help those people because they want those people to be just as high up as they are. They are not in it for power and we definitely need that more in nursing. We have it some but we need a lot more of that to build nursing up more.

Kelsey. Kelsey described the characteristics as a willingness to teach, a willingness to explain, making sure nursing students had a good understanding of how to do certain things and what was expected, competent and willing to do their job right, and respectful. She continued to believe that these were most important in the building of nursing's future.

I think that those are really important in just building up the future of nursing in general. A lot of people around the country want to be nurses. The willingness is

probably the most important thing to me, not just to teach nursing students, but also your patients. That's another thing that I see at the hospital that I wish more people would spend more time on and that is teaching their patients. I think that sometimes a leader can be born with these characteristics and then sometimes people can learn. I don't necessarily think that you have to be born a leader, you can learn some skills. I think that when people realize they are role models for others, it completely changes how they act. To be a good leader and role model you have to be aware that you are a role model. To be inspirational, like nursing instructors or people that are nurses with students coming in, you have to be aware that you are a role model.

Rachel. Several of the characteristics that Rachel listed as beneficial to a nurse leader included good communication skills, willing to teach without being frustrated, brighten up a room with a smile, caring, down to earth, and respect. Rachel believed that these qualities would assist nursing students and others in the development of a positive professional identity.

It would just make it a more enjoyable time for everyone if more people had those qualities. I think being passionate about what they're doing, not just being there, but being there because that's what they want to be doing and that they enjoy what they're doing. It's not just a job.

CHAPTER V

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The purpose of this study was to understand if professional identity development was affected for student nurses who were victims to vertical violence perpetuated by clinical staff registered nurses. Cantey (in press) defined vertical violence as “any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment.” Student nurses are the most vulnerable members of the professional group; those who will rise within our ranks and continue to care for the population as we pass on the baton to them. If they are subjected to vertical violence, what kind of work ethics, moral obligations to society, and opinions do they form when they believe that we are a caring profession? This research sought to understand the effect of this phenomenon.

Research for this study required a participant pool of student nurses who had experienced vertical violence during their clinical rotations, oppressed by clinical staff registered nurses. The specific aims for this study were (a) to have student nurses describe their stories of vertical violence (b) to describe how vertical violence shapes their professional identity as a future nurse, (c) to determine if vertical violence stories as presented by students is believed to be associated as a rite of passage into the nursing profession, and (d) to understand if transformational leadership theory can assist in fostering a positive professional identity.

To conduct this research, a qualitative narrative inquiry was used. The qualitative approach allowed students to express their thoughts and feelings. Coupled with the narrative inquiry approach, participants told the stories of their experiences and shared the meaning that evolved from that experience and how it changed over a course of time, when they either faced continued violence or were allowed to heal.

Participants in the study were in their senior year of baccalaureate nursing education and had been subjected to vertical violence by clinical registered staff nurses. This violence occurred in the clinical setting, where learning should take place. There were four participants that started with the study and completed all interviews, which is how data were collected. Each participant had at least two or more occurrences of vertical violence that were shared.

Analysis of data began during the first interviews with each of them as I listened, watching their non-verbal expressions as well as the inflections in their voice. After transcribing the interviews, I read the typewritten transcriptions multiple times during the same time period that my dissertation chair also read the transcriptions. Jointly, we identified agreed upon themes. Follow-up interviews were then conducted with each participant to ensure accuracy of the transcriptions and feelings that they experienced. Each participant discussed the themes with me and agreed that these themes were apparent. Results of the study revealed that professional identity development can be negatively affected by vertical violence in the clinical setting.

I first became interested in this phenomenon when I began working as a clinical faculty instructor 11 years ago and heard students in my own clinical group report stories of violence. It seemed then that I continually had to encourage them in their professional walk because they seemed so uncertain. As I began my doctoral education, I re-examined

my past professional life and realized that I too was victimized as a graduate nurse many years ago after I began my first job in an emergency department. This re-examination coupled with my experience as a nursing instructor initiated the journey into the research inquiry.

This narrative study allowed me to hear other nursing students' stories of vertical violence and how it made them feel. Participants discussed their professional identity development and told me stories of broken confidences sustained in the face of vertical violence. Through positive experiences with other nursing professionals and their patients and a resiliency to realize their dream, confidences were restored.

Another finding that resulted from participants stories were how some nurses considered the practice of vertical violence as a presumed rite of passage that students must go through to be initiated into the professional ranks of nursing. They viewed this as a cruel and uncaring practice, unlike the image they had originally perceived of professional nurses. They believed this to be an endangerment to the future practice of nursing. Findings also were indicative of the necessity for nurse leaders to be aware that this victimization is occurring in healthcare facilities, as staffing could be affected as well as patient care and the influx of customers.

To halt or lessen vertical violence, participants believed that nurse leaders must be aware and positive professional role models or mentors would be needed. As these changes occur in healthcare facilities and the nursing profession as a whole, they felt that recruitment and retention would improve and this could help to build our future.

One unexpected finding in each interview was the theme of perpetrator characteristics. All participants were exposed to vertical violence perpetrated by experienced clinical staff registered nurses. The participants consistently used the terms

experienced nurses or seasoned nurses, as those nurses needed most to share knowledge with the future generation. Additionally, the participants believed that each and every nurse who perpetuated this violence against them was miserable in some aspect, either in their personal or professional lives, or both. Each participant in the follow-up interviews agreed upon the characteristics as those characteristics most associated with experienced nurses who perpetrate vertical violence toward nursing student.

Findings

Five themes were gleaned from the analysis of data, thus supporting the four specific aims of the research inquiry. Broken confidence within the self and in the nursing profession were associated with the topic of professional identity development. However, professional identity development was also illustrated through a theme termed as restoring confidence when students encountered positive role models and/or the patients that they encountered by describing a revitalization process after the confidence was broken. Participants believed that some clinical staff registered nurses committed vertical violence as a rite of passage, which would lead to an endangerment to the future of nursing practice. The participants related endangerment to nurses wanting to leave the facility and the profession in the face of violence. Additionally, students identified characteristics of their perpetrators, which was a theme that unexpectedly emerged. With the need to halt or lessen vertical violence, participants identified characteristics of a positive professional role model and considered these characteristics as pertinent to building the future of nursing.

Professional Identity Development

Exploring professional identity development yielded big chunks of data that indicated participants doubted their abilities, feared clinical rotations, and broke their

confidences in themselves and/or in the profession. Overall, it was a broken confidence that they had to deal with after the episodes of vertical violence. Rude and humiliating comments in front of patients and their classmates, yelling, and ignoring behaviors made the participants second guess everything they did in the clinical setting.

Struggling against all of the negativity, they all were resilient in the fact that they wanted to realize their dream of becoming a nurse. Halse (2010) acknowledged that personal and professional identities are intertwined and the journey is met by frequent daily obstacles, while Waller (2010) implied that identities change as people go through life.

Participants experience life altering experiences that highly motivated them even more to embrace a desire to succeed and not give up on their professional goal to become a nurse. Each participant encountered either a positive professional role model and/or cared for patients that praised them in a way that made them realize they could accomplish their goal. This restored their confidence and in their narratives, they discussed these determining factors. Several mentioned in their stories how the nurses let them perform certain skills, were always available for questions, and made sure that information was comprehended.

Rite of Passage

Nursing is generally recognized as a caring profession, and the participants believe in this defining quality of nursing. However, they witnessed a dark side of nursing that has been allowed to permeate the profession for years. Before terms such as vertical violence, horizontal/lateral violence, or workplace violence were coined, it was known as nurses eating their young.

Participants believed that some nurses initiate vertical violence against students as a rite of passage into nursing. They did not think that every nurse practiced this tactic; one participant in particular felt strongly that all students and new nurses experienced a degree of vertical violence at some point early in their career. Additionally, students believed that this rite of passage initiation was endangering the future practice of nursing. If this tactic is not halted or decreased, participants strongly indicated that healthcare organizations and the profession would suffer.

An adamant declaration made by all of the participants was that nurse leaders must be aware of this phenomenon and its occurrence in a given facility. Again, all participants alleged that vertical violence would affect recruitment and retention negatively for the healthcare organization and the profession. It was also posed that vertical violence could affect patient care if information was withheld or ignored. One illustration of ignoring was that of a clinical staff registered nurse who disregarded the participant's pleas for an hour and a half to help with a vomiting patient. As a result of the nurse ignoring the student, the patient suffered longer. Nurse leaders, therefore, must be cognizant of this phenomenon to ensure that patient care is not affected.

Findings from the analysis yielded patterns related to the perpetrator characteristics, those committing these acts of violence. Participants believed that the nurses who attacked them during their clinical rotations were miserable. They also described them as loners because during the shift, the perpetrators demonstrated a pattern of absent co-worker communication, except when absolutely necessary to carry out their nursing responsibilities. Another finding was that participants identified experienced or seasoned nurses as perpetrators. Several of the participants wondered if all of the years they had spent nursing and giving to everyone had hardened them in some way or, as one

participant described, led to their meanness. This theme was unexpected because the study inquiry was focused more on the student nurse and how vertical violence affected them; but, in each interview, participants brought up the same descriptors for their assailants.

Positive Professional Role Model

Transformational leadership theory is one of the theories I utilized in this study to explore qualities that student nurses believed were necessary for nurse leaders or positive professional role models to guide student nurses entering nursing. Participants understood that leaders, many of whom hold staff nurse positions, could occupy any role in the hierarchical chain. Since none of the participants had ever heard of transformational leadership theory, I initially withheld the characteristics so as not to influence what they might deem as necessary qualities. Participants later identified characteristics of a positive professional role model as respect, competence, integrity, being organized, passionate about their job and nursing, and a willingness to teach without getting easily frustrated. One participant stated that a nurse should ask questions of students to challenge them to think critically, but in a non-threatening manner. An additional characteristic was a desire to empower others. With each participant, I waited until they had given me every characteristic that would embody their ideal role model before explaining the characteristics of a transformational leader. After the participants heard the characteristics of a transformation leader, I asked them how they felt the two lists compared. Unanimously, participants believed the characteristics were synonymous and furthermore, deemed these qualities essential in order to build the future of nursing.

Implications for Nursing Education

Student nurses begin their professional pathway in the nursing education arena. Nurses are advocates for those cared for; therefore, student nurses fit into the cared for category. Nursing educators facilitate student learning in both the classroom and the clinical setting. Students place their trust in faculty to provide them with the education they desire and require. Nursing students, just as any healthcare employees, are a vulnerable population, who might fall victim to workplace violence (Ferns & Meerabeau, 2010). Nurse educators must be cognizant of the vertical violence phenomenon and do their best to protect students.

Implications for Nursing Practice

One of the most widely recognized theories associated with violent behaviors is the theory of oppression (Farrell, 2001). Freire (1968/1974) inferred that oppressed people are dominated by a force and struggle to overcome this force. As a result of that struggle, the oppressed can become the oppressor, which leads to a vicious cycle of vertical violence among the oppressed group. Awareness of this phenomenon can prompt nursing leaders to implement measures to reduce vertical violence.

Data analysis of interviews indicated that students would refuse to work in a facility where they had been exposed to vertical violence or if vertical violence was a common known occurrence. Although the interviews only consisted of four senior level nursing students, the conclusion of refusing to work in such a facility was overwhelmingly negative. In view of this negative response, vertical violence could affect recruitment and retention for healthcare facilities (McKenna, Smith, Poole, & Coverdale, 2003; Sofield & Salmond, 2003). Some participants expressed serious doubt about their competency and their resilience to continue enrollment in the nursing

program. Difficulty with recruitment and attrition of nurses from the profession are potential outcomes for nursing practice (Stroud, 2010).

Another indication for nursing practice is the potential for compromised patient care. Vertical violence manifests in many forms, such as ignoring and withholding vital patient information from nurses or student nurses. For instance, in this study, a nurse ignored a student who was caring for a vomiting patient. The result was compromised nursing practice and care of a patient. The student nurse was so concerned for the vomiting patient that she returned to the patient's room four times, all the while conveying her concern to the nurse. During this whole episode, the nurse sat in the nurses' station and continued to ignore the student. This example illustrates how nursing care can be compromised as a consequence of a clinical staff registered nurse ignoring the student.

Professional identity development is equated to socialization with attitudes and moral views of a profession (Faulk, Parker, & Morris, 2010). That comparison becomes important as student nurses begin searching for positive professional role models to lead them in the nursing profession. As identified by the participants in this research study, many characteristics match those of transformational leadership theory, which is a popular theory in organizations. Clinical staff registered nurses who apply this theory can guide nursing students to a higher level of thinking and performance (Bass, 2008; Jung, Wu, & Chow, 2008; Northouse, 2007; Pounder, 2008).

Implications for Research

Narrative inquiry is a qualitative method used to explore life stories of a particular phenomenon or to connect several life events together (Riessman, 2008). This approach is indicated for exploring a phenomenon within the context that it occurred, especially

when there has been no research generated and very little known about the topic (Creswell, 2007). Significantly more research has been generated on workplace violence and horizontal/lateral violence in general. A limited amount of research exists on vertical violence, especially in the context of how it affects student identity development.

With the use of narrative inquiry, participants relate their life experience about a phenomenon in the context with which it transpired. Clandinin and Connelly (2000) maintained that the narrative process is a “fluid approach” (p. 184). As in this research study, participants were allowed to tell their stories of vertical violence, where it occurred, at which time in their life it happened, and how they felt about the experience. They were allowed to have open expression with only a few guiding questions (see Appendix A). Open expression is another strong indication of the necessity of narrative inquiry.

Researchers need to conduct more research on vertical violence. Whereas, horizontal/lateral violence and workplace violence have been researched some, much more needs to be known about the effects of violence when it occurs between two different levels of the hierarchical ladder. Another narrative inquiry or a different qualitative method could be utilized for a study on vertical violence for capturing feelings about physical manifestations in new nurses or in vertical violence in a specific setting.

Limitations of the Study

Narrative inquiry does not follow a set approach or structure. Clandinin and Connelly (2000) contended, “Simply stated, . . . narrative inquiry is stories lived and told” (p. 20). This statement implies several limitations. Stories consist of personal life reflections, which bring in a wealth of emotions. In light of these emotions, naturally a researcher will wonder if this was the most accurate account of the experience, but

narrative researchers must trust solely in what has been conveyed by the participant and perform follow-up interviews for fact checking. Narratives generally are lengthy; unless unlimited time is available to conduct the query, a limited sample size must be used. As was the case with this study, four nursing students participated in the research, but data saturation and interrater reliability were evident during analysis of transcribed interviews by the dissertation chair and myself.

Researcher bias can also occur in narrative inquiry. Researchers could become more involved in the experience as to sway the participant's beliefs. Additionally, if the researcher asks leading questions or has any pre-conceived notions about this phenomenon, these could influence the participant and lead to inaccurate results. Students initially began the interviews by telling stories of vertical violence, but only when the story digressed did I interject an interview question from the guide (see Appendix A). Using this approach allowed the participants to tell their own stories in an open manner. While I did experience vertical violence at the beginning of my nursing career, I never divulged this information to participants so that participants would respond to their own experiences and feelings.

Recommendations for Further Study

In planning this research study, I was hopeful that it would yield some useful results for the profession of nursing, but I never expected it to yield as much data as was discovered. From this research, there is significantly more to be explored in terms of vertical violence, such as who it affects, where it occurs, and more detailed perpetrator characteristics.

This researcher did not set a limitation of who could be in the study, such as gender, age, or actual location of work setting. Several queries that could occur would be

if males were victimized more than females, or vice versa. Both genders were included in this study but with a ratio of one male to three female participants. Another issue is whether traditional or non-traditional students were more prone to attacks. Although not a defining requirement, all students included in the study were traditional students. Another query asks, Are violent behaviors found to be more prevalent in high-stress areas, such as critical care units, or does this even matter?

Perpetrator characteristics were unexpected, mainly because I focused more on the student nurse and how violence affects that population. Even so, significantly more findings are yet to be discovered about the perpetrator and the degree to which low self-esteem or self-doubt exists, as the theory of oppression suggests. In addition, were they victimized as a student or new nurse? Much more must still be understood about the phenomenon of vertical violence and how it influences the affected ones.

Summary

As a novice narrative researcher, I have conducted this query with research rigor and to the best of my ability in hopes that beneficial findings would come to light. In conclusion, I must say that this study has been both an educational journey for me but also a humbling experience as I listened to the words, looked into the eyes, and watched the facial expressions of those affected by vertical violence. This devastating disease is scourging the body of the profession. Each student nurse, or nurse, for that matter, is an appendage that affects the larger whole. If vertical violence is allowed to rage on, damage to the profession of nursing will continue.

APPENDIX A
INTERVIEW GUIDE

As Cantey (in press) identified, “Vertical violence is defined as any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment.”

1. Describe your experiences of vertical violence committed by a clinical staff registered nurse.
2. Describe any physical or emotional effects that you believe were the effects of vertical violence.

Clough (2010) described identity development as an ongoing process that occurs between our personal and professional lives.

3. How do you believe your experience(s) with vertical violence has affected your professional identity development?
4. Do you believe that the perpetuation of vertical violence in the clinical setting is a rite of passage into the profession of nursing?
5. Do you believe that vertical violence affects recruitment and retention for healthcare agencies as well as the profession of nursing?
6. What characteristics must a leader possess that you would deem beneficial for positive growth and professional identity development both in the clinical setting and the profession of nursing?

APPENDIX B
COUNSELING SERVICES

The University of Southern Mississippi
Student Counseling Service

Address

214 Kennard Washington Hall
118 College Drive #5075
Hattiesburg, MS 39406-0001

Phone

601-266-4829
601-606-HELP (4357) – After hours for emergencies

Hours

During Semester:
Monday through Friday
8:00 a.m. to 5:00 p.m.

During Summer:
Monday through Friday
8: 00 a.m to 12:00 p.m.
1:00 p.m. to 4:30 p.m.

Walk-ins:
Monday through Friday
10:00a.m. to 12:00 p.m.
2:00 p.m. to 4 p.m.

APPENDIX C

INSTITUTIONAL REVIEW BOARD NOTICE OF COMMITTEE ACTION

**INSTITUTIONAL REVIEW BOARD**

118 College Drive #5147 | Hattiesburg, MS 39406-0001

Phone: 601.266.6820 | Fax: 601.266.4377 | www.usm.edu/irb**NOTICE OF COMMITTEE ACTION**

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
- Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: **12050805**PROJECT TITLE: **Vertical Violence and the Student Nurse: Is This Toxic for Professional Identity Development?**PROJECT TYPE: **Dissertation**RESEARCHER/S: **Sherri Williams Cantey**COLLEGE/DIVISION: **College of Health**DEPARTMENT: **Nursing**FUNDING AGENCY: **N/A**IRB COMMITTEE ACTION: **Expedited Review Approval**PERIOD OF PROJECT APPROVAL: **05/17/2012 to 05/16/2013**

Lawrence A. Hosman, Ph.D.
Institutional Review Board Chair

APPENDIX D

PERMISSION LETTER FROM THE UNIVERSITY OF SOUTHERN MISSISSIPPI
SCHOOL OF NURSING



THE UNIVERSITY OF
SOUTHERN MISSISSIPPI.

SCHOOL OF NURSING

118 College Drive #5095 | Hattiesburg, MS 39406-0001
Phone: 601.266.5445 | Fax: 601.266.5927 | nursing@usm.edu | www.usm.edu/nursing

August 26, 2010

Dr. Bonnie Harbaugh
The University of Southern Mississippi
Elizabeth Harkins Hall, 110
118 College Drive, Box # 5095
Hattiesburg, MS 39406

Dear Dr. Harbaugh:

I am interested in conducting a research study at The University of Southern Mississippi's School of Nursing. As a doctoral candidate in nursing, the focus of my research is vertical violence perpetuated by clinical registered nursing staff against student nurses and how this affects the student nurses' professional identity. Additionally, I am interested as to whether students believe vertical violence is considered a rite of passage.

Currently, I am readying my proposal for the Institutional Review Board (IRB) and have spoken to the chair of my dissertation committee, Dr. Janie Butts, who encouraged me to proceed with contacting you regarding the potential to select participants from the school of nursing. I am using a narrative method of inquiry and will do a content analysis of interview data generated. I would be interested in conducting two interviews each with three to eight participants, who have encountered vertical violence during their clinical rotations and are currently in their senior year of the generic Bachelor of Science in nursing program.

As previously indicated, my proposal must first be reviewed and approved by IRB before proceeding and I will be happy to provide you with any further information that you require in order to entertain this request. This is a query attempt on my part to be able to provide IRB with documentation of a potential participant pool for this research study. Additionally, should you grant this request and upon approval by IRB, participants would be informed of the process and would also be instructed that they may withdraw from the research study at any point they desire.

Thank you for your consideration on this matter. If you need further information, please do not hesitate to contact me at 601-527-0301. I look forward to hearing from you.

Sincerely,

Sherri W. Cantey, Ph.D (c), RN

I hereby grant approval to Sherri Cantey to seek participants for her dissertation research from The University of Southern Mississippi's School of Nursing

Bonnie Lee Harbaugh, PhD, RN

4-15-12

Research Coordinator Signature

Date

APPENDIX E

PARTICIPATION FLYER

**DISSERTATION RESEARCH EXPLORING THE EFFECTS OF
VERTICAL VIOLENCE ON PROFESSIONAL IDENTITY
DEVELOPMENT**

**RESEARCH OPPORTUNITY FOR NURSING STUDENTS
ENROLLED IN THEIR SENIOR LEVEL OF THE GENERIC
BACCALAUREATE PROGRAM**

**HAVE YOU BEEN SUBJECTED TO VERTICAL
VIOLENCE BY CLINICAL STAFF REGISTERED NURSES
DURING YOUR CLINICAL ROTATIONS?**

As Cantey (in press) identified, "Vertical violence is defined as any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment."

If you are interested in possibly participating in this research endeavor consisting of two 1-hour interviews, please contact, **Sherri Williams Cantey, Ph.D. (c), RN at 601-527-0301**. A full explanation of this study will provided and should you consent to participation, compensation of \$20 per each interview session will be provided for your time.

Sherri Williams Cantey 601-527-0301
Sherri Williams Cantey 601-527-0301
Sherri Williams Cantey 601-527-0301

Sherri Williams Cantey 601-527-0301
Sherri Williams Cantey 601-527-0301
Sherri Williams Cantey 601-527-0301

APPENDIX F

INFORMED CONSENT STATEMENT

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

AUTHORIZATION TO PARTICIPATE IN RESEARCH PROJECT

Code name: _____

Name: _____

Address: _____

Phone #: _____

Consent is hereby given to participate in the study titled:

Vertical Violence and the Student Nurse: Is this Toxic for Professional Identity

Development?

1. **Purpose:** The specific aims of this research are: (1) to have student nurses describe their stories of vertical violence (2) to describe how vertical violence shapes their professional identity as a future nurse, (3) to determine if vertical violence stories as presented by students is believed to be associated as a rite of passage into the nursing profession and (4) to understand if transformational leadership theory can assist in fostering a positive professional identity.

2. **Description of Study:** This research study focuses on stories told about experiences of vertical violence perpetuated by clinical staff registered nurses against student nurses in their clinical rotations and how these experiences affect professional identity development and if this phenomenon is believed to be a rite of passage into the

Participant's Initials: _____

profession of nursing. Throughout this research, information will be obtained through interviews to allow for open expression and descriptions of their own personal stories of vertical violence. There will be three to eight participants. Data from informants will be collected via two 1-hour interviews, which will be tape recorded and notes may be taken.

3. **Benefits:** There will be no physical benefits from participating in this study.

Participants will receive an honorarium of \$20 for each interview session.

4. **Risks:** There are no foreseeable risks involved in participating in this study. However, at time when reliving past experiences that were not pleasant can produce feelings of distress. Therefore, a listing of a counseling service will be provided with contact information.

5. **Confidentiality:** All identifying information about the participant as well as information collected during the research, including verbatim reports and tape recordings will be kept confidential. Each participant will be assigned a code when the demographic instrument is completed. After that initial information is collected, all information after that will be identified only with the code assigned to that research participant. Data will be coded, placed in a computerized file with a password access only known by the researcher, and tape recordings will be stored in a locked box. At the end of the research study all data collected during the research project will be destroyed.

6. **Participant's Assurance:** Whereas no assurance can be made concerning results that may be

obtained (since results from investigational studies cannot be predicted) the researcher

Participant's Initials: _____

will take every precaution consistent with the best scientific practice. Participation in this project is completely voluntary, and participants may withdraw from this study at any time without

penalty, prejudice, or loss of benefits. Questions concerning the research should be directed to Sherri Williams Cantey at 601-527-0301. This project and this consent form have been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820. A copy of this form will be given to the participant.

7. **Signatures:** In conformance with the federal guidelines, the signature of the participant must appear on all written consent documents. The University also requires that the date and the signature of the person explaining the study to the subject appear on the consent form.

Signature of the Research Participant

Date

Signature of the Person Explaining the Study

Date

Participant's Initials: _____

APPENDIX G
DEMOGRAPHIC QUESTIONNAIRE

Code name: _____

Name: _____

Address: _____

Phone #: _____

Age: _____

School of Nursing: _____

Anticipated date of graduation: _____

Year in Nursing School: _____

As Cantey (in press) identified, "Vertical violence is defined as any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors which transcends between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment."

Have you experienced any type of vertical violence during your clinical rotations?

Was the vertical violence from a clinical staff registered nurse? _____

How many occurrences of vertical violence did you experience? _____

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