NURSING STUDENTS’ PERCEPTIONS OF WORKPLACE VIOLENCE: A FEMINIST RESEARCH STUDY

By

LORNA M. WEISBROD

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Until the whole is exposed to question, nothing alters in the power dynamics of who chooses, who judges, who defines, who rules, who imposes...

---- Marilyn Waring as cited in Cavanaugh, 1997, para 2 ----

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Abstract

Workplace violence as experienced by nurses has received increased global attention in the last decade. Despite a proliferation of literature which focuses on nurses’ experiences of workplace violence, there is a paucity of research focusing on nursing students’ perceptions and experiences of workplace violence in clinical learning experiences. Underpinned in a feminist stance of intersectionality, a feminist participatory action research design was used to explore first and second year undergraduate nursing students’ perceptions of workplace violence as experienced by nurses. Embracing values of feminist research, perspectives of collaborative learning and consciousness-raising were woven within this multi-method research design of a survey and learning circle focus group. The results of this study indicate that nursing students have diverse and multidimensional understandings of workplace violence which are shaped by a variety of life experiences. In addition, employing a feminist stance of intersectionality reveals complex and dynamic matrices of intersections of oppression and privilege which underpin nurses’ and nursing students’ experiences of workplace violence. Recommendations arising from this research focus on raising consciousness through critical reflection and dialogue, embracing transformative pedagogical approaches in nursing education, developing self-awareness of personal intersections of oppression and privilege, and critically challenging norms of oppression and privilege to create and sustain ‘healthy’ health care workplaces.
Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study

Introduction

Workplace violence as experienced by nurses has gained increased attention within the last decade. In 2002, the Canadian Nurses Association (CNA, 2002c) issued a position statement regarding violence stating “[violence] has become a public health concern of epidemic proportion with serious consequences both for those who provide and those who receive health care” (para 7). In addition to addressing the overall prevalence of societal violence, the CNA (citing Kingma, 2005) notes the risk of workplace violence in health care settings, suggesting that “health-care professionals are at the highest risk for being attacked at work, even when compared to prison guards, police officers, bank personnel or transport workers” (para 3). The extent and gravity of workplace violence is reflected in a plethora of national and international literature which seeks to define, describe, deconstruct, and resolve workplace violence. Furthermore, a multitude of interdisciplinary and nursing literature illuminates diverse conceptualizations of workplace violence.

Despite the growing literature focusing on workplace violence as experienced by nurses, there are few research studies which focus on the perceptions and experiences of nursing students in relation to workplace violence. Although, there have been some studies originating in countries such as the United Kingdom (UK) and Australia, there is a paucity of Canadian research which focuses on nursing students’ perceptions and experiences of workplace violence. Advancing knowledge of nursing students’ perceptions and experiences of workplace violence in health care settings is critical in breaking the cycle of workplace violence and transforming the culture of violence in health care workplaces.

In extending a patriarchal, essentialist framework embraced by second-wave feminists, this research study proposes a third-wave feminist stance (Duffy, 2004; Pinterics, 2005) of
intersectionality in conceptualizing workplace violence as experienced by nurses whereby “the intertwined nature of gender, race, class, ability, sexuality, caste and other influences” (Brewer et al. as cited in Wilkinson, 2003, p. 28) are considered as “a phenomenon of merging and mingling multiple markers of difference” (Ludvig, 2006, p. 246) which create “simultaneous, multiple and interlocking oppressions of individuals” (Mann & Grimes as cited in Sokoloff and Dupont, 2005, p. 39). A feminist stance of intersectionality offers a valuable lens through which to view workplace violence as experienced by nurses, extending knowledge beyond a gender perspective and thus, providing a deeper analysis which more realistically and holistically reflects lived experiences of workplace violence. In employing a feminist perspective of intersectionality to conceptualize workplace violence, this research study proposes to answer the following two questions: ‘What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace?’ and ‘What actions are needed to transform the present culture of workplace violence in health care organizations?’.

The following paper documents a feminist participatory action research study entitled “Nursing students’ perceptions of workplace violence: A feminist research study”. First, an overview of literature relating to workplace violence as experienced by nurses and nursing students is presented. Second, a feminist stance of intersectionality in relation to workplace violence is explored. Third, the feminist participatory action research design is elucidated, followed by a description of the method of data collection and analysis. Fourth, the results and discussion of the research study are presented. Recommendations arising from the research study are proposed. Lastly, the limitations and opportunities for future research are presented. It is proposed that a feminist stance of intersectionality offers a valuable lens through which to view workplace violence in health care settings, and thus, adds to our understanding of workplace violence as experienced by nurses and nursing students.
Literature Review: Workplace Violence as Experienced by Nurses and Nursing Students

Workplace violence as experienced by nurses has been documented as a significant workplace issue since the early 1980s (Hedin, 1986; Leney, 1996; Lovell, 1981; MacIntosh, 2005; Meissner, 1986). Given the recent interest in quality work environments, workplace violence has gained increased attention as organizations strategize to transform the health workplace into healthy work environments (Brabant, Lavoie-Tremblay, Viens, & LeFrançois, 2007; Canadian Federation of Nurses, 2007; Canadian Nurses Association [CNA], 2001; Canadian Nursing Advisory Committee, 2002; Hesketh et al., 2003; Jackson, Clare, & Mannix, 2002; Love, 2007; Parsons & Newcomb, 2007; Peter, Macfarlane, & O’Brien-Pallas, 2004; Saskatchewan Health, 2005; Shamian & El-Jardali, 2007; Shields & Wilkins, 2006; Silas, 2007; Spence Laschinger, 2007; Wesorick, 2002). Rippon (2000) states

Although violence is increasing in most workplaces, it has become a significant problem in health care professions. Not only has the number of incidents increased but the severity of the impact has caused profound traumatic effects on primary, secondary and tertiary victims. (p. 452)

For the purposes of this research study, the literature review is primarily based on English-written literature which focuses on or makes connections to workplace violence as experienced in Westernized industrial nations and organizations.

A National and International Concern

It is evident that workplace violence is not only a Canadian concern, but an issue which prevails in workplace environments across the world (Ferns, 2005; International Council of Nurses [ICN], 2006; Jackson et al., 2002; Macdonald & Sirotich, 2005). The International Labour Organization (ILO) (as cited in CNA, 2002c) suggests that workplace violence has become “increasingly global and crosses borders, work settings and occupational groups” (para 9). In
citing the United Nations, Coombs & Holladay (2004) emphasize that workplace aggression is a global problem which has “psychological ramifications for the targeted employee and productivity implications for the organization” (p. 481).

Researchers have made diverse contributions to emerging and evolving understandings of the phenomenon of workplace violence. The complex and multidimensional nature of workplace violence is evident in international research contributions from Australia, New Zealand, Poland, Turkey, Thailand, United Kingdom, and United States (see Appendix A). To a lesser extent, the nature of workplace violence is reflected in Canadian literature (see Appendix B). The diversity of national and international literature reflects a plethora of conceptual understandings, employing a variety of methodological approaches to explore defining characteristics, prevalence, perpetrators, contributing factors, and theoretical underpinnings of workplace violence.

**Naming and Describing the Phenomenon**

A variety of terms are used to describe the phenomenon of violence in the workplace: *antisocial behaviour* (Robinson & O’Leary-Kelly, 1998), *assaultive behaviour* (Somboontanont et al., 2004), *bad behavior* (Griffin & Lopez, 2005), *bullying* (Bray, 2001; Edwards & O’Connell, 2007; Einarsen, 1999; Harvey, Heames, Richey, & Leonard, 2006; Heames & Harvey, 2006; Hoel, Cooper, & Faragher, 2001; Hogh & Dofradottir, 2001; Lewis, 1999; Lewis, 2006; Lefooghe, & Davey, 2001; Lefooghe & Olafsson, 1999; MacIntosh, 2005, 2006; Quine, 2001; Rayner, 1999; Salin, 2001, 2003; Strandmark & Hallberg, 2007; Thomas, 2005; Vega & Comer; 2005), *deviant workplace behaviours* (Everton, Jolton, & Mastrangelo, 2007; Robinson & Bennett, 1995), *dysfunctional nurse-nurse relationships* (Taylor, 2001), *horizontal/ lateral violence* (Baltimore, 2006; Farrell, 2001; Freshwater, 2000; Hutchinson, Vickers, Jackson, & Wilkes, 2005, 2006a, 2006b; Longo, 2007; Longo & Sherman, 2007; McKenna, Poole, Smith,
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The employment of a variety of discourses about the phenomenon of workplace violence is one of the underlying barriers of effective comparative analyses of historical and contemporary workplace violence research (Beech, 1999; Crawford, 1999; Duncan et al.; Luck, Jackson, & Usher, 2006).

Similar to the multiplicity of terms used to ‘name’ the phenomenon of workplace violence, definitions and descriptions are similarly multifaceted. Historically, workplace violence-related definitions have focused on the observable, that is, those acts “resulting in
physical injury” (Duncan et al., 2001, p. 60). More recent definitions of workplace violence have included a wide range of variables including not only physical injury but also mental, emotional, and sexual abuse. For example, Duffy (as cited in Webb, 2002) describes horizontal violence as including “overt and covert non-physical hostility, such as criticism, sabotage, undermining, infighting, scapegoating and bickering” (p. 112). Longo and Sherman (2007) add that horizontal violence is

an act of aggression that’s perpetrated by one colleague toward another colleague….is usually verbal or emotional abuse, it can also include physical abuse and may be subtle or overt. Acts of horizontal violence can include talking behind one’s back, belittling or criticizing a colleague in front of others, blocking information or chance for promotion, and isolating or freezing a colleague out of group activities. (p. 35)

The term ‘incivility’ is noted to conjure a variety of meanings including “low-level, deviant behaviour” (Hutton, 2006, p. 22) to “a variety of nuances – from breaches of etiquette to professional misconduct, from general civil unrest to moral decay” (Andersson & Pearson, 1999, p. 455). In addition, the ICN (2006) suggests that “excessive workloads, unsafe working conditions, and inadequate support can be considered forms of violence” (para 3). Farrell (1997) notes the difficulty in embracing an all-encompassing definition of workplace aggression and instead employs a non-descriptive statement, saying “an omnibus concept like aggression is best defined in terms of what people say it is” (p. 503). Presenting another interpretation of workplace violence, Smythe (2002) refers to the “violence of the everyday in health care” (p. 164) as “a kind of constraining and violencing of the spirit” (Oxford English Dictionary as cited in Smythe, p. 168). For the purposes of this research, the term workplace violence is used “in a broad sense to encompass verbal and emotional abuse, physical violence and sexual harassment” (CNA, 2002c, para 7, emphasis added).
Comparative analyses of the prevalence of workplace violence experienced by nurses are hampered by research variations of descriptors, sampling populations, methodological approaches, culture, workplace settings, and societal understandings of violence (Duncan et al., 2001; Luck et al., 2006; Merecz et al., 2006). Yet, there are commonalities as noted by Ross (2002): “violence directed at health care providers, including nurses and nursing students, is reported as endemic and considered an occupational hazard” (p. 15). To illustrate, Shields and Wilkins (2006) report that 29% of Canadian nurses experience physical assault and 44% experience emotional abuse. In a study of Alberta and British Columbia nurses, Duncan et al. suggest that “46% of nurses…experienced one or more types [of workplace violence] in the last five shifts” (p. 67). From an international perspective, the Royal College of Nursing (as cited in Randle, 2003) reports “one in six nurses had been subjected to bullying from a colleague in the last year” (p. 399). Authors metaphorically describe the pervasiveness of workplace violence: “a cancer that blights the dignity of our workplaces” (Olsen and Needham as cited in Speedy, 2006, p. 248), a culture of violence which pervades health care organizations (Duncan et al.), “professional terrorism” (Farrell, 1997, p. 504), poisoned work environment (ICN, 2006), and toxic work environment (Hutton, 2006; Montgomery et al., 2004). The workplace environment of nurses is described as harmful, fearful, abusive (Hutchinson et al., 2006b), hostile (Smith et al., 1996) and chaotic (Taylor, 2001).

The perpetrators of workplace violence as experienced by nurses are commonly identified as patients, patients’ family members, physicians, and co-workers (Duncan et al., 2001; Edwards & O’Connell, 2007; Hesketh et al., 2003; Pekrul, 1992; Sofield & Salmond, 2003). In 1992, Pekrul found that patient-initiated abuse accounted for three quarters of nurse abuse incidents.
More recent workplace violence research indicates a changing trend in sources of workplace violence (Farrell, 1997, 1999, 2001). For example, Duncan et al. and MacIntosh (2005, 2006) suggest that a high incidence of emotional abuse originates from co-workers. In addition, Hesketh et al. point to patients (and to a lesser extent, patients’ family members) as perpetrators of physical violence directed towards nurses in a variety of health care settings (p. 314).

The increased concern of co-worker-initiated violence is reflected in contemporary research which focuses primarily on co-worker bullying (for example, Bray, 2001; Duddle & Boughton, 2007; Edwards & O’Connell, 2007; Kupperschmidt, 2006; Lewis, 2006; Longo & Sherman, 2007). Harvey et al, (2006) provide linkages of playground bullying to workplace bullying. Einarsen (as cited in Harvey et al.) states “bullying at work is claimed to be more crippling and devastating problem for employees than all other work related stress put together” (p. 1, emphasis in text). In addition, Baltimore (2006) focuses on horizontal violence stating “not only do nurses eat their ‘young’ or those new to a situation, but ‘older,’ experienced nurses can also be mistreated by more tenured staff” (p. 28).

Although there is less focus on physician-perpetrated workplace violence in the contemporary literature, physicians continue to be identified as initiators of workplace violence against nurses. Hesketh et al. (2003) suggest that the incidence of physician-initiated workplace violence is closely linked to a number of factors such as specific health care settings and types of workplace violence. For example, Hesketh et al. indicate that the highest incidence of physician-perpetrated workplace violence is verbal sexual harassment occurring with greater incidence in critical care settings. In addition, Rosenstein, Russell, & Lauve (2002) report “a strikingly high prevalence of disruptive physician behavior that’s affecting nurse retention” (p. 8). The incidence of physician-initiated workplace violence is occasionally obscured in the literature where researchers (for example, Hesketh et al.; Duncan et al., 2001) use broad categories such as ‘co-
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workers’ to refer to nurse co-workers, physicians, and others health care professionals as perpetrators of workplace violence targeted against nurses.

_Silencing of Nurses’ Experiences of Workplace Violence_

Although workplace violence is recognized as a serious and ubiquitous problem, the literature suggests that nurses do not actively confront aggressive behaviour in their workplaces. For example, Duncan et al. (2001) suggest that 70% of nurses do not report abuse, referring to an “acceptance of a _culture of violence_ in hospitals, particularly by mid- and late-career nurses” (p. 71, emphasis in text). Societal trends of tolerance for escalating levels of violence and a reluctance to disclose violence to administrators have further contributed to the norm of non-reporting workplace violence (Duncan et al.; Farrell & Cubit, 2005; Rippon, 2000; Shaw, 2004). As a result, non-reporting of workplace violence enables both the abuser and victim to function in a “covert world” (Ferns, 2006, p. 42), supporting a “conspiracy of silence” (Farrell, 2001, p. 30).

Yet, MacIntosh (2005) frames non-reporting of violent incidents with a different lens. In citing several authors, MacIntosh (2005) suggests that “workplace bullying may go unaddressed, unacknowledged, and even unnamed because of its sometimes subtle, insidious, and secretive beginnings” (p. 893). Skillings (as cited in Thomas, 1997) states “as long as we [nurses] are silent, the cycle of oppression will continue to separate us, cause us pain, and (dis)honor our diversity” (p. 7).

_Personal, Organizational, and Societal Effects of Workplace Violence_

The effects of workplace violence are far-reaching, exacting a toll on personal, professional, organizational (health care system), community, and societal health (Almost, 2006; Burton & Hoobler, 2006; CRNNS, 2007; Coombs & Holladay, 2004; Croker & Cummings, 1995; Farrell, 2001; Farrell & Cubit, 2005; Hockley, 2003; Johnson & Indvik, 2001; LeBlanc & Barling, 2004; Lewis, 2006; Longo, 2007; Manitoba Nurses’ Union [MNU], 2005; Merecz et al.,
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2006; Royal College of Nursing, 2002, 2005; Rumsey et al., 2007; Salin, 2003; Thomas, 2005; Vartia, 2001; Vega & Comer, 2005). The ICN (2006) states “violence is destructive and has a profoundly negative impact on observers, victims, their family members” (para 14). Citing several authors, MacIntosh (2005) refers to the negative effects which impact victims and observers of workplace violence: physical symptoms (for example, cardio-vascular disease), burnout, diminished self-esteem, fatigue, sleep disturbances, depression, and social isolation. In citing Speedy, the CRNNS recognizes the “ripple effect” of witnessing workplace violence which includes “reactions such as feeling sorry for the victim, worrying about becoming a victim, being fearful of taking action, and changing jobs to avoid the problem” (p. 4).

Serantes and Suárez (2006) suggest that an organization suffers both tangible and intangible consequences of workplace violence (p. 230). Vega and Comer (2005) elucidate these organizational effects as being reduced productivity, efficiency, creativity, and innovation. In citing several authors, the CRNNS (2007) add that workplace violence impacts the cost of health care recruitment and results in “nurses leaving the profession at a time when healthcare is facing a dire nursing shortage” (p. 4). Harvey et al. (2006) cite extensive organizational destruction as a result of workplace bullying, which impacts daily abilities of employees, destroying employee organizational loyalty, controlling change agents, and “work[ing] as an organizational cancer, eventually killing the entire firm” (p. 3). In regards to patient care, the ICN (2006) suggests that “violence in the health workplace threatens the delivery of effective patient services and, therefore, patient safety” (para 3). Beyond the organization, there is potential for significant social losses (for example, alienation and unemployment) which have implications for the well-being of families, communities, and society (Vega & Comer).
Workplace Violence and Nursing Students

Even though there is emerging literature focusing on workplace violence, there is limited research dedicated to examining nursing students’ experiences (See Appendix C). Freshwater (2000) refers to an increasing amount of literature relating to horizontal violence but suggests that the literature does not adequately address the problem in relation to the nursing student. It is evident that the hostile atmosphere of the clinical setting is one in which nursing students are “normalized” into their professional role (Freshwater; Randle, 2003; Robinson & O’Leary-Kelly, 1996, 1998).

Thomas (1997) refers to a generation-to-generation cycle of abuse which acts to oppress nursing newcomers who may threaten to imbalance the status quo of the health care patriarchy. The phrase, “nurses eat their young” (Anonymous, 1999; Daiski, 2004; Meissner, 1986; Rowe & Sherlock, 2005), suggests that both student nurses and beginning graduate nurses are “quickly socialized into a culture of nurse-to-nurse abuse” (Farrell, 2001, p. 28) through “tribal tests” and brainwashing reflective of “insidious cannibalism” (Randle, 2003, p. 399). Hutchinson et al. (2006a) speak of abusive indoctrination of nurses into bully-defined work norms.

Of significance, Randle (2003) explores UK nursing students’ experiences in clinical placements finding “bullying…to be commonplace in the transition to becoming a nurse” (p. 395). Similarly, Foster, Mackie, & Barnett (2004) suggest “bullying is a problem for nursing students” (p. 67). Kohnke (as cited in Farrell, 2001) likens the circular and generational abuse within nursing to that of child abuse stating “because they [nurses] were treated badly as beginning level nurses they see it as their right to do the same to juniors” (p. 28). Citing Randle, Snow (2006) states “students often find themselves on the receiving end of bullying tactics simply because they are on the lowest rung of the ladder” (p. 42). In a beginning exploration of horizontal violence among nursing students, Longo (2007) found that nursing students experience
several types of violence in their clinical experiences: “being put down by a staff nurse”, “being humili- liated”, “having a sarcastic remark made about them”, and “being talked about behind their back” (p. 178). The cycle of violence and the role of power and oppression, with its impact on the socialization of nursing students, are also explored by Freshwater (2000).

In a study of Turkish nursing students, Celik and Bayraktar (2004) found that all students experience verbal, academic, sexual, or physical abuse during their nursing education which is initiated by classmates, faculty, nurses, physicians, patients, and patients’ families. Canadian nursing students, Theriault and Landry (1999), suggest that nursing students feel vulnerable to workplace violence as a result of a “lack of status in the clinical setting and…educational institutions of learning, low self-esteem, [and] lack of confidence in clinical competency” (p. 5).

Nursing students’ respond to abuse in clinical learning experiences by doing nothing (Celik and Bayraktar, 2004; Longo, 2007) and working at “‘fitting in’ and ‘playing the game’” (Stevenson, Randle, & Grayling, 2006, p. 48). Freshwater (2000) suggests that this translates into adopting the workplace social norms of the oppressive working environment. Thus, nursing students are quickly socialized and silenced in a patriarchal culture of nurse-to-nurse abuse where working in highly interdependent work roles translates to “monkey see, monkey do” (Robinson & O’Leary-Kelly, 1998, p. 658).

International literature focusing on nursing students’ experiences of workplace violence clearly points to the need for further Canadian research. As only beginning research of the phenomenon of workplace violence as experienced by nursing students has been undertaken, further comprehensive research of nursing students’ lived-experiences is critical in breaking the cycle of violence. Beardsley (2003) states “the nursing student may enter the workforce as a nurse perpetuating the cycle of silent victim of violence or take on the challenge to break the cycle, opening the way to improving the nursing profession” (abstract).
Theoretical Underpinnings of Workplace Violence

Workplace violence is described as “a broad, multidimensional and complex phenomenon” (Serantes & Suárez, 2006, p. 233). This is reflected in a variety of theoretical underpinnings which are employed to further the understanding of workplace violence such as biological theory (Luck et al., 2006), Broken Windows theory (Wilson & Kelly as cited in Hesketh et al., 2003), Buss’s aggression classification (Coombs & Holladay, 2004; Rippon, 2000), Clegg’s circuits of power (Hutchinson et al., 2006b), critical race theory (Allen & Cherry, 2006), feminist theory (Farrell, 2001; Ferns, 2006), gendered organization (Bray, 2001; Lee, 2002; Morgan, 1997), generational differences (Kupperschmidt, 2006), hierarchical structure (Baltimore, 2006; Daiski, 2004), multi-causal approaches (Registered Nurses’ Association of Ontario, 2007; Salin, 2003), oppression theory (including oppressed group theory) (Farrell, 2001; Freshwater, 2000; Hutchinson et al., 2006a; Longo & Sherman, 2007; Randle 2003; Sofield & Salmond, 2003; Taylor, 2001), organizational theory (Hoobler & Swanberg, 2006; Matthiesen & Einarsen, 2001; Morgan; Quine, 2001), personality theory (Edwards & O’Connell, 2007), powerlessness (Chambers, 1998), psychoanalytic theory (Luck et al.), social interaction/socialization (Andersson & Pearson, 1999), social learning theory (Luck et al.; Robinson & O’Leary-Kelly, 1998), spiral of incivility (Andersson & Pearson, 1999), triangular model of bullying (Harvey et al., 2006), and workplace abuse continuum (Johnson & Indvik, 2001) (see Appendices A, B, and C). In addition, a patriarchal approach to conceptualizing workplace violence is prevalent in nursing and multidisciplinary literature (for example, Farrell, 2001; Fletcher, 2006; Freshwater; Hedin, 1986; Lovell, 1981, 1992; Luck et al.; Meachin & Webb, 1996; Morgan; Rayner, 1999; Simpson & Cohen, 2004; Yodanis, 2004).
Conceptualizing Workplace Violence Using a Feminist Intersectionalist Perspective

In considering gendered violence, Crow and Gotell (2005) suggest that the limited patriarchal, essentialist frameworks embraced by second-wave feminists “have revealed themselves as insufficient to explore the complex power relations through which violence is enacted and legitimized” (p. 230). Sokoloff and Dupont (2005) support this in stating that the “traditional feminist approach” of theorizing violence has “increasingly been questioned by scholars and activists who recognize the need to give voice to women marginalized by the largely White, middle-class feminist movement” (p. 41). In addition, Crow and Gotell propose that “analysis of the causes and consequences of gendered violence cannot proceed without careful attention to the contextual intersections of race, gender, class and sexuality” (p. 233). To this end, Perilla, Frndak, Lillard, and East (2003) argue that there is a need for “stretching feminist parameters…by analyzing this issue [of violence] as a human problem rather than a gender problem” (p. 18).

Duffy (2004) refers to third-wave feminisms as “[having] developed a more complex and nuanced understanding of violence” (p. 128). The Canadian Panel on Violence Against Women (2000) supports a “feminist lens [which] enables us to see how gender, race and class oppress women and how these forms of oppression are interrelated and interconnected” (p. 363). Sokoloff and Dupont (2005) argue for an “intersectionality theory” which focuses on “multiple oppressions and difference” (p. 39). Duffy further adds support of this feminist approach, stating “pursuing this theoretical thread has led to greater attention being paid to the diversities of women’s lives and the complex interconnections between axes of oppression and subordination” (p. 145). Acker (as cited in Bell, 2007) calls for research that “really connects gender, race, ethnicity, and class in a critical way”, stating “the move to intersectionality is really important. It’s really not enough any more to just concentrate on gender” (p. 248, emphasis in text). This
A multifaceted and complex approach to conceptualizing workplace violence, a feminist theory of intersectionality includes “simultaneous, multiple and interlocking oppressions of individuals” (Mann & Grimes as cited in Sokoloff and Dupont, 2005, p. 39). Deaux (as cited in Wilkinson, 2003) describes intersectionality as a “condition in which a person simultaneously belongs to two or more social categories or social statuses and the unique consequences that result from that combination” (p. 28). Steinbugler, Press and Dias (2006) add that “intersecting forms of domination create both oppression and opportunity…. [and] because hierarchies of power are cross-cutting, it is likely that a person will be simultaneously advantaged by particular identities and disadvantaged by others” (p. 808).

Unlike the interdisciplinary literature, there is an absence of nursing literature which supports a feminist intersectionality approach to conceptualizing workplace violence. A beginning embracement of a third-wave feminist stance (Duffy, 2004; Pinterics, 2005) of intersectionality by one contemporary nurse author is noted: when referring to the proliferation of workplace violence as experienced by nurses, Webb (in citing Davies, 2002) states “the gendered nature of work in health care has been widely agreed to be one of the root causes, but race and social class must not be ignored as contributors” (p. 112). Furthermore, the RNAO (2007) allude to a more complex construction of workplace violence which extends beyond a one-dimensional focus of gender, stating “nurses who are disabled, racizialized, immigrants, gay, lesbian, bisexual, or transgender experience discrimination from patients, clients, and colleagues. It is therefore likely that they could face increased violence in the workplace” (p. 2).
Intersections of Oppression and Privilege

Although Berdahl and Moore (2006) point to the difficulty in limiting the complexity and multidimensionality of intersections in exploring workplace violence, three primary intersections of oppression and opportunity (privilege) are widely cited and explored in the literature: gender, class, and race (Acker, 2006; Berdahl & Moore; Crow & Gotell, 2005; Das Gupta, 2005; Fudge & Vosko, 2005; Kline, 2005; Perilla et al., 2003; Salin, 2003; Sokoloff & Dupont, 2005; Steinbugler et al., 2006; Webb, 2002; Wilkinson, 2003; Yodanis, 2004). In addition, Rummens (2003) and Wilkinson suggest that other intersections of diversity should be considered in order to fully understand systems of oppression and privilege. These intersections of diversity (or ‘social identity types’ as referred by Rummens) might include: Aboriginal status, newcomer status, ability/disability, age, sexual orientation, ethnicity, religion, language, immigration, region/territory, religion, and culture (Calasanti & Slevin, 2006; Rummens; Wilkinson). In addition, Rummens suggests that each type of social identity has a wide range of sub-types (for example, immigrant and refugee identities are sub-types of the newcomer identity). Further adding to the complexity of a feminist perspective of intersectionality, Rummens notes that intersections of oppression and privilege (and identities associated with these intersections) are not concrete nor do they occur in a vacuum:

Identification is socially constructed….Identification is relational as it is very much dependent on socio-culturally salient comparisons. It is also contextual – historically, socially, and culturally situated – as well as situational (context-specific) and thus informed by both the nature of interaction and the particular social actors involved. Identification is processual rather than simply inherent….Identification is, moreover, both fluid and flexible: It changes over time and often from situation to situation. Identities overlap and
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intersect. They may be multiple, even for a single type of identity, and may sometimes even be mixed. (Rummens, p. 25)

Acker (as cited in Bell, 2007) adds “the whole question of borders and categories is really difficult; extraordinarily complex, both in research and in the way in which society actually operates right now” (p. 248).

Complexities of Intersections of Oppression and Privilege

Citing several authors, Steinbugler et al. (2006) reinforce that an intersectionality perspective treats categories of oppression and privilege as “mutually constituted system of relationships…rather than discrete and unitary concepts” (p. 805). For example in considering gender, it is known that women are more likely than men to be victims of violence (Huch, 2000; Robinson, 2003; Statistics Canada, 2006). From an intersectionality perspective, one needs to consider what oppression (and thus, vulnerability) women experience when gender is intersected with other identities such as race, age, and class (Sengupta, 2006; Wilkinson, 2003).

The complex relationships of interlocking/ intertwining intersections of oppression and privilege are conceptualized in a variety of ways. Several authors (for example, Berdahl & Moore, 2006; Brewer et al., 2002; Burman, 2004; Donaldson & Jedwab, 2003; Hadley, 2005; Steinbugler et al., 2006) address ‘how intersections of oppression and privilege intertwine’ by juxtaposing a double burden or jeopardy of oppressions (that is, an additive relational form of two intersecting oppressions/ privileges such as gender and race) with a more complex notion of a triple burden or jeopardy (that is, a multiplicative relationship of three intersecting oppressions/ privileges such as gender, class, and race). Yet, in citing Takagi, Ward (2004) suggests that “counting oppressions is problematic for the very reason that it treats oppressions as ‘equal,’ or unrankable, by obscuring important contextual differences between them” (p. 83). Referring to “geometries of oppression” (p. 13), Valentine (2007) suggests that neither an additive nor
multiplicative analogy adequately describes the complexity of intersections of oppression and privilege.

Rummens (2003) problematizes a number of possible conceptualizations of how identities interface. For example, Rummens utilizes pictorial illustrations to demonstrate the shortcomings of employing stacking, radial, and centrifugal frameworks of intersectionality. To this end, Rummens supports a multi-dimensional, “multiple jeopardy” perspective where “multiple minority identifications intersect to effect an even less equitable social standing and outcome for the individual or population category in question than might be expected from any one such identification on its own” (p. 20). Thus, the intertwining of intersections of oppression and privilege extend beyond geometric equations or one-dimensional pictorial frameworks. In citing Kessler and McKenna, Valentine (2007) more accurately describes enmeshed categories of identities as producing specific effects that “abrade, inflame, amplify, twist, negate, dampen and complicate each other” (p. 13).

_Narrowing the Research Lens of Intersectionality_

Although the use of a holistic approach in examining matrices of oppression and privilege is supported by contemporary literature (for example, Wilkinson, 2003), there is a variety of cautionary notes which alert researchers to the complexity of employing a wide-open stance of intersectionality which includes an indefinite list of oppressions which intersect in infinite ways (Ludvig, 2006). Conversely, although several authors point to three or four primary (classical) oppressions, other authors suggest that this does not holistically reflect societal realities of oppressions and privileges:

While [gender, class, and race] may indeed be critical to a better understanding of many existing social structures and processes, other types of identities and kinds of identifications may also play a key role. It is therefore important to explore other potentially salient
identities and identifications, and to subsequently determine their relative – as well as their combined – impact on both personal and social outcomes. (Rummen, 2003, p. 25)

Ludvig, who refers to the endlessness of differences as “the Achilles heel of intersectional approaches”, poignantly states “the approach starts to get blurred with questions….Who defines when, where, which, and why particular differences are given recognition while others are not” (p. 247, emphasis in text). Berdahl and Moore (2006) metaphorically pose this limitation of intersectionality theory as “the Oppression Olympics: Who has it worse?” (p. 427). The problem then is, how should researchers who embrace a feminist perspective of intersectionality ‘manage’ (Ludvig; McCall, 2005) the complexity of intersectionality so that the realities of social interactions in given contexts might be understood in a holistic and comprehensible manner?

The literature provides a variety of contradictory suggestions for narrowing the lens of intersectionality for the purposes of research ‘manageability’. For example, McCall (2005) suggests a continuum of three methodological approaches which are described in terms of stances towards complex categories of oppression: anticategorical complexity, intercategorical [categorical approach] complexity, and intracategorical complexity. Other authors (for example, Ludvig, 2006; McCall; Valentine, 2007) suggest that the complexity of a feminist intersectionality perspective in research might be somewhat ‘managed’ through employment of case study methods which provide in-depth explorations of individuals’ experiences of intersections of oppressions and privileges in relation to specific social contexts. Despite “rejecting the validity of categorizations” (Ludvig, p. 248), Ludvig admits it is impossible to avoid categories and thus, employs an intra-categorical (gender, class, and ethnicity) research approach in a specific spatial and temporal context “in order to make their intersectionality transparent” (p. 251). Valentine also points to the difficulty of attempting to include an analysis of the full implications of all intersecting oppressions and privilege in a single research article.
Thus, Valentine cautiously supports some narrowing of the focus of intersections, explaining “when studies...have looked at intersectional types of issues they have tended to limit their analyses to the relationship between particular identities....for the sake of comprehension” (p. 14). Therefore, in narrowing the research lens of intersectionality for the purpose of this research study, a categorical and interrelational lens of intersectionality is employed to explore three primary intersections of oppression and privilege: gender, class and race.

Workplace Violence and Categorical Identities of Gender, Class, and Race

It is with caution that the intersections of gender, class, and race are unraveled and separately considered recognizing that this process temporarily suspends and isolates intersections of oppression and privilege from each other and potentially minimizes the essence and complexity of a feminist intersectionality perspective. In addition, it is noted that providing static descriptions of identities of gender, class, and race runs the risk of clouding the dynamism, spatiality, and temporality of intersections of oppression and privilege (Brewer et al., 2002). In citing several authors, Staunæs (2003) suggests that “Social categories are done, undone and redone in relation to other doings.... Social categories are performed, quoted, reproduced and transgressed....People can populate social categories and social categories can acquire people and make certain traits visible” (p. 104).

Even though attempts to unravel the matrices of gender, class, and race potentially provides a narrowed perspective from an intersectionality stance, this unraveling provides an important vantage point from which to begin to understand intersections of oppression and privilege as related to workplace violence. Wilkinson (2003) suggests that there is a need to “include the influence of the intersections of multiple identity markers in addition to their individual impact on social outcomes” (p. 31, emphasis added). Thus, the three primary
categories of gender, class, and race are considered individually with linkages to workplace violence from a multidisciplinary and nursing perspective:

*Intersections of Gender*

Referring to “components of inequality regimes” (Acker, 2006, p. 444), Acker states “gender, as socially constructed differences between men and women…[is] present in all organizations” (p. 444). Morgan (1997) illuminates the gendered organization as an extension of the family where “the dominant influence of the male is rooted in the hierarchical relations found in the patriarchal family” (p. 227). Perhaps the most revealing work in regards to nurses’ subordinated position in the patriarchal health care organization is provided by Lovell (1992). In her article, *Daddy’s Little Girl: The Lethal Effects of Paternalism in Nursing*, Lovell (1992) clearly delineates the assumed familial roles and power structures within the health care system. Under medicine’s hegemony, the order of the household (i.e. health care organization) is controlled by physicians (males), who assume the father-husband role. In citing Gamarnikow, Bray (2001) extends this hegemonic notion by stating “the division of labour between doctor and nurse is not primarily technical but sexual, based on patriarchal capitalist relations” (p. 26).

In regards to sexuality, Acker (2006) notes that “heterosexuality is assumed in many organizing processes …. Homosexuality is disruptive…because it flouts the assumptions of heterosexuality…. [and] carries a stigma that produces disadvantages of lesbians and gays” (p. 445). In citing several authors, Brooks et al. (1996) highlight workplace violence as experienced by men in nursing: “historically, males have had to cope with loneliness…guarded acceptance…and attribution of homosexuality” (p. 5). Duncan et al. (2001) also cite several authors in stating that “being male [in nursing] has been associated with higher rates of abuse-related injury” (p. 61). In their discussion of nursing students’ experiences of being bullied, Stevenson et al. (2006) state that “male nurses indicated experiencing significantly more sexual
harassment than their female colleagues” (para 40). Although nursing workplace violence literature is silent about the experiences of those who are lesbian, bi-sexual, queer, transgendered, or two-spirited, Duffy (2004) suggests that “lesbians…are subject to heightened rates of institutional and interpersonal violence” (p. 144), and Sokoloff and Dupont (2005) elucidate a linkage between violence and “the greater context of homophobia in society” (p. 44).

Intersections of Class

“Class…refers to enduring and systematic differences in access to and control over resources for provisioning and survival….class is intrinsic to employment and to most organizations” (Acker, 2006, p. 444). Smith et al. (1996) refer to a “‘chain of command’ in the hierarchical healthcare system”, with doctors holding “superior rank in the echelon” (p. 24). A class sub-hierarchy within nursing places some nurses above others and ranks patients at the bottom of the organizational ladder (Daiski, 2004; Hutchinson et al., 2006a; Randle, 2003; Smith et al., 1996). For example, those nurses who are intra-professionally subordinated are: junior level nurses (Hutchinson et al., 2006a; Smith et al.); newcomers/ young/ less experienced nurses (Daiski; Luck et al., 2006); and nursing students (Foster et al., 2004; Randle; Stevenson et al., 2006; Theriault & Landry, 1999). In addition, Daiski refers to inter-professional hierarchical relationships which are “inextricably intertwined” (p. 44).

Intersections of Race

Acker (2006) refers to race as “socially defined differences based on physical characteristics, culture, and historical domination and oppression, justified by entrenched beliefs” (p. 444). In citing Westley, Rice (2005) argues that race “is nothing more than a changing range of attributes that have been labeled as racial…race, in short, is socially created” (p. 325). Salin (2003) suggests a link between minority status and bullying.
Although the research into the relationship of race to workplace violence experienced by nurses is not plentiful, the available literature paints a bleak picture. For example, Canadian research into the experiences of immigrant nurses who have filed grievances for employers’ discriminatory practices surfaced the following themes: being marginalized, acknowledging and naming racism, experiencing physical stress and emotional pain, strategizing to cope and survive, and recommending policy changes (Hagey et al., 2001). Arising from this research, Hagey et al. note differential treatment for Black nurses who speak out against discrimination. In addition, Hagey et al. question the distribution of nurses into segmented health care labour markets where nurses of colour are streamed into long-term care and White nurses are asked for their specialty preferences (p. 390). Although not directly referring to race, Freshwater (2000) and Hutchinson et al. (2006b) link horizontal violence amongst nurses with concepts of colonization. In envisioning nursing in 2020 (Toward 2020), the CNA (2006) writes “Gender imbalances [in nursing] have been overlaid with broader society realities of white privilege….Canadian nursing’s decision-making and authority structures are still the territory of English-speaking, white women….described as ‘cappuccino equity’ – white on the top and brown on the bottom” (pp. 59-60).

Research Goals and Questions

Based on the literature review which supports research focusing on nursing students’ perceptions of workplace violence and a feminist stance of intersectionality of gender, class, and race, a feminist participatory action research project was employed to explore nursing students’ perceptions of workplace violence. The goals of this research project were fourfold: to describe nursing students’ perceptions of the nature of workplace violence; to explore nursing students’ perceptions of causes of workplace violence; to suggest strategies for transformation of the culture of workplace violence; and to raise consciousness of workplace violence. Two research
questions were proposed: ‘What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace?’ and ‘What actions are needed to transform the present culture of workplace violence in health care organizations?’ It was proposed that workplace violence as experienced by nurses is firmly rooted in the patriarchal organization of health care where multiple oppressions of gender, class, and race intertwine to create a hostile work environment.

Background

The research study entitled ‘Nursing students’ perceptions of workplace violence as experienced by nurses’ was located at the Saskatchewan Institute of Applied Science and Technology (SIAST), Wascana Campus in Regina, Saskatchewan, Canada. SIAST partners with the University of Saskatchewan and First Nations University of Canada to deliver the collaborative Nursing Education Program of Saskatchewan (NEPS). The SIAST Nursing Division delivers the first two years of the four year baccalaureate degree program. The researcher of this project is a faculty member employed by SIAST with educational roles and responsibilities in the first and second year of the NEPS at SIAST, Wascana Campus.

The humanities, social sciences, and life sciences provide the foundation for the NEPS (NEPS, 2006). The NEPS curriculum is process oriented with the premise “that client, students and faculty all draw their own personal meaning from experiences and interactions, and all are valued” (NEPS, p. I-2). The curriculum is based on a primary health care framework with themes of health, caring, ethics, diversity, and critical thinking incorporated in every course. In addition, “the approach to curriculum implementation is based on humanism, critical social theory, and phenomenology” (NEPS, p. I-7). “It is acknowledged that the student population is likely to be diverse, with a variety of previous health-care or work experiences, differing levels of maturity,
cultural background, varying learning style and preferences, family responsibilities and skills” (NEPS, p. I-2).

The NEPS curriculum “fosters the centrality of clinical experience” (NEPS, 2006, p. I-2), and it is in the context of these clinical learning experiences that nursing students are potential witnesses to the phenomenon of workplace violence as experienced by nurses. In the first year of the NEPS, nursing students have approximately 40 hours of clinical learning experiences, and in the second year, nursing students have approximately 530 hours of clinical learning experiences. Theory related to workplace violence as experienced by nurses is integrated in several courses throughout the program with nursing students exploring beginning foundational concepts in the first term of the first year of the nursing program.

Currently, there are approximately 155 first year and 146 second year nursing students in the NEPS at Wascana Campus, SIAST (SIAST, 2007). Age, gender, race/ethnicity, previous educational preparation, and employment status demographics of the NEPS (Wascana Campus, SIAST) student population are noted in Appendix D. Approximately 72.1% (n=217) of NEPS Year 1 and 2 students at Wascana Campus, SIAST are 24 years of age and under, and 91.0% (n=274) of the students are female (SIAST). In addition, approximately 7.3% (n=22) of NEPS Year 1 and 2 students at Wascana Campus, SIAST are Aboriginal and 6.3% (n=19) are Visible Minority (SIAST).

Research Design: Employing a Feminist Participatory Action Research Approach

A feminist participatory action research (PAR) approach was utilized, seeking “to honor the voices of participants, to create opportunities for reciprocal learning, and most importantly, to empower participants to change the conditions of their lives” (Kirsch, 1999, p. 3). A variety of feminist research perspectives as proposed by numerous authors (for example, Kirsch; Morris, 2002; Rose, 2001; Seale, 1998b; Skinner, Hester, & Malos, 2005; Struebert & Carpenter, 1999;
Taylor, 2001) underpinned this research study. Feminist perspectives relating to the research focus, valuing of life experiences, methodological pluralism, action orientation, collaboration, challenging of social norms, individual and community transformation, focusing on the affective component, a caring approach, and reflexivity were embraced. Utilizing values and principles of feminist research as noted by Kirsch, Morris, and Skinner et al., the present research study was well situated within a feminist perspective (see Appendix E).

A feminist perspective of research supports using a variety of methods to collect information-rich data. To this end, Morris (2002) offers research methods which align within a PAR methodology. In seeking the possibility of “gaining different perspectives from data and using them to give a fuller picture” (Williamson, 2005, p.7), several authors suggest the use of methodological triangulation in action research for the purpose of facilitating close collaborative relationships, empowering participants, and uncovering new knowledge (for example, Adami, 2005; Tuckett, 2005). Thus, a mixed-methods approach using a brief survey and learning circle focus group was used to answer the research questions.

Survey

A convenience sample (Macnee, 2004) of first and second year undergraduate nursing students were surveyed through the use of a brief questionnaire designed to collect demographic information, participants’ perceptions of violencing of nurses in the clinical setting, and suggested transformative strategies. Open-ended questions/ statements which required free text responses were utilized for data-gathering (Rattray & Jones, 2007). Using this method, an example of a survey item included “Write about a specific time when you observed an incident of workplace violence experienced by a nurse (or nurses) while in clinical learning experiences” (adapted from Heinrich, 2006). Participants who had not observed workplace violence were
asked to write about what they thought would be a typical incident of workplace violence as experienced by nurses in clinical workplaces (adapted from Foster et al., 2004) (see Appendix F).


Learning Circle Focus Group

A purposive sampling (Macnee, 2004) of six first and second year undergraduate nursing students were recruited for in-depth data collection through a learning circle focus group approach. This participatory action research approach was chosen as a method of “promoting the experiential learning of the participants and allowing the required data collection” (MacIntosh, 2005, p. 896). Placing an emphasis on learning by the researcher and participants, a learning circle approach offered a safe environment (Hiebert, 1996; Lepp & Zorn, 2002; MacIntosh, 2005) where participants could “share their experiences, their reflections on those, and their theorizing about those experiences….and begin to visualize and discuss action steps” (MacIntosh, 2005, p. 896). The action research method of the learning circle presented “an opportunity for participants and [researcher] to work together toward ‘constructed knowing’” (MacIntosh, 2006, p. 896).

Chinn’s (2004) PEACE (Praxis, Empowerment, Awareness, Cooperation, Evolvement) and Power processes for gatherings were embraced to “overcome dynamics that set up advantage for some and disadvantage for others” (p. 1) (see Appendix G). An unstructured, in-depth interview method (Seale, 1998b) was employed so that participants’ descriptions could be “explored, illuminated and gently probed” (Wimpenny & Gass, 2000, p. 1487).

**Ethical Considerations**

The Athabasca University Research Ethics Board (REB) granted approval to conduct this research project. As part of the research ethics approval process, letters of support were provided by the Director of Applied Research (SIAST), Dean of Nursing (SIAST), and Program Head, NEPS (Wascana Campus, SIAST).

In implementing this research project, ethical and legal obligations outlined by the educational institution (Athabasca University), the researcher’s employer (SIAST), and the researcher’s professional associations (Saskatchewan Registered Nurses Association and Canadian Nurses Association) were observed. The following documents were utilized in consideration of feminist ethical approaches to this research project: *Ethical Review Guidelines for Research Involving Students or Other Individuals Related to the Researcher as Research Participants* (Athabasca University, 2004); *Policy for Research Involving Humans* (Athabasca University, 2001); *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research [CIHR], 1998); *Code of Ethics for Registered Nurses* (CNA, 2002a); and *Ethical Research Guidelines for Registered Nurses* (CNA, 2002b).

The following CIHR (1998) ethical principles were observed: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and
confidentiality, respect for justice and inclusiveness, achieving an appropriate balance between potential harms and benefits, and minimizing harm and maximizing benefit.

Respect for Free and Informed Consent and Voluntary Participation

Participation in the project was on a volunteer basis. Research project information regarding the purpose, duration and nature of participation, potential benefits and risks, confidentiality, anonymity, and voluntary participation was distributed through the use of posters, distribution e-mails (see Appendix H), and informational sheets (see Appendix I). Researcher contact information was included in all communications with the offer of further information/clarification of the research study as needed.

The survey was conducted after potential participants had time to consider the research project information. An informational face page informed participants that the completion of the survey indicated their willingness and voluntariness to partake in the project.

Interested participants for the learning circle focus group were asked to contact the researcher to set an appointment to discuss the research process. The participants were encouraged to take time to review the written information and reflect on the informational discussion prior to giving written consent (see Appendix J). In addition, participants of the learning circle were asked for their ongoing consent at the beginning of each learning circle (Kirsch, 1999). Potential participants were informed that participation and sharing of information was voluntary in all aspects of the research process. Information regarding the freedom to withdraw from the research study at any time without penalty or repercussion was included in written information and informational sessions related to the research study.

Respect for Vulnerable Persons

Faculty need to be particularly cognizant of potential ethical issues when involving their students in research (Athabasca University, 2004; Clark & McCann, 2005; Ferguson, Myrick, &
Yonge, 2006). Citing Edwards and Chalmers, Ferguson et al. refer to the position of dual agency where one is “fulfilling two roles simultaneously in relation to the same individual….The double agency creates a situation [of]…conflicting loyalties as teachers and researchers” (p. 707). Olesen (2005) adds “relationships with participants lie at the heart of feminist ethical concerns” (p. 255).

Athabasca University (2004) provides guidelines for research involving students. As the participants in this research project were recruited from the educational program in which I teach, these guidelines were of particular importance. As a possible power relationship might be interpreted to exist, there was potential for a perception of participation coercion. To minimize this, data collection was conducted towards the end of the academic year when the researcher had no further teaching obligations with the nursing students. Perceptions of coercion were also minimized through written and verbal statements regarding voluntariness, informed consent, anonymity, confidentiality, risks and benefits of participation, time commitment, contact information, freedom to participate, and right to refuse to participate and withdraw from the study at any time without repercussions (Athabasca University, 2004; Ferguson et al., 2006; Clark & McCann, 2005). The following statement was included in research study informational documents: “Your participation or non-participation in this study will not have any influence on your academic studies at SIAS” (adapted from Athabasca University, 2004). In addition, research information indicated that the research was conducted by the researcher as a student of the Master of Arts-Integrated Studies program, Athabasca University. In reporting of the research results, participant consent for the use of quotes from the learning circle gatherings was obtained (see Appendix K).

To avoid any perception of misuse of course time, data collection from the survey and learning circle focus group were scheduled outside of nursing students’ class and clinical learning
experiences (Clark & McCann, 2005). The survey was conducted in the participants’ educational institution in one of the classrooms. The learning circle focus group gatherings were held at the participants’ educational institution but were held in a location away from typical classroom areas.

Although there were several potential ethical issues, Ferguson et al. (2006) state “nursing education needs more research to develop the evidence on which curricular and programmatic decisions are made” (p. 705). In addition, Ferguson et al. elucidate the need to involve nursing students as “essential participants in most nursing education research, and thus, of necessity, [nursing students] must be involved as participants” (p. 705). Recognizing and addressing potential issues of conflict of interest are critical in the dual agency of the researcher and educator (Clark & McCann, 2005; Ferguson et al.). Furthermore, topics of sensitive nature need to be researched with increased sensitivity when the researcher is in a dual role (Ferguson et al.).

**Respect for Privacy and Confidentiality**

Confidentiality, anonymity, and privacy were assured through implementation of several safeguards. For example, measures were taken to ensure that learning circles were convened in privacy, data files were stored safely, raw data was de-identified in regards to participants and any identified third party individuals or organizations, and arrangements were made for the anonymous return of completed email surveys. Participants were informed of the researcher’s professional obligations to confidentiality and to report any information about an action which is illegal or might be deemed harmful to the participant or others.

The survey results were compiled and stored electronically on computerized disks and printed as necessary for data analysis. Only the principal researcher and professional services personnel had access to the raw data collected during the study. The professional services
personnel, who provided transcription and other clerical services, signed a confidentiality agreement (see Appendix L).

The audiotape transcription of the learning circle gatherings were stored electronically on a computerized disk and printed as necessary for data analysis purposes. The audiotapes, paper documents (surveys, compilation of surveys, transcriptions), and computerized disks were kept in a secure, locked location during the research study. Where data could be stored electronically, paper copies were personally shredded following the approval of the research study report.

The computerized disks of the compilation of survey results and transcriptions of learning circle focus groups will be stored in a secured, locked location only accessible by the researcher for a period of five years after the completion of the research study at which time any remaining raw data related to the research study will be shredded/destroyed by the researcher. Any identifying information (such as consent forms) will be kept securely locked in a separate location away from the survey compilation and focus group transcription data, and shredded five years following the research study.

*Respect for Human Dignity/Minimizing Harm and Maximizing Benefit*

As violence is a sensitive subject, it was important to identify the potential for emotional distress which might be experienced. Participants were informed of the potential risk of the research study methods to create uncomfortable feelings or resurface emotions from the past. Potential participants were informed that participation is voluntary, and if they chose to participate, it was with the understanding that they could refuse to answer certain questions and withdraw during the data collection period. Participants were reminded at the beginning of the survey and learning circle focus group gathering that they should share their stories according to their comfort level. If any questions caused discomfort, the participants were advised to leave those questions unanswered. The final portion of each learning circle was devoted to debriefing,
circling, and check-out. Contact information of SIAST and public-access care providers (such as counselors, health nurses, harassment prevention advisors, Elders, and First Nation education advisors) was available in the event that follow-up care was needed. A letter was sent to SIAST care providers informing them of the research study and the possible risks involved (see Appendix M).

Measures to avert researcher compassion stress were implemented through peer support, journaling, and work-life balancing (Morris, 2002; Rager, 2005). As the focus of this research study was sensitive, the researcher ensured professional services personnel had opportunities to debrief during and following compilation and transcription of the research data.

Method

Distribution of Information and Invitation to Participate

Approximately one week prior to the survey, an invitation letter to participate in the research study (see Appendix H) and the Research Study Information Sheet and Invitation to Participate (see Appendix I) were sent to first and second year nursing students through the educational institution’s email system. This email provided information about the research study and invited participation in the survey and learning circle focus group.

Prior to the survey, the researcher met with prospective participants and provided verbal and written information about the research study. The invitation letter (Appendix H) and the Research Study Information Sheet and Invitation to Participate (see Appendix I) were distributed and used as a script for the informational session. There were opportunities for potential participants to ask questions about the research study during and following the information session. The invitation letter (see Appendix H) was posted on bulletin boards to advertise the research project.
Potential participants for the learning circle focus group were asked to contact the researcher to set appointments to further discuss the research study process. The participants were encouraged to take time to review the written information and reflect on the informational discussion prior to giving written consent. Discussions with potential participants for the learning circle were by email, phone, and in-person.

Participants

Survey

A convenience sample (Macnee, 2004) of 37 nursing students (18.9% of the total potential participants) was obtained from a target population of approximately 82 first year nursing students enrolled in an intersession course and approximately 114 second year nursing students enrolled in an intersession clinical practicum course (total of 196 potential participants). Of the total potential first year participants, 37.0% (n=30) participated in the survey, and of the total potential second year participants, 6.1% (n=7) participated in the survey. Of the 37 participants who participated in the survey, 81.1% (n=30) were first year nursing students and 18.9% (n=7) were second year nursing students.

The demographics of the survey participants and the demographics of nursing students enrolled in the first and second years of the Nursing Education Program of Saskatchewan at SIAST, Wascana Campus are compared in Appendix D. Participants of the survey represented both genders (94.6% [n=35] of the participants were female and 5.4% [n=2] were male). The ages of the learning circle participants ranged from ‘20 and under’ to ‘36 to 45’ years of age. In regards to race/ethnicity, 94.6% (n=35) of participants were Caucasian and 5.4% (n=2) were Visible Minority. No Aboriginal nursing students participated in the survey.
Learning Circle Focus Group

A purposive sampling (Macnee, 2004) of six nursing students were recruited from first year nursing students enrolled in an intersession course and second year nursing students enrolled in an intersession clinical practicum course. The first six nursing students who volunteered and consented to participate in the learning circle participated in both the first and second learning circle gatherings.

The demographics of the learning circle participants and the demographics of nursing students enrolled in the first and second years of the Nursing Education Program of Saskatchewan at SIAST, Wascana Campus are compared in Appendix D. Participants of the learning circle represented both genders (83.3 % [n=5] of total participants were female and 16.7% [n=1] were male). The ages of the learning circle participants ranged from ‘21 to 25’ to ‘36 to 45’ years of age. In regards to race/ethnicity, 66.7% (n=4) of participants were Caucasian and 33.3% (n=2) were Visible Minority. No Aboriginal nursing students participated in the learning circle. Fifty percent (n=3) of the learning circle participants had a post secondary certificate, 33.3% (n=2) had completed university classes, and 33.3% had completed a university degree. All of the learning circle participants had work experience, with 50% (n=3) having work experience in health-related employment.

Data Collection

Survey

The survey was conducted following nursing classes. Potential participants were informed that participation in the survey was considered to be an indication of informed consent as stated on the first page of the survey. Participants were asked to retain the survey informational face page for their records. Consenting participants answered the survey questions (see Appendix F) taking approximately 15 to 20 minutes to complete. One survey participant wrote extensively and
required approximately forty five minutes to complete the survey. Completed surveys were returned to the researcher in sealed envelopes to protect anonymity and confidentiality. As there was limited survey participation by the second year nursing students (6 participants), the survey was also distributed to these potential participants through the educational institution’s email system. One completed survey was returned through this email survey process.

**Learning Circle Focus Group**

The learning circle focus group met on two occasions (five days apart) for approximately one and a half hours and two hours respectively. Chinn’s (2004) PEACE and Power processes for gatherings were discussed at the beginning of the first learning circle emphasizing components such as check-in and closing circle (see Appendix G). The research design of a learning circle focus group approach was briefly overviewed emphasizing the goal of and desire for mutual learning for the participants and researcher.

A topic guide (see Appendix N) was developed by the researcher prior to the first learning circle. Tentative topics included perceptions of workplace violence, contributing factors, and transforming the culture of violence in the health care workplace. These discussion topics were validated with participants at the first learning circle. Following check-in of the first learning circle gathering, a question was posed by the researcher (“How would you describe workplace violence?”) as a starting point to the discussion about nursing students’ perceptions of workplace violence as experienced by nurses. Following this, an unstructured interview approach was employed with the researcher providing prompting responses (Krueger, 1994) and some probing questions to validate learning circle dialogue. With the permission of the participants, the learning circles were audio-recorded.

In preparation for the second learning circle, the researcher compiled and themed survey responses to the survey Question #10: “What two questions do you think should be considered
for discussion by this focus group?”. At the end of the first learning circle, participants were given a copy of these questions (see Appendix O) and asked to consider one question which they thought to be most important to discuss in the second learning circle. During check-in of the second learning circle, each participant offered a research question which he/she had chosen from the distributed themed questions. These questions provided the foundation for the second learning circle dialogue. The following six questions were chosen by the learning circle participants for discussion: “Whose responsibility is it to decrease workplace violence?”, “Why are nurses afraid to report violence?”, “As students coming into the profession, did the students have any doubt about the career because of the workplace environment?”, “How can workplace violence be preventable?”, “How would you prepare for a known hostile client who is being admitted to your ward?”, and “What can be done to make the workplace safer for nurses?”. The learning circle participants dialogued about their knowledge, experiences, thoughts, and ideas in relation to these questions and through this dialogue, many other aspects of workplace violence were explored.

Prior to closing circle (check-out) of the second learning circle, the researcher’s preliminary thematic analysis from the first learning circle was distributed for validation, clarification, and revision by the learning circle participants. The themes were reviewed by the participants and researcher, and the learning circle participants clarified/validated topics utilizing a gentle probing process by the researcher. Following the closing circle (check-out) of the second learning circle, informed consent was sought from the learning circle participants for permission to use their quotes in the final report of the research study (see Appendix K).

Data Analysis

Data analysis occurred alongside data collection. A thematic analysis approach was used to analyze the collected data from the survey, audiotapes/transcriptions of learning circles, and
the researcher’s field notes, reflective journal (Munhall, 2001), and audit trail (Orb, Eisenhauer, & Wynaden, 2001). Simple statistical compilations were used for demographic information collected from the survey and learning circle participants (Morris, 2002). Colaizzi’s (as cited in Chambers, 1998) framework for thematic analysis was used to analyze the collected data, including presencing (naïve reading), multiple readings, thematic clustering, validation, and descriptive writing.

The raw data from the survey was reviewed several times prior to the first learning circle. Preliminary survey themes were identified and the responses to survey Question #10 “What two questions do you think should be considered for discussion by this focus group?” were compiled by themes. These questions were distributed to the learning circle participants for their consideration for discussion.

The audiotapes from the first learning circle were reviewed several times prior to the second learning circle. A thematic analysis approach was used in identifying preliminary themes which were reviewed by the participants in the second learning circle. As the first learning circle audiotapes were not yet transcribed, handwritten and computerized notes were made as the researcher listened to the audiotapes. From these notes, themes were identified, coded, revised, added, and deleted with each subsequent audio review. In addition, reflective notes from the ongoing research process were reviewed to validate and spark further critical analysis of the survey responses and learning circle dialogue. In the second learning circle, themes were shared with the participants for the purposes of validation, clarification, and revision (Kirsch, 1999; Morris, 2002; Skinner et al., 2005).

Following the second learning circle, the survey responses were compiled and learning circle audiotapes were transcribed. Initially, the audiotapes from both learning circles were reviewed in the absence of and then alongside the verbatim transcriptions. The transcriptions
were checked closely for accuracy and corrections/ additions were made as necessary. In
addition, any identifying information was removed from the transcriptions and survey
compilation. Subsequently, transcriptions were formatted with a large left hand column, double
spacing, and line numbering for coding, comments, and tracking of data. The transcriptions were
then re-read several times to identify themes. The Microsoft Word Edit/Find function was used as
a validating method to search the transcriptions for repeated words or themes. A similar approach
was used in identifying themes in the survey compilation.

Thematic clustering was accomplished through several methods. The learning circle
verbatim and survey responses were organized into separate electronic documents according to
identified themes/ codes. Electronic documents of verbatim and survey responses were created
for each of the following overall themes: naming and describing the phenomenon of workplace
violence, prevalence of workplace violence, perpetrators of workplace violence, silencing of
workplace violence, theoretical underpinnings, individual, organizational, and societal effects,
and transformation of the culture of violence in the health care workplace. Each theme derived
from verbatim transcripts was again reviewed several times using a thematic analysis approach
resulting in sub-themes within each of the thematic categories.

Finally, each learning circle participant’s verbatim transcript was separated and clustered
with a view towards weaving together each participant’s story of workplace violence. Using a
thematic analysis approach, the participants’ stories were critically analyzed for further insight
into the previously identified themes and sub-themes. Specific themes of raising consciousness
and transformatory learning related to workplace violence were noted.

Additional sources used for the development of the data analysis approach included the
following: Chiovitti and Piran (2003), Duggleby (2005), Krueger (1994), Lindseth and Norberg
(2004), Randle (2003), and Seale (1998b).
Results

The goals of this research study form the framework of the data analysis. The themes and sub-themes are organized according to the following goal categories: nursing students’ perceptions of workplace violence as experienced by nurses (descriptions, prevalence, perpetrators, silencing, and effects of workplace violence), causes of workplace violence as experienced by nurses (a feminist stance of intersectionality), transformation of the culture of violence in the health care workplace, and raising consciousness of workplace violence as experienced by nurses.

Nursing Students’ Perceptions of the Nature of Workplace Violence as Experienced by Nurses

Descriptions of Workplace Violence

Survey and learning circle focus group participants described their perception of the nature of workplace violence as experienced by nurses. The difficulty of providing an all-encompassing description of workplace violence was evidenced by the diversity of responses provided by both survey and learning circle participants.

Survey. Survey participants provided a wide variety of descriptors of workplace violence as experienced by nurses with statements such as “Workplace violence can be described as a client overreacting on a nurse, or verbally or violently hurting the nurse.”; “I think workplace violence can be common and I think it is for the most part very subtle in the way nurses talk and interact with each other, often done behind each other’s back.”; and “[Workplace violence is] any situation/ conversation in that the nurse is trying to provide care [where] the patient becomes unaccepting of care and expresses a variety of ways that are harmful towards the nurses.”

Although participants primarily spoke of nurses as victims of workplace violence, the message of potential violencing of patients in the workplace was evident, yet subtle: “Workplace violence would be any incident where the nurse or client feels threatened, demeaned, or ashamed
through no fault of their own.”; “Nurses can be yelled at, called demeaning names or be hit by aggravated clients or nurses can hit, yell, or mistreat their clients when stressed.”; and “Workplace violence may be anything which endangers the patient or nurse in a physical, emotional, or verbal role.”

In addition, the uncertainty of understanding and describing workplace violence is clearly elucidated by one survey participant:

“To be honest, I am unsure. Workplace violence happens everywhere when you consider all types of violence including verbal. I am not saying it happens all the time. It is just something people need to be more aware of and help prevent it through collaboration with other health care professionals.”

Learning circle. When asked to describe workplace violence as experienced by nurses during the first learning circle, one participant stated: “I think that’s difficult because there’s no consensus….it’s hard to define…there’s so many aspects that may actually be workplace violence”. Another learning circle participant agreed with this statement, adding “it’s a broad topic…it’s in every profession, and it’s unacceptable…but it is hard to determine…everybody takes it differently”. Other learning circle participants concurred, suggesting that the topic of workplace violence is “broad” and “diverse” making it difficult to provide a specific description. As described by one learning circle participant, the personal experience of those being violated is central to the naming of violence: “I think that everybody has a definition of violence and a different degree of what violence is, and some people are able to walk away from some things and other people can’t”.

Overall, the research participants pointed to a multidimensional understanding of workplace violence including physical, verbal, emotional, racial, and sexual underpinnings.
Prevalence of Workplace Violence

Survey. Although not specifically questioned, the perceived prevalence of workplace violence as experienced by nurses emerged in both the survey responses and learning circle discussions. A continuum of prevalence was perceived where workplace violence was seen as “almost non-existent” to “happen[ing] often”. Some participants differentiated between the prevalence of verbal and physical workplace violence: “I think nurses all experience mild forms of workplace violence. However, I don’t think many experience severe violence” and “I would say it’s minor physical incidents [and] mostly verbal and emotional abuse”.

Several participants commented on the increasing prevalence in relation to nurses’ acceptance of workplace violence “as part of the job”: “It’s becoming a norm. People (nurses) are starting to just accept violence as part of the job” and “I think violence is experienced too much by nurses. I believe that many nurses feel that it is ‘just part of their job’ so they put up with it”.

Learning circle. Nursing students who participated in the learning circle described the prevalence of workplace violence in relation to a number of contextual circumstances such as “newness” of the nurse, type of clinical and community setting, patients’ history of substance abuse, leadership styles, nurses’ workload, and shortages of nurses. Although the learning circle participants initially agreed that workplace violence “happens frequently and daily”, “is a huge issue”, and “exists everywhere and probably 100%”, further reflective dialogue resulted in the learning circle participants becoming more discriminating in their view of the prevalence of workplace violence. One learning circle participant stated

“I personally think it’s getting better, when you look…at our teachers constantly telling us that we have to be assertive, that we have to stick up for each other, we have a voice…I really personally feel that nurses are starting to get stronger.”
One learning circle participant stated “I think the drastic physical abuse…is getting worse just because you see a lot of substance abuse, so that impacts. So I think there’s a lot more violence that way”, and another learning circle participant referred to the complex and changing nature of workplace violence:

“I don’t say it’s particularly getting better or that it’s even getting worse. What I’m saying is maybe with some severe forms, things are being implemented to deal with it, and that’s good. Yet, I think on the other hand, there’s new ways of doing [workplace violence]. Unfortunately harassment is creeping in the workplace for various reasons, and technology is one example that is allowing that to happen….I’m saying it’s changing….I don’t know if people’s perceptions of it are changing but I think the forms of it [are] changing.”

The learning circle participants also made comparisons of the prevalence of workplace violence to broader social and global issues of violence. A participant stated that “workplace violence is a common problem in any country”, and another participant referred to violence as being “everywhere, it’s all over TV, it’s everywhere”. At times, the learning circle dialogue focused broadly on violence issues beyond the workplace, and one participant queried: “should we be surprised that there is violence in the workplace given it’s pervasiveness in our world, in our species?”, and subsequently offered “it [violence] becomes so overwhelming…it’s so proliferated”.

*Perpetrators of Workplace Violence*

*Survey.* Survey participants identified a variety of perceived perpetrators of workplace violence as experienced by nurses. Clients and co-workers were identified most often as being perpetrators of workplace violence. To a lesser extent, patients’ family members and physicians were mentioned as initiating workplace violence. For example, survey participants offered the following descriptions of workplace violence: “A nurse found a client’s medication in his bedside
table. She attempted to remove the medication and the man grabbed the nurse’s wrist. He raised his voice and attempted to strike her” and “I think verbal abuse would be the worst in the workplace, from nurse to nurse, other hospital staff to nurse and clients to nurse”.

When citing the ‘patient as perpetrator’ of workplace violence, survey participants frequently associated patients’ mental health challenges with incidents of workplace violence. For example, patients perpetrating workplace violence were described as having “cognitive impairment”, “confusion”, “dementia”, “disorientation”, “substance abuse”, and “mental illness”. In addition, patient-perpetrators were viewed as being under stress, fearful, frustrated, angry, and anxious. The elderly age group was cited most frequently as being responsible for patient-perpetrated workplace violence: “I have seen a lot of workplace violence toward nurses working with the elderly” and “The elderly use violence when they are not cognitively aware of his/ her surroundings”.

Learning circle. Participants of the learning circle gatherings also described patients, co-workers, patients’ family members, and physicians as potential perpetrators of workplace violence as experienced by nurses. Whereas the survey respondents cited workplace violence incidents initiated by patients most frequently, learning circle participants’ discussions focused primarily on violencing of nurses by co-workers (other nurses, practical nurses, special care aides, and nurse managers), providing diverse examples of incidents where nurses were perceived to beviolenced.

After conversing extensively in the first learning circle gathering about nurse-perpetrated incidents, the following conversation ensued when prompted by the researcher to identify someone who was perceived to most frequently initiate workplace violence against nurses:

Participant A: “I’d want to say doctor but I’ve never worked in that experience”
Participant B: “I think doctors because…they have a tendency to belittle the nurse in front of patients which then the patient may start to question…”

Participant C: “I think the clients in general…”

Participant A: “Ones that do the most significant damage, I’d say would be like somebody that’s supposed to be on your team, right?

This dialogue demonstrated the diversity of learning circle participants’ thinking and knowing of workplace violence as experienced by nurses. Yet, these particular ideas presented by the learning circle participants were tentative and suggested that their ways of knowing about perpetrators of workplace violence in health care organizations were not solely premised on clinical learning experiences as nursing students.

*Silencing of workplace violence*

Survey. Several survey participants pointed to the silencing of workplace violence as experienced by nurses. One participant wrote “I think [workplace violence] is underplayed or brushed aside. Nurses tend to think…that because the person is a patient, the abuse/ violence is part of the job….I really think a common phrase has become ‘it’s part of the job’”. Another participant stated “[workplace violence] is an additional stressor and rather than being discussed and ‘solved’, it is pushed aside, and not dealt with”. It was suggested that nurses may be “ashamed” to report workplace violence. In addition, another participant wrote about his/ her own silence about workplace violence, stating: “I am a perfect example – I’ve seen it but have done nothing but forget about it”.

When asked “What concerns you most about workplace violence as experienced by nurses?”, many survey participants responded with concerns of silencing of workplace violence: “Not being reported”, “That it is becoming a norm and an accepted part of the job”, and “The fact that nurses think it is part of the job and therefore see it as acceptable”.
Learning circle. Referring to the survey Question #10 “What two questions do you think should be considered for discussion for this focus group?”, one learning circle participant chose the following question to discuss in the second learning circle gathering: “Why are nurses afraid to report violence?” (see Appendix O). Dialogue related to this question included:

“I think some nurses may be afraid of losing [their] job or losing money, and if they report an incident of violence maybe that person who made the violence is the head of the department or the manager or doctor. Maybe they don’t want to get some other trouble such as bad relationships. Maybe the person will tell some bad gossip which will [make] me feel uncomfortable.”

“You don’t report it maybe because you actually don’t even realize that it’s in your make-up in a sense. You don’t even recognize that it’s going on anymore after awhile.” and “Nurses have different cultural backgrounds….They [specific cultures] always respect others even [if] they do some not nice things. They can understand, accept that situation so maybe they don’t report them. Give them some chances to correct themselves”.

One learning circle participant referred to the context of the health care environment as being a perceived barrier to reporting workplace violence:

“I think with the chaotic-ness of the actual workplace, you’re constantly going, you’re constantly moving, and maybe there’s more important things going on in your head. Then, by the time you get back to it, you almost second guess yourself…‘did they really do it that way?…‘am I just having a bad day?’”

Another participant added “It’s hard as a new person to change anything because everybody accepts. So you should too, blend in and be happy”. 
The participants also commented on the importance of breaking the silence. A participant stated “Before anything is going to be done, I think more instances have to be reported….Could you imagine the impact that it would have if everybody realized what actually was going on?”.

Effects of workplace violence

Survey. In response to the survey Questions #5 (c) and 6 (c), “How do you think workplace violence affects nurses?”, survey participants shared a variety of perceptions about actual and potential effects of workplace violence. In addition, concerns of the effects of workplace violence as experienced by nurses also emerged in response to the survey Question #8 “What concerns you most about workplace violence as experienced by nurses in the clinical setting?”. Questions about the effects of workplace violence were also posed by survey participants in response to the survey Question #10 “What two questions do you think should be considered for discussion for this focus group?” (see Appendix O).

A thematic analysis of the data provided by survey participants revealed four themes of effects of workplace violence as experienced by nurses: effects on the nurse, effects on the patient, organizational (health care system) effects, and societal effects. Survey participants wrote primarily of nurse-related effects followed by organizational effects (where applicable, the number of similar survey responses is included in parentheses).

Although concern for personal safety (n=9 responses) and physical injuries (n=7) (for example, “loss of life”) was identified, there was more concern expressed for nurses’ (personal) mental and emotional well-being. Survey participants cited a range of possible adverse effects on nurses’ mental health resulting from workplace violence: feelings of being silenced (n=13), stress (n=9), anxiety (n=8), decreased self-esteem (n=7), decreased confidence (n=5), fear (n=5), depression (n=5), burn-out (n=4), anger (n=3), frustration (n=2), decreased self-image (n=1), shame (n=1), difficulty in developing trust in interpersonal relationships (n=1), and suicide (n=1).
In addition, participants posed questions related to the impact of workplace violence on nurses. For example, one participant questioned “How, as nurses, would workplace violence affect your career?”. Survey participants also questioned the potential effect of workplace violence on nursing students, asking: “As a nursing student, do you feel at risk? Why?” and “How does [workplace violence] affect nursing students before they become nurses?”.

The survey participants also cited many far-reaching organizational effects which result when nurses areviolenced in their workplaces: decreased ability to recruit and retain nurses \( (n=11 \text{ responses}) \), decreased work competency \( (n=9) \), increased time away from work \( (n=8) \), negative/stressful/distracting work environments \( (n=6) \), decreased job satisfaction \( (n=6) \), decreased productivity \( (n=3) \), and strained interpersonal relationships \( (n=3) \). The survey participants also expressed concerns that workplace violence would affect their attitudes towards the nursing profession. When answering the survey Question #8 “What concerns you most about workplace violence as experienced by nurses in the clinical setting?”, survey participants responded: “That I will not enjoy my job because of it”, “Losing my love for nursing”, and “[That I will] dislike being a nurse”. Participants also posed questions in relation to concern for organizational effects. For example, one participant queried “What does this [workplace violence] mean for the health care system?”. In addition, the survey participants recognized the relationship of violating of nurses in their workplace with the safety and well-being of patients in the health care system \( (n=13 \text{ responses}) \). For example, one survey participant stated “The [nurses] will be frightened and timid at work and won’t give the clients the care and attention they deserve.” Another survey participant stated “[Workplace violence] makes it difficult to do safe practice”. A survey participant elaborated on the effect of workplace violence on patient care:
“[Workplace violence] could affect how they [nurses] function. They may begin to feel incompetent in their role because their clients respond negatively to them and their care. I also think it produces negligence by nurses. It becomes a common feeling that ‘I don’t have to deal with that’ and care is neglected instead of saying ‘There’s a problem and I need to do something to change it.’”

Two survey participants expressed concern that the violencing of nurses might result in nurses’ reciprocation of violence to patients (that is, the cycle of violence would be perpetuated), “particularly if it [the violencing of a nurse] was physical”. Survey participants also pointed to patients’ vulnerability in being a target of workplace violence. One survey participant suggested that when nurses are stressed, they can “hit, yell or mistreat their clients” and another suggested that “workplace violence would be any incident where…[a] client feels threatened, demeaned, or ashamed through no fault of their own”.

Finally, the survey participants also recognized potential overall societal effects of workplace violence as experienced by nurses. Participants stated “this [workplace violence] may have an effect on many areas of their [nurses’] life [sic] – not just work” and “family life can be strained”. Two participants suggested that the anger that nurses felt towards being violated in the health care workplace might be expressed outside of the work environment. Several participants pointed to the potential need for nurses to take extended time off work as a result of experiencing workplace violence, and one participant referred to the impact this would have on nurses’ families as a result of financial strain.

**Learning Circle.** The learning circle participants also recognized the widespread effects of workplace violence as experienced by nurses. The thematic analysis of the learning circle dialogue revealed deeply embedded themes of the effects of workplace violence on nurses, patients, the health care system and society. Learning circle participants also demonstrated a
primary concern with effects of workplace violence on their personal safety and well being with discussion focusing to a lesser extent on concerns of effects on patients and the health care system. One learning circle participant stated “it affects everybody, us as well as the clients”.

The learning circle participants also spoke of the use of defense mechanisms to protect against violencing in the health care setting. ‘Being silent’ was viewed as a protective mechanism against further workplace violence. One participant who was employed in a health care setting stated “I’m just becoming sensitized to it. It could be a sign of accepting hopelessness….it’s kind of like a defense mechanism. ‘I’m just going to forget…put a blind eye to it…block it out.’ Otherwise it will affect you.”. Gender differences in relation to the use of defense mechanisms and coping skills were identified. For example, one participant stated “Thick skinned men don’t cry you know. [They] either go out and punch somebody out or have a beer. It’s kind of dealing with it. It’s not right”. One participant was willing to accept the workplace violence which she experienced in the clinical learning setting even though there were feelings of being emotionally hurt: “It doesn’t matter. I think it’s normal because human beings are not perfect you know. So I can accept it”. Another participant spoke of nurses’ fears of escalating workplace violence if attempts were made to resolve workplace conflict:

“I’ve asked people…Why do you put up with that? If that was me, I would be doing this and this…No, they wouldn’t dare, you know. They said it just gets worse. That’s constantly the response. I don’t want to say anything because it will just be ten times worse after.”

One learning circle participant spoke of job resignation as a defense against workplace violence but this was viewed as creating an ethical dilemma: Who should leave – the nurse or the client?

“Who really wants to work in a place like that, that’s violent? So you’re going to leave and you’re going to go elsewhere. I wouldn’t put up with it, and if nobody’s getting disciplined, I would find another job because I don’t need to be here. So that’s my frame of
reference….It would be easier for them [the employer] to find another client [than to find another nurse] to put in that spot…. It does open the door. Where are they [the clients] going to go?”

The concern of the effect of workplace violence as experienced by nurses on recruitment of potential students into nursing education programs was addressed when one learning circle participant raised the following question posed by a survey participant: “As students, coming into the profession, did the students have any doubt about the career because of the workplace environment?” Although one learning circle participant considered the nature of the health care work environment prior to entering the nursing education program, the other learning circle participants were not aware until after they started their nursing program that nurses experienced workplace violence. In considering this question in a broad sense, the learning circle participants felt that misconceptions and a lack of public education about the nursing profession adds to the perpetuation of workplace violence as experienced by nurses.

Perceptions of the Causes of Workplace Violence: A Feminist Intersectionalist Perspective

When viewing workplace violence as experienced by nurses through a feminist stance of intersectionality, it was evident that multiple and complex intersections of oppression and privilege are interconnected. The data provided by the survey and learning circle focus group participants pointed to the dynamic nature of the intersections of gender, class, and race which complexly intertwine, influencing nurses’ work, the context of nurses’ work, and the emergence of workplace violence. As indicated below, the data analysis revealed that observing workplace violence as experienced by nurses through a lens of intersections of gender, class, and race provided a critical perspective of the nature and causes of workplace violence. Other influencing intersections of oppression (such as age, education, ability, and language) also emerged on analysis of the research data.
Although it is difficult to neatly unravel the tightly woven matrices of intersections of oppression and privilege, attempting to do so provided a tentative lens through which to observe the complexity of workplace violence from a feminist stance of intersectionality.

**Intersections of Gender**

The research data revealed a limited overt recognition by the participants of the influence of the intersection of gender on the prevalence and nature of workplace violence as experienced by nurses. For example, when considering factors contributing to workplace violence experienced by nurses, one survey participant referred to “hostility to members of the opposite sex” and another survey participant suggested that “people view the nurse as meek and docile”. One learning circle participant referred to health care work as “feminine jobs”.

The data analysis of the learning circle discussions revealed that the recognition of the relationship of gender oppression to workplace violence experienced by nurses was not explicit. The learning circle respondents did not openly identify the oppression and privilege created by gender in relation to workplace violence but rather the intersection of gender was deeply embedded in various aspects of the learning circle dialogue. Workplace violence as experienced by nurses was linked to contexts where nurses (and thus, women) are perceived to be resisting socially-accepted and enforced gender roles and norms. In addition, where nurses were viewed as not assuming socially accepted gender norms and behaviour, they were considered vulnerable to workplace violence. In turn, workplace violence was seen as acting to oppress nurses and keep them aligned with gendered societal norms of being subservient, passive, and invisible.

For example, one learning circle participant circuitously spoke of nurses’ historical subservience, comparing nurses’ (women’s) lack of power to the perceived over-all power and strength of doctors (men):
“I really personally feel that nurses are starting to get stronger…more ties to each other…will-power….They’re also getting a better name….Before nurses were so much lower than doctors’ level but now are starting to get more recognition for nurses….You can actually take action against violence whereas before you wouldn’t even say anything.”

Another learning circle participant spoke of nurses’ attempts to adopt patriarchal attitudes in order to gain power in the health care system. This participant suggested that nurses increase their power through aligning themselves with those who are perceived to have more power: “Nurses compete for doctors’ attention because they get more praise and they get to be seen as the hero…It’s almost too, like the nurses, if they get to hang out with the doctors socially, it’s more of a prestige thing”.

The female participants of the learning circle also felt that adopting socially accepted gender roles in families gave nurses more power in their health care roles, and conversely, where those roles were not assumed, female nurses were viewed to be irresponsible (“a party-girl”) and thus, more vulnerable to workplace violence. Those nurses who did not fit in the social norm of having a family were perceived to not be taken as seriously in their professional work, and thus, perceived to be shunned in the clinical setting: “Somebody whose maybe got the family and the kids…is more put together than a party-girl….it’s responsibility. And you know, you’re older, you’ve got a family. You’re looked at as being responsible”.

Although being part of a family and having children was perceived to provide a sense of power/privilege over the “party-girls” in the clinical setting, this proved to be a lightly threaded gain of power for women. Motherhood conversely ran the risk of creating yet another intersection of oppression and vulnerability to workplace violence. One learning circle participant described her experience of others doubting her capability of meshing motherhood with nursing education. Stepping on the “mommy track” (Daft, 2005, p. 446) meant others openly doubting her decision-
making ability, even suggesting ‘craziness’ in attempting to mix motherhood and nursing education: “Everyone is saying ‘How do you do it [be a mother and a nursing student]? This is crazy. How can you do that?’ … So I said, ‘There’s people who have it harder than I do.’ So I got through that”.

For the male learning circle participant, it was evident that “being responsible” by having a family did not contribute to his personal power in the same way that it did for females. Rather, having the power of ‘being male’ was perceived to buffer other intersections of oppression in the health care setting.

Perceptions of physical strength also created gendered intersections of oppression and privilege. One learning circle participant commented on women’s vulnerability for being the target of physical workplace violence:

“You know, men are strong if they get attacked or with serious effects on the life or the body. Maybe men can handle that, but for women, for the female nurses, if the male [who] attacked is very strong, should… we just draw a med as quickly as possible?”

Another learning circle participant juxtaposed women’s vulnerability to physical violence with men’s vulnerability to psychological workplace violence in the health care workplace:

“It’s not very often that you hear a woman saying ‘Get that nurse out of my room. I don’t want to see her.’ But it’s more often that you hear ‘I don’t want a man nurse in my room. Get him out. Get him out.’ So it turns around and makes you feel kind of, not incompetent, but it’s kind of a blow…. I think that plays more of an issue in the psychological part.”

Conversely, another participant viewed male nurses to be at less of a risk for psychological workplace violence than female nurses: “I think for men, it [psychological workplace violence] might not be as much of a big deal…. I think for guys maybe they have more of an advantage because they don’t take stuff personally like we [women] would”.
One participant made a historical comparison of the oppression of women in male-dominated professions to the current perceived oppression of men in female-dominated professions (such as nursing), pointing out that men and women who do not accept social norms of gendered work are considered “different” in their workplaces, and thus, vulnerable to workplace violence:

“Look at how long women tried to get into big corporations and work in a man’s world….They weren’t [considered to be] family centered. They were goal orientated. So what’s wrong with them because women are supposed to be kind and caring, stay home with the kids? And now, there’s men entering nursing. It’s like, what’s wrong with you? Are you overly sensitive?”

Lastly, one learning circle participant spoke of nurses’ vulnerability to violencing when engaged in male-normed political action. It was perceived that when nurses attempted to resist gender-normative behaviours of passivity, the public pressured nurses to realign (“build up their reputation”) to accept societal norms related to gender and class:

“It wasn’t too long ago when the strike was going on and of course, with healthcare being backed up, it was the public’s perception that, ‘Why can’t these nurses just go back to work?’ We’re paying them enough.’ They didn’t understand that. So I think for quite awhile nurses have had to build up their reputation again.”

Intersections of Class

The survey participants related causes of workplace violence as experienced by nurses to perceived inter-professional and intra-professional class hierarchies: “lack of respect to someone of a different status: for example doctor, RN [registered nurse], LPN [licensed practical nurse], SCA [special care aide]”, “power trip from a doctor”, and “dispute between RN and LPN”. In
addition, the reflective dialogue of the learning circle participants provided a rich exploration into the complexity of intersections of class and its relationship to workplace violence.

*Inter-professional class.* Learning circle participants discussed the perceived existence of an inter-professional patriarchal hierarchy which undisputedly placed physicians on the highest rung. One participant shared “There’s a pecking order. There’s somebody who’s going to be a top dog kind of nasty all of the time and they want to stay there”. When prompted to further describe this perceived “pecking order”, participants shared:

- Participant A: “Doctors and specialists at the top, then…head nurses.”
- Participant B: “Nurse, head nurse.”
- Participant C: “Charge nurse.”
- Participant A: “The nurse, the RN. Then what?”
- Participant B: “The LPN.”

With further reflective dialogue, learning circle participants felt that nurses’ status on this perceived hierarchy (and thus, oppression) was tightly interwoven with complex and diverse contextual variables in health care organizations. Relating to personal work experience in a health care setting, one learning circle participant stated:

“I think at my work the nurses basically get attacked because there’s not so many of them to kind of sit together and support each other….It’s kind of like ganging up on them. I think they receive the most abuse….I think the nurses get all the punches.”

Another learning circle participant agreed that nurses may be on the bottom of the “pecking order”, relating similar concerns based on experiences as a health care worker. In this learning participant’s view, nurses experience workplace violence where they are verbally challenged by inter-disciplinary co-workers about nursing roles, salary, and education:
“I’ve constantly heard the [other health care workers] say right to the nurses’ face: ‘Why don’t I get paid as much as you? I work ten times harder’. And the nurse snaps back:

‘Because I’ve got two or four years of education and you don’t’."

Although not referring to ‘it’ as workplace violence, one learning circle participant referred to the “ripples” between disciplines as a “battle over power”.

_Intra-professional class:_ The learning circle participants also shared their perception of the existence of an intra-nursing hierarchy which has linkages to workplace violence as experienced by nurses. They felt an intra-disciplinary ‘pecking order’ was influenced by many intersections of oppression and privilege such as “newness” to the workplace/ profession, education (i.e. student, diploma prepared nurse, baccalaureate prepared nurse), age, motherhood, familial status (i.e. single versus ‘with family’), employment status (casual versus full time), seniority, work experience, and language.

When discussing the perceived intra-professional hierarchy, one learning circle participant stated

“Students are at the bottom just because you’re inexperienced. I think even part-time casuals would be at the bottom just because….you get this call and you’re not familiar with that. You may be thrown into a different situation on a daily basis. So you still don’t know who to stay away from. You’re just kind of feeling that out I guess. So I think students and definitely part-time casuals are at the very bottom.”

The learning circle participants spoke of their personal experiences of workplace violence in clinical learning experiences which they perceived to be primarily initiated by nurses. The discussion of this aspect of workplace violence was perplexing for the learning circle participants as they attempted to come to understand the underpinnings of nurses’ violencing of nursing students. They expressed disappointment in that they did not find collegial relationships with
some nurses and yet other health care professionals seemed to be more supportive of their clinical learning:

“I found the nurses were actually the most rude to us, and we’re actually nursing students….They [RNs] just didn’t have the time and didn’t want to waste the time with you but the SCAs and LPNs, I found were the most helpful. They were so friendly, and they just, I don’t know, they appreciated us being there…I’m not sure if it’s because we could be viewed as a future job competition for the RNs and for the LPNs, obviously not.”

Another participant added her experience of workplace violence as a nursing student:

“A couple of RNs [were] standing there…and it was like they were upset at the fact that we [nursing students] were [performing a nursing procedure]….So I don’t know whether she was just grumpy or, like you said, a job threat, or whatever. But no, it certainly was a different reception from the RNs to the LPNs to the SCAs. And even when you were doing debriefing, or you were getting the notes, whenever they were talking about the clients, the LPNs and SCAs included what the students were doing with them [the clients], but to the RNs you, you were invisible, like you were just, you weren’t even there. You were just to sit back and be quiet and that was that.”

Another participant shared her emotional despair in beingviolenced in a clinical learning experience:

“I think that most of the nurses are very nice and helpful but I admit…during [a nursing procedure], the older nurse shouted to me. But I do not [understand]…[She] wouldn’t stop [shouting]. She was very anxious….and actually I also want to find something to help her but she hurried so I had to ask another one for an explanation.”

Being a nursing student who spoke English as a second language, a learning circle participant referred to her position on the perceived intra-nursing hierarchy. Relating a specific
personal experience of nurse-to-nursing student violencing, the participant emotionally stated “especially for me, I think that I’m the lowest of the bottom”.

One learning circle participant felt that being a new employee was “a profound vulnerable time [for workplace violence] because I’ve seen staff make other staff cry” and added “I’ve heard even new [nursing] grads go through hell. Like from the nursing program that told me some things that they’ve experienced and I’ve constantly heard from comments”.

When new employees begin working in the health care setting, there is a perceived “hazing period” or “a sink or swim period”. One participant spoke of being treated like a child in a new job as a health care worker: “I remember when I was first hired and how people acted towards me….I think I was the youngest person there, and I was treated like a child….They’re like ‘Go sweetie’ [in a child-like voice] and all that stuff”.

Intersections of Race

The perceived relationship of the intersection of race to workplace violence as experienced by nurses did not surface until the second learning circle gathering. It was perceived by the researcher that this was a particularly sensitive topic area for the learning circle participants. Primarily, only one learning circle participant spoke of recognition and personal experiences of the relationship between race and workplace violence. The transcripts revealed that this learning circle participant raised the topic early in the second learning circle gathering and engaged in a short description of experiences in the health care system as an employee, at which time the discussion topic changed.

The intersection of race was later raised in the second learning circle gathering as a result of a prompt from the researcher. The same learning circle participant assumed the spokesperson role when non-verbally delegated to speak on this topic while the other learning circle participants actively listened. Based on the dynamics of the learning circle discussion when
consideration was given to the relationship of workplace violence and race, it was perceived by the researcher that the privilege of being white in a Western society (or the oppression of being ‘other’ than white) and the relationship of this privilege (or oppression) to workplace violence were neither fully nor easily recognizable to all of the learning circle participants. In considering the sensitive learning circle ‘dialogue’ of race and workplace violence in which one learning circle participant primarily gave voice, the following statement provides insight: “whiteness is so deeply entrenched as the ‘norm’ that white people fail to recognize they too have a race/ethnicity” (Valentine, 2007, p. 12).

The contribution of this learning circle participant in regards to the relationship of intersections of race and workplace violence was moving and powerful. It is evident that in a work role in the health care system, the participant felt doubly oppressed by intersections of race: oppressed by patients and oppressed by co-workers. The learning circle participant offered the following narrative:

“I have had some instances when [patients] would say some racial things to me and then try to throw things….Then I constantly get assigned to this group, and I tell the nurse ‘You’ve got to do something about this because it’s either you have a meeting and talk to this person and tell them it’s not acceptable’ or well, I can’t avoid working on the [unit] because that’s ridiculous I think…Then the nurse would be, like a couple of times, ‘Oh, that’s how they are. They’re just like that to [people who are ‘other’ than white]’….It’s like they’re given excuses to do whatever they do because they’re [patients]….It’s kind of hard to defend something like that when the person who’s supposed to be in charge thinks it’s normal to be treated like that.”

The learning circle participant further explained her feelings of helplessness in changing her oppression: “What’s the point of me going to report this because you’re going to get the same
excuse, ‘Oh, that’s the way they are. Maybe get someone who’s a different colour than you.’ So, nothing is done about it”.

This learning circle participant was deeply reflective of the impact of her oppression and experiencing of violencing in the health care system, recognizing the cyclical nature of workplace violence and the potential impact on client care. Open dialogue with all involved was perceived to be a reasonable solution but was also perceived to be difficult to achieve:

“So maybe they may say that I notice that this person is like that, and I’m like, okay, they’re racist. Then I probably wouldn’t give them the same treatment…We need to sit with a [patient] to ask them and tell them it’s changed. It’s both ways. [Patients] can get abused too and they can abuse you too.”

Other Intersections of Oppression and Privilege

Although intersections of gender, class, and race in relation to workplace violence experienced by nurses were primarily explored in the analysis of the survey responses and learning circle discussions, it was evident that a multitude of complexly intertwined and interrelated intersections of oppression and privilege contribute to workplace violence in health care settings. Based on the depth of the learning circle dialogue and the multiple ways of knowing of the participants, the intersection of age emerged as another predominate intersection of oppression and privilege for the learning circle participants. Further intersections of oppression and privilege related to education, ability, and language were evident in the learning circle discussions.

Intersections of age. The intersection of age as a source of oppression and privilege was perceived to be closely related to workplace violence as experienced by nurses. When analyzing the research data, this intersection was not easily teased out from other intersections of oppression and privilege such as informal learning (work and life experiences), education, and
workplace seniority. For example, increasing age was seen to closely correlate with life and work experiences which were viewed to garner power in the health care workplace (and thus, protection against workplace violence).

The learning circle participants recognized a fine line of age-related oppression and privilege associated with workplace violence. Nurses who were perceived to be young and new to the nursing profession were seen to hold less power in their workplace, yet ‘older’ nurses were also viewed to be at risk of losing or lacking power due to a perceived compromised ability to effectively perform the work of a nurse:

“I think that the way the RNs perceive us [nursing students] is based on age because a lot of experiences through nursing come with life experiences….I think it is a bias that does exist….Some of us may be as old as their children, so we are treated as children.”

A dichotomy of age-related oppression and opportunity was pointed out:

“I think it comes from two ends. On one end you’ve got ‘We’ve paid the price. We went through this to get to where we are.’ And now on the other end, it’s like “God you new people are going to push me out of my job because I can’t do it as fast. I’m older…The ageism factor steps in.”

**Intersections of education.** The learning circle participants spoke of changing intersections of oppression and privilege which were influenced by education. In their roles as nursing students, the participants felt that their experiences of beingviolenced by others in clinical settings were partially influenced by their level of education. As the participants gained more education, they spoke of gaining privilege in relation to other people. For example, one participant spoke of how beginning nursing students might be treated badly by other students who are further along in the nursing program. In the learning circle participants’ work roles, the fluidity of intersections of oppression and privilege were evident as the participants spoke of their
changing vulnerabilities to workplace violence in relation to formal and informal educational experiences. One learning circle participant spoke of gaining ‘acceptance’ in the health care workplace as a result of being enrolled in the nursing program.

*Intersections of language.* A participant of the learning circle who spoke English as a second language verbalized her feelings of being placed on the bottom rung of a perceived intra-professional (nursing) hierarchy, stating “especially for me, I think that I’m the lowest of the bottom”. One learning participant spoke about feelings of isolation when health care workers used unfamiliar languages to converse amongst themselves. Another learning circle participant spoke of how people who speak English as a second language were stereotyped:

“The common misconception that people make with English as a secondary language is that they put that stigma on them, that they’re stupid, and they don’t understand. But the fact [is that] they understand more than what people give them credit for. People get frustrated with them and then they don’t bother to go into full details or explain things the way they should. So it’s ‘I just don’t have the time. I don’t have the patience’.”

Another learning circle participant spoke of feelings of isolation when working in a health care setting with others who spoke a language which was different from her own: “They’re talking their own language and it’s kind of hard to fit in. I never really realized that until I was put in that situation….I really never noticed how that can make someone feel isolated”.

*Intersections of ability.* One survey participant shared “Bullying of nurses on WCB [Workers Compensation Board] is a complaint that I have heard….This decreases the likelihood that a nurse will return to work or want to return, increases time off, decreases productivity, and decreases self-esteem and confidence”.

Complexities of Intersections of Oppression and Privilege

The learning circle participants discussed the causes of workplace violence as experienced by nurses in diverse ways giving voice to a variety of sub-themes and employing diverse ways of knowing. Although the learning circle participants had insight into some elements of oppressive situations and identities, it was the perception of the researcher that the participants were not explicitly cognizant of the intersections of oppression and privilege. Learning circle participants spoke of workplace violence in relation to identities of perpetrators (for example, gender or professional status), identities of themselves as victims (for example, nursing student status), and specific contextual circumstances in which workplace violence occurred but the participants did not necessarily recognize the dynamic and complex matrix of oppressions and privileges of which they were giving voice. In addition, although some of the learning circle participants tentatively (and fleetingly) verbalized the possibility of themselves becoming perpetrators of workplace violence, it was perceived by the researcher that the participants did not relate this potentiality to specific intersections of privilege which might come to exist in specific temporal moments and spatial contexts of the health care workplace.

The following learning circle excerpts provide insight into the complexity, dynamism, multidimensionality, spatiality, and temporality of intersections of oppression and privilege as related to workplace violence. In the first excerpt, the changing intersections of oppression and privilege are evident as the learning circle participant shared a narrative of experiences of workplace violence. The intersections of oppression and privilege related to education, work experience, enculturation/resistance of workplace norms, inter/intra-professional class, and seniority in the context of the gendered health care organization are voiced. The notion that “not all differences are created equal” (Ward, 2004, p. 83) was apparent where one oppression experienced by the participant was not easily ‘cancelled out’ by another perceived privilege. The
gaining of privilege in a specific space over a period of time was evident, and for this participant, achieving egalitarianism within the health care organization involved an ongoing ‘doing, undoing, and re-doing’ of intersections of oppressions (Staunæs, 2004; West and Fenstermaker as cited in Valentine, 2007).

“I feel more accepted [in my workplace] now that I am in the nursing program by [the nurses]….But when I was new…I think it was six months before I felt like somebody was talking to me rather than at me, or down. You know, ‘Go do this, do it now and, don’t ask any [questions].’ Well, you can ask questions but otherwise I don’t want to hear from you. Do it right too’. Being a [specific identity] actually was an asset…but for different reasons….I had no experience, sure I had a young family…but no experience….[so] I took a course after working [for a period of time]. You basically gain the knowledge through osmosis in a sense or if you want to call it that, on work experience….Maybe, there’s kind of, what you call that, a hazing period. It’s like a sink or swim period. We don’t want to get too close to get to know you too well because you may not last six months. So you’re just a number until you can show that you’re…a part of that [workplace culture].”

This learning circle participant summarized the personal experience of changing intersections of oppression over time. As new intersections of oppression and privilege were done and redone (Staunæs) in the context of the workplace, the cycle of workplace violence in the health care organization was viewed to be potentially (and apologetically) perpetuated. It was also noted that the eventual gain of intersections of privilege by this participant resulted in a co-worker (who previously held intersections of privilege related to seniority and work experience) becoming ‘the oppressed’, and thus, vulnerable to workplace violence:
“As you’re getting that experience, you know, you become more competent, more comfortable, more confident in what you can do and eventually you can tell your colleague whose maybe got twenty years seniority [to] ‘Get lost.’ Sorry.”

The complexity and fluidity of intersections of oppression and privilege were evident as the learning circle participants’ juxtaposed narratives of workplace experiences. For example, although most of the participants felt that being classed as a ‘newcomer’ in the intra-professional nursing hierarchy created vulnerability for workplace violence (as evidenced in the above verbatim), one participant questioned the universality of this oppression/vulnerability, suggesting that diverse intersecting variables of co-workers’ identities and organizational structures might intertwine to create a positive experience of being welcomed and supported as a new employee in a health care workplace:

“It depends on the job and it depends on the people you work with. I’ve had my most recent experience [in a specific health care workplace] and most of, a lot of the women have [specific] degrees….I totally went in there knowing nothing….I think one way in how you’re treated and welcomed is how well they like their job. If they like their job, they’re happier people, they enjoy working, they love to have new faces. I was so welcomed there and all the women had been there for 30 years or more…I was the youngest and I felt so welcomed….It definitely depends if you’re happy with your job.”

Another participant’s verbatim demonstrated the dynamic nature of intersections of oppression which varied as personal identities became intertwined with the diverse identities of other co-workers within given social contexts. In contexts with others who held certain identities, this participant felt oppressed and vulnerable to workplace violence. Yet in other contexts, a shared identity provided a source of privilege and protection:
“Sometimes you have lots of [people of ‘Race A’] working and then sometimes you might have on one unit, lots of people [of ‘Race B’], then you’re the only single white person or single black person….I never noticed the difference but one time I was working on the unit and I was the only [person of ‘Race B’]. The rest of the girls were [‘Race A’] and the nurse is [‘Race C’] and one nurse is [‘Race A’]….It’s kind of uncomfortable…They’re talking their own language and it’s kind of hard to fit in. I never really realized that until I was put in that situation….I really never noticed how that can make someone feel isolated until I was put in that position so you learn from things like that…. [When I work with other people who are the same race as me], I can relax. They’ll watch my back or something like that and I’m sure the other people would feel the same way too.”

Lastly, the participants spoke of their feelings of being violence in their clinical experiences and how their identities (such those related to age, education, language, and work experience) intersected with others’ identities to create vulnerabilities to workplace violence. In reference to their clinical learning experiences, the participants referred to the backdrop of the health care environment in which classed identities of nurses, nursing students, LPNs, SCAs, physicians, patients, and patients’ family members intersected. It was evident that the multitude of intersecting identities was perceived to be strongly impacted by structural aspects of the health care environment. Participants spoke of health care situational factors which they felt contributed to their personal experiences of workplace violence. For example, the participants cited workplace stress, short-staffing, influenza outbreaks, and less-than-desirable work environments as being linked to occurrences of workplace violence.

The intersections of oppression and privilege and the matrices of these intersections as related to workplace violence were deeply hidden in the verbatim of the learning circle. A critical analytical stance enabled the researcher to recognize, surface, and give voice to some of these
matrices but it is highly suspected that intersections of oppression and privilege still remain deeply entrenched within the learning circle verbatim not only unrecognizable to the learning circle participants but also to the researcher.

Transformation of the Culture of Violence in the Health Care Workplace

Survey. The responses of the survey participants to the survey Question #9 “What strategies would you suggest are needed to transform this workplace environment?” were diverse and multidimensional. Using a thematic analysis approach, the following themes were identified: nurse-related strategies, patient/family-related strategies, organizational (health care system) strategies (with sub-themes of staffing, psychosocial support, policy-setting, and reporting), and educational strategies.

There was a focus on organizational strategies with suggestions of reducing nursing shortages and workload (n=9 responses), implementing buddy work systems (n=4), and improving work scheduling (n=3). Organizational policy-setting strategies (n=10) were focused on suggestions of zero tolerance policies with guidelines and strategies for intervening in abusive situations and other conflicts which are “hard to solve” (survey participant). One survey participant suggested “increased access to health care services to decrease stress on clients and families”. Survey participants also made suggestions for reporting workplace violence (n=4): “A safe way for nurses to report violence without fear of segregation from others” and “Make it easier for nurses to report workplace violence”. Availability of psychosocial support for nurses within health care organizations in the form of counseling services, support groups and centers, peer counseling, communication and conflict resolution groups was frequently suggested (n=9). One survey participant suggested that involvement in an “effective communication group” should be mandatory.
Educational strategies (n=15 responses) were also viewed by survey participants as having potential for transforming the work environment. These strategies were two-pronged: health care worker-focused (n=11) and public-focused (n=4). Suggestions for education for health care workers focused on increasing awareness (for example, “on the different types of abuse”), prevention (for example, “workshop on preventative measures”), and intervention (for example, “how to deal with abusive situations”) of workplace violence. One survey participant suggested that there be “education on ways to approach co-workers with issues you may have” and another participant suggested “specific training in the areas of illness that lead to violence behaviours such as dementia”. Public education strategies focused on “what will not be tolerated while being cared for” and “effects workplace violence may have on patient care”.

Nurse-centered and patient-centered strategies were cited to a lesser extent. Nurse-centered strategies (n=8 responses) focused primarily on communication, being attentive (“have caution”) and being assertive (“standing up for her/ himself”). Patient-centered strategies (n=6) focused on the need for comprehensive mental health assessments, substance abuse screening, counseling services, and “repercussions for clients who are violent”.

In responding to the survey Question # 10 “What two questions do you think should be considered for discussion by this focus group?”, the survey participants responded with several questions which focused on transforming the culture of workplace violence and safety/ protection against workplace violence (see Appendix O).

Learning circle. The survey participants’ interest in transforming the culture of workplace violence was echoed by the learning circle participants who chose the following questions for discussion: “Whose responsibility is it to decrease workplace violence?”, “How can workplace violence be preventable?”, “What can be done to make the workplace safer for nurses?”, and “How would you prepare for a known hostile client who is being admitted to your ward?” (see
Appendix O). These questions were considered in the second learning circle gathering with discussion ensuing in relation to all of these questions.

When considering the question related to “Whose responsibility it is to decrease workplace violence”, learning circle participants dialogued:

Participant A: “I think it’s everybody’s responsibility to do a little bit. Clearly, one person can’t tackle all the responsibility because it’s not attainable for one person or for one group….I think everybody needs to start maybe stepping it up. Maybe looking, keeping more of an open mind as to what exactly workplace violence is. You know, if we started to do that, then people may start to notice changes.”

Participant B: “I agree. I think that it is everybody’s responsibility to decrease workplace violence.”

Participant C: “And I do agree that everybody needs to get involved because let’s say if there’s something going on and I decide to take responsibility for something, and then everybody else decides to take responsibility for everything else then it will work out. Well, it’s not a perfect world, not everyone will do that.”

Beyond individual responsibilities, the learning circle participants described the collective responsibility of the health care system, labour unions, and management for roles in transforming the health care work environment in relation to workplace violence as experienced by nurses.

Although the learning circle participants considered each of the questions “How can workplace violence be preventable?” and “What can be done to make the workplace safer for nurses?”, the thematic analysis illustrated that ideas related to transformation of the workplace environment did not solely emerge when conversing about these two questions. There was an overall focus on transformation of the work environment in the second learning circle. In addition, the multidimensional nature of the suggested transformational strategies was reflective
of the learning circle participants’ diverse understandings of workplace violence. Specific strategies were offered such as weekly interdisciplinary table sessions, inclusive staff meetings (“everyone needs to get involved”), reporting policies, patient and family involvement in preventing workplace violence, consistent disciplinary measures (“a unified approach”), comprehensive patient assessments, and strengthened legislation in relation to workplace violence. One participant expressed concern that the current strategies were not addressing the underlying causes of workplace violence and that transformation of the workplace environment needed to address the roots of the problem (rather than using superficial approaches which were perceived to further contribute to the invisibility of workplace violence). Learning circle participants expressed a sense that one overall strategy would not effectively address all perceived underlying causes of workplace violence.

One learning circle participant stressed the importance of developing critical thinking and assertiveness in nursing education: “I just love how [nursing faculty] push assertiveness…. challenging your thoughts and stereotypes [by saying] ‘Why do you think like this? You need to change that or can you change that?’”. In referring to undergraduate nursing education, another participant stated “I think that [nursing] teachers can inspire nursing students to keep this positive awareness [of workplace violence] or consciousness to continue”. There was an expressed need for further opportunities in nursing education to discuss the realities of the health care workplaces and how to deal with these: “There needs to be some…class that is dealing with…the reality of what the actual nursing world is like and talking about how to deal with things using more emphasis on using your co-workers as allies to get things done”.

In addition, the learning circle participants suggested that learning about workplace violence as experienced by nurses in undergraduate nursing education was just a starting point:
“There needs to be some kind of continuing education that maybe once every three months you go and view another topic. About sexual harassment is one. Then the next, it could be handling physical violence. Then the next would be gender issues or it’s something that is continually educating people.”

Another participant felt that a continuing educational focus on therapeutic communication skills for all health care workers would be valuable in “eliminating a lot of the incidences that lead up to violence or harassment”.

Health care system issues were viewed to “foster workplace violence”. One learning circle participant stressed the importance of resolving these issues:

“Workload…I think that’s a huge issue that provides a setting for violence to easily take place….If you weren’t over worked, you maybe can find some creative ways to deal with an abusive family member or patient. You’d have more time to be able to do that, just step back, to react, to think, whatever. But you don’t have that so you’ve got to act fast, you know, because you’ve got so much to do.”

The discussion of strategies to transform the health care workplace led the learning circle participants to consider the relationship of broader societal issues of violence with workplace violence. Learning circle participants felt that nurses have an important role to play in the transformation of social norms of violence which, in turn, would eventually impact the workplace:

“I think you could start [with education about violence] in elementary school. It kind of stems from how you are raised as a child…It’s taught to you. So, I think a lot of that to be prevented, maybe there needs to be more school things….Teaching kids at the younger age that is…It’s societal change I guess, but it could prevent some things for the future too.”
Public education in regards to acceptable patient and family behaviour in the health care workplace was also suggested:

“I really like the posters that when you walk into a building - ‘violence will not be tolerated’. This, this, this and this is considered violent. I think that also lets them [patients] know that if they go there, they’re going to be escorted out….It’s important to give them as much information too so that they know that these types of issues are violent.”

Learning circle participants spoke of the need to challenge, involve, and educate patients and their family members about societal stereotypes which impact workplace violence as experienced by nurses.

Finally, the learning circle participants discussed the survey response question “How would you prepare for a known hostile client who is being admitted to your ward?”. This question initiated discussion as participants challenged the labeling of a client as “known hostile”. Although this discussion did not necessarily reveal concrete strategies for dealing with a client who is hostile, it led to a critical challenge of how stereotypes and biases influence perceptions of workplace violence as experienced by nurses.

*Raising Consciousness of Workplace Violence as Experienced by Nurses*

The survey and learning circle focus group data analysis revealed that both research methods offered opportunities for consciousness-raising for research participants. The survey Questions #5 “Write about a specific time when you observed an incident of workplace violence experienced by a nurse (or nurses) while in a clinical learning experience. Include factors which you think contributed to this incident.” (alternatively, Question #6 “Write about what you think might be a typical incident of workplace violence experienced by nurses in clinical workplaces. Include factors which you think might contribute to this typical incident”) offered the opportunity for critical reflection of personal experiences related to workplace violence. For example,
evidence of the experience of a disorientating dilemma and consciousness-raising was noted in one participant’s response to the survey Question #10 “Write any additional thoughts about workplace violence as experienced by nurses”: “The seriousness of violence and harassment does need to be addressed. I’m a perfect example. I’ve seen it but have done nothing but forget about it. I’m unable to even pinpoint exact examples”.

The raising of consciousness of workplace violence through participation in the learning circle focus group is noted within several of the learning circle participants’ comments. In addition, the data analysis revealed an increasing depth of critical reflection and dialogue which evolved from the initial check-in of the first learning circle gathering until the closing circle of the second learning circle as participants assumed “a more inclusive, discriminating, permeable, and integrative perspective” (Mezirow & Associates, 1990, p. 14) of workplace violence as experienced by nurses. A glimpse into the learning circle participants’ evolving consciousness of workplace violence is demonstrated by their comments shared in check-ins and closing circles (see Appendix P).

Discussion

A feminist participatory action research approach was effectively used to explore nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses and strategies needed to transform the present culture of workplace violence in health care organizations. Situating this research study within feminist perspectives of valuing life experiences, methodological pluralism, action orientation, collaboration, challenging of social norms, individual and community transformation, focusing on the affective component, and using a caring approach (see Appendix E) resulted in the successful implementation of this research study with the purpose to “inform, educate, evaluate, implement, and confirm ideas and theories” (Morris, 2002, p. 52).
Employing a feminist stance of intersectionality of gender, class, and race, the nature and causes of workplace violence were explored by the researcher and research participants. Framing research data through a lens of intersectionality provided valuable insight into the underpinnings of workplace violence as experienced by nurses. In addition, exploring nursing students’ perceptions of workplace violence though a feminist perspective provided opportunities for nursing students’ voices to be heard and “empower[ed] participants to change the conditions of their lives” (Kirsch, 1999, p. 3). The research data indicated that this research study provided an opportunity for previously silenced voices to be heard and a critical consciousness of workplace violence to be developed. The learning circle approach to research offered opportunities for transformative learning for the researcher and research participants.

**Nursing Students’ Construction of Knowledge of Workplace Violence**

Although it was anticipated that nursing students perceptions of workplace violence as experienced by nurses would primarily be constructed from clinical learning experiences, it was evident early in the data collection phase of this research study that the participants’ perceptions of workplace violence was shaped by a variety of life experiences previous to and alongside clinical learning experiences in the nursing education program. Although 48.6% (n=18) of the survey participants (43.3% [n=13] of first year nursing student participants and 71.4% [n=5] of second year nursing student participants) shared narratives of incidents of workplace violence which they had witnessed in clinical learning experiences, at least two of these responses appeared to be partially constructed based on experiences of workplace violence in other aspects of the participants’ lives. Conversely, 51.4% (n=19) of the survey participants (56.7.0% (n= 17) of first year nursing student participants and 28.6% [n=2] of second year nursing student participants) had not witnessed workplace violence and instead provided narratives of what they believed to be a ‘typical incident’ of workplace violence as experienced by nurses.
The survey responses and learning circle discussions provided insight into nursing students’ construction of knowledge about workplace violence. Work experiences (in the health care workplace or otherwise) were frequently cited by both survey and learning circle participants in their discussions of workplace violence. In addition, it was evident that mass media contributes to nursing students’ perceptions of workplace violence as experienced by nurses. References to television programs such as Grey’s Anatomy, ER, and M*A*S*H were made by learning circle participants.

Survey participants also spoke of their informal knowledge of workplace violence which was rooted in family relationships with health care workers: “I know because my father was a [health care professional] so I got to see all of this, first hand, so it can get ugly, it really can.” and “My [relative] is a nurse and…she tells me daily what goes on, and so, every time we talk there’s violence and problems that she’s talking about”. In researching nursing students’ opinions of interpersonal violence, Kiner (1995) states “contemporary [nursing] students enter nursing programs with appreciable educational and work related experiences and at a sophisticated level in regards to cognizance about sociological issues” (p. 325).

A deeper analysis of the construction of workplace violence knowledge is provided through an intersectionality perspective. Ludvig (2006) suggests that “how a person perceives or conceives an event (and speaks about it)...vary according to how she [sic] is culturally constructed, what she [sic] identifies with and/ or differentiates herself [sic] from” (p. 249, emphasis in text). In addition, Manderson, Bennett, and Andajani-Sutjahjo (2006) refer to the social context of the research encounter which shapes the research interaction, stating

Each [interview] is a unique outcome of the characteristics of the individuals and the uniqueness of the time and place in which they interact. Yet, structural factors, including
class, gender, and age, also shape the relationships of the research participants and the process of the interviews. (p. 1319).

Thus, one needs to draw attention to the intricate weaving of the intersections of oppression and privilege amongst those involved in the research study. For example, how did the participants’ identities of gender, race, class, age, education, language, and work experience create intersections of oppression and privilege in the telling of their stories of workplace violence in the context of the research study? Furthermore, what influence did the researcher’s privileged identity as a White, middle-class, educated faculty member of the nursing education program have on the participants, and therefore, on their construction of workplace violence knowledge in the specific temporality and spatiality of this research study? Manderson et al. suggest

Any change in an interview – time, place, gender, or age of interviewer – might produce a different account, with different inflections, interpretations, and claims. This does not render such an account invalid, but it draws attention to the complexity and variability of experience and the significance of social interactions in collecting and interpreting research data. (p. 1331).

*Nursing Students Perceptions of the Nature of Workplace Violence*

The research data focusing on the nature of workplace violence mirrored many of the published studies which describe workplace violence as experienced by nurses (for example, MacIntosh, 2005, 2006; Priest, 2006; Rippon, 2000). Research participants gave voice to workplace violence as being complex and multifaceted. In addition, the prevalence of workplace violence as experienced by nurses was perceived to be impacted by the fluidity of a number of complex variables in a complex health care environment. Similarly, the perceived perpetrators of workplace violence as experienced by nurses were viewed to be impacted by the same complexity of variables. Although a ‘typical incident’ of workplace violence did not emerge,
research participants expressed concerns about the prevalence of emotional and physical workplace violence perpetrated by patients, patients’ family members, co-workers, and physicians. Research participants identified effects of workplace violence on nurses, patients, health care organizations, and society as a whole. Research participants expressed concern about nurses’ and patients’ physical and emotional well-being, being silenced, being unprepared to deal with workplace violence incidents, and developing personal negativism towards the profession of nursing.

**Nursing Students’ Perceptions of the Causes of Workplace Violence**

Survey and learning circle participants examined the perceived causes of workplace violence as experienced by nurses. The survey participants offered patient/family related causes, nurse/co-worker related causes, organizational (health care system) factors, communication factors, and societal influences as contributing factors to workplace violence. It was evident from the data analysis that the reflective dialogue which developed in the learning circle focus group provided the opportunity to more fully explore and develop understandings of the multidimensionality of factors contributing to workplace violence. The participants developed a deeper understanding of workplace violence as they reflected, actively listened to each others’ narratives, posed critical questions, connected to a variety of ways of knowing (for example, empirical, experiential, intuitive, and emotional), acknowledged and respected each others’ diversity, and inter-personally connected through respectful and trusting dialogue within a safe learning/research environment.

Employing a feminist stance of intersectionality in analyzing the research data revealed a complexity of dynamic intersections of oppression and privilege which influences the emergence of workplace violence. Based on the literature review of a feminist stance of intersectionality theory, the framework of this research study was initially underpinned with three ‘classical’
categories of oppression and privilege: gender, class, and race (for example, Staunæs, 2003; Ward, 2004; Wilkinson, 2003). Thus, through this lens, the intersections of gender, class, and race as related to workplace violence were explored as individual categories of oppression and privilege and as complex matrices of multiple intersecting oppressions and privileges.

Several authors (for example, Burman, 2004; Curry-Stevens, 2007; Ludvig, 2006; Staunæs, 2003; Valentine, 2007) point to the difficulty of determining a hierarchy of oppressions and question the process of attributing categorical importance: that is, who determines what intersections of oppressions are most important? With this caution in mind, other intersections of oppression and privilege - age, education, ability, and language - were recognized in this study as underpinnings of workplace violence as experienced by nurses based on the extent of participants’ comments and dialogue of these intersections, the multiple ways of knowing expressed by the participants, and the emotionality attributed to the life experiences which were shared.

It is acknowledged that the researcher’s and participants’ personal intersections of oppression and privilege influenced what has been observed and voiced and what remains invisible. For example, the intersections of oppression and privilege as related to sexual orientation and workplace violence experienced by nurses did not surface in this research study. Was the relationship of workplace violence to nurses’ sexuality absent from the survey and learning circle participants’ responses or were they present but invisible to this researcher? Curry-Stevens (2007) states “marginal identities and experiences are easy to name because they have been so thoroughly ‘othered’ but where dominance stays cloaked in the guise of ‘normal’ and ‘natural’…[it] is difficult to identify” (p. 46). In addition, it is also possible that if an ‘open’ stance towards intersections of oppression (that is, if the categories of oppression were not
‘named’ as conceptual underpinnings prior to the data collection/analysis phase, other matrices of oppression and privilege might have emerged or been observed in different ways.

Analysis of the learning circle dialogue clearly revealed that intersecting forms of oppression and privilege create complex power hierarchies and that “a person will be simultaneously advantaged by particular identities and disadvantaged by others” (Steinbugler et al., 2006, p. 808). The initial ‘unraveling’ of the intersections of oppression provided an important starting point in moving towards understanding how intersections of oppression and privilege influence the ‘health’ of the health care workplace. The fluidity and multiple intricacies of intersections of oppressions and privileges related to workplace violence, interlocked within spatial and temporal contexts, were evident in the analysis of the learning circle participants’ dialogue. The multidimensionality and unpredictable, shifting nature of how ‘raveled’ identities intersect in complex matrices within complex contexts in which workplace violence as experienced by nurses occurs (and as expressed within the context of this research study) was difficult to comprehend at times (as forewarned by authors such as McCall, 2005; Valentine, 2007). Ludvig (2006) refers to the “seemingly insurmountable complexity” of intersectionality, stating “it is impossible to account all the differences that are significant at any given moment” (p. 246, emphasis in text).

*Transforming the Culture of Workplace Violence*

The survey and learning circle participants identified diverse strategies for transforming the culture of workplace violence in health care organizations. The thematic analysis of the survey data revealed nurse-related strategies, patient-related strategies, organizational strategies, and educational strategies. The learning circle participants placed an emphasis on raising consciousness and education regarding workplace violence as a strategy for transforming the
culture of workplace violence in health care organizations. As one learning circle participant stated at the end of the second learning circle gathering:

“I just see a different side of things….Awareness, I think that it’s important. It’s good to see that there are six people [in the learning circle] but too bad it couldn’t be bigger so there’s more impact. I guess that’s our [learning circle participants’] job, to take this back to the other people.”

Through a feminist lens of intersectionality, the participants’ suggested strategies had a common thread: that of having the potential for altering intersections of oppression and privilege in relation to workplace violence as experienced by nurses. The multitude of suggested strategies serves to balance a number of existing intersections of gender, class, and race (along with a multitude of other intersections of oppressions and opportunities). Using an intersectionality lens, the suggested strategies could be perceived to serve as intersectional homeostatic mechanisms where nurses’ intersections of oppression (for example, gender) might be offset by strategies which create intersections of privilege (such as creating legitimate power through organizational policy setting). The re-balancing (‘re-doing’ [Staunæs, 2003]) of intersections of oppression and privilege were evident in the learning circle dialogue as participants spoke about possible solutions. For example, as education was viewed as creating class-based ‘privilege’ for some people in the violencing of nurses, education for all (health care workers and the public) was viewed to have the potential to create egalitarianism. Wilkinson (2003) suggests that “an intersectional perspective [in research and policy development] must be inclusive of all stakeholders, Governments, service agencies, academics, individuals who are personally involved…and the general public are all represented to give voice to all decisions” (p. 33). This inclusive involvement of a variety of people and organizations in transforming the culture of violence in health care settings was evident in the strategies suggested by the participants.
Raising Consciousness of Workplace Violence

In employing a feminist participatory action research approach to studying nursing students’ perspectives of workplace violence as experienced by nurses, consciousness-raising was considered a critical underpinning. Critical reflection on life experiences is key to transformative learning (Cranton, 1994, 1998; Merriam, 2004; Mezirow, 1991, 1997; Mezirow & Associates, 2000; Taylor, 1998). In addition, Taylor suggests that common themes of the process of transformative learning include “the centrality of the experience, critical reflection, and rational [reflective] discourse” (p. 8). Although the survey offered the opportunity for critical reflection, the learning circle approach, which employed Chinn’s (2004) PEACE and Power principles and processes for community building, incorporated all three themes. Diverse life experiences related to workplace violence were shared in a safe and trusting environment which fostered critical reflection and analysis, challenged prevailing social norms, honored diverse ways of knowing, supported individual transformation, and sought possibilities for community transformation. Disorientating dilemmas emerged which challenged ways of thinking and opened doors for new possibilities.

Recommendations

This research study demonstrates that a feminist theory of intersectionality focusing on multiple oppressions and privileges is useful in providing insight into workplace violence as experienced by nurses in health care settings. These multiple intersections are deeply embedded in social norms and tightly interwoven and interrelated in complex ways. Employing methods to raise critical consciousness of the nature, causes, effects, and strategies are needed to transform the culture of workplace violence in health care settings. Thus, the following recommendations arise from this research study:
1. Nurse educators, nurses, and nursing students should have opportunities for critical reflection and reflective dialogue in safe and trusting environments in order to raise consciousness, critically challenge, and transform cultures of workplace violence in health care settings (for example, through learning circles [Lepp & Zorn, 2002; Hiebert, 1996; MacIntosh, 2005], philosophers’ cafés [Griffiths, 2004], and reflective practice [Fletcher, 2006; Taylor, 2001]).

2. Nurse educators should embrace transformative pedagogical approaches (for example, Curry-Stevens’ ‘Pedagogy for the Privileged’ Model, 2007) which assist nursing students to explore matrices of oppression and privilege in relationship to workplace violence.

3. Nurses and nursing students should have opportunities to develop self-awareness of the complexity and fluidity of personal intersections of oppression and privilege and how one’s intersections of oppressions and privileges intertwine with others’ identities in the changing contexts of health care workplaces.

4. Nurses and nursing students should have opportunities to envision and strategize how intersecting norms of oppression and privilege can be critically challenged and transformed to create and sustain ‘healthy’ health care workplaces.

Limitations and Opportunities for Further Research

The present research study has created opportunities for further research of workplace violence as experienced by nurses and nursing students based on a feminist stance of intersectionality. The limitations of the present research and opportunities/recommendations for further research are discussed using three themes: research participation and participants, complexity of a feminist perspective of intersectionality in research, and influences of the researcher’s intersections of oppression and privilege.
Research Participation and Participants

One limitation of this study was the small survey sample which included students enrolled in only the first and second years of one nursing program. In addition, there was under-representation of specific groups of students such as Aboriginal and second year nursing students. It is recommended that future research should focus on strategies for ensuring a broader representation of research participants. From a feminist research perspective, nursing students should be consulted and involved as co-researchers in the study of nursing students’ perceptions of workplace violence in health care organizations. In addition, collaboration with Elders, Native Access Program to Nursing/Medicine (NAPN/M) advisors, and Aboriginal nursing students is recommended to assist in exploring appropriate research methods for including Aboriginal nursing students in this research focus (Barton, 2004; Canadian Institutes of Health Research [CIHR], 1998; Kenny, 2004; Loppie, 2007). Although the reasons for low participation of second year nursing students in this research study are unknown, one needs to question: are second year nursing students already silenced in regards to workplace violence as experienced by nurses (Celik & Bayraktar, 2004; Foster et al., 2004; Randle, 2003; Stevenson et al., 2006)?

As there is limited Canadian research which focuses on nursing students and workplace violence, further research which explores nursing students’ lived experiences of workplace violence in clinical learning settings in various stages of nursing education is recommended (for example, focusing on research questions such as “What are nursing students’ experiences of workplace violence in clinical learning experiences?” and “How do experiences of workplace violence affect nursing students’ clinical learning?”). In addition, longitudinal case studies (Tjaden, 2004) underpinned in a feminist stance of intersectionality which explore nursing students’ perceptions and experiences of workplace violence as they progress through
undergraduate nursing education would provide insight into the relationship of workplace violence and professional socialization of nursing students in clinical learning experiences.

_Complexity of a Feminist Intersectionalist Perspective in Research_

Applying a feminist perspective of intersectionality to explore workplace violence proved to be a daunting task. The complexity of intersectionality in relation to workplace violence as experienced by nurses in this research study was somewhat tempered by pre-identifying the primary intersections of gender, class, and race and initially exploring these as non-interlocking categories (that is, by unravelling the intersections). Although this proved to be helpful on one hand, this stance potentially narrowed the identification of a multitude of other intersecting identities and somewhat minimized the multidimensionality of intersectionality. In the present research study, it is possible that other axes of oppression and privilege might have emerged as predominate influences in the absence of a pre-determined gender-class-race framework. In addition, although several authors cautiously suggest a categorical research approach of intersectionality, one needs to question if intersections of oppression and privilege can realistically be studied as ‘stand-alone’ oppressions/privileges in isolation of others.

If this research study was replicated, knowledge of intersectionality of oppression and privilege in relation to workplace violence might be further extended if the categorical identities are not pre-determined (that is, adopting an open-categorical stance at the outset of the research study). In addition, it would be useful if diverse intersections of oppression and privilege related to workplace violence were explored in _relationship with each other as they emerge_. If an open-categorical stance of intersections of oppression and privilege was employed, other methods of ‘managing’ the complexity of intersectionality might be considered. For example, Ludvig (2006), McCall (2005), and Valentine (2007) suggest that the complexity of a feminist intersectionality perspective in research might be ‘managed’ through employment of case study methods. Thus, it
is suggested that future research of workplace violence as experienced by nurses/ nursing students that is underpinned in a feminist stance of intersectionality should consider the following key question in the preliminary phases of research proposal development: “How can an intersectional perspective account for all the possible interconnections of identity markers that make up an individual without being burdened by an endless combination of intersecting characteristics?” (Wilkinson, 2003, p. 31). It is highly recommended that a feminist perspective of intersectionality be employed in future research endeavours to further the understanding of workplace violence as experienced by nurses, nursing students, and other health care providers.

Influences of the Researcher’s Intersections of Oppression and Privilege

As this research study unfolded, it became evident that the research results were susceptible to the influences of the researcher’s personal identity (personal intersections of oppression and privilege) and the interconnections of this identity with the research participants’ intersections of oppression and privilege in the context of the research study. One needs to question, how does the researcher’s personal intersections of privilege and oppression obscure what might be seen through an intersectionality lens? Alvesson and Skoldberg (as cited in Freshwater and Rolfe, 2001) state “There is no one way street between the researcher and the object of the study; rather, the two affect each other mutually and continually in the course of the research process” (p. 526, emphasis in text). Thus, a highly reflexive stance is recommended in research underpinned in a feminist perspective of intersectionality (Freshwater & Rolfe; Kirsch, 1999; Olesen, 2005; Seale, 1998b). Strategies such as reflective writing, post-interview journaling, and dialogue with others are important in raising the researcher’s critical consciousness of personal intersections of oppression and privilege and how these interconnect with others’ identities in the research context (Freshwater & Rolfe, p. 533).
Reflective Thoughts

As I reflect and review my research notes, I see a myriad of thoughts, quotes, disappointments, revelations, dilemmas, and personal life experiences. At times, my reflective journaling speaks of feelings of powerlessness and helplessness in making the slightest impact on workplace violence experienced by nurses! At other times, I see where I have been re-energized by new insights into the underpinnings of workplace violence and by connections with others who have provided support and validation for my research. My lens through which I have viewed workplace violence related to this research study has changed many times.

The following reflective writing shares some of my earlier thoughts of workplace violence when the idea for this research study was only a seed waiting to grow:

*My nursing ‘lived experiences’ have led me to the realization that the silence and cycle of violence in nursing has continued throughout my years in the nursing profession. My earliest recollection of a physical assault by a patient was in my first year of nursing practice in an intensive care unit. While attending to a male patient’s nursing needs, a co-worker was struck in her chest as I watched from the other side of the bed. My co-worker informally reported the incident and was away from work for several days. For the rest of us on the unit, it was ‘business as usual’. I was never asked about my perception of the incident and was not offered any emotional support. I recall feeling embarrassed by the incident. To this day, the incident remains as clear to me as if it occurred yesterday.*

*Over twenty years later, I listen to nursing students relate a story of a workplace violence incident which occurred in a clinical setting. Nursing students are directly involved, and the details have a close likeness to recollections of my early experience of workplace violence as a new graduate nurse. Since I teach concepts of workplace violence in the classroom setting, these students challenged: “Why do you teach all those things about workplace violence in class when...*
they mean nothing in the clinical setting?”. These voices of concern were those of novice students who were not yet acculturated to the norms of the hostile health care workplaces where violence is accepted, practiced, and silenced (Randle, 2003). Farrell (2001) would describe these nursing students as tall poppies, not yet transformed to squashed weeds by “the socialization process [of nursing]” (Randle, p. 399).

Morris (2002) states “to most of us, the subject of our research is dear to our hearts, part of our daily lives and experience” (p. 17). Thus, I reflect: Were the roots of this research project solely focused on giving voice to nursing students’ concerns? Or was this research focus an avenue of release of unresolved feelings of violation from within my nursing practice? On reflection, I realize that my professional life experiences as a clinical nurse and nurse educator form a deep emotional connection with the focus of this research. As a result, it was critical that reflexivity was embraced within this research process (Freshwater & Rolfe, 2001; Kirsch, 1999; Olesen, 2005; Seale, 1998a).

There have been many disorienting dilemmas along this transformative learning journey. The struggle to find an ‘understanding’ of the underpinnings of workplace violence took many turns: Macdonald (2002) suggests that this process of discernment is suitably illustrated “by the image of an unfolding spiral, a spiral that moves upward, peaks, loops back on itself, and then moves upwards again, an ongoing evolution” (p. 174). For example, in one of my graduate courses, I wrote about workplace violence from a gendered organization perspective: Keeping Nurses in their Place: Workplace Violence from a Gendered Organization Perspective (Weisbrod, 2006). Although this exploration provided me with deep insight into workplace violence as experienced by nurses from a gendered perspective, I continued to be faced with the dilemma that this perspective seemed ‘incomplete’. In my view, it seemed that a gendered perspective lacked coherency in attempting to make sense of nurse to nurse workplace violence.
Underpinning the present research project with a third-wave feminist stance of intersectionality extended the one-dimensional gender perspective of workplace violence to a more realistic multidimensional perspective of life events.

From a gendered perspective, Wilson (1996) speaks of ‘gender blindness and deafness’ in organizations. A feminist stance of intersectionality extends this notion and calls into question the blindness/deafness of oppressions and privileges related to many other identities such as class, race, age, language, sexuality, “and so on” (Ludvig, 2006, p. 246). For myself, the most disorienting dilemma of this research process was the recognition that my personal intersections of privilege and oppression (which includes an identity of being female, White, middle-class, middle-aged, and educated and having an occupational status of being a nurse and educator) initially rendered me blind (or myopic) and deaf (or hard of hearing) to some of the intersections of oppression and privilege which the research participants were giving voice. It was only through deep critical analysis that I began to see the complexity of the matrices of intersections of oppression and privilege and how this related to workplace violence as experienced by nurses and nursing students. Through this analysis, I further questioned and challenged the matrices of intersections of privileges and oppression of my own identity. For example, although I found it unsettling that only one learning circle participant primarily spoke about the relationship of race to workplace violence, this dis-ease pushed me to question how my own ‘whiteness’ influences what I might/might not see in relation to intersections of oppression and privilege of race. I wondered: how would I have contributed to the discussion of race and workplace violence as a research participant? More importantly, would I have contributed to the discussion of race and workplace violence as a research participant or would I have remained silent? A critical question lingers: What other matrices of privileges and oppressions (of self and others) related to
workplace violence as experienced by nurses still remain unacknowledged, unaddressed, unnamed, invisible, and silenced?

Conclusion

Based on a feminist stance of intersectionality and a review of nursing and multidisciplinary literature which focuses on workplace violence, a feminist participatory action research approach was used to study first and second year undergraduate nursing students’ perceptions of workplace violence as experienced by nurses. Although intersections of gender, class, and race were identified as primary identities of oppression and privilege in this exploration of the nature and causes of workplace violence, it became evident that other intersections of oppression and privilege are also closely linked to workplace violence in complex and multifaceted ways. The categorical approach of intersectionality employed in this research study provided valuable insight into the nature of workplace violence as experienced by nurses. A further analytical approach of studying ‘ravelled’ matrices of intersections of oppression and privilege within contextual moments of time and space revealed a more holistic (but complex) view of the underpinnings of workplace violence. Employing a feminist stance of intersectionality revealed that workplace violence as experienced by nurses is firmly rooted in the patriarchal organization of health care where multiple oppressions of gender, class, and race (and others) intertwine to create a hostile work environment.

Furthermore, this research study offered opportunities for nursing students to share their perceptions of workplace violence in a safe and trusting learning/research environment. Underpinned in feminist research values, mutual learning and consciousness-raising were realized through research methods of a survey and learning circle focus group. Critical reflection, reflective dialogue, and valuing of life experiences provided opportunities for transformatory learning (Taylor, 1998). Thus, a feminist participatory action research approach which
underpinned workplace violence as experienced by nurses with a feminist stance of intersectionality offered a valuable lens through which to conceptualize workplace violence in health care settings, adding to the understanding of workplace violence as experienced by nurses and nursing students.
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Appendix A Selected International Literature related to Workplace Violence:
Multidisciplinary and Multidimensional Perspectives

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Nursing Students’ Perceptions


### Nursing Students’ Perceptions

Appendix B Overview of Selected Canadian Literature related to Workplace Violence: Multidisciplinary and Multidimensional Perspectives

<table>
<thead>
<tr>
<th>Author/Phenomenon/Discipline</th>
<th>Definition of phenomenon</th>
<th>Prevalence cited</th>
<th>Nature of phenomenon</th>
<th>Conceptual/Theoretical Underpinnings</th>
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</thead>
<tbody>
<tr>
<td>Almost (2006) Conflict with co-workers Nursing (Canada)</td>
<td>Historical and contemporary perspectives of conflict are identified. In the last two decades, “conflict was no longer perceived as being good or bad but rather good and bad” (Deutsch as cited in Almost, p. 447, emphasis in text).</td>
<td>“In nursing work environments, conflict among nurses is becoming a significant issue resulting in job dissatisfaction, absenteeism and turnover” (p. 444). In Canada and Australia, “conflict with nursing co-workers is on the rise” (p. 444). Attributes of conflict include stages of conflict, types of conflict. Antecedents of conflict include individual characteristics, interpersonal factors, organizational factors, conflict management style. Consequences of conflict include effects on people, interpersonal relationships, organizational effects.</td>
<td>Underpinnings include attributes of conflict, antecedents and consequences of conflict. “A more thorough understanding of the sources of conflict within nursing work environments would enable a shift from conflict management to conflict prevention” (p. 451).</td>
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<tr>
<td>Author/ Phenomenon/ Discipline</td>
<td>Definition of phenomenon</td>
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<td>College of Registered Nurses of Nova Scotia (CRNNS) (2007) Violence in the workplace Nursing/ workplace incivility (Canada)</td>
<td>Workplace violence is “any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. These behaviours would originate from customers or co-workers at any level of the organization. This definition would include all forms of harassment, bullying, intimidation, physical threats or assaults, robbery and other intrusive behaviours” (Canadian Initiative on Workplace Violence as cited in CRNNS, p. 1). “Workplace incivility is distinct from workplace violence in that, in the former, there is an ambiguous intent to harm (p. 2). “Once there is a targeted individual or a clear intent to harm, workplace incivility becomes workplace violence “(Hutton as cited in CRNNS, p. 2).</td>
<td>“A growing body of literature recognizes that nurses are profoundly vulnerable to abuse, threats, violence and injury in the workplace, and acknowledges violence as an international epidemic” (p. 2).</td>
<td>Cites many risk factors which “can put a workplace at risk” (p. 4) such as unrestricted movement of public, lack of staff training, working alone, working as a ‘boundary spanner’, overcrowded waiting rooms, poor environmental designs, increasing presence of gang members, prevalence of hand guns (p. 4). Workplace violence results in human and organizational costs. Incivility has “the potential to negatively affect the quality of patient care” (p. 2).</td>
<td>“The foundation of a healthy work environment is one in which all staff members have a genuine respect for one another” (Schaffner, Stanley &amp; Hough as cited in CRNNS, p. 1). Workplace violence is a complex issue. “Individuals in health care often tolerate or enable behaviours such as berating, abusive language, and condescending communication between colleagues” (citing several authors, p. 2). “In the healthcare sector, staffing patterns, shift work, demanding workloads, poor security, and interventions requiring close physical contact place nursing and other health personnel at a greater risk of violence (ICN as cited in CRNNS, p. 2).</td>
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<tr>
<td>Croker &amp; Cummings (1995) Physical assault Nursing in medical-surgical hospital settings (Canada)</td>
<td>Not defined.</td>
<td>22% of respondents had been physically assaulted by patients in the preceding five years. “Nurses tend to deny, rationalize, and minimize assault” (p. 88).</td>
<td>66% of respondents stated they reported incidents of assault. 31% of respondents indicated that their response was to learn and change.</td>
<td>Emotional, biophysiological, and social reactions to assault. Coping mechanisms. Rationalization.</td>
</tr>
<tr>
<td>Author/ Phenomenon/Discipline</td>
<td>Definition of phenomenon</td>
<td>Prevalence cited</td>
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<tr>
<td>Daiski (2004) Dis-empowering relationship patterns Nursing (Canada)</td>
<td>No definition given.</td>
<td>“Sadly it remains widely expected that a ‘good’ nurse is one who accepts their place in the hierarchy and learns to do things the ‘way it is done here’” (p. 49).</td>
<td>The following themes were found: nurses look up to other professionals, nurses eat their hyoung, role of women and societal expectations, suggestions for change. “Nurses can improve their own conditions by recognizing and changing their own dis-empowering practices” (p. 49).</td>
<td>Oppressed group behaviour. Powerlessness (“women in general are seen as a powerless group” (p. 44). “Powerless groups…tend to admire and imitate those they perceive as powerful. In contempt of their peers, they long to join the ranks of the oppressors and thus they accept their values, while disregarding their own” (p. 44). “Submissiveness invites exploitation, while lack of autonomy and assertiveness suppresses creativity and initiative” (p. 49).</td>
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<tr>
<td>Duchscher &amp; Cowin (2004) Marginalization Nursing (new nursing graduate) (Canada)</td>
<td>Historical and contemporary conceptual understandings of marginalization are explored. “The experience of living between 2 cultures that have asymmetrical power” (p. 289). “Marginalized persons view themselves, and are viewed by others, as being different from the norm” (p. 290, emphasis in text).</td>
<td>“It is likely that within every profession there exists a gap between the culture of the profession transmitted in the teaching institution and the actualities of practice in the field. However, the tension created by these polarized ideals of care in nursing, if left unchecked, may contribute unnecessary stresses for the graduate in socializing to their new professional roles” (p. 293).</td>
<td>“For many, the journey from nursing student to professionally practicing nurse is chaotic, unsupported, and painful” (p. 293). Strategies to minimize marginalization of new nursing graduates are presented (p. 294).</td>
<td>Socio-cultural relations (reality shock, role expectations, professional identity) and socio-political conditions (role socialization) influence the new nursing graduates’ experiences of marginalization.</td>
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<tr>
<td>Author/ Phenomenon/ Discipline</td>
<td>Definition of phenomenon</td>
<td>Prevalence cited</td>
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<tr>
<td>Duncan et al. (2001) Nurses in hospitals (Canada)</td>
<td>“Definitions of violence vary to the extent that they sometimes encompass incidents that do not result in physical injury such as verbal or emotional abuse….there is an emerging consensus that violence encompasses multiple forms of aggression, rooted in the dynamics of power and control” (citing several authors, p. 60). Five categories of violence used in the survey.</td>
<td>“Comparison across populations with respect to the incidence and prevalence of workplace violence is hindered by the lack of standardized definitions….Despite the inconsistencies in definition, there are indications that nursing is at high risk for workplace violence relative to other occupations” (p. 60). 46% of the respondents experienced workplace violence in the last five shifts worked.</td>
<td>Workplace violence originates from patients, physicians, patients’ families/ friends, supervisors, co-workers. 70% of respondents did not report violent incidents. This might be related to an acceptance of a culture of violence particularly by mid and late career nurses (synchronous with increasing societal trend of tolerance of violence).</td>
<td>Dynamics of power and control. Personal, interpersonal, organizational framework of predictors (complex, systemic factors).</td>
</tr>
<tr>
<td>French &amp; Serman (2007) Bullying/ workplace violence/ assault/ sexual incidents Multidisciplinary (Canada)</td>
<td>Refers to the Canadian Initiative on Workplace Violence definition of workplace violence “any incident in which a person is abused, threatened or assaulted in circumstances relating to their work….This definition would include all forms of harassment, bullying, intimidation, physical threats or assaults, robbery and other intrusive behaviours” (para 6)</td>
<td>Refers to a Canadian Union of Public Employees study (1994) which found that 70% of employees had experienced verbal aggression, 40% had been struck, and 30% had been grabbed or scratched. Statistics of workplace violence are “staggering” (para 5).</td>
<td>Cites difficulty in legislators, union officials, and employers being “unable to agree on a clear, universally accepted definition of workplace violence” (para 5). Employers must be aware of their duty to provide a violence-free workplace. Workplace violence results in significant personal and organizational costs.</td>
<td>None cited.</td>
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<td>Hagey et al. (2001)</td>
<td>Racism in the workplace</td>
<td>“Head (1985) observed that attitudes toward equity become positive n times of job surplus, but racial discrimination is exacerbated in periods of economic downturn” (p. 389). Cites Calliste who argues that “the distribution of nurses constitutes a segmented labour market” (p. 390) where nurses of colour are streamed into long-term care and White nurses are asked for their specialty preferences. Four themes emerged from study: being marginalized and acknowledging and naming racism; experiencing physical stress and emotional pain; strategize to cope and survive; and recommending policy changes.</td>
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<td>Immigrant nurses (Canada)</td>
<td>Not defined but findings included themes of being marginalized and acknowledging and naming racism. Uses the term ‘discrimination’.</td>
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<td>Hesketh et al. (2003)</td>
<td>Workplace violence</td>
<td>“Previous workplace violence research has been inconsistent or unclear about the definitions of violence used, making cross-study comparisons difficult” (Duncan et al. as cited in Hesketh et al., p. 313). Violence categories (Duncan et al., 2001): physical assault threat of assault emotional abuse verbal sexual harassment sexual assault.</td>
<td>“Workplace violence is a significant and widespread public health concern among health care workers” (p. 311). Emergency/ psychiatry nurses experienced most overall violence. Critical care nurses experienced least violence. Medical-surgical nurses experienced the highest incidence of physical violence. Hospital staff was “more frequently cited as sources of non-physical violence” (p. 314). Many violent acts are originated by patients. Significant portion of incidents of emotional abuse/ sexual harassment from co-workers. Many incidents go unreported. Included domestic violence occurring in the workplace. Type of violent episode impacted job satisfaction: those experiencing both emotional abuse and one other form of violence had least job satisfaction.</td>
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<td>Nursing in hospitals (Canada)</td>
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<td>“The image of Whiteness confers privileges of normality, authority, freedoms for flexibility, capacities for being heard, opportunities for control, events being predictable, and having information about the correct means and channels. Being categorized as ‘lesser than,’ by contrast, means being not only different, but also marginal – someone who can be subordinated, disadvantaged, restricted, silenced, not told about opportunities nor given cooperation for control” (p. 390).</td>
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<td>Broken Windows Theory (of criminal acts) suggests “tolerating ‘lesser’ criminal acts…in a community creates an environment where more crime takes place” (Wilson &amp; Kelling as cited in Hesketh et al., p. 320).</td>
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<td>Kling et al. (2006)</td>
<td>Internationally, health care workers are at risk. In 2000, Workers’ Compensation Board of BC reported 40% of all violence related claims came from health care workers” (p. 481).</td>
<td>“Violence in health care differs from violence in other industries. Health care workers must interact closely with patients and families, often under difficult circumstances” (p. 481)</td>
<td>Risk indicators as precursors to violence. Client assessment.</td>
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<td>LeBlanc &amp; Barling (2004)</td>
<td>Not described.</td>
<td>Citing Baron et al., aggressive workplace behaviours have 3 categories: Expressions of hostility Obstructionism Overt aggression. Insider-initiated aggression is complex due to multiple sources, targets, causes. Categorized according to assailant’s relationship to victim: Type I No legitimate relationship Type II Legitimate relationship with the organization Type III Offender is a current/ former employee Type IV Offender has an ongoing relationship with the victim.</td>
<td>Insider-initiated aggression prompted by: Individual perspectives (alcohol, hostile bias), organizational perspectives (injustice, overcontrolling supervision). Effects of workplace aggression.</td>
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<td>Macdonald &amp; Sirotich (2005)</td>
<td>Prevalence in this study difficult to ascertain “respondents were frequently unable to remember the number of times they were verbally harassed” (p. 775).</td>
<td>Refers to only one other Canadian study on client violence experienced by social workers (Macdonald &amp; Sirotich, 2001). Overall, respondents do not feel vulnerable to violence.</td>
<td>Raising consciousness.</td>
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<td>MacIntosh (2005) Workplace bullying Nursing in rural areas (Canada)</td>
<td>“Broadly defined as psychological, physical, or sexual abuse or hostility within the workplace” (p. 894). Bullies: “perpetrators of actions” (p. 898). Targets: “recipients of bullying” (p. 898). Distinctions between bullies and targets not always clear (p. 899).</td>
<td>“Participants believed that bullying could occur in any workplace where it was possible to abuse power and control” (p. 899).</td>
<td>Citing several authors, “Workplace bullying may go unaddressed, unacknowledged, and even unnamed because of its sometimes subtle, insidious, and secretive beginnings” (p. 893). Common features include “persistence and repetition; offensive, unsafe, unwanted, or intimidating behaviors; and abuse of power or control in the workplace” (p. 894). Targets are often competent, committed employees who want/try to do a good job (p. 900). Bullies could be anyone who exerts legitimate/ illegitimate power over another. Personal (physical, mental, emotional, instrumental), social, and organizational side effects.</td>
<td>Power dynamics. Personal, social, organizational impact.</td>
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<td>MacIntosh (2006) Workplace bullying Nursing in rural areas (Canada)</td>
<td>“Repeated unwanted psychological, physical, or sexual abuse, or harassment…. characterized by frequent, objectionable behaviour imposed upon by an employee or by another person” (p. 666).</td>
<td>“In 2000, a Canadian survey of labour unions revealed that more than 70% of respondents reported incidents of harassment and bullying at work” (French &amp; Morgan as cited in MacIntosh, p. 666).</td>
<td>“Braverman and Denenberg (1999) suggested that incidents of workplace bullying were not random or unexpected and that most resulted from ‘disputes that have been allowed to fester’” (p. 667).</td>
<td>Personal, group, and organizational level approaches to tackling workplace bullying.</td>
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<td>Manitoba Nurses’ Union (2005) Bullying Nurses (Canada)</td>
<td>“Bullying is a persistent unwelcome behaviour, mostly using unwarranted or invalid criticism, nit-picking, and faultfinding. It often includes exclusion, isolation, being singled out and treated differently, verbal put downs and insults, being shouted at and humiliated. Bullying tactics in the workplace may also include: excessive monitoring, unreasonable work demands, disregard for exemplary work, having verbal and written warnings imposed, and much more” (p. 4).</td>
<td>Many sources of abuse: “patients, clients, residents, family members or visitors, other health care practitioners, managers or the general public” (p. 6). Prevalence of bullying not directly cited although narratives of bullying provided.</td>
<td>“Bullies have long ruined nurses quality of life and driven many good nurses out of the profession” (p. 5). 70% of those targeted by a bully leave their workplace, 33% for their health (citing The Workplace Bullying and Trauma Institute). Code Pink is a method of dealing with bullying: “refers to the practice of supporting the victim of bullying by surrounding the victim as the perpetrator is carrying out the act” (p. 7).</td>
<td>“Bullies may be narcissistic, attention seeking personalities. They seldom accept responsibility for their behaviour. In fact, what bullies fear most is being called publicly to account for their behaviour” (p. 5). Three types of bullies: accidental bully, narcissistic bully, psychopathic bully.</td>
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<td>Priest (2006) Workplace violence Nursing human resources (Canada)</td>
<td>“Physical assault, verbal aggression, threat of assault, or emotional abuse” (p. 9).</td>
<td>“Difficult to know exactly how prevalent violence is at work” (p. 9). “38% of nurses experienced hurtful remarks, humiliation from co-workers, or coercion” (Duncan et al. as cited in Priest, p. 9). “Risks of violence in all settings are increasing” (p. 9). Psychiatric nurses are more likely to experience violence than RNs/ LPNs.</td>
<td>Affects whether nurses are absent from work. Perpetrators may be colleagues, other professionals, patients or their families.</td>
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<td>Registered Nurses’ Association of Ontario (RNAO) (2007) Workplace violence Nursing (Canada)</td>
<td>Workplace violence is “an incident of aggression that is physical, sexual, verbal, emotional or psychological that occurs when nurses are abused, threatened or assaulted in circumstances related to their work” (ILO, ICN, &amp; PSI as cited in RNAO, p. 1).</td>
<td>“It is estimated that 50 percent of health-care workers will be physically assaulted during their professional careers, and nurses are three times more likely to experience violence than any other professional group” (citing several authors, p. 1).</td>
<td>“Clients and families are involved in the majority of incidences of violence toward nurses” (p. 3, emphasis in text). “Physicians have been cited as the major source of verbal abuse that nurses are subjected to on almost a daily basis” (p. 3, emphasis in text). “Nurse to nurse violence is often ignored or downplayed by both nurses and institutions….often referred to as ‘bullying’ or ‘interpersonal conflict’” (p. 3).</td>
<td>“Violence toward nurses originates from multiple sources and risks are multifaceted. It is important to take a broad approach, examining societal, workplace, and individual factors, and recognizing the dynamic relationship between them” (p. 2).</td>
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<td>Rippon (2000) Aggression/ violence Health care professions (Canada)</td>
<td>Lack of clear definition. Considerable discussion of difficulty in defining terms. Suggests that the word ‘violence’ has replaced the word ‘aggression’. Concludes “aggression is behavior with intent that is directed at doing harm….can be physical or verbal, active or passive, and can focus on the victim(s) directly or indirectly” (p. 456). “By definition, violence is synonymous with aggression” (p. 456).</td>
<td>“Violence in health care settings is a pervasive problem and an epidemic that constitutes an occupational hazard (Soloff, 1987; Lipscomb &amp; Love, 1992)” (p. 453). Citing several authors, “Between 35% and 80% of hospital staff have been physically assaulted; between 65% and 82% have experienced verbal abuse.</td>
<td>The impact of aggression/violence has “profound traumatic effects on the primary, secondary, and tertiary victims” (p. 452) Citing several authors, “In addition to the immediate trauma of the assault, the frequency of exposure to aggression in the workplace can have a cumulative effect on the victims, the greater the frequency and severity, the greater the probability of psychological trauma” (p. 453).</td>
<td>Buss’s eight different kinds of aggression in a three dimensional model: physical-verbal; active-passive; direct-indirect.</td>
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<td>WorkSafeBC (2005) Violence in health care Multidisciplinary</td>
<td>Refers to the Occupational Health And Safety Regulation’s definition of violence: “the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker” (p. 9). “Violence also includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury” (p. 9).</td>
<td>40% of all violence-related claims (of workers compensation) come from health care workers: “these workers . . . have more accepted claims and lose more days of work due to acts of violence than any other group” (p. 8).</td>
<td>The Occupational Health and Safety Regulations form the underpinnings. A five step program is recommended: establishing a working group, conducting a risk assessment, developing and implementing control measures, providing education, and conducting an annual review.</td>
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### Appendix C Overview of Selected Literature related to Nursing Students’ Experiences of Workplace Violence: Multidimensional Perspectives

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<td>Beech (1999)</td>
<td>Refers to “verbal and physical threats and abuse” (p. 610).</td>
<td>“Accurate figures on the incidence of violence…are difficult to determine for several reasons: differing definitions, different research and data-collection methods” (p. 611). “Violent incidents are not evenly distributed throughout the category 'nurses'….In the UK the largest study of this area [Health Services Advisory Committee, 1987] showed that, of all health professions and grades, student nurses were at the greatest risk of being the victim of a work-related violent incident” (p. 611).</td>
<td>“The increased risk to students existed across all categories of violence ranging from verbal abuse through to major assault. Yet, paradoxically, training in self-protection and pro-active management of aggression and violence remains pre-dominantly a post-registration preserve” (p. 611).</td>
<td>Program of instruction for pre-registration students is needed. This should include definitions, theories and models of aggression and violence, incidence, self-awareness, risk factors, dos and don’ts of verbal/non-verbal interaction (theory and practice) (p. 612).</td>
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<td>Beech &amp; Leather (2003)</td>
<td>No definition cited.</td>
<td>“There is a growing evidence for the distressing nature of aggression by other health professionals towards nurses and nurse-to-nurse aggression” (p. 605).</td>
<td>“Training has seldom been viewed as necessary or provided for student nurses. This is perverse, given their high ranking in the studies of professional groups affected by violence” (p. 605).</td>
<td>“Manifestations of aggression are complex and should not be construed as limited to patient or relative aggression towards nurses” (p. 605).</td>
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<td>Bronner, Peretz, &amp; Ehrenfeld (2003) Sexual harassment Nurses, nursing students (Israel)</td>
<td>“Definitions of sexual harassment emphasize the essence of harassment as any unwelcome, offensive and undesireable sexual conduct that interferes with an employee’s ability to perform their job” (citing several authors, p. 638). “Is referred to as behaviour which is sexual in nature and directly or indirectly adversely affects or threatens to affect a person’s job security, prospects of promotion or earning, working conditions, or opportunity to secure a job, living accommodation, or any kind of public service” (Knox as cited in Bronner et al., p. 638).</td>
<td>“A major workplace problem that causes humiliation and embarrassment and damages health care workers’ performance” (citing several authors, p. 638). “The frequency of sexual harassment among nurses and nursing students is relatively high, according to participants in various studies” (p. 638). Sexual harassment is also common among other health care providers. In this study, 91% of the subjects reported experiencing at least one type of sexual harassment. Gender differences impact experiences of sexual harassment.</td>
<td>Perpetrators are often doctors or administrators with the most common perpetrators being men. Various types of sexual harassment include: teasing remarks, hearing sex jokes, proposition to intimate relationship, physical touch, intimate touch, forced to touch intimately, and attempt to have sex (p. 640). There are status-based differences of incidents of sexual harassment: “nurses were significantly more exposed than nursing students” (p. 643). “When confronted with sexual harassment, most nurses and nursing students used passive coping strategies, mainly in the form of ignoring the behaviour or getting away from the perpetrator” (p. 643).</td>
<td>Results of sexual harassment in the workplace are multifaceted. Both men and women who are harassed at work experience low self-esteem, loss of control over identity as a person and worker. “Male students and nurses deserve special attention because they are subjected to the more offensive sexual conducts, and lack the ability to respond in an assertive way” (p. 643).</td>
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<td>Celik &amp; Bayraktar (2004) Nursing student abuse Nursing students (Turkey)</td>
<td>Lengthy list of types of abuse organized by categories of verbal, academic, sexual, physical.</td>
<td>Participants felt abused verbally (100%), academically (83%), sexually (53%), physically (6%).</td>
<td>Classmates, faculty, nurses, physicians, patients, and patients’ families, physicians are sources of abuse. “Doing nothing” was most common response to abuse (abstract). Abuse is a traumatic experience having long term physical, psychological, social effects. Nurses’ productivity decreases with abusive experiences.</td>
<td>Coping methods. Physiological, psychological, social effects.</td>
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<td>Curtis, Bowen, &amp; Reid (2006)</td>
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Horizontal violence (HV).  |
Nursing (Australia) | “Bullying and aggression involving inter-group conflict” (p. 157).  |
|  |  | 34% of new graduates reported rude, abusive, humiliating, unjust criticism made by other nurses (McKenna as cited in Curtis et al., p. 157). Nursing students commonly experience HV during clinical experiences.  | Emergency and mental health clinical areas are known to encounter high levels of occupational violence (p. 157). “HV appears to be tolerated to a much higher level in nursing compared with other professions” (p. 157). Cycle of HV begins during nursing education.  | 5 major themes: Humiliation/ lack of respect. Powerlessness and being invisible. Hierarchical nature of HV. Coping strategies. Future employment choices. |
| Foster, Mackie, & Barnett (2004)  |
Bullying Nursing students (Australia) | Ignoring/ excluding were reported to be the worse behaviour experienced, followed by intimidation and being set up to fail (social aspects of the job).  | “Bullying is a problem for nursing students and…a high percentage of the bullies were senior nurses” (p. 67). The majority of participants were in their second year when they experienced their worse case of bullying. 90% of participants reported experiencing some form of bullying. “Increasing trend towards student and junior nurses being bullied” (p. 78).  | There was no age that was deemed safe against bullying. Effects of bullying costly to organizations in terms of sickness, low morale, low retention. A high percentage of students were able to talk to a confidant about being bullied. Male and female students reported being bullied. “Bullying is occurring within the nursing profession rather than outside it” (p. 80, emphasis in text). 52% of participants “expected to be bullied while on clinical placement” (p. 81).  | Power imbalance between trainer and trainee. Cycle of violence: “vicious cycle where a nurse is bullied by another colleague, who is often more senior, they then lose confidence and become a victim. As a way of diminishing the victim’s role they have assumed and to make themselves feel better, they in turn bully another more vulnerable colleague” (p. 80). Senior nurses believe that since they had to endure tyrannical and rigorous training (including bullying), their juniors should also have to put up with it. |
| Freshwater (2000)  |
Horizontal violence  |
Nursing/ nursing education (England) | “Behaviours include overt and covert non-physical hostility such as sabotage, infighting, scapegoating, back-stabbing and negative criticism” (McCall, Farrell, Leap as cited in Freshwater, p. 482).  | “There are…few studies that comment on the extent of horizontal violence in nursing and none that address this in relation to the student nurse” (p. 482).  | “Nurse on nurse aggression is felt to be more upsetting than that from patients” (p. 482). Professional terrorism. Professional jealousy. Undermining, covert behaviour.  | Oppression theory. Power dynamics. Patriarchical health care system. Colonization. Cultural narration. Unexpressed conflict. Transformatory learning/ conscientization. Reflective practice. |
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<td>Gray (2006) Workplace bullying</td>
<td>“Forms of bullying [range] from being ‘frozen out’ to public humiliation’ (p. 1)</td>
<td>“Bullying has long been recognized as a serious problem for many qualified nurses but the situation is even worse for students” (p. 1). Citing Randle, “adult branch nurses, men and students aged over 35 suffer most harassment, while diploma students are more likely to be bullied than those on degree courses. Students in children’s nursing were least likely to experience problems” (p. 1).</td>
<td>Citing Randle, “some bullied students said they had also witnessed bad behaviour towards patients” (p. 1). “A person who lacks empathy with the inexperienced but eager student is unlikely to strike up a warm, caring relationship with vulnerable patients” (p. 1). Most students take no action. “Unacceptable misery” (p. 1). “[Students] tell themselves that staff are having a bad day or that this is a normal part of being a student” (p. 1).</td>
<td>“People bully students because they think they can get away with it. Bullying behaviour often springs from the bully’s own low self-esteem and they take it out on someone they perceive to be less powerful or those whose talents and enthusiasm they find threatening” (p. 1).</td>
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<td>Hoff &amp; Ross (1995) Violence Nursing curricula (Canada)</td>
<td>Consider: Child abuse Women abuse/ battering Abuse of older adults</td>
<td>“Attention to the worldwide plague of violence against women and children is gaining momentum” (p. 137). One half of Canadian women have endured at least one incident of violence. Urgent health issue.</td>
<td>Several intersecting factors: “Health professionals’ earlier collusion (if only by silence and inattention) in the traditional definition of violence as a ‘private’ matter, rather than a public one” (p. 137)</td>
<td>Gender framework.</td>
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<td>Longo (2007) Horizontal violence Nursing students (United States)</td>
<td>Citing several authors: “act of subtle or overt aggression perpetrated by one colleague toward another colleague; the aggressive act may be physical, verbal, or emotional. Examples include belittling words or gestures, sarcastic comments, faultfinding, and ignoring or minimizing another’s concerns” (p. 177).</td>
<td>“None of the participants reported being physically or verbally threatened, and only one student (2%) reported being pushed or shoved. The behaviour that was most frequently reported was being put down by a staff nurse….This was followed by being humiliated…having a sarcastic remark made about them…and being talked about behind their back” (p. 178).</td>
<td>The observation of an act of horizontal violence between a staff member and a classmate was reported by 34% of the participants. Incidences of horizontal violence involving the participants were not reported by 49% of the participants. Most participants did not discuss incidences of horizontal violence with a peer or significant other.</td>
<td>None cited. “Is the concept underpinning nurses’ descriptions of ‘eating their young’ (p. 177).</td>
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<td>Randle (2003) Bullying Nursing students (United Kingdom)</td>
<td>Defines self esteem. Bullying is “the persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self esteem” (Adams as cited in Randle, p. 399).</td>
<td>“Bullying was found to be commonplace in the transition to becoming nurse. Students were bullied and also witnessed patients being bullied by qualified nurses” (p. 395). “One in six nurses had been subjected to bullying from a colleague in the last year” (Royal College of Nursing as cited in Randle, p.399). Insidious cannibalism (citing Meissner).</td>
<td>“The internalization of nursing norms meant that students then bullied others. Students’ self esteem was low” (p. 395). “Socialization process can be akin to brainwashing” (p. 399). “The process of becoming a nurse necessitated adjustment and acculturation to a hierarchical system that they [nursing students] maintained to achieve a professional role” (p. 399). “To gain a sense of belonging to the profession, they may even have to pass a ‘tribal test’ (Mozingo et al. 1995), where they are put through a set of tasks that are difficult or unpleasant in order to gain an identity of belonging” (p. 399). Being bullied “appeared to render the students powerless” (p. 397).</td>
<td>Grounded theory framework. Professional socialization. Power dynamics. Self-esteem. Oppressed groups (Freire).</td>
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<td>Ross (2002) Violence (including violence in the workplace) Nursing education (Canada)</td>
<td>Not defined.</td>
<td>“Directed at health care workers, including nurses and nursing students, is reported as endemic and considered an occupational hazard” (citing several authors, p.15). “Increasingly, the safety of nurses and nursing students is emerging as critical concerns to the profession” (citing Whitly et al., p. 15).</td>
<td>“Violence is also perpetuated by nurses…the most common form of abuse was embarrassing or offensive comments, rough treatment, or yelling and swearing” (citing the College of Nurses of Ontario, p. 16).</td>
<td>Nurses’ education in violence prevention, detection, intervention. Interdisciplinary conceptual approach including: family dynamics role theory sex-role stereotyping power disparities feminist analysis social change theory sociocultural context.</td>
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<td>Stevenson, Randle, &amp; Grayling (2006) Inter-group conflict/ bullying Nursing students (United Kingdom)</td>
<td>Quine’s 25 possible negative interactions used in study. Taking no action against bully was most common response to abuse. ‘Fitting in’ and ‘playing the game’ were common responses to abuse.</td>
<td>Most frequently reported negative behaviour was being frozen out/ ignored/ excluded. Least frequently reported behaviour was physical assault. Less bullying in pediatrics clinical placements. Students over 35 years experienced more negative behaviours.</td>
<td>“The process showed that the process of becoming a nurse was a distressing and psychologically damaging one for students” (para 17). Doctors and non-nurse trained staff were perpetrators. Male students experienced more sexual harassment than female colleagues.</td>
<td>Grounded theory framework. Gender and bullying. Socialization into a culture of abuse in work placements. Organizational structure. Power dynamics.</td>
</tr>
<tr>
<td>Theriault &amp; Landry (1999) Violence and abuse Nursing students (Canada)</td>
<td>Two forms of violence: When someone feels threatened with loss of personal power. People who are violent by nature. Violence: “Typically portrayed as a dramatic physical act, generally stemming from a person’s frustration or suppressed anger” (p. 10-11). Abuse: “Arising from the destructive use of power within relationships. Abuse could be physical, verbal, sexual, emotional, or involve any action that results in another person ‘feeling like less of a person, humiliated or embarrassed”’ (p. 11).</td>
<td>Feeling unprepared “like a rabbit caught in the middle of the road at night blinded by oncoming headlights, with no idea of how to get off the road” (p. 10).</td>
<td>Number of factors work synergistically to enhance students’ vulnerability to abuse: Students personal characteristics Limited support to students Patient frustration Lack of confidence Low self esteem Lack of knowledge of student rights Perceived lack of status. Feel intensely vulnerable Initial clinical experiences Clinical evaluations Last year in the program Interaction with patients’ family Seeing nursing staff being abused/ feeling helpless Questioning nursing staff Home visiting a client Sharing personal beliefs.</td>
<td>Power as the root of violence. Historical context. Social context. Hierarchical nature of health care. Cycle of violence.</td>
</tr>
<tr>
<td>Author/ Phenomenon/ Discipline</td>
<td>Definition of phenomenon</td>
<td>Prevalence cited</td>
<td>Nature of phenomenon</td>
<td>Conceptual/ Theoretical Underpinnings</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Watson (1998)</td>
<td>Not defined.</td>
<td>Citing a survey by the Health Services Advisory Committee (1985), “a wide range of staff, particularly nurses in training grades” (p. 63).</td>
<td>“Student nurses need to receive appropriate training so they can develop the skills necessary to work safely and confidently during placements” (p. 63).</td>
<td>A number of factors place student nurses at risk: feeling tired, pressured or isolated, being unfamiliar with the unit and patients, and trying to balance learning outcomes, complete assignments, and pass exams.</td>
</tr>
<tr>
<td>Whitley, Jacobson, &amp; Gawrysz (1996)</td>
<td>Extensive literature review presented which demonstrates the variation of definitions, effects, contributing factors. Although the literature review is not focused on nursing students’ experience, the purpose is to propose recommendations for nursing education based on the findings of the literature review of nurses’ experiences in a variety of workplace settings.</td>
<td>“The environment within the health care arena is fraught with violence and potential risk. Violence affecting nurses in the workplace continues to escalate” (p. 211). The incidence of violent and assaultive behaviour in psychiatric, emergency, long-term, and home care settings is discussed.</td>
<td>A variety of conceptual understandings are presented based on literature review focused on specific health care setting.</td>
<td>Nursing education strategies.</td>
</tr>
</tbody>
</table>
Appendix D Research Participants’ Demographics in Comparison with Demographics as reported by Saskatchewan Institute of Applied Science and Technology (SIAST)

Survey Participants

Year 1 nursing students: 37.0% \((n=30)\) of potential participants (total enrollment in intersession course = 82 students).

Year 2 nursing students: 6.1% \((n=7)\) of potential participants (total enrollment in intersession clinical course = 114 students).

Age

Note: Age categories of survey participants and NEPS students differ by one year.

<table>
<thead>
<tr>
<th>Survey Participants</th>
<th>SIAST Wascana Campus *</th>
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</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td><strong>% ((n))</strong></td>
</tr>
<tr>
<td>20 and under</td>
<td>51.4 (19)</td>
</tr>
<tr>
<td>21 to 25</td>
<td>32.4 (12)</td>
</tr>
<tr>
<td>26 to 30</td>
<td>10.8 (4)</td>
</tr>
<tr>
<td>31 to 35</td>
<td>2.7 (1)</td>
</tr>
<tr>
<td>36 to 45</td>
<td>2.7 (1)</td>
</tr>
<tr>
<td>46 to 55</td>
<td>0 (0)</td>
</tr>
<tr>
<td>56+</td>
<td>0 (0)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100 (37)</strong></td>
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</table>

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Survey Participants</th>
<th>NEPS Year 1 and 2 Students SIAST Wascana Campus *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>94.6 (35)</td>
<td>91.0 (274)</td>
</tr>
<tr>
<td>Male</td>
<td>5.4 (2)</td>
<td>9.0 (27)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100(37)</strong></td>
<td><strong>100 (301)</strong></td>
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</table>

Race/ Ethnicity

<table>
<thead>
<tr>
<th>Race/ Ethnicity</th>
<th>Survey Participants</th>
<th>NEPS Year 1 and 2 Students SIAST Wascana Campus *</th>
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</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>94.6 (35)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>First Nations</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Visible Minority</td>
<td></td>
<td>5.4 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100(37)</strong></td>
<td><strong>13.6 (41)</strong></td>
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</table>
Learning Circle Participants

### Age

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<thead>
<tr>
<th>Age Range</th>
<th>% (n)</th>
<th>NEPS Year 1 and 2 Students</th>
<th>SIAST Wascana Campus *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Age Range</td>
<td>% (n)</td>
</tr>
<tr>
<td>20 and under</td>
<td>0 (0)</td>
<td>19 and under</td>
<td>27.6 (83)</td>
</tr>
<tr>
<td>21 to 25</td>
<td>33.3 (2)</td>
<td>20 to 24</td>
<td>44.5 (134)</td>
</tr>
<tr>
<td>26 to 30</td>
<td>33.3 (2)</td>
<td>25 to 29</td>
<td>14.6 (44)</td>
</tr>
<tr>
<td>31 to 35</td>
<td>16.7 (1)</td>
<td>30 to 34</td>
<td>6.3 (19)</td>
</tr>
<tr>
<td>36 to 45</td>
<td>16.7 (1)</td>
<td>35 to 44</td>
<td>4.7 (14)</td>
</tr>
<tr>
<td>46 to 55</td>
<td>0 (0)</td>
<td>45 to 54</td>
<td>2.0 (6)</td>
</tr>
<tr>
<td>56+</td>
<td>0 (0)</td>
<td>55+</td>
<td>0.3 (1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 (6)</strong></td>
<td><strong>Total</strong></td>
<td><strong>100 (301)</strong></td>
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### Gender

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<tr>
<th>Gender</th>
<th>Learning Circle Participants</th>
<th>NEPS Year 1 and 2 Students</th>
<th>SIAST Wascana Campus *</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>83.3 (5)</td>
<td>91.0 (274)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16.7 (1)</td>
<td>9.0 (27)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 (6)</strong></td>
<td><strong>Total</strong></td>
<td><strong>100 (301)</strong></td>
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</table>

### Race/ Ethnicity

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<thead>
<tr>
<th>Race/ Ethnicity</th>
<th>Learning Circle Participants</th>
<th>NEPS Year 1 and 2 Students</th>
<th>SIAST Wascana Campus *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>66.7 (4)</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>First Nations 0 (0)</td>
<td>Aboriginal 7.3 (22)</td>
<td></td>
</tr>
<tr>
<td>Visible Minority</td>
<td>33.3 (2)</td>
<td>6.3 (19)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 (6)</strong></td>
<td><strong>13.6 (41)</strong></td>
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</tbody>
</table>
Educational Preparation

Note: Participants may be in more than one category of educational preparation.

<table>
<thead>
<tr>
<th>Educational Preparation</th>
<th>Learning Circle Participants</th>
<th>NEPS Year 1 and 2 Students SIAST Wascana Campus*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Post secondary certificate</td>
<td>50.0 (3)</td>
<td>8.6 (26)</td>
</tr>
<tr>
<td>Post secondary diploma</td>
<td>0 (0)</td>
<td>5.3 (16)</td>
</tr>
<tr>
<td>University not completed</td>
<td>33.3 (2)</td>
<td>32.2 (97)</td>
</tr>
<tr>
<td>University degree</td>
<td>33.3 (2)</td>
<td>8.6 (26)</td>
</tr>
</tbody>
</table>

Work Experience

Note: NEPS Year 1 and 2 Students SIAST, Wascana Campus comparable work experience demographics are not available.

<table>
<thead>
<tr>
<th>Work Experience</th>
<th>Learning Circle Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
</tr>
<tr>
<td>Health-related employment</td>
<td>50 (3)</td>
</tr>
<tr>
<td>Non health-related employment</td>
<td>50 (3)</td>
</tr>
<tr>
<td>Total</td>
<td>100 (6)</td>
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</table>

Years of Employment

Note: Years of employment demographics for NEPS Year 1 and 2 Students SIAST, Wascana Campus are not available.

<table>
<thead>
<tr>
<th>Years of Employment</th>
<th>Learning Circle Participants</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
</tr>
<tr>
<td>Less than two years</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>5 to 10 years</td>
<td>66.7 (4)</td>
</tr>
<tr>
<td>Greater than 10 years</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Total</td>
<td>100 (6)</td>
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Appendix E Situating ‘Nursing Students’ Perceptions of Workplace Violence’ Research Study within Feminist Perspectives

1. Feminist Perspectives of Research Focus

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<tbody>
<tr>
<td>Research on women, for women, by women (p. 2, 8). Attend to patriarchal, hierarchical, and colonial features of much traditional social science research (p. 8).</td>
<td>“What makes feminist research uniquely feminist are the motives, concerns, and knowledge brought to the research process” (Brayton as cited in Morris, p. 53). “Issues of privilege, race, class, culture, ability, age, location, language, and sexual orientation/sexuality are important factors we need to consider” (p. 54). “Avoid producing work that perpetuates marginalization and colonization” (p. 55).</td>
<td>Feminist research is not only providing space for women’s voices to be heard; attempts to bring to the fore voices of marginalized people (p. 13). “Acknowledge the voices and experiences of the individual but do not seek to suggest that this is representative of all” (p. 14).</td>
<td>A feminist stance of intersectionality of gender, race, class, and sexuality underpins the research study (Acker, 2006; Sokoloff &amp; Dupont, 2005). Third-wave feminist stance of oppressions beyond patriarchal hegemony is theorized. Within the nursing sub-hierarchy, nursing students are subordinated/marginalized (Daiski, 2004; Foster et al, 2004; Hutchinson et al., 2006a, 2006b; Randle, 2003; Stevenson et al., 2006; Theriault &amp; Landry, 1999). Research focus of nursing students’ perceptions gives voice to violencing in the workplace. Research purposes: to suggest strategies for transformation; to raise consciousness.</td>
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2. Feminist Perspectives of Valuing of Life Experiences

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<tr>
<td>Use of situation-at-hand studying common environments (p. 3, 4). Get to know participants in context of their lives. “Ask research questions which acknowledge and validate women’s experiences” (p. 4). “Analyze how social, historical, cultural factors shape the research site as well as participants’ goals, values, experiences” (p. 5).</td>
<td>“Researcher must base research in experience, work on research that matters” (p. 53). “Support the meaning women give their experiences” (Brayton as cited in Morris, p. 54).</td>
<td>“Enabling voices of women and other marginalized groups to be heard and their experiences to be valued” (p.12).</td>
<td>Focus is on nursing students’ perception of workplace violence. Considering the prevalence of workplace violence, nursing students are immersed in a harmful, hostile, and abusive environment in clinical learning experiences. Survey questions and learning circle focus group concentrate on students’ lived experiences in clinical experiences and other aspects of life. PEACE and power processes for gatherings (Chinn, 2004) focus on praxis, empowerment, awareness, cooperation, and evolvement. Strategies such as circling, sparking, random ravings ensure equal participation (Chinn).</td>
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3. Feminist Perspectives of Methodological Pluralism

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<tr>
<td>Methodological pluralism: different research questions invite different research methods (p. 6-7). Feminist perspective rather than feminist methodology. Researchers “likely to ask ‘better’ questions which, in turn, can lead to ‘better’ answers (p. 12).</td>
<td>“Connect ways of knowing with ways of researching” (Hall as cited in Morris, p. 54). Choose the methods that best suit the audience/ community (p. 61). “create a toolbox of skills and strategies” (p. 62).</td>
<td>Not accepting of dichotomous methodological camps; instead “trying to use the ‘right method for the research question’ rather than being purist qualitative researchers” (p. 17). Favour multiple methods including surveys, large scale data sets, alongside different ways of ‘knowing’ such as focus groups and interviews, diaries, and internet discussions (p. 17).</td>
<td>Methodological triangulation (mixed-methods) employed through use of a brief survey and learning circle focus group. Researcher used field notes, reflective journaling, and an audit trail. Methods of research fit the research purpose of raising consciousness and giving voice to workplace violence.</td>
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4. Feminist Perspectives of Action Orientation

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<tr>
<td>Action orientation “keeps the research project focused on emancipatory goals, allows feminist researcher to engage in political action, to influence public policy, and to create the potential ability of feminist research to change the lives of women” (p. 3). Empowering (p. 3). Acknowledges limitations/ contradictions/ alternative interpretations of data.</td>
<td>“Use research to inform, educate, evaluate, implement, and confirm ideas and theories” (p. 52). “Action research is a process that allows someone or a group to create or add to knowledge… through a collaborative and reflective process” (p. 52). Involves change (p. 53). “Provides a process for community mobilization” (Kelly as cited in Morris, p. 54).</td>
<td>Assertion of the importance of political active and emancipatory research (p.14). Acknowledges the voices and experiences of the individual (p. 14).</td>
<td>Action research method of the learning circle presented “an opportunity for participants and researchers to work together toward ‘constructed knowing’” (MacIntosh, 2006, p. 896). In learning circles, participants engaged in conversations “characterized by equality, flexibility, and interaction within a trusting relationship” (MacIntosh, 2006, p. 897). Chinn’s (2004) PEACE and Power principles and processes were used within the learning circle focus group (e.g. circling). Research study was emancipatory, empowering, and transformatory. Research results will have the potential for individual change and changes of social policies</td>
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### 5. Feminist Perspectives of Collaboration

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<tr>
<td>“Collaborate with participants as much as possible so that growth and learning can be mutually beneficial, interactive, and cooperative” (p. 4). Participant-researcher relationship is more interactive, collaborative, respectful, and less hierarchal” (p. 6). Involve participants in formulating research questions, interpretation of data. Participants are full collaborators, coauthors, coresearchers (p. 64). “Periodic renegotiation of consent” (p. 40).</td>
<td>Collaborative and reflective process (p. 52). “Negotiated process” between researcher and other bodies, both individual and institutional” (p. 53). Collaboration and partnership allows for many different perspectives to be heard (p. 59). Ethical issues of ownership of research should be explored (p. 37). “PAR assumes equality, but true equality is impossible in a society of differences and exclusion” (p. 18). “In PAR, you have to be aware of these dynamics [of differences and exclusion]” (p. 19).</td>
<td>Rejection of the distinction between researcher and ‘researched’ (p. 11). Minimize power imbalances between researcher and subject – researcher is on a more equal footing or is less powerful (p. 12). Involve the participants in decision making about the best means for them to participate (p. 12). “Encompass the participants’ active involvement in developing research tools, data collection and interpretation” (p. 11). Democratisation of the research process (p. 12). Openness (p. 12). Provide opportunities for participants to comment on findings at an every stage (p. 12).</td>
<td>Chinn’s (2004) PEACE and Power principles and processes were used. Strengths of learning circle are democratic atmosphere and collaborative learning for change, growth, and action (Hiebert, 1996). Potential power-over due to dual agency of faculty-researcher was recognized and minimized using practical strategies suggested by Clark &amp; McCann (2005) and Ferguson et al., (2006). Research project was inclusive. Research process was guided by input from the participants. Survey question asked participants to suggest important research questions/topics to consider. Learning circle focus group participants were asked for further input into topic guide of focus group gatherings. Participants validated the thematic analysis. Participant input was sought in relation to dissemination of the research findings. Permission was sought in using direct quotes in reporting research findings. Research findings were written in a manner that is accessible (Morris, 2002; Kirsch, 1999).</td>
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### 6. Feminist Perspectives of Challenging Social Norms

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<tr>
<td>“Correct androcentric norms by calling into question what has been considered ‘normal’ and what has been regarded as ‘deviant’” (p. 5).</td>
<td>Embraces diversity (p. 53). “Welcomes understanding and knowledge which may contradict established norms (p. 54).</td>
<td>Focus on gender and gender inequality along with other intersections of oppression such as age, ethnicity, culture (p. 11).</td>
<td>Feminist stance of intersectionality of gender, race, class, and sexuality (multiple intersections of oppression and privilege) underpins research project (Acker, 2006; Sokoloff &amp; Dupont, 2005)</td>
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7. Feminist Perspectives of Individual and Community Transformation

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<tbody>
<tr>
<td>Design research that benefits participants and their communities.</td>
<td>New information used to create change at personal and community levels (p. 52). Consciousness-raising for research participants (p. 60). Research can create feminist knowledge, strengthen a social movement, educate, build a community, challenge the status quo (p. 9).</td>
<td>“[Make] sure every effort is made so that findings have a positive impact on policy or practice” (p. 12-13). Enable voices of the marginalized to be better heard by practitioners (p. 14). Bridge the gap between research and practice (p. 15).</td>
<td>Participants potentially benefited personally from research participation (for example, having opportunity to give voice to workplace violence, reflecting/sharing of personal experiences). Variety of avenues for dissemination is preferable. Summary of research findings will be distributed to practice settings. Participants, nursing students and colleagues will be informed of the availability of research project findings in the Athabasca Digital Thesis and Project Room.</td>
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8. Feminist Perspectives of Focusing on the Affective Component

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<tr>
<td>Attention to the affective component: “an important vantage point from which to understand the lives of participants” (p. 3). “Affective components of research can become an important occasion for reflection and insight” (p. 4). Researchers learn emotionally charged information (p. 47). Interpretive conflicts may affect participants’ emotional well-being, reputations, and safety (p. 45-46). “Researchers bear responsibility of intervention” (p. 39).</td>
<td>“Bad research’ hurts the participants, either physically or emotionally, or doesn’t get their informed consent” (p. 11).</td>
<td>Attend to the emotional and physical well-being of the researcher and participants (p. 16).</td>
<td>Participants were alerted to the potential harm of resurfacing feelings about personal experiences of violence. Caring professionals were notified of the research study in the event that participants required emotional care (intervention as needed). The survey and learning circle provided opportunities for sharing of feelings, thoughts, and attitudes. Check-in/ closings (Chinn, 2004) were used to ensure all participants have opportunity to express knowledge, feelings, and ideas. Participants co-interpreted data through validation and feedback of preliminary thematic analyses. Preventive measures such as peer support, journaling, work-life balance considerations were employed to attend to potential researcher compassion stress (Rager, 2005).</td>
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9. Feminist Perspectives of a Caring Approach

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<tr>
<td>Consider probable/actual effects of representing others in research.</td>
<td>“Ensure that research process does not exploit women” (p. 53). “Be sensitive as to how your presentation might be interpreted differently or not be accessible” (p. 40).</td>
<td>Conscius of the possible emotional side effects of the research (p. 16). Ensure data collection does not result in ‘re-victimisation’ and trauma (p. 12). Enable ‘safe’, equal, and confidential participation (p. 12)</td>
<td>PEACE and Power processes (Chinn, 2004) and learning circles (Hiebert, 1996; MacIntosh, 2005) are caring, supportive processes. Potential participants were alerted to the sensitivity of the research focus. Ongoing consent was obtained. Participation was voluntary. Participants were able to withdraw from the research study at any time without any penalty or repercussion. Confidentiality, privacy, and anonymity of research participants is maintained. Data storage is confidential and safe. Raw data related to participants, third parties, and organizations was de-identified. Caring professionals were alerted to research project and potential need for services. Participants would be referred to professionals if emotional care was required. Professional services personnel had opportunities to debrief during and following compilation and transcription of the research data.</td>
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10. Feminist Perspectives of Reflexivity

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<tr>
<td>Reflexivity: “allows researcher to engage in…critical reflection and analysis….enables researchers to be introspective, to analyze the research process in response to participants, and to adjust and refine their search goals as they learn more about those they study” (p. 3). “Analyze how the researchers’ identity, experience, training and theoretical framework shape research agenda, data analysis, and findings” (p. 5).</td>
<td>“Whatever the perspective of the researcher, it is important to: acknowledge it, to identify how it affects the researcher and research process, and to develop and implement strategies to move the project forward” (p. 57). “The process of reflection must also consider the social, environmental, and institutional or structural factors influencing the direction and the conclusion of the research” (p. 53).</td>
<td>Reflexivity: “the process of standing outside and gazing back to see what we can from afar”” (Stanko as cited in Skinner et al., p. 15, emphasis in text). Open acknowledgement by the researcher of assumptions, beliefs, sympathies, biases (p. 15).</td>
<td>Researcher used reflective journaling to explore assumptions and presuppositions related to the research process. Field notes were utilized to document reflective thoughts on the research process. The researcher engaged in critical dialogue with others in regards to the research study/ focus. Social, environmental, and institutional factors influencing the research study were considered. Reflective writing within the final report of the research study presents the researcher’s open acknowledgement of personal intersections of oppression and privilege.</td>
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Appendix F Survey

Survey of Nursing Students’ Perceptions of Workplace Violence

Instruction Sheet

The survey of the research project entitled *Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study* seeks to answer the following research questions:

*What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace?*  

*What actions are needed to transform the present culture of workplace violence in health care organizations?*

Your participation in this study is voluntary. Your participation or non-participation in this study will not have any influence on your academic studies at SIAST. You may choose to not participate in this survey without any consequence. If you choose to participate in the survey, it is with the understanding that you may refuse to answer certain questions and may withdraw during the data collection period. If you choose to participate, your participation in the survey indicates that you have read and understood the information provided in the *Research Study Information Sheet and Invitation to Participate* and this instruction sheet, and any questions you have about this study have been answered satisfactorily.

The answers that you provide will be kept anonymous, and any identifying information relating to you, third parties, or organizations will be removed in the data compilation. All information that you provide will be held confidential, except when legislation or a professional code of conduct requires that it be reported.

If you choose to participate in this survey, please answer the questions at your personal level of comfort. If any questions cause you discomfort, you may leave those questions unanswered. If you feel that you need support following this survey, please contact me for a list of suggested care providers.

This survey takes approximately 15 to 20 minutes to complete. If you choose to participate, answer the questions on the survey sheets. If you require additional space, use the back of the survey sheets, clearly identifying the question number. Place the completed survey in the provided envelope, seal it, and return it to me. Please keep the provided *Research Study Information Sheet and Invitation to Participate* and this Instruction Sheet for your records.

Lorna M. Weisbrod, RN, BScN, MA(IS)(c)  
Nursing Education Program of Saskatchewan  
Nursing Division, Wascana Campus, SIAST  
4500 Wascana Parkway  
Regina, Saskatchewan S4P 3A3  
Phone: 306-798-0138  
Email: weisbrod@siast.sk.ca
Please note that, by answering this survey, you have given informed consent to participate in the research study.

SURVEY OF NURSING STUDENTS’ PERCEPTIONS OF WORKPLACE VIOLENCE

Survey Questions

For the purposes of this survey, the term workplace violence is used to encompass verbal and emotional abuse, physical violence and sexual harassment. Violence can therefore be physical or non-physical and direct or subtle. Some other terms which have been used when referring to workplace violence are: bullying, nurse abuse, workplace incivility, ward rage, anti-social workplace behaviours, and workplace hostility.


1. What is your age?
   ____ 20 years or younger
   ____ 21 to 25 years
   ____ 26 to 30 years
   ____ 31 to 35 years
   ____ 36 to 40 years
   ____ 41 to 45 years
   ____ 46 to 50 years
   ____ over 50 years

2. What is your gender?
   ____ Female
   ____ Male

3. What is your racial/ethnic background?
   ____ Caucasian
   ____ First Nations
   ____ Visible Minority
   ____ Other

4. (a) While in your clinical learning experiences, have you observed workplace violence experienced by nurses? Consider verbal and emotional abuse, physical violence and sexual harassment as defined above.
   (b) If you have observed workplace violence experienced by nurses, approximately how many times have you observed this while in your clinical learning experiences?

Complete either question 5 or question 6.

5. If you have observed workplace violence experienced by nurses while in your clinical learning experiences:
   (a) Write about a specific time when you observed an incident of workplace violence experienced by a nurse (or nurses) while in a clinical learning experience. Include factors which you think contributed to this incident
(b) In general, how would you describe workplace violence as experienced by nurses?

(c) How do you think workplace violence affects nurses? (proceed to question 7).

6. If you have **not observed** workplace violence experienced by nurses while in your clinical learning experiences:
   (a) Write about what you think might be a typical incident of workplace violence experienced by nurses in clinical workplaces. Include factors which you think might contribute to this typical incident.

(b) In general, how would you describe workplace violence as experienced by nurses?

(c) How do you think workplace violence affects nurses? (proceed to question 7).
Complete the remaining questions.

7. Overall, what do you think are the causes of workplace violence as experienced by nurses in the clinical setting?

8. What concerns you most about workplace violence as experienced by nurses in the clinical setting?

9. Several researchers describe the workplace environment of nurses as harmful, fearful, abusive, and hostile. What strategies would you suggest are needed to transform this workplace environment?

10. In the second part of this research study, a learning circle focus group approach will be used to further explore nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in clinical workplaces.

What two questions do you think should be considered for discussion by this focus group?
1.
2.

11. Write any additional thoughts you wish to share about workplace violence as experienced by nurses.

Please submit your completed survey to the researcher in the sealed envelope.

Thank you for your participation in this survey.
Appendix G Peace and Power Processes for Gatherings (Chinn, 2004)

**PEACE and Power processes**

- Give every perspective full voice.
- Demystify all processes and structures.
- Fully respect different points of view and integrate these into the whole.
- Include attention to the process itself so that how you do things is just as important as what you do.
- Rotate and share leadership according to ability and willingness.
- Value learning new skills so that the opportunity to do so is accessible to all.

The four basic components of the PEACE and Power process for a gathering are:

- **Check-in:** “a brief…statement by each individual that centers the attention of the group on the shared purpose for being together” (Chinn, p. 42)

- **Rotating chair:** “assures that every perspective if given full consideration; equalizes and balances power within the group” (Chinn, p. 45);
  - the agenda is built and affirmed during check-in
  - whoever is speaking is the ‘chair’
  - everyone in the group listens actively to the person speaking
  - the chair is passed to someone who indicates a desire to speak (Chinn, p. 46)
  - sparking, circling, random ravings are acceptable methods of promoting discussions

- **Value-based decision-building:** “assures the best decisions that are possible at the time the decisions are made…brings together different perspectives on a situation, rather than polarizing points of view in opposition to one another…nurture s understanding, insight, and wisdom for everyone who participates” (Chinn, p. 57)

- **Closing:** “is a time when all members share thoughts and feelings about what has happened during the gathering, and about what they would like to happen next….each individual’s closing is a three-part statement that includes…appreciation…critical reflection…affirmation” (Chinn, p. 71)
Appendix H Invitation to Participate in Research Study

<date>

Dear <nursing student>

This letter is to inform you of my research study entitled *Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study*. As a Master of Arts-Integrated Studies (Adult Education) student with Athabasca University, I am conducting this research as a requirement of the completion of my graduate program. The research study seeks to answer the questions: What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace? and What actions are needed to transform the present culture of workplace violence in health care organizations?. Using a feminist participatory action research approach, I will be using a survey and learning circle focus group approach to data collection. The attached *Research Study Information Sheet and Invitation to Participate* provides further information about my research study.

During the <week/ date>, I will be speaking with the <Year 1/ Year 2> students about my research study and asking for your consideration of participation in the survey and learning circle focus group. The *Research Study Information Sheet and Invitation to Participate* (attached) will be reviewed, and there will be an opportunity to ask questions about the research study. Following your consideration of the research study information and informed consent, I will be conducting the survey after a < Class/ Lab> at <location>. The learning circle focus group (two gatherings) of a maximum of six participants will follow in subsequent days. **You do not need to have observed workplace violence in order to participate in the survey or the learning circle focus group.** Your participation in any aspect of this research study is voluntary and confidential. Your participation or non-participation in this research study will not influence your studies at SIAST.

As I am a student with Athabasca University, this research study has been reviewed and approved by Athabasca University Research Ethics Board (AU REB). As part of the AU REB process, SIAST has granted me permission to access the SIAST facilities, recruit research participants and conduct the research.

If you have questions or require additional information about the research study, please contact Lorna Weisbrod at 798-0138 or email at weisbrod@siast.sk.ca.

Yours truly,

Lorna M. Weisbrod, RN, BScN, MA(IS)(c)  
Student, Master of Arts-Integrated Studies, Athabasca University  
Faculty, Nursing Education Program of Saskatchewan  
Nursing Division, Wascana Campus, SIAST  
4500 Wascana Parkway  
Regina, Saskatchewan S4P 3A3  
Phone: 306-798-0138  Email: weisbrod@siast.sk.ca
PROJECT TITLE: Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study

WORKPLACE VIOLENCE: The term workplace violence will be used “in a broad sense to encompass verbal and emotional abuse, physical violence and sexual harassment” (Canadian Nurses Association, 2002, para 7).

INVITATION TO PARTICIPATE: You are invited to participate in a research study focusing on nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace. This feminist participatory action research study includes a mixed-methods approach of a survey and learning circle focus group. Participants are being recruited from the Nursing Education Program of Saskatchewan (NEPS), Wascana Campus students who are enrolled in the NEPS 218.3 Education for Health and NEPS 233.6 Practicum 1 courses. This study is being conducted by Lorna Weisbrod, a graduate student in the Master of Arts-Integrated Studies (Adult Education) program, Athabasca University, Alberta.

Please review this information sheet carefully, and ask any questions you have prior to consenting to participate in this research study.

CONTACT INFORMATION:

PRINCIPAL INVESTIGATOR
Lorna M. Weisbrod, RN, BScN, MA(IS)(c)
Student, Master of Arts-Integrated Studies,
Athabasca University
Faculty, NEPS
Nursing Division, Wascana Campus, SIAST
4500 Wascana Parkway
Regina, Saskatchewan S4P 3A3
Phone: 306-798-0138
Email: weisbrod@siast.sk.ca

FACULTY SUPERVISOR
Dr. Cathy Bray, PhD
Master of Arts-Integrated Studies
Athabasca University
1 University Drive
Athabasca, AB T9S 3A3
Phone: 1-800-788-9041(ext. 6792)
Email: cathyb@athabascau.ca

RESEARCH DESCRIPTION: A qualitative feminist participatory action research methodology will be employed. Values and principles of feminist research are incorporated into the research design: focusing on giving voice; valuing life experiences, employing methodological pluralism; taking an action orientation stance based on collaboration; challenging social norms; focusing on individual and community transformation; embracing a caring approach, and engaging in reflexivity (Kirsch, 1999; Morris, 2002; Skinner, Hester, & Malos, 2005). A brief survey and learning circle focus group approach will be used to answer two research questions:

What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace?
What actions are needed to transform the present culture of workplace violence in health care organizations?

The purposes of this feminist participatory action research study are fourfold:
1. To describe nursing students’ perceptions of the nature of workplace violence.
2. To explore nursing students’ perceptions of causes of workplace violence.
3. To suggest strategies for transformation of the culture of workplace violence.
4. To raise consciousness of workplace violence.
DURATION AND NATURE OF PARTICIPATION:

You do not need to have observed workplace violence in order to participate in the survey or the learning circle focus group.

Survey: Should you agree to take part in the survey, you will be asked to complete a brief questionnaire which includes closed and open-ended questions/directive statements. The survey will take approximately 15 to 20 minutes to complete. The questions will focus on your perceptions of the nature and causes of workplace violence as experienced by nurses in clinical workplaces and your suggestions for changing the culture of workplace violence in health care organizations. The survey will take place following one of your nursing classes.

Learning Circle Focus Group: If you choose to take part in the learning circle focus group, your participation will include two semi-structured learning circle interviews focusing on your perceptions of workplace violence and your suggestions for transforming the culture of workplace violence. A learning circle approach places an emphasis on learning by both the researcher and participants and offers a safe environment where participants “share their experiences, their reflections on those, and their theorizing about those experiences….and begin to visualize and discuss action steps” (MacIntosh, 2005; p. 896).

In the second learning circle gathering, you will have the opportunity to provide input into the researcher’s preliminary learning circle thematic analysis. The learning circle focus group will meet twice for approximately 60 to 90 minutes at a time convenient for the learning circle participants and researcher. The learning circle gatherings will be held in privacy at SIAST, Wascana Campus. With your written permission, the interviews will be audio-taped and transcribed. A maximum of six participants are needed for this part of the research study.

POTENTIAL BENEFITS: The overall benefit of the study is that of raising consciousness of workplace violence. The possible benefit to you is the satisfaction you might experience in sharing your perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace. In addition, you might experience satisfaction in knowing that you have contributed to breaking the silence and cycle of workplace violence in health care organizations. Sharing of your ideas for change could potentially impact the working conditions of present and future generations of nurses.

POTENTIAL RISKS: This research addresses the sensitive topic of workplace violence. Although it is intended to facilitate discussion regarding workplace violence, such an exploration might create uncomfortable feelings or might resurface emotions from the past. You are welcome to talk to the researcher about these concerns. Because of the sensitive nature of this research, the Health Services Counsellor, Harassment Prevention Advisor, Native Access Program to Nursing Advisors and Health Nurses at SIAST, Wascana Campus have been notified of this research study. If you wish, contact information of these services and other community resources will be provided.

If you choose to participate in the learning circle focus group, a debriefing will occur at the end of the each learning circle gathering. At the end of the second learning circle gathering, participants will have an opportunity to share thoughts about the research process.

There will be no cost to you to participate in this research study.
VOLUNTARY PARTICIPATION: Taking part in this study is voluntary. Your participation or non-participation in this study will not have any influence on your academic studies at SIAST. If you choose to participate, you may refuse to answer certain questions. If you choose to participate, you have the right to withdraw without prejudice at any time during the data collection period.

CONFIDENTIALITY: All information will be held confidential, except when legislation or a professional code of conduct (such as the Saskatchewan Registered Nurses Association) requires that it be reported. Your confidentiality in these circumstances and processes will be maintained to the highest degree possible.

Only the principal researcher and clerical support personnel will have access to the raw data collected during the study. Clerical support personnel will have access to the raw data for the purposes of compilation and transcription, and will be required to sign a confidentiality agreement.

Participants and identified organizations/third parties will be assigned pseudonyms in all aspects of the study. Any identifying information regarding people or places will be removed. Data will be stored in a secure, locked location, and after five years, the data will be shredded/destroyed by the principal researcher.

RESULTS OF THE STUDY: If you choose to participate in the learning circle focus group, you might be anonymously quoted in the final reporting of the research findings. You will have the option of reviewing your quote(s) which is/are proposed for use in the reporting of the research findings. If you choose to review the proposed quotes, you will be asked to sign a form to acknowledge that the proposed quotes are accurate and that you consent to the use of the quotes in the reporting of the research findings. You have the right to refuse the use of any quotes provided by you which are proposed for use in the reporting of the research findings.

The report of the research findings will be available from the SIAST, Wascana Campus Library and the Athabasca University Library Digital Thesis and Project Room. A summary report of the research study will be provided to you if requested. The summary report will be distributed to nursing education programs, student support services, and professional/governmental organizations. The research findings may also be presented at professional conferences and published in journals. Other methods of dissemination (such as informal local presentations) may be considered.

INFORMED CONSENT: Giving informed consent means that you have read this information and agree to participate in the study, on the understanding that you may refuse to answer certain questions, and you may withdraw during the data collection at any time.

Survey: Your participation in the research study survey will indicate that you have read and understood the information contained in this Research Study Information and Invitation to Participate and the Survey Instruction Sheet and have given your consent to participate.

Learning Circle Focus Group: If you would like to take part in the Learning Circle Focus Group, please contact Lorna Weisbrod at 798-0138 or weisbrod@siast.sk.ca. I will set an appointment with you to discuss the research study and informed consent. A consent form will be signed prior to participation in the Learning Circle Focus Group. Participants who are under the age of eighteen years will also need parental or guardian consent to participate in the learning circle.
FURTHER INFORMATION: For more information, you may contact the Principal Investigator, Lorna Weisbrod, at 798-0138 or by email at weisbrod@siast.sk.ca. As this is a student project, you may also contact Dr. Cathy Bray, Faculty Supervisor, Master of Arts-Integrated Studies, Athabasca University, by email at cathyb@athabascau.ca.

This project has been approved by the Athabasca University Research Ethics Board. If you have any concerns regarding the research process, you may contact the Chair of the Research Ethics Board at Athabasca University (phone: 1-800-788-9041 or email: aurc@athabascau.ca).

REFERENCES:


Appendix J Informed Consent for Participation in Learning Circle Focus Group

Informed Consent for Participation in Learning Circle Focus Group

The nature of the research study Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study and the extent of my participation, including the risks and benefits involved, have been explained to me as known and available. I understand that I am free to choose to participate. I have read and understood the information provided in the Research Study Information Sheet and Invitation to Participate and my questions have been answered satisfactorily. In addition, I have read this consent form, and freely give my consent to participate in the Learning Circle Focus Group of this research study on the understanding that I may refuse to answer certain questions, and I may withdraw during the data collection period without consent. I understand that if I am under the age of eighteen years, written parental consent is required for participation in the Learning Circle Focus Group.

I understand that the Learning Circle Focus Group gatherings will be audio-taped and transcribed for data analysis. I consent to being audio-taped and understand that I am free to request the researcher to stop the audio-taping at any time during the Learning Circle Focus Group gathering.

I acknowledge that a copy of the information sheet and signed consent form have been given to me.

________________________________________________________________________________________
Signature of Participant                            Signature of Parent/ Guardian (if participant under the age of eighteen years)
________________________________________________________________________________________
Date                                                Date

Do you wish to receive a summary of the research findings? Yes   No

If so, please provide contact information.

Name ________________________________  
Address ______________________________
Phone ________________________________
Email ________________________________

PRINCIPAL INVESTIGATOR
Lorna M. Weisbrod, RN, BScN, MA(IS)(c)  
Student, Master of Arts-Integrated Studies, Athabasca University  
Faculty, Nursing Education Program of Saskatchewan  
Nursing Division, Wascana Campus, SIAS T  
<contact information>
Appendix K Consents for Using Quotes (Anonymously) in Reporting of Research Findings

Consent for Using Quotes (Anonymously) in Reporting of Research Findings

In the reporting of the research findings of the study entitled Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study, the researcher might want to quote you anonymously. If you choose to review the proposed quote(s), you will be asked to sign a consent form to give the researcher permission to use your quotes. You have the right to refuse the use of any quotes provided by you which are proposed for use in the reporting of the research findings.

Please indicate your preference for the use of quotes provided by you in the learning circle focus group by checking the appropriate statement:

_____ I, <name>, consent to the use of any quotes provided by me in the learning circle focus group in the reporting of the research findings. I understand that the quotes will be used in a confidential and anonymous manner.

OR

_____ I, <name>, wish to be contacted by Lorna Weisbrod, Principal Investigator, if any quotes provided by me in the learning circle focus group are proposed for use in the reporting of the research findings. I understand that I will be able to review the proposed quote(s) and will be asked for written consent to use the quotes. I understand that the quotes will be used in a confidential and anonymous manner. I have provided my contact information in the event that quotes provided by me are proposed for use in the reporting of the research findings.

I acknowledge that a copy of this signed consent form has been given to me.

___________________   ____________________
Signature      Date

Contact Information

Email Address: ____________________________________________

Phone: ___________________________________________________

Mailing Address: __________________________________________

If further information is required regarding this consent or any other aspect of the research study, please contact:

Lorna M. Weisbrod, RN, BScN, MA(IS)(c)
Student, Master of Arts-Integrated Studies, Athabasca University
Faculty, Nursing Education Program of Saskatchewan
Nursing Division, Wascana Campus, SIAST
4500 Wascana Parkway
Regina, Saskatchewan S4P 3A3
Phone: 306-798-0138  Email: weisbrod@siast.sk.ca
Appendix L Professional Services Confidentiality Agreement

Professional Services Confidentiality Agreement

I, <name>, in providing professional services (such as transcription and other clerical assistance) in support of the research study Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study (Principal Investigator: Lorna Weisbrod), agree to maintain confidentiality of participant information and data arising from this research study. I also agree to store any research data in my possession during the course of this study in a secure location.

At the completion of this study, I agree to return/forward all forms of research data (such as surveys, transcription audiotapes, and computerized disk files) which have been used or developed in the course of providing professional services in this research study. In addition, I also agree to delete/destroy research study electronic files in my possession at the conclusion of the research study as directed by the Principal Investigator.

I understand that this research study has been approved by the Athabasca University Research Ethics Board which follows the Privacy and Confidentiality guidelines of the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (1998).

I acknowledge that a copy of this signed Confidentiality Agreement has been given to me.

________________________________________
Signature

________________________________________
Date

Reference


PRINCIPAL INVESTIGATOR
Lorna M. Weisbrod, RN, BScN, MA(IS)(c)
Student, Master of Arts-Integrated Studies, Athabasca University
Faculty, Nursing Education Program of Saskatchewan
Nursing Division, Wascana Campus, SIAST
4500 Wascana Parkway
Regina, Saskatchewan S4P 3A3
Phone: 306-798-0138
Email: weisbrod@siast.sk.ca
Appendix M Letter of Notification of Research Study to Care Providers

Letter of Notification of Research Study

Distribution to Native Access Program to Nursing/Medicine (NAPN/M) Advisors
Counsellor, Health Services, SIAST, Wascana Campus
Harassment Prevention Advisor, SIAST, Wascana Campus
Health Nurses, SIAST, Wascana Campus

<date>

Dear <name>

This letter is to inform you of my upcoming research study entitled: Nursing Students’ Perceptions of Workplace Violence: A Feminist Research Study. As a Master of Arts-Integrated Studies (Adult Education) student with Athabasca University, I am conducting this research as a requirement of the completion of my graduate program. The research study seeks to answer the questions: What are nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in the clinical workplace? and What actions are needed to transform the present culture of workplace violence in health care organizations?. Using a feminist participatory action research approach, I will be using a brief survey and learning circle focus group approach to data collection.

On <date>, I will be speaking with the <students> about my research study and asking for their consideration of participation in the survey and learning circle focus group. The students will be provided with the Research Study Information Sheet and Invitation to Participate (attached), and there will be an opportunity for students to ask questions about the research study. Following their consideration of the research study information and informed consent, I will be conducting the survey on <date>. The learning circle focus group (two gatherings) will follow in subsequent weeks (to be completed by <date>). All aspects of this research study are of a voluntary and confidential nature.

As I am a student with the Athabasca University, this research study has been reviewed and approved by the Athabasca University Research Ethics Board (AU REB). As part of the AU REB process, SIAST has granted me permission to access the SIAST facilities, recruit research participants and conduct the research. Also, I wanted to notify you of this upcoming research study as it addresses the sensitive topic of workplace violence. One potential risk of the research study is that such an exploration by participants might create uncomfortable feelings or resurface emotions from the past. If needed, participants will be provided with contact information of supportive services available at SIAST and in the community.

If you have questions or require additional information about the research study, please contact me at 798-0138 or email at weisbrod@siast.sk.ca.

Yours truly,

Lorna M. Weisbrod, RN, BScN, MA(IS)(c)
Student, Master of Arts-Integrated Studies, Athabasca University
Faculty, Nursing Education Program of Saskatchewan
Appendix N Learning Circle Focus Group Process and Topic Guide

Learning Circle Focus Group Process and Topic Guide

An action research method of a learning circle will be employed “promoting the experiential learning of the participants and allowing the required data collection” (MacIntosh, 2005, p. 896). Placing an emphasis on learning by the researcher and participants, a learning circle approach offers a safe environment where participants “share their experiences, their reflections on those, and their theorizing about those experiences….and begin to visualize and discuss action steps” (MacIntosh, 2005, p. 896). Chinn’s (2004) PEACE (Praxis, Empowerment, Awareness, Cooperation, Evolvement) and Power processes for gatherings will be utilized to “overcome dynamics that set up advantage for some and disadvantage for others” (p. 1) (Appendix D). The learning circle focus group will meet twice (with about one week in between) for approximately 60 to 90 minutes each.

A topic guide will be employed in a semi-structured, in-depth interview method (Seale, 1998b) so that “participants’ descriptions can be explored, illuminated and gently probed” (Wimpenny & Gass, 2000, p. 1487). A preliminary topic guide will be constructed prior to the first learning circle based on a thematic analysis of the survey question: ‘What two questions do you think should be considered for discussion by the learning circle focus group?’ Possible topics might include perceptions of workplace violence, contributing factors, and envisioning the future. These topics will be validated, revised, and prioritized by participants at the first learning circle.

In the second learning circle, themes from the first learning circle will be shared with the participants for the purpose of confirmation, validation, and revision (Brooks, Thomas, & Droppleman, 1996). In addition, the learning circle participants will be asked for input and suggestions regarding dissemination of research findings.

Both learning circle gatherings will conclude with a circling/ check-out, giving the participants an opportunity for debriefing and to share any final thoughts from the learning circle.

Possible Questions might include:

What is your perception of workplace violence as experienced by nurses in clinical workplaces?
What do you think are the possible causes of workplace violence as experienced by nurses?
What do you think are some strategies for transforming the culture of workplace violence in health care organizations?
What educational strategies are needed for transforming the culture of workplace violence?

Suggested final questions of the second learning circle gathering:

What has it been like for you to participate in this learning circle focus group? and
What have you learned about workplace violence from participating in this focus group?
Appendix O Participants’ Questions for Consideration by the Learning Circle Participants

**Nursing Students’ Questions for Consideration by the Learning Circle Participants**

(Organized by Themes)

Responses to Survey Question #10: In the second part of this research study, a learning circle focus group approach will be used to further explore nursing students’ perceptions of the nature and causes of workplace violence as experienced by nurses in clinical workplaces. What two questions do you think should be considered for discussion by this focus group?

**Nature of Workplace Violence**

- For the students who have witnessed violence, what was the environment and did the nurse precipitate the workplace violence?
- What needs to be done to change violence to stop/prevent it from continuously happening?
- What kind of violence is most common?
- What constitutes violence?

**Causes of Workplace Violence**

- Is workplace violence related to burnout?
- Is the disease process of the client overlooked when violence is involved?
- Why it occurs?
- Whose responsibility is it to lower the incidences?
- **Whose responsibility is it to decrease workplace violence?**
- Whose responsibility is it?
- What are the main causes of violence in the workplace?
- What are the causes?
- What assessment of patients would be beneficial?
- What is the main source of violence and what type of violence?
- Why is there violence in the workplace?
- Why it happens?
- When it happens most?

**Silencing of Workplace Violence**

- Is there provision in the workplace to safely and anonymously (if necessary) report violence?
- **Why are nurses afraid to report violence?**
- How can nurses stand up to workplace violence?

**Individual, Community, and Societal Effects of Workplace Violence**

- As students coming into the profession, did the students have any doubt about the career because of the workplace environment?
- What does this mean for the health care system?
- How, as nurses, would workplace violence affect your career?
Impact of Workplace Violence on Nursing Students’ Clinical Learning

- Have any of you experienced workplace violence?
- As a nursing student, do you feel at risk? Why?
- How can we approach the students to allow them to feel safe?
- How it affects nursing students before they become nurses?

Raising Consciousness of Workplace Violence

- How can awareness be raised about workplace violence?
- How to increase accuracy of perceptions of workplace violence?

Transforming the Culture of Workplace Violence

- What needs to be done to reduce workplace violence?
- How can workplace violence be preventable?
- How is this preventable?
- What can nurses do to lessen the incidents of workplace violence?
- What strategies are needed to transform the abusive environment?
- How can nurses transform violence in the workplace?
- How can it be prevented?
- What should grad nurses do to promote a violence-free workplace?
- What to do with workplace violence?
- How to cope with stress?
- How can we stop workplace violence?
- Where can nurses go when they experience violence?
- Strategies to transform the workplace and keep nurses safe.
- Should workshops on how to deal with workplace violence be implemented into NEPS?
- What can we do to reduce workplace violence?
- What are ways in which we could change the workplace environment?
- As nurses what can we do to eliminate violence?
- How would you deal with a nurse who was bullying you or felt you were bullying them?
- **How would you prepare for a known hostile client who is being admitted to your ward?
- Should there be repercussions for the clients who are violent?
- Is it ever OK to hit a client back?
- What options are there for nurses who experience violence?
- How to cope/deal with workplace violence?
- Brainstorm for possible ways of dealing with this problem.
- What is a way to lower the number of workplace violent acts?
Protection against Workplace Violence

- What actions can we implement to protect ourselves?
- What are some safety precautions that are in place or should be in place to prevent injuries?
- What should I do if I meet the violence?
- Who can protect me?
- What is the health district doing to protect the nurses?
- **What can be done to make the workplace safer for nurses?**
- Should there be different qualifications for nurses working with residents who have different diagnosis related to violence (i.e. dementia)?
- What sort of things worked in your workplace that could be passed on to other work places in regards to controlling or keeping violence down to a minimum?

** Survey questions chosen by learning circle participants for discussion in the second learning circle gathering.
Appendix P Raising Consciousness of Workplace Violence: Learning Circle Participants’ Comments

The following learning circle check-in and closing circle statements demonstrate the participants’ evolving critical consciousness of workplace violence. Researcher prompts prior to circling were as follows:

Learning Circle (LC) 1: Check-in: “What interests you most about this research study? or “What are you hoping to gain from participating in this research study?”

Learning Circle 1: Closing circle: “Is there anything else that you would like to share or anything that you’d like us to carry forward for discussion in the next learning circle?”

Learning Circle 2: Check-in: “Are there any reflective thoughts that you would like to share from the last time we met?” Participants were also asked to share their question which they had chosen for discussion.

Learning Circle 2: Closing circle: “What have you learned from your participation in this focus group? and/ or “What has the experience been like for you to participate in this research study?”

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<tr>
<th>Participant 1</th>
<th>LC 1: Check-in</th>
<th>LC 1: Closing Circle</th>
<th>LC 2: Check-in</th>
<th>LC 2: Closing Circle</th>
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<td>“I’m hoping to gain more of an awareness when we are in a workplace….I really haven’t been around to see very much, so hoping that it opens my eyes a little bit”</td>
<td>“It would be beneficial to have a class on this.”</td>
<td>“My reflections from last time, I thought it went really well. I really appreciate letting everybody share. It’s nice that we trust each other.”</td>
<td>Question from Survey #10</td>
<td>“[This research study] definitely raised my awareness 100%. I don’t want to be one of those people after my first year of being in the workplace, that becomes desensitized to it. I want to build on everybody and help people become more aware. I also like learning and hearing everybody’s perspectives. And to you, Lorna, it kind of made me more aware of research….I find it very interesting, the way you’ve done it. Definitely took my eyes in a research perspective.”</td>
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<td>Participant 2</td>
<td>LC 1: Check-in</td>
<td>LC 1: Closing Circle</td>
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<td>“I’m interested in this [research study] because I see harassment and violence in the workplace on a daily basis....It’s high time things were changed and hopefully we’ll be able to get some more awareness out of this project, as well, maybe some personal healing.”</td>
<td>“I’d just like to thank you for the opportunity to participate in this valuable study. The awareness of it is so necessary, but also it’s given me a chance to vent and I appreciate that.”</td>
<td>“My reflection after the last session is a question. Should we be surprised that there is violence in the workplace given it’s pervasiveness in our world, in our species? And I’m not talking about being biologically ingrained. That’s not the issue. The issue is our many dominant institutions such as predatory capitalism, what it does, it’s effect on globalization and all the effects it has throughout our societies and all the world.”</td>
<td>“For me it’s been a positive experience….It was nice to get to know my colleagues more but also nice to partake in a subject or topic that’s critically important…not only for our profession but I think for the advancement of our society….It’s nice to be able to take part in something positive like this.”</td>
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<td>Question from Survey #10</td>
<td>“As students coming into the profession, did the students have any doubts about the career because of the workplace environment?”</td>
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<td>Participant 3</td>
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<td>LC 1: Closing Circle</td>
<td>LC 2: Check-in</td>
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<td>“I haven’t seen any violence in the nursing field…but in previous jobs there’s been physical and emotional violence. I guess what I would like to take away from this is more of an awareness of what is going on and for better preparation when I graduate and get into the nursing field.”</td>
<td>“I think it’s great because I’ve got to see five other people’s points of view on things and that’s the whole part of nursing. No one is ever completely right, especially with an issue like this that is existing so much. Because we’re the ones that are coming up, we are the ones that are probably going to be the ones to start changing this.”</td>
<td>“It was nice to hear other people’s opinions on what’s going on as students in our actual classes and hear everybody’s ideas of what violence is to them and the effects that it can have on people.”</td>
<td>“I think it’s like [an] eye-opener. Just looking around the table, we all come from different backgrounds and we’ve all got different circumstances. It’s kind of nice to know that you’re feelings are not alone on the topic, yet you’re also individual enough to have a different opinion. And that the people who you are going to be working with and the graduating class…have a grasp on the ideas of what this is about.”</td>
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<th>Participant 4</th>
<th>LC 1: Check-in</th>
<th>LC 1: Closing Circle</th>
<th>LC 2: Check-in</th>
<th>LC 2: Closing Circle</th>
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<td>“I was told there’s some kind of violence for the nurses. This is a responsibility for nurses to take part in this project and find the effective way to protect themselves and the patient.”</td>
<td>“I think this project is a wonderful project which can bring a lot of thoughts of awareness to improve how to decrease the workplace violence.”</td>
<td>“I think that workplace violence is a common problem in any country.”</td>
<td>“I’m very optimistic because more nursing students have noticed this problem and they’re trying to prevent it.”</td>
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<td>Question from Survey #10</td>
<td>“How would you prepare for a known hostile client who is being admitted to your ward?”</td>
<td>Question from Survey #10</td>
<td>“Why are nurses afraid to report violence?”</td>
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<td>Participant 5</td>
<td>LC 1: Check-in</td>
<td>LC 1: Closing Circle</td>
<td>LC 2: Check-in</td>
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<td>“I have seen violence in the workplace and sometimes I see it and I don’t know what steps to take in that kind of situation. So, I’m hoping to see what kind of steps someone will take to prevent it or just an awareness of what to do.”</td>
<td>“I think it’s great that we have this awareness. It starts out with this little number and then we all go in our workplace and if we see something happening – like violence – one of us can do something. It just passes on knowledge and then something can be done about it.”</td>
<td>“I’ve just been paying more attention on all the harassments now at work and it’s not so bad as I guess as I thought.”</td>
<td>“How can workplace violence be preventable?”</td>
<td>“I have a good awareness of what violence is and some things that I never noticed. Probably I have done things too….It’s nice to have this because I know…we’re learning about violence or prevention in school. We’re being introduced to it and we know about it. When you go out there, and I experience something, I know I can come to like, her [indicating a learning circle participant]. Then I know she will understand…and it’s a good experience.”</td>
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<td>Participant 6</td>
<td>LC 1: Check-in</td>
<td>LC 1: Closing Circle</td>
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<td>“I’m pretty just interested in the topic in general, violence, just because it affects everybody – us as well as the clients. I’m just interested in the awareness and prevention. Preventing it for the future.”</td>
<td>“I think it’s also important to look at what people are going to do after you’ve been in a violent situation, now what? This can affect you ten years down the road. You may be fine now but ten years down the road, you’re going to have a mental breakdown. I think you have to think of the repercussions later on and think about all that. You can’t necessarily prevent it from happening…you can help alleviate some of the things. But if it’s going to happen, you need to know how to deal with it.”</td>
<td>“I agree that workplace violence is kind of a societal issue and maybe there’s different things, like the society, that’s assisting the violence.”</td>
<td>“I had a positive experience. I like the word eye-opener. It’s just seeing everybody else’s different experiences. I’ve never dealt with conflicts between workers. More of the physical or violence [from clients]….I just see a different side of things. I’m more ready to get out there and start preventing it and awareness. I think that’s important….It’s good to see that there’s six people [here]…too bad it couldn’t be bigger so there’s more impact. But I guess that’s our job to take that back to other people.”</td>
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