

**THE MAGNITUDE OF INTRA-PROFESSIONAL VIOLENCE THAT SOUTH  
AFRICAN UNDERGRADUATE NURSING STUDENTS ARE EXPOSED TO IN  
THE CLINICAL LEARNING ENVIRONMENT**

**NATASJHA ENGELBRECHT**

**THE MAGNITUDE OF INTRA-PROFESSIONAL VIOLENCE THAT SOUTH  
AFRICAN UNDERGRADUATE NURSING STUDENTS ARE EXPOSED TO IN  
THE CLINICAL LEARNING ENVIRONMENT**

by

**NATASJHA ENGELBRECHT**



Submitted in partial fulfilment of the requirements for the degree

**Magister Curationis (Clinical)**



## DECLARATION

### **DECLARATION**

I declare that the dissertation titled "The intra-professional violence that South African, undergraduate nursing students are exposed to in the clinical learning environment" which I hereby submit for the degree Magister Curationis at the University of Pretoria, is my own work and has not previously been submitted by me for a degree to any other university.

**Signature**

**Natasjha Engelbrecht**

**Date**



## ABSTRACT

### ABSTRACT

The number of new graduates greatly affects the existence of any profession and for the nursing profession this rings very true. However, in this caring and nurturing profession many undergraduate nursing students indicate that they consider leaving the profession due to exposure to intra-professional violence. Intra-professional violence may take many forms, is perpetrated by different individuals and have negative effects on patients, staff and institutions therefore it should be identified and managed. In South Africa it has, so far, been a topic which has not received much attention.

#### **Purpose**

Determine the presence of intra-professional violence experienced by undergraduate nursing students in South Africa and then create an awareness of intra-professional violence to eliminate the occurrence thereof.

#### **Design**

A quantitative, non-experimental, explorative and descriptive design was used.

#### **Methods**

The data was collected by means of a questionnaire. The questionnaire was distributed to undergraduate nursing students at nine NEI in South Africa.

#### **Findings**

Although characteristics of oppressed group behaviour are present in undergraduate nursing students it to a low extent. Undergraduate nursing students are experiencing intra-professional violence in the clinical learning environment from different perpetrators. The most likely perpetrator is the registered nurse. The intra-professional violence does cause stress but are deemed controllable according to the undergraduate nursing students. Furthermore the results show that the presence of stress results in an increased control of intra-professional violence. The most likely coping mechanism for intra-professional violence is to do nothing.



## ABSTRACT

### **Conclusion**

The findings correlated with international results and indicate that intra-professional violence is experienced by undergraduate nursing students in South Africa. Oppressed group behaviour is a contributing factor, but is not the sole cause. Undergraduate nursing students do need education about intra-professional violence and engaging coping mechanisms.

### **Clinical relevance**

If intra-professional violence is controlled, interpersonal relationships can improve. This would create an environment in which learning can be promoted and undergraduate nursing students will be able to develop their clinical skills with confidence. Furthermore, attrition will decline and nursing shortages can be countered.

### **Key words:**

Clinical learning environment, intra-professional violence, undergraduate nursing students

*"Nonviolence means avoiding not only external physical violence but also internal violence of spirit. You not only refuse to shoot a man, but you refuse to hate him. "*

Martin Luther King, Jr.



## ACKNOWLEDGEMENTS

### ACKNOWLEDGEMENTS

Glory be to God, for without Him this dissertation would not have been initiated or completed. He was and still is my pillar and strength. I thank Him for placing all the right people in the right places at the right time.

A word of appreciation to the following people:

My husband who encouraged me to register and then supported me through the course of this year

GJ, Marine & Klarissa, my beautiful children, for the patience you had when I was not as attentive as I should be

My mom, Doyce, who not only assisted when the children needed care but also when data had to be captured

Seugnette and Varshika for your friendship, advice and words of encouragement

My supervisor, Dr. T. Heyns and my co-supervisor, Dr. I. Coetzee, for your patience, guidance, honesty and support

Dr. K. Stanley, for assisting me to find a questionnaire and for being a sound board when the terminology were confusing

Dr. R. DeMarco and Dr. J. Cooper for giving permission to use the NWS and the BNEQ, respectively. Also thank you for answering questions pertaining to analysis of findings

Joyce Jordaan and Loina Bodenstein for making sense of the statistics and the feed back on Chapter 4

Dr. Erik Hofstee for assistance with issues of referencing

Alexa Barnby for the time and effort you put into the language editing

Monica & Mike from the Academic Information Services, thank you for not only finding and providing articles but also for the patience and kindness

A special thanks to the NEI coordinators, Elsabe Bornman, Rachele Lebeso, Eunice Seekoe, Yolinda Uys, Karien Jooste, Petra Brysiewics, Kefilwe Thopola and Maude Tshabalala.

All my colleagues for the support and motivation when I felt tired and dispondent.



## TABLE OF CONTENT

### TABLE OF CONTENTS

DECLARATION	i
ABSTRACT	ii
ACKNOWLEDGEMENTS	iv
TABLE OF CONTENTS	v
LIST OF TABLES	xi
LIST OF FIGURES	xii
LIST OF ANNEXURES	xiii
LIST OF ABBREVIATIONS	xiv
CHAPTER 1	1
ORIENTATION TO THE STUDY	1
1.1 Introduction	1
1.2 Background	1
1.3 Problem statement	5
1.4 Research question	5
1.5 Aim and objectives of the study	6
1.6 Frame of reference	6
1.6.1 Role of the researcher	7
1.6.2 The setting	8
1.6.3 Paradigm	10
1.6.4 Assumptions	11
1.6.5 Conceptual framework	14
1.6.5.1 Theory of Oppressed Group Behaviour	15
1.6.5.2 Transactional Model of Stress and Coping	15
1.6.5.3 Nursing as an oppressed group	16



## TABLE OF CONTENTS

1.6.6	Conceptual definitions	18
1.6.6.1	Clinical learning environment	18
1.6.6.2	Intra-professional violence	18
1.6.6.3	Nursing and nursing categories	19
1.6.6.4	Oppressed group behaviour	21
1.6.6.5	Undergraduate nursing student	22
1.7	Significance of the study	22
1.8	Scope and limitations	24
1.9	Layout of the study	25
1.10	Conclusion	25
	CHAPTER 2	26
	LITERATURE REVIEW	26
2.1	Introduction	26
2.2	Violence	26
2.2.1	Definition	27
2.2.2	Theory bases	28
2.2.3	Types	29
2.3	Workplace violence	31
2.3.1	Definition	31
2.3.2	Risk factors	32
2.4	Workplace violence in nursing	35
2.4.1	Contribution of risk factors	36
2.4.1.1	Individual characteristics	36
2.4.1.2	Organisational characteristics	37
2.4.1.3	Psychosocial characteristics	38





## TABLE OF CONTENTS

2.4.2	Violence terminology in nursing	40
2.4.3	Extent of workplace violence	43
2.4.3.1	Physical versus non-physical violence	43
2.4.3.2	Prevalence of intra-professional violence in nursing	44
2.4.4	Effects of intra-professional violence	48
2.5	Intra-professional violence in nursing	51
2.5.1	Exposure to intra-professional violence	51
2.5.2	A vulnerable population	55
2.5.3	Effects and responses	56
2.6	Conclusion	60
	CHAPTER 3	62
	RESEARCH METHODOLOGY	62
3.1	Introduction	62
3.2	Research aim and objectives	62
3.3	Research design	63
3.3.1	Quantitative design	64
3.3.2	Non-experimental design	66
3.3.3	Survey design	67
3.3.4	Descriptive and explorative design	67
3.4	Research methodology	68
3.4.1	Population	68
3.4.2	Sample	69
3.4.3	Sampling plan	70
3.4.4	Data collection	71
3.4.4.1	Advantages and disadvantages	71



## TABLE OF CONTENTS

3.4.4.2	Data collection instrument	72
3.4.4.3	Pre-test data collection instrument	76
3.4.4.4	Data collection procedure	77
3.4.5	Data analysis	79
3.5	Validity and reliability	82
3.5.1	Validity	82
3.5.1.1	Validity of the research design	82
3.5.1.2	Validity of the research instrument	83
3.5.2	Reliability	85
3.6	Ethical considerations	86
3.7	Conclusion	89
	CHAPTER 4	90
	RESEARCH RESULTS AND DISCUSSION	90
4.1	Introduction	90
4.2	Overview of the participating NEI	90
4.3	Overview of the respondents	92
4.4	Results and discussion	94
4.4.1	Section A: Demographic information [V1-V4]	95
4.4.1.1	Academic year of study [V2]	95
4.4.1.2	Gender distribution [V3]	97
4.4.1.3	Age distribution [V4]	99
4.4.2	Section B: Behavioural characteristics [V5.1-V5.12]	101
4.4.2.1	Behavioural characteristics for total group	102
4.4.2.2	Behavioural characteristics versus academic year of study	103
4.4.2.3	Behavioural characteristics versus gender	105



## TABLE OF CONTENTS

4.4.2.3.1	Dissection of behavioural characteristics across gender	107
4.4.2.4	Behavioural characteristics across age	108
4.4.3	Section C: Behaviour experienced [V6.1-V6.12]	110
4.4.3.1	Behaviours	111
4.4.3.2	Perpetrators	115
4.4.4	Section D: Significance of behavioural events [V7.1-V7.2]	118
4.4.4.1	Behavioural event as stressful	118
4.4.4.2	Significance of behavioural event as controllable	119
4.4.4.3	Stressful versus controllable	120
4.4.5	Section E: Coping mechanisms [V8.1-V8.12]	122
4.5	Conclusion	125
CHAPTER 5		126
CONCLUSIONS AND RECOMMENDATIONS		126
5.1	Introduction	126
5.2	Research aim and study objectives	126
5.3	conclusions and recommendations	127
5.3.1	Distribution and return of questionnaires	127
5.3.2	Section A – Demographical information	128
5.3.3	Section B – Behavioural characteristics	129
5.3.4	Section C – Behaviours experienced	131
5.3.5	Section D – Significance of behavioural events	132
5.3.6	Section E – Coping mechanisms	133
5.4	Recommendations	133
5.4.1	Education and information	134
5.4.2	Improved communication	134



## TABLE OF CONTENTS

5.4.3	Role models	135
5.5	Recommendations for further research	136
5.6	Limitations	136
5.7	Researcher reflection	137
5.8	Conclusion	138
	REFERENCE LIST	139



## LIST OF TABLES

### LIST OF TABLES

<b>TABLE 1.1</b> A SUMMARY OF SEARCH ENGINES AND KEYWORDS USED IN LITERATURE SEARCH	3
<b>TABLE 1.2</b> SUMMARY OF POSITIVIST ASSUMPTIONS	13
<b>TABLE 2.1</b> DESCRIPTION OF WORKPLACE VIOLENCE TERMINOLOGY APPLICABLE TO NURSING	42
<b>TABLE 2.2</b> SUMMARY OF RESEARCH STUDIES WITH REGARD TO INTRA-PROFESSIONAL VIOLENCE AMONG NURSES (2005-2010)	47
<b>TABLE 2.3</b> PHYSICAL AND PSYCHOLOGICAL MANIFESTATIONS OF INTRA-PROFESSIONAL VIOLENCE	50
<b>TABLE 2.4</b> THEMES DEFINED AND RELATING QUOTATIONS	52
<b>TABLE 2.5</b> OCCURRENCE OF INTRA-PROFESSIONAL VIOLENCE IN UNDERGRADUATE NURSING STUDENTS	54
<b>TABLE 2.6</b> SEVERITY OF INTRA-PROFESSIONAL VIOLENCE	55
<b>TABLE 3.1</b> THE QUANTITATIVE DESIGN APPLIED	65
<b>TABLE 3.2</b> RESEARCHER'S DECISION ABOUT THE DESIGN FEATURES	66
<b>TABLE 3.3</b> OUTLINE OF STUDY QUESTIONNAIRE	74
<b>TABLE 3.4</b> DIFFICULTIES EXPERIENCED DURING DATA COLLECTION	78
<b>TABLE 3.5</b> APPLICATION OF DESCRIPTIVE STATISTICS	80
<b>TABLE 3.6</b> APPLICATION OF INFERENCE STATISTICS	81
<b>TABLE 3.7</b> APPLICATION OF RELIABILITY IN STUDY QUESTIONNAIRE	86
<b>TABLE 3.8</b> SUMMARY OF THE PRINCIPLES OF THE NUREMBURG CODE	87
<b>TABLE 4.1</b> NEI REPRESENTATION BY PROVINCE	91
<b>TABLE 4.2</b> OVERVIEW OF ACCESSIBLE POPULATION	94
<b>TABLE 4.3</b> MEAN AND MEDIAN AGE OF STUDY POPULATION	100
<b>TABLE 4.4</b> BEHAVIOURS EXPERIENCED VERSUS PERPETRATORS	111
<b>TABLE 4.5</b> LITERATURE CONTROL WITH REGARD TO BEHAVIOURS EXPERIENCED	113
<b>TABLE 4.6</b> LITERATURE CONTROL WITH REGARD TO PERPETRATORS	117
<b>TABLE 4.7</b> SIGNIFICANCE OF BEHAVIOURAL EVENTS AS STRESSFUL	118
<b>TABLE 4.8</b> SIGNIFICANCE OF BEHAVIOURAL EVENTS AS CONTROLLABLE	120
<b>TABLE 5.1</b> NUMBER OF COPIES OF QUESTIONNAIRE DISTRIBUTED AND RETURNED	128



## LIST OF FIGURES

### LIST OF FIGURES

<b>FIGURE 1.1</b> INTRA-PROFESSIONAL VIOLENCE IN NURSING	14
<b>FIGURE 2.1</b> TYPES OF VIOLENCE AND RELATED PERPETRATOR	29
<b>FIGURE 2.2</b> FACTORS AFFECTED BY INTRA-PROFESSIONAL VIOLENCE IN NURSING	48
<b>FIGURE 2.3</b> BALANCE BETWEEN STRESS AND CONTROL	59
<b>FIGURE 2.4</b> IMBALANCE BETWEEN STRESS AND CONTROL	60
<b>FIGURE 3.1</b> COMPONENTS OF THE QUANTITATIVE RESEARCH DESIGN APPLIED IN THIS STUDY	64
<b>FIGURE 3.2</b> TARGET POPULATION, STUDY POPULATION AND SAMPLE	69
<b>FIGURE 3.3</b> STEPS OF DATA COLLECTION PROCEDURE	77
<b>FIGURE 4.1</b> COMPARISON OF NEI AND PROVINCE REPRESENTATION IN THIS STUDY	92
<b>FIGURE 4.2</b> REPRESENTATION OF ACADEMIC YEAR OF STUDY	96
<b>FIGURE 4.3</b> GENDER DISTRIBUTION	98
<b>FIGURE 4.4</b> AGE DISTRIBUTION OF THE STUDY POPULATION	100
<b>FIGURE 4.5</b> SCORES FOR BEHAVIOURAL CHARACTERISTICS	102
<b>FIGURE 4.6</b> SCORES FOR BEHAVIOURAL CHARACTERISTICS ACCORDING TO ACADEMIC YEAR	104
<b>FIGURE 4.7</b> SCORES FOR BEHAVIOURAL CHARACTERISTICS ACCORDING TO GENDER	106
<b>FIGURE 4.8</b> COMPARISON OF SCORES ACCORDING TO YOUNGER AND OLDER AGE GROUPS	109
<b>FIGURE 4.9</b> AVERAGE OF BEHAVIOURS EXPERIENCED	112
<b>FIGURE 4.10</b> PERPETRATOR FREQUENCY	116
<b>FIGURE 4.11</b> RESPONDENTS' INDICATION OF COPING MECHANISMS EMPLOYED	124



## LIST OF ANNEXURES

### LIST OF ANNEXURES

<b>ANNEXURE A</b> ETHICAL APPROVAL TO CONDUCT RESEARCH	154
<b>ANNEXURE B</b> LETTER OF INVITATION TO THE NEI TO PARTICIPATE IN THE STUDY	158
<b>ANNEXURE C</b> QUESTIONNAIRE	159
<b>ANNEXURE D</b> LETTER FROM THE STATISTICIAN	164
<b>ANNEXURE E</b> LETTER FROM THE EDITOR	165



## LIST OF ABBREVIATIONS

### LIST OF ABBREVIATIONS

<b>BNEQ</b>	Bulling in Nursing Education Questionnaire
<b>NEI</b>	Nursing education institution(s)
<b>NRF</b>	National Research Foundation
<b>NWS</b>	Nurse Workplace Scale
<b>SANC</b>	South African Nursing Council
<b>UK</b>	United Kingdom
<b>USA</b>	United States of America





## CHAPTER 1

# CHAPTER 1

## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION

Nursing is described as a caring, nurturing profession that has as goal, the prevention of illness and the promotion of health as delineated by Mellish and Brink (1990: 1). Yet statements like: "I was reprimanded, in front of everyone, for performing my duties according to the book", "... you, undergraduate students do not take orders ...", "... you are an undergraduate student, you should know. I'm not going to help you ..." are heard on a daily basis in the clinical learning environment. These statements do not portray the spirit of nursing; on the contrary, they reflect a certain type of intra-professional violence. In fact, Meissner (1986: 52), writing in the 1980s, refers to this type of conduct as "eating our young". This is underlined by a study done twenty years later, in which students related, in narratives, that we "are still eating our young" (Thomas & Burk 2009: 231).

The aim of this study is to investigate the intra-professional violence that South African undergraduate nursing students are exposed to in the clinical learning environment.

### 1.2 BACKGROUND

The researcher is a lecturer at a tertiary Nursing Education Institution (NEI) in Gauteng. This institution provides education and training to under- and postgraduate students. As a lecturer, the researcher is responsible for the theoretical and practical components of the subject Medical-Surgical Nursing Science and lectures to second-year undergraduate students. One of her responsibilities pertaining to the practical component of the programme is the



## CHAPTER 1

accompaniment of undergraduate students in the clinical learning environment. Furthermore, the researcher is the guardian lecturer of the second-year students. For this reason, the undergraduate nursing students often share their experiences with the researcher.

When students confide in the researcher, they usually describe specific incidents which relate to verbal or non-verbal behaviour by different sub-categories of nurse, including nurse managers, registered professional nurses, enrolled nurses, auxiliary nurses, nursing students enrolled for a four-year diploma programme and sometimes their own peers. These experiences leave them feeling humiliated, frustrated and unsure about the clinical learning environment. It was these reported incidents that motivated the researcher to investigate the extent to which this type of behaviour occurs in the clinical learning environment.

During the preliminary literature search, the researcher found that this type of behaviour has been called by many names, depending on who the perpetrator is. Lamontagne (2010: 59) defines horizontal violence as being "within the peer group". Longo (2010: [2]) calls it "lateral violence" and identifies it as aggression towards someone on the same hierarchical level, whereas Huston (2006: 233) identifies violence between employees working in the same organisation as internal violence. Furthermore, violence within the nursing profession, specifically violence towards undergraduate nursing students, has been studied in the United States of America (Cooper *et al.* 2009; Thomas & Burk 2009), Australia (Curtis, Bowen & Reid 2006) and the United Kingdom (Lewis 2006; Levett-Jones & Lathlean 2009).

To determine the presence of intra-professional violence in South Africa the researcher used the keywords and search engines depicted in Table 1.1.



CHAPTER 1

**Table 1.1 A summary of search engines and keywords used in literature search**

Search Engines	Keywords
CINAHL (Cumulative Index to Nursing and Allied Health)	Horizontal violence
NRF website	Lateral violence
Africa healthinfo	Hierarchical violence
Medline (Ovid)	Bullying
Pubmed	Intimidation
Google	Verbal abuse
	Nurse-on-nurse violence

From the search, the following was found:

- one article pertaining to the levels and types of violence among nurses in public hospitals in Cape Town (Khalil 2009)
- a descriptive study initiated in 2008 pertaining to violence among nurse learners, but no results seem to be available (NRF 2010).

The researcher did find a synthesis report compiled by Di Martino (2002) for a joint programme initiated by the International Labour Office, the International Council of Nurses, the World Health Organization and Public Services International, which focused on and was titled "Workplace violence in the health sector". The report included findings from case studies carried out in Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand. One of the findings was that psychological violence, and specifically, verbal abuse, occur everywhere, but of the seven countries, South Africa had the second highest occurrence. The report also showed that patients were perpetrators of physical violence, but psychological violence was perpetrated by staff members. This report studied nurses as a group and did not distinguish between the different sub-categories.



## CHAPTER 1

Griffin (2004: 258) indicates that 60% of new graduates leave their first nursing position as a result of intra-professional violence. If one considers the global nursing shortage, this attrition is an event that the profession can ill afford.

For the past two decades, researchers have been pointing to the role that oppressed group behaviour plays in intra-professional violence (Roberts 1983: 21; Griffin 2004: 257; Longo & Sherman 2007: 35, Stanley *et al.* 2007: 1248; Roberts, DeMarco & Griffin 2009: 289; Thomas & Burk 2009: 226). Accordingly, oppressed groups experience oppression from superior groups and, owing to an inability to change the situation, become frustrated, which results in them either acting out towards their fellow oppressed or else the individual leaves the profession. The decision to either act out or leave relates to an individual's appraisal of their experiences and their appraisal of their own ability to manage the situation (Glanz, Rimer & Lewis 2002: 212). In this regard, the Transactional Model of Stress and Coping elaborates on the relationship between stress and the coping mechanisms implemented to engage in or disengage from stressful events. In this case, the stressful event is the intra-professional violence.

It is thus important to determine to what extent oppressed group behaviour is present in undergraduate nursing students, since this increases the risk for intra-professional violence. Furthermore, it is important to determine whether students appraise the intra-professional violence as stressful as well as whether they are able to control it, since these two factors determine their coping mechanisms and engagement.

This study provides statistics that describe the extent to which oppressed behaviour is present in undergraduate nursing students in South Africa. The students' experiences of, and coping mechanisms for, intra-professional violence are revealed through the use of quantitative research methods.



## CHAPTER 1

### 1.3 PROBLEM STATEMENT

In light of the introduction and background given above, the researcher has deduced that undergraduate nursing students are exposed to intra-professional violence during their placement in the clinical learning environment. This placement in the clinical learning environment is vital to ensure that the nursing students develop specific clinical skills (Chan 2002: 69). However, the exposure to intra-professional violence, which could result in physical and psychological difficulties, might adversely affect the students' abilities to develop these clinical skills. Furthermore, the students may develop disruptive behaviours to cope with the intra-professional violence and even become perpetrators themselves (Longo 2007: 177; Stanley *et al.* 2007: 1249; Roche *et al.* 2010: 14). The presence of intra-professional violence in the clinical learning environment also results in poor nursing care, low staff retention and decreased patient safety (Lamontagne 2010: 55; Longo 2010:[2-3]; Roche *et al.* 2010: 14; Rucker 2010: [1]).

Based on the introduction and background, the researcher has formulated the following problem statement:

Nurse managers, in the clinical learning environment, and nurse educators need to gain knowledge, insight and awareness of the magnitude and effects of intra-professional violence as perceived by undergraduate nursing students. Such awareness will enable nurse managers and nurse educators to empower undergraduate nursing students who have been exposed to such violence.

### 1.4 RESEARCH QUESTION

The research question, based on the problem statement, was formulated as follows:



## CHAPTER 1

What is the magnitude of the intra-professional violence that South African undergraduate nursing students are exposed to in the clinical learning environment?

### **1.5 AIM AND OBJECTIVES OF THE STUDY**

The aim of this study is to:

Investigate the intra-professional violence that South African undergraduate nursing students are exposed to in the clinical learning environment.

The objectives of this study are to

- determine the presence of oppressed group characteristics in South African undergraduate nursing students
- assess intra-professional violence that South African undergraduate nursing students' are exposed to in the clinical learning environment
- determine South African undergraduate nursing students' primary appraisal of intra-professional violence
- evaluate coping responses that South African undergraduate nursing students implement when confronted with intra-professional violence in the clinical learning environment.

### **1.6 FRAME OF REFERENCE**

The frame of reference or framework of the study aims to give a logical structure or guide for developing the study (LoBiondo-Wood & Haber 2006: 114). Both the philosophical paradigm and the research design contribute to this structure. Moreover, the researcher's frame of reference can be described in terms of the role of the researcher, the setting in which the study will be conducted, the



## CHAPTER 1

relevant paradigm, the assumptions, the conceptual framework and the conceptual definitions.

### **1.6.1 Role of the researcher**

The role of the researcher is described as the influences that the researcher brings to the study (Struwig & Stead 2001: 227). According to Terre Blanche and Durrheim (1999: 49) these influences should be considered before the data collection period begins, since this is the time during which they have most effect. Influences that the researcher may bring to the study include her status as a registered professional nurse and her experiences in the clinical learning environment, as well as her current role as nurse educator of the undergraduate nursing students from whom the researcher became aware of intra-professional violence. These roles had an influence on the choice of research topic, as well as the research method used to address the research question.

The researcher should decide whether to be present during the data collection process and whether the context should be manipulated, as these factors are usually determined by the paradigm that the researcher follows (Terre Blanche & Durrheim 1999: 49).

For the purpose of this study, the researcher decided not to be present when the respondents completed the questionnaire. The researcher, however, acknowledges that this will have both advantages and disadvantages. In the view of Terre Blanche and Durrheim (1999: 49), the absence of the researcher will reduce the effects that personal traits and relationships might have; however, on the other hand, there will be no opportunity for either the respondents or the researcher to clarify information.

The only manipulation of the setting that will take place in this study will be that the respondents will not be in the clinical learning environment when they



## CHAPTER 1

complete the questionnaires, but in a lecture hall. This would prevent exposure to the perpetrators of intra-professional violence and thus increase the truthfulness of the responses, as suggested by Terre Blanche and Durrheim (1999: 50).

### 1.6.2 The setting

The research setting refers to the surroundings in which the research will be conducted (Burns Grove 2009: 35; Polit & Beck 2010: 62). Polit and Beck (2010: 62) further distinguish two types of settings by referring to the amount of control that the researcher will enforce, namely a naturalistic setting (uncontrolled) or a laboratory setting (highly controlled). Burns and Grove (2009: 35) agree with this, indicating that a naturalistic setting entails real-life situations, where no manipulation occurs. Laboratory settings, on the other hand, entail artificially created surroundings that allow the researcher to limit the variables that might affect the results. However, Burns and Grove (2009: 362) further mention settings where partial control is practised. This means that some variables have been manipulated in the setting, but not all, resulting in partial control over variables. According to Polit and Beck (2010: 62), the site within a setting refers to the overall location where the study will be conducted, for example "an institution is a community". One or more sites may be used.

The Nursing Act No 33 of 2005 (Republic of South Africa 2005:6) defines a "*nursing education institution*" as any nursing education institution accredited by the South African Nursing Council (SANC). According to the SANC terminology list (SANC 1994:21), a nursing education institution is a post-secondary educational institution approved by the SANC as a nursing school and which meets the following prerequisites:

- legal enablement for its existence and maintenance
  - co-operation agreement with a university





## CHAPTER 1

- organisational structures
  - College Council and College Senate with committees
- approved curriculum
- approved system for the management of examinations
- adequately prepared teaching staff
- access to adequate facilities supported by formal agreements with authorities (public or private) in respect of each of the clinical facilities.

According to the SANC Regulation R.425 of 1985 (1) a "*nursing college*" means a post-secondary educational institution which offers professional nursing education at basic and post-basic level where such nursing education has been approved in terms of section 15 (2) of the Nursing Act 50 of 1978 (replaced by 42[1-4] of the Nursing Act 33 of 2005). Furthermore, the head of the department is a registered nurse who holds at least a baccalaureus degree and additional qualifications in education and administration.

For the purposes of this study, the sites include all nursing education institutions (NEI) involved in the education and training of undergraduate nursing programmes in South Africa. These NEI consist of departments of tertiary education institutions in South Africa.

The content of all undergraduate nursing programmes is determined by the South African Nursing Council (SANC 2005: 8). The undergraduate nursing programme is a four-year programme comprising both theoretical and clinical skills development. To ensure theory-practice correlation, nursing students are placed in a clinical learning environment in collaboration with academic hospitals, community services and psychiatric facilities. According to Regulation 425 (SANC 1985: 8), the placement of nursing students in the clinical learning environment should not only focus on clinical nursing, nursing interventions, management and teaching, but also on providing opportunities for the development of "... sound interpersonal relationships".



## CHAPTER 1

In the clinical learning environment, students are exposed to different members of the multidisciplinary team, including registered professional nurses, enrolled nurses (in this study referred to as staff nurses), auxiliary nurses (in this study referred to as nursing assistants), nursing students enrolled for a four-year diploma programme (in this study referred to as diploma nursing students), peers enrolled for the undergraduate course, allied health professionals (physiotherapists, radiographers) and medical professionals.

The data will be collected in a naturalistic setting, since the nursing students will be requested to complete the questionnaires in a lecture hall of the NEI in which they have enrolled for the undergraduate nursing programme. Partial control will be practised since the nursing students will not be in the clinical learning environment, where they might feel threatened and thus answer less truthfully.

### **1.6.3 Paradigm**

The *Collin's South African dictionary* defines 'paradigm' as a "very general *conception* of the nature of scientific endeavour within which a given enquiry is undertaken". 'Conception' is defined as the idea, origin, design, plan or description under which someone considers something. Thus, the paradigm provides a point of origin as well as the structure according to which research questions will be asked and answered, which is consistent with the view of Kuhn (1970: 24).

LoBiondo-Wood and Haber (2006:133) state that philosophical beliefs form the basis for all research, but that not all researchers use the same paradigm. In the view of Polit and Beck (2008: 14), the paradigms accepted in nursing research are the positivistic and naturalistic paradigms.



## CHAPTER 1

The goal of positivist-directed research is to describe, explain, predict and control the cause of the phenomenon under study (LoBiondo-Wood & Haber 2006: 135). Accordingly, objectivity, control and a neutral observer, free of values and bias, are of utmost importance during data collection (LoBiondo-Wood & Haber 2006: 135; Polit & Beck 2008: 14). Positivism maintains that only observable phenomena are true, that theoretical speculation is rejected and that there is a causal relationship between phenomena.

In this study, the reality to be described is intra-professional violence and a positivist paradigm will be used to guide the research. The researcher will not interact with the respondents during data collection, resulting in data that are bias free. Subsequently, objectivity will be maintained through the use of a questionnaire containing close-ended questions and only partial control will be enforced since respondents will not be in the clinical learning environment during data collection. The evidence will then be measured and analysed statistically, thus complying with the characteristics of positivism as supported by Brown, Crawford and Hicks (2003: 24-25), LoBiondo-Wood and Haber (2006: 134) and Polit and Beck (2008:14).

### **1.6.4 Assumptions**

Polit and Beck (2008: 14) explain assumptions as basic principles that are believed to be true without verification. The reader is thus expected to believe them without offering evidence (Hofstee 2006: 88). LoBiondo-Wood and Haber (2006: 31) maintain that assumptions are accepted truths, while Burns and Grove (2009: 40) point out that, assumptions can be found in the philosophical frameworks of studies.



## CHAPTER 1

Positivist assumptions have been summarised as determinism, reductionism, objectivism, theory verification, and the role of evidence and scientific method by Giddings and Grant (2007: 54).

Assumptions of the positivist paradigm will apply to this study since the reality to be described is intra-professional violence. This reality can be observed and measured by means of a fixed design that will provide quantitative information, unbiased and unaffected by values and morality. The researcher will not affect the research findings, since the reality of the undergraduate nursing students' exposure to intra-professional violence cannot be so affected.

Table 1.2 was compiled from information contained in Brown *et al.* (2003: 24-25), LoBiondo-Wood and Haber (2006:134), Giddings and Grant (2007: 54-55), and Polit and Beck (2010: 14-16) in order to provide a summary of positivist assumptions as they relate to the philosophical questions. Table 1.2 indicates how these assumptions apply to this study.



## CHAPTER 1

**Table 1.2 Summary of positivist assumptions**

Philosophical question	Description in positivism	Application in study
<b>Ontology:</b> What is the nature of reality?	<b>Determinism:</b> A causal relationship exists between phenomena and can be observed, measured and understood.	The intra-professional violence that undergraduate nursing students are exposed to can be measured to create a better understanding.
<b>Epistemology:</b> Why, how and what does the researcher know about the phenomena?	<b>Objectivism:</b> Reality exists and can be sought via replicable observation. Researcher is independent of the phenomena	Findings with regard to extent of intra-professional violence will replicate what has been found in other parts of the world.
<b>Axiology:</b> What is the role of values in the inquiry?	<b>Objectivism:</b> Empirical knowledge is separable and should be kept separate from morality. Facts speak for themselves and thus value-neutral knowledge should be obtained.	Close-ended questionnaires will limit the effect of bias and values. Morality will not affect answers provided by respondents thus findings will be value neutral.
<b>Methodology:</b> How is the evidence obtained?	<b>Reductionism:</b> Experience can be reduced to discrete, specific concepts.  <b>Scientism:</b> Scientific knowledge is the only true and reliable knowledge. This knowledge is to be obtained through fixed, specified design, measured, quantitative information and statistical analysis with the aim to generalise findings.	Specific concepts from undergraduate nursing students' experiences of intra-professional violence will be researched.  Quantitative design will ensure empirical data to be collected. Statistical analysis will be preformed. Researcher will be able to generalise results.

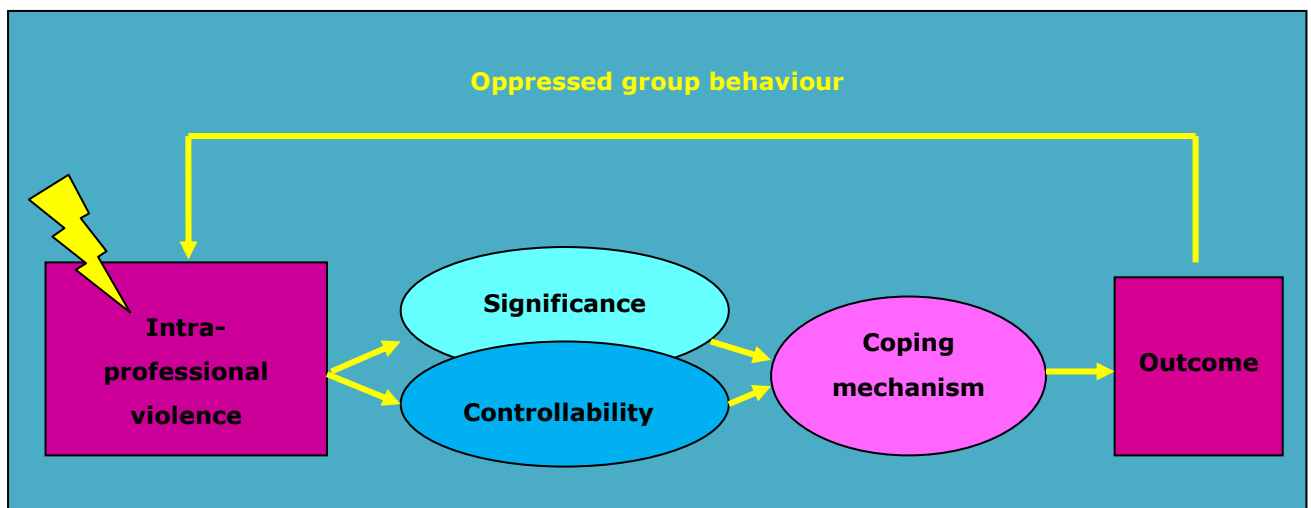


## CHAPTER 1

### 1.6.5 Conceptual framework

Researchers follow either inductive or deductive reasoning when approaching a research problem (LoBiondo-Wood & Haber 2006: 121). In terms of deductive reasoning, the researcher will use a conceptual framework from which to make predictions with regard to phenomena or behaviour, as suggested by Polit and Beck (2010: 64). These predictions will assist in developing research question(s) and the conceptual definitions.

Based on the quantitative design, for this study deductive reasoning, will be applied, as exemplified by the Theory of Oppressed Group Behaviour (Freire 1970), as well as the Transactional Model of Stress and Coping (Glanz *et al.* 2002). Figure 1.1 depicts the Transactional Model of Stress and Coping within the Theory of Oppressed Group Behaviour, which will be discussed in sections 1.6.5.1, 1.6.5.2 and 1.6.5.3.



**Figure 1.1 Intra-professional violence in nursing**

(Adopted from Glanz *et al.* 2002: 215; Longo & Sherman 2007: 37; Martin, Stanley, Dulaney and Pehrson 2008: 58)



## CHAPTER 1

### 1.6.5.1 Theory of Oppressed Group Behaviour

The Theory of Oppressed Group Behaviour relates to groups that demonstrate certain behaviours resulting from oppression. Oppression, which occurs as the result of being controlled by a force outside of oneself, implies a dominant and a subordinate group (Roberts 1983: 21). The dominant group distinguishes itself from the subordinate group by acting differently and establishing its norms and values as the only acceptable norms and values. Both the dominant group and the subordinate group internalise these norms and values, giving the dominant group the ability to control and exploit (Roberts 1983: 22; Freire 1993: 47). To improve their circumstances, the subordinate group will try to be more like the dominant group, leaving individuals without identity.

Characteristic behaviour within the oppressed group includes sexism, self-hatred, low self-esteem, self minimisation, frustration and aggression (Roberts 1983: 22-23) as well as "... striking out at their own comrades ..." (Freire 1993: 62). According to De Marco and Roberts (2003: 113) and Martin, Stanley, Dulaney and Pehrson (2008:58) these characteristics manifest in a cyclical pattern which then results in individuals leaving the group or the group failing to attain its goal.

### 1.6.5.2 Transactional Model of Stress and Coping

The Transactional Model of Stress and Coping provides a structure according to which the process of coping with stressors or demands can be evaluated (Glanz *et al.* 2002: 212). The model identifies primary and secondary appraisals as key concepts of this process, which is intended to initiate coping mechanisms that result in outcomes like "...psychological well-being, functional status and adherence ..." (Glanz *et al.* 2002: 212). Stress occurs if the demand exceeds the coping resources of the individual (Manderino & Berkey 1997: 49).



## CHAPTER 1

In addition, according to Lazarus (1976: 58), the individual's psychological state, and social and cultural resources will affect this process.

Glanz *et al.* (2002: 213) refer to primary appraisal as the judgement that individuals make with regard to significance of the stressor. This significance will determine the impact that the stressor may have and can vary between stressful, positive, controllable, challenging, benign and irrelevant.

The secondary appraisal relates to what the individuals perceive their abilities to be, in terms of changing or managing the stressor (Glanz *et al.* 2002: 216). This reflects on individuals' self-efficacy or belief in their ability to be successful in producing an intended result (*Collins South African dictionary 2007*); the intended result being the ability to control the situation. High self-efficacy results in positive outcomes and low stress, whereas low self-efficacy results in disengaging strategies like behavioural distancing and denial that, ultimately, increase distress (Glanz *et al.* 2002: 217).

### **1.6.5.3 Nursing as an oppressed group**

Authors such as Roberts (1983: 25), DeMarco and Roberts (2003: 113), and Martin *et al.* (2008: 58) have identified nurses as an oppressed group by referring to the work of Freire (1971) and Fanon (1963). These authors have studied, explored and described intra-professional violence among nurses, commenting on the cyclical nature of powerlessness, self-silencing, dissatisfaction towards peers, tension, verbal abuse and bullying (Martin *et al.* 2008: 58).





## CHAPTER 1

This applies to undergraduate nursing students in a compounded form. In order for these students to be accepted, they have to provide evidence of their knowledge and skills within an environment that they do not yet have much experience of. Some of the nursing colleagues with whom they have contact in the clinical learning environment are registered professional nurses, who have already proved their knowledge and skills, and who set the norms and values in this environment. Such professional nurses might also have experienced intra-professional and inter-professional violence that have left them powerless and frustrated. Thus, undergraduate nursing students become the target of this unresolved tension.

Following the principles of the Transactional Model of Stress and Coping (Glanz *et al.* 2002: 212), the nursing students will appraise the intra-professional violence and, depending on their psychological, social and cultural resources, judge the significance thereof. This process will be followed by secondary appraisal, namely the decision on how to manage the situation. If the Theory of Oppressed Group Behaviour is taken into consideration, the nursing students will, most likely, choose disengaging strategies, such as silencing the self and self-reliance, as well as experiencing feelings of powerlessness, which may lead to more distress. They may also become the perpetrators of intra-professional violence themselves, which will then perpetuate the cyclical pattern, as presented in Figure 1.1 (Longo & Sherman 2007: 35; Martin *et al.* 2008: 58; Sheridan-Leos 2008: 400).



## CHAPTER 1

### **1.6.6 Conceptual definitions**

In this study, and for the sake of simplicity and consistency throughout this proposal, the key conceptual definitions are defined.

#### **1.6.6.1 Clinical learning environment**

The *Collins South African dictionary* (2007) defines 'environment' as external surroundings in which people work; and 'clinical' as at the bedside of the patient. Chan (2006: 678) indicates that the undergraduate nurse will also have contact with nursing staff, nurse mentors and nurse educators.

The clinical learning environment is described by Chan (2002: 70) as the hospital or other health care institutions in which undergraduate nursing students are placed to develop their clinical skills.

For the purpose of this study, the clinical learning environment will refer to the hospital setting, which includes the medical-surgical and midwifery wards, community practices and psychiatric institutions in which South African undergraduate nursing students are placed.

#### **1.6.6.2 Intra-professional violence**

Lewis (2006: 53) uses the term 'intra-professional', to describe bullying "between nurse and nurse". Other terms that relate to this are 'horizontal', 'lateral', 'vertical' and 'hierarchical violence'.

Lamontagne (2010: 59) defines horizontal violence as occurring within the peer group. Longo (2010: [2]) mentions lateral violence as aggression towards someone on the same hierarchical level, whereas Huston (2006: 233) uses the



## CHAPTER 1

term internal violence to describe violence between employees working in the same organisation. Violence is perpetrated through disruptive behaviour. Accordingly, disruptive behaviour is summarised as verbal abuse, harassment, bullying, mobbing and intimidation (Longo 2010: [2]). According to the *Collins South African dictionary* (2007), violence is the unjust, unwarranted display of force to induce change to your will, or to cause injury or to overawe.

For the purpose of this study, the term 'intra-professional' violence will be used to describe violence towards undergraduate nursing students and give an indication of who the perpetrators are in the nursing environment. Accordingly, intra-professional violence is disruptive behaviour within the nursing profession that may lead to physical or psychological harm.

This type of behaviour is acted out towards undergraduate nursing students, and the perpetrators of such behaviour may be registered professional nurses, enrolled nurses, auxiliary nurses, students registered for the diploma course or other undergraduate students.

### **1.6.6.3 Nursing and nursing categories**

The Nursing Act (33 of 2005: 6) defines nursing as the following:

...a caring profession practised by a person registered under section 31. [A person] which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives in comfort and with dignity until death.

The Nursing Act (2005: 25) states in section 31(1a-e) that: "Subject to the provisions of section 37, no person may practise as a practitioner unless he or she is registered to practise in at least one of the following categories:



## CHAPTER 1

- Professional nurse;
- Midwife;
- Staff nurse;
- Auxiliary nurse;
- Auxiliary midwife.”

Section 30(1-5) of the Nursing Act (2005: 25) provides the following descriptions for the different categories:

- “A *professional nurse* is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice.
- A *midwife* is a person who is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice.
- A staff nurse is a person educated to practise basic nursing in the manner and to the level prescribed.
- An auxiliary nurse or an auxiliary midwife is a person educated to provide elementary nursing care in the manner and to the level prescribed.”

Section 32(1 & 2) of the Nursing Act (2005: 27) reads as follows in terms of individuals who are not yet registered and are still undergoing education:

(1) A person undergoing education or training in nursing must apply to the Council to be registered as a learner nurse or a learner midwife. (2) The Council must register as a learner nurse or a learner midwife, any person who has complied with the prescribed conditions and has furnished the prescribed particulars for a training programme at a nursing education institution.” Both universities and colleges are currently presenting nursing education in South Africa. Thus learners either receives a degree or a diploma in nursing, resulting in two groups of students namely, undergraduate nursing students (see section 1.6.6.5) and nursing students enrolled for a four-year diploma programme.



## CHAPTER 1

For the purpose of this study, all of the above-mentioned categories are considered as possible perpetrators and will be referred to as follows:

- Registered professional nurse, which refers to both the professional nurse and the professional midwife
- Staff nurse
- Assistant nurse, which refers to both the auxiliary nurse and the auxiliary midwife
- Diploma nursing student, also referred to as nursing students enrolled for a four-year diploma programme
- Undergraduate nursing students

Nurse managers and nurse educators are not included as possible perpetrators in this study.

### **1.6.6.4 Oppressed group behaviour**

Duchscher and Myrick (2008: 194) define oppression as "... an experience that results from dominating patterns of ideas or structures that characterise, normalise and perpetuate unequal relationships and role determinations within a social system".

Roberts (1983: 21) describes oppressed group behaviour as behaviour such as marginalisation, internalisation, self-hatred and low self-esteem that surfaces when a subordinate group is oppressed by a superior group. Since the oppressed are powerless to change the circumstances, intergroup conflict (horizontal violence) results.



## CHAPTER 1

In this study, oppressed group behaviour will include behaviour that is present because of power differentials, as summarised by Daiski (2004: 44) and Martin *et al.* (2008:58):

- Internalisation of a superior group's values
- Internal sexism
- Not opposing the superior group or silencing the self (self minimisation)
- Feeling powerless, frustrated, humiliated
- Imitating those in power
- Committing intra-professional violence

### **1.6.6.5 Undergraduate nursing student**

The undergraduate nursing student is a university scholar, who has not yet obtained a first degree (*Collins South African dictionary 2007*).

In this study, 'undergraduate nursing student' will refer to a student:

- registered at a university to obtain a first degree in Nursing Science, and
- registered full time for a four-year period.

## **1.7 SIGNIFICANCE OF THE STUDY**

LoBiondo-Wood and Haber (2006: 51) state that the significance of a study relates to its potential to contribute to the body of scientific knowledge. From the literature review it is clear that intra-professional violence occurs in clinical learning environments and that undergraduate nursing students are exposed to this form of violence (see section 2.5.1). However, little is known about the extent to which South African undergraduate nursing students are exposed to intra-professional violence (see section 1.2).



## CHAPTER 1

In South Africa, the statistics provided by the SANC currently show an increase in the number of registered undergraduate students (SANC 2010). Yet, a report compiled by the Solidarity Research Institute, indicates that only 13% of nursing students (undergraduate and diploma programmes) graduate. Even though the Solidarity Research Institute mentions that a certain amount of attrition in tertiary institutions is expected, it raises the question as to why students in South Africa leave the profession in such numbers (Solidarity Research Institute 2009: 12). Internationally, nursing shortages have often been ascribed to high nurse turnover resulting from intra-professional violence and for the past two decades, nursing scholars have researched intra-professional violence in nursing against the background of oppressed group behaviour. The results of these studies do not show any statistics that pertain to South Africa. Therefore it would be appropriate to determine whether oppressed group behaviour and intra-professional violence are experienced by undergraduate nursing students in South Africa.

Nurse managers, nurse educators and undergraduate nursing students may develop awareness of oppressed group characteristics and their tendency to result in intra-professional violence. In terms of management, an awareness of the extent and effects of intra-professional violence will enable nurse managers and nurse educators to address the issue within the clinical learning environment. In addition, coping mechanisms can be developed to address and attempt to prevent intra-professional violence from occurring. Moreover, research could be initiated to determine personal attributes that contribute to and/or inhibit intra-professional violence.

The findings from this study will be disseminated to the nursing community by means of the published dissertation and related articles presenting the results. In addition, the NEI that participated in the study will receive a report with regard to the research findings. Findings will also be presented at conferences nationally and internationally.



## CHAPTER 1

### **1.8 SCOPE AND LIMITATIONS**

The scope of this study is only applicable to undergraduate nursing students in South Africa. Therefore, it is not representative of other nursing groups or of circumstances in other countries. As the study relates only to the nursing profession, violence perpetrated by or experienced by other health care professionals will not be included.

The clinical learning environment referred to in this study includes facilities utilised for the placement of undergraduate nursing students for medical-surgical, community, psychiatric and midwifery development. Samples will not be stratified for this purpose nor will the investigation explore in which specialisation field intra-professional violence is most prevalent. This could be examined in a future study.

As the theory of oppressed group behaviour is used as background for the Transactional Model for Stress and Coping, the study results may provide more information with regard to negative coping efforts and outcomes. Future studies could assess both the positive and negative coping efforts initiated by undergraduate nursing students.

Measures to minimise error will be implemented, but since respondents will be required to complete a self-report questionnaire, the assumption will be made that respondents will answer truthfully.





## CHAPTER 1

### **1.9 LAYOUT OF THE STUDY**

The layout of this study will be as follows:

Chapter 1 presents the outline and introduction to the research as well as a brief introduction of the research design and methods that were used in this study.

Chapter 2 covers the literature review regarding intra-professional violence globally, based on the model used in the study.

Chapter 3 describes the research method in detail.

Chapter 4 contains the findings of the research and the literature control applicable to the findings.

Chapter 5 contains the conclusions, recommendations and limitations of the research.

### **1.10 CONCLUSION**

Intra-professional violence is a reality for undergraduate nursing students, who are exposed to this type of violence in the clinical environment. Consequently, exposure to violence may have detrimental effects for students, patients and the profession. In South Africa, intra-professional violence and contributing factors still need further investigation. Thus chapter 2 will elaborate on violence, its presence in the workplace and its effects on the nursing profession.



## CHAPTER 2

# CHAPTER 2

## LITERATURE REVIEW

### 2.1 INTRODUCTION

A comprehensive review of the literature was conducted to obtain in-depth knowledge on the origins of intra-professional violence. The review provided a theory base on which the research could be built and provided the researcher with the opportunity to ascertain the specific knowledge gaps and research process that could be used to contribute to the existing body of knowledge in the South African context.

### 2.2 VIOLENCE

Violence has become such a part of our daily lives that it is hard to imagine a time without it. DeMeo (2005: 423) describes an exhibition in the Natural History Museum, Vienna, in which war-like weapons were presented from 4000 BC. Interestingly, this part of the exhibition was called "Civilization begins". Just to demonstrate how violent human beings became, Pinker (2007: [1]) provides a description of cat-burning which served as entertainment during the 16th century. Pinker (2007: [1]) is of the opinion that acts such as torture for entertainment or otherwise and homicide are less common currently. This author proposes that "we are getting kinder and gentler" and therefore that violence is declining. Roche *et al.* (2010: 14) contradict this statement by pointing out that insolence in service negotiations, and bullying in primary schools and on the internet signify a continuation of violence and a decline in civility.

North, Wallis and Weingast (2009:13) are of opinion that violence can only be "contained and managed", not eliminated. Since violence is ignorant of age, gender, race, social status, state borders, religions and occupations it is a



## CHAPTER 2

problem that every society faces. The International Council of Nurses (ICN) (2009) appropriately refers to violence as a global epidemic.

All of these authors are, however, in agreement that violence is a reality, which is part of everyone's lives. It manifests itself in different forms and is a threat to civility.

In defining violence it is clear that individuals' experience and act out violence uniquely in terms of their perspective of violence itself.

### **2.2.1 Definition**

Various authors refer to violence as a huge and diverse topic that could make delineation of the concept difficult (North *et al.* 2009:13; Wieviorka 2009: 3). Although violence can be investigated as smaller units, Felson (2006: 7) emphasises that one should keep the bigger picture in mind, namely, violence is violence no matter where it occurs.

The *Collins South African dictionary* (2007) as well as the Merriam Webster's online dictionary, define violence as "an unjust, unwarranted or unlawful display of force, intended to injure or overawe ..." Reiss and Roth (1993) describe violence as "behaviour by persons against persons that intentionally threatens, attempts, or actually inflicts physical harm". The authors add that "aggression" and "antisocial behaviour" are closely related and may be indicated as lesser forms of violence. Butchart *et al.* (2008: 4) give a similar description of violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation". It is clear that all these authors agree that violence is an intentional action that has a specific result in mind.



## CHAPTER 2

Rutherford *et al.* (2007: 676) indicate that the different definitions of violence affect policies and practices. Furthermore they are of opinion that “the definitions of violence depend upon their purpose”.

### 2.2.2 Theory bases

Felson (2006: 8) presents two perspectives as an explanation for the occurrence of violence (aggressive behaviour), namely rational choice and frustration-aggression.

*Rational choice* supports the view that aggressive behaviour has a purpose. Therefore, aggressive behaviour is instrumental behaviour intended to sway or persuade others to provide a reward (Felson 2006: 8). Other people’s rewards include acknowledgement, fair treatment and esteem. The aggressive behaviour may also be portrayed because some individuals are excited by risk taking. This perspective puts forward the view that aggressive behaviour is practised because individuals can force compliance, correct a perceived wrong, improve their image and amuse themselves with risky actions.

The *frustration-aggression* perspective views aggressive behaviour as a reaction to an aversive stimulus, thus not instrumental but expressive behaviour. According to Felson (2006: 8), this approach posits that retaliation, after an individual has experienced pain or frustration, satisfies an innate urge.

In both perspectives costs are evaluated and may inhibit aggressive behaviour. Costs relate to morals and penalties (Felson 2006: 8). Both perspectives will follow indirect aggression if the cost is high. However, if the cost is high and indirect aggression is not possible, the rational choice perspective sees no reason to initiate displaced aggression, whereas frustration-aggression theorists predict displacement to an innocent third party (Felson 2006: 9).

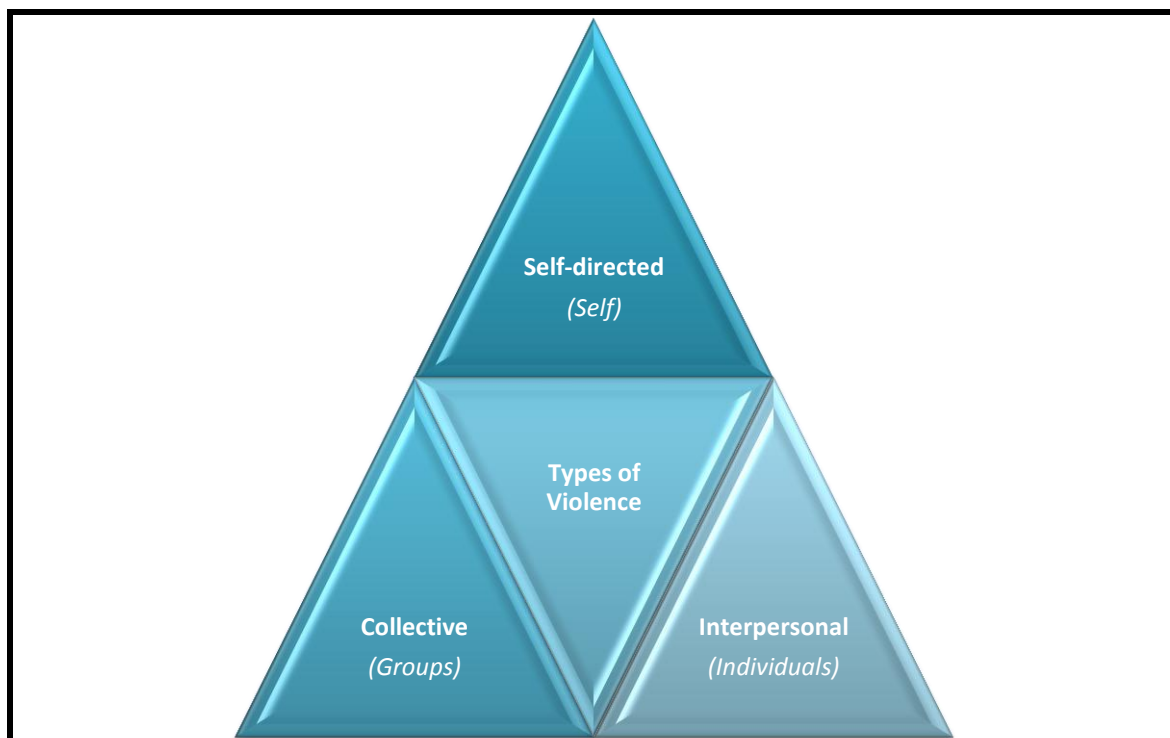


## CHAPTER 2

### 2.2.3 Types

Since many opinions exist on the types of violence, the researcher offers the description given by the WHO (WHO 1996).

The World Report on Violence and Health (Krug, *et al.* 2002: 1084) quotes the WHO (1996) to provide three categories of violence according to who the perpetrator is. The categories are self-directed, interpersonal or collective violence, as is depicted in Figure 2.1. Rutherford *et al.* (2007: 676) agree with these categories and provide further clarification of the concepts.



**Figure 2.1 Types of violence and related perpetrator**

*Self-directed* violence is described as actions intended to harm the self. This type of violence focuses on suicidal behaviour and self-abuse. The self-abuse usually relates to deeds of self-mutilation without the intention to commit suicide (Rutherford *et al.* 2007: 676). *Interpersonal violence* relates to violence between



## CHAPTER 2

relatives, intimate partners or individuals (either acquaintances or strangers). Within this category the result of the violence is not intended to benefit a group (Rutherford *et al.* 2007: 676). The third category mentioned by Rutherford *et al.* (2007: 677) is *collective violence*. This category is perpetrated by members of a group against another group and has as its aim social, political and economic gain, for example terrorism and gang warfare.

In each of the three categories the nature of violence may vary between physical, sexual, psychological and deprivation/neglect. Rutherford *et al.* (2007: 676) point out that self-directed, interpersonal and collective violence may be present simultaneously.

The WHO (2009a: [2]) offers examples of behaviours that relate to physical and psychological violence. In both instances the violence may result in physical and/or psychological harm. However, physical violence has physical force as a cause of harm and psychological violence is usually emotional abuse. Emotional abuse would include verbal abuse, bullying, harassment and threats (WHO 2009a: [3]).

In addition, Rutherford *et al.* (2007: 676) distinguish violence according to the nature of the violence by discussing sexual, gender, intimate partner, domestic, family, age-related, structural, armed and workplace violence.

Consistent with the view of North *et al.* (2009:13), it is evident that violence is a vast topic and is revealed in many dimensions. One of the dimensions that have been receiving a lot of attention in recent years is workplace violence.



## CHAPTER 2

### 2.3 WORKPLACE VIOLENCE

Hinchberger (2009: 37) expresses the concerns that workers, employers and governmental agencies are experiencing as a result of increasing workplace violence. Jacobson (2007: 26) provides an overview of studies relating to workplace violence that were conducted in the United States of America, Canada, Australia, Japan and Turkey, while Rocker (2010: [1-2]) refers to studies conducted in the United Kingdom, Canada and Australia. One is thus made aware that workplace violence is a problem worldwide.

#### 2.3.1 Definition

It is evident that there are various opinions when defining workplace violence. Schat and Kelloway (2006: 580) distinguish between workplace aggression, workplace violence and workplace psychological aggression. These concepts are defined depending on the purpose of the actions. According to Schat and Kelloway (2006: 580), workplace violence is physical behaviour like biting or kicking, with the purpose of both physical and psychological harm. Nonphysical actions, be it verbal or nonverbal, comprise workplace psychological aggression, since psychological injury is intended. Schat and Kelloway (2006: 580) are of opinion that both workplace violence and workplace psychological aggression are forms of workplace aggression which is "behaviour by an individual or individuals within or outside an organisation that is intended to physically or psychologically harm a worker or workers and occurs in a work-related context".

Griffin and O'Leary-Kelly (2004: 63-64) agree with the definition of workplace aggression provided by Schat and Kelloway (2006: 580). Along with sexual harassment and general unsafe practices, physical violence and verbal and psychological violence are referred to as "dark side behaviours that harm others" in the workplace.



## CHAPTER 2

Spector, Fox and Domagalski (2006: 30) indicate that the target of harm in the workplace may specifically be the organisation. However, although the target is the organisation, the behaviour is towards individuals. The authors refer to this as counterproductive work behaviour and include both physical violence and minor forms of aggression.

Mayhew and Chappell (2005: [1]), Rutherford *et al.* (2007: 678), and the Canada Safety Council (CSC) (2010: [1]) quote Di Martino's (2003: 5) definition of workplace violence, which has been developed for the health sector: "... incidents where employees are abused, threatened, assaulted or subject to other offensive behaviour in circumstances related to work." This definition seems to place more emphasis on physical acts of violence. A coroner's inquest, after a shooting rampage in Ottawa, recommended that psychological violence be included in definitions of workplace violence (CSC 2010: [1]). The fact that physical and psychological violence tend to overlap in practice makes efforts to classify these two types of violence difficult (Di Martino 2003: 6).

Although many definitions are available for describing and researching workplace violence, the emphasis is on the key factors that arise from the definitions, as highlighted by Schat and Kelloway (2004: 64):

- the behaviour is intentional
- the objective is to cause harm
- the behaviour is unwanted by the target
- issues arise from within the organisation

### 2.3.2 Risk factors

The WHO (2009b: [1]) states that workplace violence occurs in all work environments and worker groups. It is, however, necessary to realise that certain occupations have characteristics which make the employees more





## CHAPTER 2

vulnerable to the occurrence of workplace violence. These characteristics may be referred to as risk factors (Mayhew & Chappell 2005: [1]).

Di Martino (2003) groups risk factors as personal, interpersonal, gender, environmental, organisational and change, while Camerino *et al.* (2008: 36) only describe three, namely, individual characteristics, organisational characteristics and psychosocial characteristics. Although these authors differ in terms of categorising the risk factors, they agree on the key concepts.

Key concepts like age, level of experience, job title, negative attitude and gender are included under the individual characteristics that may contribute to increased risk for workplace violence. Camerino *et al.* (2008: 37) indicate that younger staff members, with less experience and low job titles, as well as a tendency to focus on negativity, are more prone to workplace violence. These authors are of the opinion that the role gender plays in violence is not yet clear, but Di Martino (2003: 2) and WHO (2009b: [1]) agree that females are at higher risk than males of being a victim of workplace violence. Dellasega (2009: 53), however, points out that, females are also more likely to be perpetrators of workplace violence. This difference in opinion may be attributed to the type of violence the authors refer to. Although Di Martino (2008: 2) acknowledges that non-physical violence is problematic, the author appears to focus more on physical violence, whereas Dellasega (2009: 53) refers to non-physical violence.

According to Camerino *et al.* (2008:37), organisational characteristics refer to the setting where service is rendered. In nursing, the setting will be any one of the clinical areas in hospitals, nursing homes and community care institutions. Camerino *et al* (2008:37) moreover state that all of the settings are exposed to the different types of violence.



## CHAPTER 2

The two primary risk factors put forward by Mayhew and Chappell (2005: [1]) may provide some rationale for experiences of violence in the different settings:

- personal contact with clients
- high-value goods or cash on site

Mayhew and Chappell (2005: [2]) illustrate the variation in the level of risk by comparing taxi drivers and white collar workers. Taxi drivers experience high levels of verbal abuse and the homicide rate is increased owing to the face-to-face contact with customers. White collar workers, on the other hand, have minimal contact with the public and therefore the incidence rate of workplace violence is lower (Mayhew & Chappell 2005: [2]).

Poor labour relations, group cohesion and work atmosphere and ineffective management skills affect the psychosocial structure of an organisation. When disputes are not resolved or senior staff members abuse their seniority, the risk for workplace violence escalates (Camerino *et al.* 2008: 37; The Joint Commission 2008). In addition, Longo (2010: [3]) adds that power differences and power shifts may also increase the occurrence of workplace violence in an organisation.

Di Martino (2003: 2) draws attention to the relationship between stress and violence. Stress alone does not result in a perpetrator, but stress along with individual and organisational characteristics increase the risk for workplace violence. Workplace violence, conversely, does cause stress. Dellesega (2009: 53) adds that scrutiny of nursing activities results in increased stress levels, creating an atmosphere in which violence flourishes.



## CHAPTER 2

These risk factors are part of all employment sectors, thus the possibility for workplace violence is always present. Of the occupations that have direct contact with their clients or customers, Roche *et al.* (2010: 14) names policing, teaching and nursing as specific professions where workplace violence occurs.

### 2.4 WORKPLACE VIOLENCE IN NURSING

In 2002, Anderson (2002: 351) stated, "... the majority of healthcare workers experience at least one workplace violent event during their professional lifetime". This statement supports the fact that professional health care workers are a high-risk group for workplace violence. The report compiled by Di Martino (2002) using data from Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand, revealed that 50% of health care workers had been exposed to some form of workplace violence in the previous 12 months. Mayhew and Chappell (2005: [4]) reported that 67% of health care workers in Australia experienced verbal abuse during the course of 2005. During the same year, Smetzer and Cohen (in Lamontagne 2010:54) found that 40% of the 1 565 nursing and pharmacist respondents surveyed had been subject to intimidation.

Health care workers have a high risk to be exposed to workplace violence (Hesketh *et al.* 2002: 311; Joint Commission 2008 [1]). According to statistics the nursing profession has the highest exposure of the different health care workers (Roche *et al.* 2010: 15).

In an attempt to clarify the occurrence of workplace violence in nursing, which is regarded as a caring profession, it is necessary to

- analyse the contributory role that the risk factors for workplace violence (see section 2.4.1) play in nursing
- depict the types of workplace violence that configure in nursing (see sections 2.4.2 and 2.4.3.1)



## CHAPTER 2

- indicate the extent of the types of workplace violence in nursing (see 2.4.3.2)
- describe the effects of workplace violence in nursing (see section 2.4.4)

### 2.4.1 Contribution of risk factors

Of the risk factors for workplace violence discussed in section 2.3.2, nursing bares the individual, organisational and psychosocial characteristics (Camerino *et al.* 2008: 36). Gender as an individual characteristic as it relates to nursing will be discussed in section 2.4.1.1. Age and level of experience will be discussed in relation to the undergraduate nursing student in section 2.5.2, organisational and psychological characteristics will be discussed in sections 2.4.1.2 and 2.4.1.3 respectively.

#### 2.4.1.1 Individual characteristics

Gender, as an individual characteristic, appears to be the most controversial risk factor that contributes to workplace violence in nursing. It has dual possibilities:

- Firstly, it is indicated that being of the female gender increases the risk of being a victim of workplace violence (Di Martino 2003: 2; Hinchberger 2009: 37). More specifically, female nurses are susceptible to physical violence such as sexual harassment (Di Martino 2003: 24). Both male and female nurses are victims of physical assault, but female nurses are assaulted less. Di Martino (2003: 23) and Nachreiner *et al.* (2007: 298) have also found that the perpetrators of physical harassment and assault are usually men.
- The second possibility that the female gender allows for, is that nurses are the perpetrators. Briles (2007: [1]) states that in eight studies conducted within the health care and general practice environment, females tended



## CHAPTER 2

to target females while males are indifferent to gender. Dellesega (2009: 52) agrees and labels the type of violence committed among women as relational aggression. Relational aggression is expressed through betrayal, humiliation, character defamation and exclusion. Theorists have not resolved why women engage in this type of behaviour, but Dellesega (2009: 53-54) offers the following from theorists:

- **Hormonal control of stress response** (Taylor *et al* in Dellesega 2009: 53): Where male stress responses (flight and fight) are controlled by testosterone, females respond through oxytocin, which follow a “tend-and-befriend” method.
- **Developmental origin of relation aggression** (Archer & Cote in Dellesega 2009: 53): Women prefer indirect forms of violence.
- **Internal sexism** (Chesler in Dellesega 2009: 53): Just because someone is a female, does not mean that she works well with, trusts or even likes other females.

Although theorists have not been able to resolve the exact mechanism behind the behaviour, the evidence does point toward the fact that nurses experience workplace violence as victims at times, but at times they perpetrate the behaviour on colleagues (see section 2.4.1.3).

### 2.4.1.2 Organisational characteristics

Nachreiner *et al.* (2007: 299) and Camerino *et al.* (2008: 37) include the setting where the workplace violence occurs, as well as the type of patient in the setting, when referring to organisational characteristics, for example, the

- heavily injured patient in the emergency department
- mentally impaired patient in the psychiatric department
- elderly in nursing homes



## CHAPTER 2

Notable in these three settings is the amount of direct contact with the patient when rendering nursing care.

All health care settings require direct contact with patients and their families. What makes nurses different from other health care professionals is that the nurse, in many cases, is the first contact as well as the most continuous direct contact. Nurses spend 12 hours at a time in contact with their colleagues and patients. Dewitty *et al.* (2009: 32) found that longer shifts resulted in higher levels of conflict. This, along with individual characteristics and psychosocial characteristics, creates an environment conducive to workplace violence.

### **2.4.1.3 Psychosocial characteristics**

Psychosocial characteristics that contribute to workplace violence can be summarised as poor managerial skills, poor working conditions and climate and poor communication; more specific factors include working shifts, power shifts, misuse of seniority, low organisational justice, low supervisory support and unmet expectations (Di Martino 2003: 26-28, Nachreiner *et al.* 2007: Camerino *et al.* 2008: 37). All of these are affected by power, or the lack thereof, and authority (Longo 2010: [3]). Freire's Theory of Oppressed Group Behaviour (1993: 47) points out that power differences result in subordinate and superior groups which, in turn, creates the opportunity for oppression. Freire explains that the subordinate group reveals characteristic behaviour resulting from the oppression.

Roberts (1983: 26) maintains that nursing is an oppressed group and therefore portrays oppressed group behaviour. To comprehend this statement the following aspects are considered:

- the dynamics of oppressed groups
- oppressed groups
- nursing as an oppressed group



## CHAPTER 2

**The dynamics of oppressed groups:** Oppression, as a result of being controlled by a force outside of oneself, implies a dominant and a subordinate group (Roberts 1983: 21). The dominant group distinguishes itself from the subordinate group by acting differently and establishing its norms and values as the only acceptable norms and values. Both the dominant group and the subordinate group internalise these norms and values, giving the dominant group the ability to control and exploit (Roberts 1983: 22; Freire 1993: 47).

Characteristic behaviour within the oppressed group includes self-hatred, low self-esteem, internal sexism, frustration and aggression (Roberts 1983: 22-23, Matheson & Bobay 2007: 226), as well as "... striking out at their own comrades ..." (Freire 1993: 62). According to De Marco and Roberts (2003: 113) and Martin *et al.* (2008:58), these characteristics manifest in a cyclical pattern (see Figure 1.1) which then results in individuals leaving the group or the group failing to attain its goal.

To improve their circumstances some individuals of the subordinate group try to be more like the dominant group. These individuals now belong neither to the subordinate group nor to the dominant group and are marginalised. The marginalised individuals have divided loyalties which consequently create conflict in relationships with both the superiors and the oppressed groups.

**Oppressed groups:** Blacks, Latin Americans, Jews and women have been identified as oppressed groups (Roberts 1983: 21). Women became an oppressed group as a result of earlier socialisation. Lynaugh (1980: 268) indicates that women were raised to know their place, be quiet, suppress their feelings and opinions (self-minimisation) and submit to their male counterparts who set the norm. Lynaugh (1980: 268) adds that this paternalistic viewpoint not only deemed it unnecessary but also hazardous for women to receive a college education.



## CHAPTER 2

***Nursing as an oppressed group:*** According to Matheson and Bobay (2007: 227), Roberts was one of the first nursing academics to consider oppressed group behaviour in nursing in 1983. In support of her opinion, Roberts (1983: 26) refers to findings from Twaddle and Hessler, Ehrenreich and English and Torres who pointed out that nursing lost autonomy around the 1900's when care became institutionalised. Until that time women healers were independent and physicians had no authority over nursing practice or education. Roberts (1983: 26) states that societal forces and increased control from the field of medicine have contributed to the oppression of nursing and to oppressed group behaviour within this profession. Simons (2008: E50) calls attention to the fact that nurses have been socialised into a powerless role owing to the "altruistic" nature expected from the profession.

Oppressed group behaviour includes self-hatred, low self-esteem, frustration and aggression towards the oppressor. The frustration and aggression are not voiced towards the oppressors, whom in this case may vary between physicians, nurse managers and marginalised colleagues. Consequently, the aggression is not resolved, leaving the nurse powerless and dissatisfied. The only "safe outlet" for this aggression is towards fellow nurses (Roberts 1983: 27, Martin *et al.* 2008: 58, Simons 2008: E50). Researchers have concluded that this is still a prevailing problem after twenty years of research.

### **2.4.2 Violence terminology in nursing**

Violence in nursing is a reality and statistics show that it is on the rise (Hader 2008: 13). Different terminology is used to describe and define workplace violence in nursing.

One of the first terms used to describe "intergroup conflict" was introduced by Fanon (1963: 45), as "horizontal violence". The term referred to the oppressed, who killed one another since they were not able to attack their oppressors.





## CHAPTER 2

Nurses act out horizontal violence for the same reason but in a more subtle manner (Roberts 1983: 27). Similar terms used to name this behaviour are “lateral violence” (Sheridan-Leos 2008: 399), “horizontal hostility” (Simpson 2008: [1]) and “nurse-on-nurse aggression” (Rocker 2010: [1]; Stanley 2010: [1]). Both lateral and horizontal violence entails behaviour that results in psychological injury, but which may escalate to physical harm. Stanley (2010: [1]) adds that perpetrators and victims of this type of violence are on the same power level.

Vivar (2006: 202) describes conflict that develops between individuals as a result of power differences. An example of this type of conflict is when the authority of the head nurse is challenged by a student nurse. Dewitty *et al.* (2009: 32) call this type of conflict “hierarchical violence”. Violence is not only perpetrated upward, however, as the nurse manager or senior nursing staff may also perpetrate violence downward. Thomas and Burk (2009: 227) refer to this type of violence as “vertical violence”, while Stanley (2010: [1]) indicates that researchers specifically place bullying with hierarchical violence. Lamontagne (2010: 59) also adds intimidation to this type.

Longo (2010:[1]) quotes the American Medical Association when referring to physical or verbal conduct that has, or may have harmful effects on patient care as disruptive behaviour. Longo (2010: [2]) and Capitulo (2009: 39) add refusal to answer questions, condescending remarks and retribution as examples of disruptive behaviour.

Table 2.1 provides a summary of the terminology used to name the behaviours present in workplace violence in nursing.



## CHAPTER 2

**Table 2.1 Description of workplace violence terminology applicable to nursing**

Type of violence	Description
<b>Physical</b>	Use of <u>physical force or power</u> to injure an individual (WHO 2009a: [2])
<b>Non-physical</b>	Usually <u>emotional abuse</u> . This would include verbal abuse, bullying, harassment and threats (WHO 2009a: [3]).
<b>Horizontal/lateral</b>	Usually verbal or emotional abuse; can include physical abuse. Subtle or overt. Acted out <u>between colleagues on equal power levels</u> . Also called horizontal hostility nurse-on-nurse aggression (Longo & Sherman 2007: 35; Stanley 2010: [1])
<b>Vertical</b>	Conflict between individuals on <u>different power levels</u> . Portrayed by <u>superior towards subordinate</u> (Thomas & Burk 2009: 227).
<b>Hierarchical</b>	Conflict between individuals on <u>different power levels</u> . Usually subordinate challenges superior (Vivar 2006: 202; Dewitty et al. 2009: 32)
<b>Disruptive behaviour</b>	Overt or covert, verbal or physical conduct that affects patient care (Longo 2010:[2])
<b>Intimidation</b>	"Unjust verbal statements by someone in authority that result in disturbing and stressful consequences in the recipient ..." <u>To indicate ability/authority to complicate circumstances</u> for another if compliance is not achieved. Considered an <u>individual event</u> (Lamontagne 2010: 59; Walrath, Dang & Nyberg 2010: 108).
<b>Bullying</b>	Relentless salvo of behaviours aimed at harming the target. Escalates <u>over time</u> . Includes: harassment, torment, ignorance, sabotage, insults, ganging up & humiliation (Hutchinson et al. 2008: 21). Learned behaviour (Lewis 2006: 52). Power differential exists (Stanley 2010: [1])
<b>Mobbing</b>	"Where the bully engages others to participate in the bullying (willingly or unwillingly)" (Ramsey, Foley & Dakin 2007: 14). This <u>group</u> "gangs up" and portrays behaviour that force an individual to leave the work group (Stanley 2010: [1]).



## CHAPTER 2

Thomas and Burk (2009: 227), Vessey *et al.* (2009: 300) and Lamontagne (2010: 62) indicate that conceptual confusion exists and overlapping occurs where terminology is concerned and this hinders comparisons.

A term that might be used and is all-encompassing of violence within the nursing profession is “intra-professional violence”. Lewis’ (2006: 53) describes intra-professional violence as conflict between nurses, without any mention of hierarchical differences. Thus, “intra-professional” relates to all the members of the profession and “violence” to all behaviour that causes injury, such as intimidation, bullying, mobbing, and horizontal and lateral violence.

### **2.4.3 Extent of workplace violence**

Workplace violence in nursing can be attributed to the fact that the nursing profession entails face-to-face contact with patients and their families (Anderson 2002: 351; Rowe & Sherlock 2005: 242; Roche *et al.* 2010: 14), it is a female dominant occupation (Bartholomew in Johnston *et al* 2009:287) and the presence of oppressed group behaviour (Rowe & Sherlock 2005: 243; Sheridan-Leos 2008: 399; Roberts *et al* 2009: 289). The vastness of violence is again emphasised when you look at the amount of research it has generated, as well as the various topics that attempt to pin it down. Before the occurrence of workplace violence in nursing is described, it is necessary to define the different terms that relate to it.

#### **2.4.3.1 Physical versus non-physical violence**

The root cause of workplace violence is violence. Violence has been shown to include physical and non-physical (psychological) behaviour that causes direct or indirect physical or psychological harm. Researchers have found that nurses tend to engage in non-physical disruptive behaviour to act out frustration and



## CHAPTER 2

aggression (Stanley *et al.* 2007: 1248; Dellasega 2009: 53). Psychological aggression in nursing include swearing, yelling, spreading rumours, public ridicule, bullying, mobbing, emotional abuse, undermining, scapegoating, backstabbing and intimidation (Griffin 2004: 257; Schat & Kelloway 2006: 581; Spector *et al.* 2006: 30; Dellasega 2009: 52; Lamontagne 2010: 55).

### 2.4.3.2 Prevalence of intra-professional violence in nursing

Hader (2008: 13) reports that in a survey conducted in 2008 it was found that 80% of nurse leaders had been exposed to workplace violence. Of the 1 377 respondents, 92.8% were female. According to the report, the perpetrators included patients (53.2%), although 51.9% of cases the perpetrators were nursing colleagues, nursing directors, nursing managers and nursing supervisors. Verbal abuse was most common, with intimidation, angry outbursts and hypersensitivity to criticism rating highest (Hader 2008:16). In the study carried out by Rowe and Sherlock (2005: 245), they reported that 96.4% of the 213 respondents were verbally abused. These respondents indicate that fellow nurses were the most common perpetrator.

In an online survey performed by the Center for American Nurses, 53% of the 858 nursing respondents indicated that conflict was common in the workplace. Lateral and hierarchical conflict were most common, thus conflict between nurses occurred most frequently (Dewitty *et al.* 2009: 32). In South Carolina, Jacobs and Kyzer (2010: [1]) found that 85% of nurses in the Upstate have experienced lateral violence. The most common forms were nonverbal insinuations and backstabbing. The authors also found that, generally, novice nurses are the victims and the experienced nurses are the perpetrators. Stanley *et al.* (2007: 1254) found that 46% of 663 nursing staff members, practising at a medical centre in the southeast of South Carolina, experienced lateral violence as "very serious".



## CHAPTER 2

To assess workplace bullying of nurses in Turkey, in 2007, Yilidirim conducted a study in one of the teaching hospitals situated in Ankara. Of the 286 respondents, 21% had been exposed to bullying (Yilidirim 2009: 507). The most common bullying behaviour was attacks on professional status and administrators were found to be the most common perpetrators. In comparison, Kisa (2008: 204) found that, of the 339 respondents in a descriptive study at the same hospital, 269 (79.4%) had been victims of verbal abuse. Perpetrators were identified as patients' relatives, patients, physicians, co-workers and head nurses in that order.

In an electronic survey conducted across the United States of America (USA), Vessey *et al.* (2009: 299) found that 70% of the 303 respondents experienced bullying in the workplace. The authors reported that the bullying took place within the first five years or less in practice and the most likely perpetrators were nursing colleagues: senior nurses (24%), charge nurses (17%) and nurse managers (14%).

Although the 413 respondents that participated in a study conducted in Poland were divided into two groups, psychiatric and non-psychiatric nurses, the findings with regard to verbal abuse were similar. Both groups indicated that two-thirds had experienced "... verbal aggression from their superior ...". However, 50.8% of the non-psychiatric group had experienced aggression from their peers, where as the psychiatric group had experienced only 37.8% (Merecz *et al.* 2006: 445).

Roche *et al.* (2010:17) report on findings from two studies conducted in Australia in 2007 and 2009. A total of 2 487 nurses responded and of these 65% perceived emotional abuse. Although patients and their families were indicated as the main perpetrators, a fifth was reported to be co-workers. The authors point out that the incidence in this study shows an increase when compared to the studies conducted in 2001 and 2004 that Hegney *et al.* (2006) reported on.



## CHAPTER 2

In South Africa, Khalil (2009: 207) investigated “levels of violence among nurses in Cape Town public hospitals.” The author reported on various aspects relating to violence:

- Is violence present among nurses?
- Which type was most prevalent?
- Who are the perpetrators?

The research findings concluded that, of 471 respondents, 54% indicated that violence did occur among nurses, while psychological violence at 45% was the most common type and professional nurses and nursing managers were the most likely perpetrators (Khalil 2009: 211).

Table 2.2 provides a summary of some of the research findings with regard to workplace violence among nurses. Based on the findings, it is clear that this is still a prevalent problem with harmful effects for individuals, groups and institutions in the nursing profession.



CHAPTER 2

**Table 2.2 Summary of research studies with regard to intra-professional violence among nurses (2005-2010)**

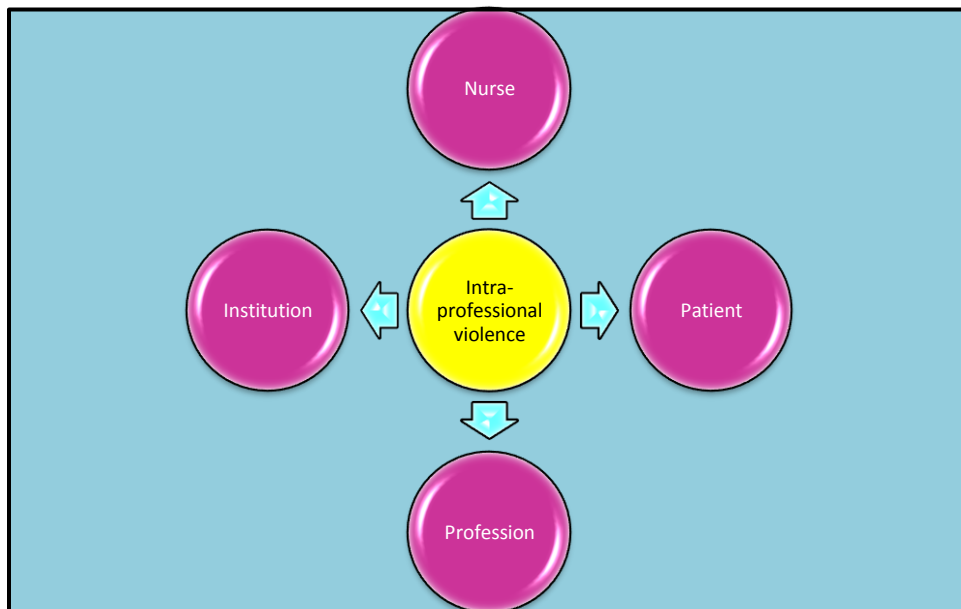
Year	Country	Respondents	Type of violence	Findings	Author
2005	United States of America	213	Verbal abuse	75%	Rowe & Sherlock (2005: 245)
2005	United States of America	633	Lateral violence	46% "very serious"	Stanley <i>et al.</i> (2007: 1254)
2006	Poland	413	Verbal aggression	66.7%	Merecz <i>et al.</i> (2006:445)
2007 & 2009	Australia	2 487	Emotional abuse	65%	Roche <i>et al.</i> (2010: 17)
2007	Turkey	286	Bullying	21%	Yilidirim (2009: 504)
2008	Turkey	339	Verbal abuse	79.4%	Kisa (2008: 204)
2008	USA & 17 Other countries	1 377	Workplace violence	80%	Hader (2008: 13)
2009	Republic of South Africa	471	"Among nurses"	54%	Khalil (2009: 210)
		213	Psychological	45%	
		396	Vertical	33%	
2009	United States of America	858	Lateral and hierarchical conflict	53%	Dewitty <i>et al.</i> (2009: 32)
2009	United States of America	27	Backstabbing	85%	Dellasega (2009: 52)
2009	United States of America	303	Bullying	70% of staff RN's	Vessey <i>et al.</i> (2009:
2010	United States of America		Lateral violence	85%	Jacobs & Kyzer (2010:[1])



## CHAPTER 2

### 2.4.4 Effects of intra-professional violence

Huston (2006: 232) states, “[v]iolence is not so much the act itself”, but rather the “outcome of a harmful experience”. The author further indicates that the harmful outcome may be to a person, or to a third party. Thus intra-professional violence in nursing affects the nurse, patient, profession or organisation (see Figure 2.2).



**Figure 2.2 Factors affected by intra-professional violence in nursing  
(Adopted from Huston 2006: 232)**

The Joint Commission Sentinel Event Alert (2008) has stated that the safety of patients depends on teamwork, communication and a collaborative environment. However, intra-professional violence has been found to break down communication between members of the health team. This results in medical errors, decrease in patient safety and care, increased cost in care, and patient dissatisfaction (Sheridan-Leos 2008: 401). According to open comments made in the study





## CHAPTER 2

conducted by Rosenstein and O'Daniel (2008: 467), it is not only errors that occur, but also "slow response times".

Harmful outcomes for the profession and organisation include staff shortages resulting from resignations, a decrease in quality of care and financial losses related to high staff turnover, recruitment and training costs, and absenteeism (Woelfle & McCaffrey 2007: 124; Rosenstein & O'Daniel 2008: 464; Rucker 2010: [1]). Nursing shortages are being mentioned globally (Canada, USA, UK, Australia and South Africa) and research has shown that attrition resulting from intra-professional violence compounds the problem (Duchscher & Myrick 2008: 191; Simons 2008: E48; Sheridan-Leos 2009: 400; Solidarity Research Institute 2009: 2). Recruiting staff becomes difficult if the unit or institution has a reputation of tolerating intra-professional violence (Sheridan-Leos 2009: 401).

Nurses experience physical, psychological and professional effects as a result of intra-professional violence. According to Vessey *et al.* (2009: 301), clinical manifestations present owing to the stress experienced during intra-professional violence. These clinical manifestations vary depending on the individual's coping mechanisms, which may include withdrawal, avoidance and so forth. Some of the physical and psychological manifestations are summarised in Table 2.3



## CHAPTER 2

**Table 2.3 Physical and psychological manifestations of intra-professional violence**

Physical effects	Psychological effects
Headaches	Panic attacks
Disturbed sleeping patterns	Anxiety
Hypertension	Depression
Cardiac palpitations	Tearfulness
Anorexia	Mood swings
Gastrointestinal upset	Decreased self-confidence
Weight gain/loss	Irritability
Decreased libido	Increased use of tobacco, alcohol or other substances
Suicide	Disconnected from other staff

(Adapted from Longo & Sherman 2007: 37; Sheridan-Leos 2008: 400; Vessey *et al.* 2009: 301; Yilidirim 2009: 508)

Vessey *et al.* (2009: 301) point out that the physical and psychological disturbance affects the individual's "professional mastery." Yilidirim (2009: 508) found that job motivation, energy levels and commitment declined in an environment filled with hostility. Levett-Jones and Lathlean (2009: 2874) conclude that hostility undermines belonging and therefore impairs cognitive development, emotional patterns and behavioural responses.



## CHAPTER 2

### 2.5 INTRA-PROFESSIONAL VIOLENCE IN NURSING

“Nursing students are the future of the nursing profession ...” (Ferns & Meerabeau 3007: 436). However, authors report that this future might not be as bright when newly registered nurses and students are leaving the profession faster than entering it (Thomas & Burk 2009: 226). Intra-professional violence has been shown to be one of the main reasons for attrition (Pellico, Brewer & Kovner 2009: 194; Lamontagne 2010: 60).

#### 2.5.1 Exposure to intra-professional violence

Although the different types of violence have all been researched over the past 20 years, Curtis *et al.* (2007: 161) state that the survey conducted by them provides the first detailed study of student nurses’ experiences of horizontal violence.

Curtis *et al.* (2007) invited second- and third-year degree students to complete five open-ended questions that related to horizontal violence. The researchers found that 57% of the respondents had experienced or observed horizontal violence (Curtis *et al.* 2007: 159). Five themes were identified from the data: “humiliation and lack of respect; powerlessness and becoming invisible; the hierarchical nature of horizontal violence; coping strategies; and future employment choices”. Ninety per cent of the respondents indicated that the experience would have an influence on their future career choices (Curtis *et al.* 2007: 161). Table 2.4 depicts the themes identified in the study conducted by Curtis *et al.* (2007: 161).



## CHAPTER 2

**Table 2.4 Themes defined and relating quotations**

Themes	Quotations
<b>Humiliation and lack of respect</b>	"... was our first clinical placement treated us nursing students with arrogance and indifference ... not allowed to use tea room ... comments like get those lazy student nurses to do something ..."
<b>Powerlessness and becoming invisible</b>	"... told to sit at a different table ... The two people I was assigned to ... completely ignored me ... did not answer my questions appropriately ..."
<b>The hierarchical nature of horizontal violence</b>	"... if you want to be an RN look after her by yourself ... you're lower than an enrolled nurse because you're a student ..."
<b>Coping strategies</b>	"You need to develop a 'thick' skin. ... everyone accepts that nursing is a tough job ... Something I never want to become."
<b>Future employment choices</b>	"Nobody has the right to stop me from doing what I want to do. Not sure I am going to stay in the profession. Somewhere [where] I feel supported."

(Adapted from Curtis *et al.* 2007: 159-1610)

In the study conducted by Longo (2007: 178,) respondents had to indicate whether they had been victims of the following behaviours that are characteristic of horizontal violence: being put down; being humiliated; being called an insulting name; having a sarcastic remark made about them, having been talked about behind their backs; being physically or verbally threatened; or being pushed or shoved. The participants in this study were described as senior baccalaureate nursing students. Of the 47 respondents, 25 (53%) indicated that they had been victims of "being put down", 19 (40%) of "being humiliated" and 15 (32%) of



## CHAPTER 2

sarcastic remarks. Seventy-two per cent of the respondents agreed with the statement “nurses eat their young” (Longo 2007: 178).

Cooper *et al.* (2009: [8]) focused on final-year nursing students seeking an associate or baccalaureate degree. The researchers found that 95.6% of students had experienced at least one act of bullying during the previous year and the most likely perpetrators were classmates. The respondents indicated that the coping mechanism used most often was to “do nothing” or secondly to “put up barriers”.

One hundred per cent of the student nurse respondents to an online survey, conducted by Hinchberger (2009: 42), indicated that they had observed or experienced violence (bullying, harassment, verbal abuse). The sample consisted of 126 student nurses registered for an online nursing course in health promotion. The most likely perpetrators were staff members and the verbal abuse was the most common type of violence experienced.

Table 2.5 provides evidence of research studies conducted between 2005 and 2010 to determine the occurrence of intra-professional violence in undergraduate nursing students. It places emphasis on the internal conflict within nursing, the impact on the profession as well as the need to focus on intra-professional violence in undergraduate nursing on a global level.



## CHAPTER 2

**Table 2.5 Occurrence of intra-professional violence in undergraduate nursing students**

Type of violence	Country	Occurrence	Other information of importance	Author
Horizontal	Australia	57%	The violence would impact on career choices	Curtis <i>et al.</i> 2007
“Being put down”	USA	53%	“Nurses eat their young”	Longo 2007
Bullying	USA	95.6%	Class mates most likely perpetrators.	Cooper <i>et al.</i> 2009
Bullying Harassment Verbal abuse	USA	100%	Most likely perpetrators were fellow staff members.	Hinchberger 2009

Undergraduate nursing students are experiencing intra-professional violence. The perpetrators include staff members and even fellow undergraduate nursing colleagues. These experiences affect the choices the undergraduate nursing students will make in terms of continuing in the nursing profession.

To elaborate on the descriptive statistics in Table 2.5, findings from a study conducted by Thomas and Burk (2009) between 2004 and 2007 are provided. In this study the researchers requested junior nursing students in a Bachelor of Science programme to write narratives relating to situations in which the students experienced anger either within the class setting or in the clinical setting. Two hundred and twenty one (221) narratives were included in the final analysis. Two themes dominated the stories, namely unjust treatment of students and violation of patient rights (Thomas & Burk 2009: 228). The researchers focused mainly on the



## CHAPTER 2

student experiences and found that the usual perpetrators were hospital staff nurses. The severity of the events were conceptualised as depicted in Table 2.6.

**Table 2.6 Severity of intra-professional violence**

Level	Type of incident
1	"We were unwanted and ignored"
2	"Our assessments were distrusted and disbelieved"
3	"We were unfairly blamed"
4	"I was publicly humiliated"

(Adapted from Thomas & Burk 2009: 228-230)

### 2.5.2 A vulnerable population

Undergraduate nursing students entering into the clinical learning environment are vulnerable to intra-professional violence. These students not only possess many of the characteristics mentioned as risk factors for workplace violence (see section 2.3.2), but, as the authors point out, also other factors that compound their susceptibility to intra-professional violence. It is important to keep in mind that the undergraduate nursing students may not only be the victim, but also the perpetrator, of violence.

Vallant and Neville (2006: [1]) highlight the fact that owing to undergraduate nursing students' learning needs, they are dependent of clinicians. The clinicians are required to facilitate the undergraduate nursing students' learning, which not only entails teaching and sharing knowledge and skills, but also necessitates role modelling. The clinicians' past experiences may hamper this process (Curtis *et al.* 2007: 157; Crotty 2010: 51). These authors posit that intra-professional violence had become an accepted element in the profession and therefore clinicians may act



## CHAPTER 2

it out. On the other hand, the clinicians may see it as a method to “toughen up” the students, and the undergraduate nursing students have to be submissive in order to learn the practice skills (Khalil 2009:209). According to Randle (2003: 396), self-esteem is dependent on significant others and therefore students will conform to clinicians’ expectations to attain self-esteem.

“Uni [versity] students don’t know much about ‘real’ nursing.” Curtis *et al.* (2007: 160) mention an “us and them” mindset where exception is made with regard to where the students are receiving their training from. Crotty (2010; 52) offers the following after an informal survey was conducted: clinicians may feel insecure and intimidated by the undergraduate nursing students’ current knowledge and skills. Other authors refer to the role of the generation gap within the current nursing workforce. Kupperschmidt (2006: [2]) and Anthony (2006: [1]) describe the different worldviews of the Baby Boomers and Generation Xers. The Baby Boomers view the Generation Xers’ self-reliance as an act of arrogance and disrespect placing the two groups in direct opposition of one another.

With so many contributing factors, intra-professional violence is bound to occur, leaving the future of the profession to the response of the undergraduate nursing students.

### **2.5.3 Effects and responses**

On a personal level, the harmful outcomes of intra-professional violence in undergraduate nursing students, are humiliation, anxiety, depression, self-silencing, conforming to group behaviour and feeling excluded from the group (Levett-Jones & Lathlean 2009: 2871; Lamontagne 2010: 55). These personal outcomes affect





## CHAPTER 2

students' professional outcomes, namely the ability to gain competence and success.

Vallant and Neville (2006: [1]) and Ferns and Meerabeau (2009: 2684) show that negative experiences with clinicians impair learning. Vallant and Neville (2006: [1]) held focus groups with eleven nursing students at the end of their three-year bachelor's degree course. The key issues that arose from the interviews were: "being invisible in the relationship", "not stepping on toes", "lost opportunities for learning", "nurturance" and "reciprocity" (Vallant & Neville 2006: [3]). Longo and Sherman (2007: 36), Ferns and Meerabeau (2009: 2684), Haddy (2009: 5), Hinchberger (2009: 43) and Lamontagne (2010: 63) all agree that a vicious cycle may ensue and that some undergraduate nursing students may contemplate leaving the profession. From the study conducted by Curtis *et al.* (2007: 159) similar findings were made. However, in this study some respondents indicated that they would not allow disruptive behaviour to force them out of their chosen profession. Their intentions were not to treat their "young" as they had been treated (Curtis *et al.* 2007: 160).

To understand these diverging responses, intra-professional violence can be evaluated against the background of the Transactional Model of Stress and Coping.

The Transactional Model of Stress and Coping provides a structure according to which the process of coping with stressors or demands – in this case intra-professional violence can be evaluated (Glanz *et al.* 2002: 212). The model identifies primary and secondary appraisals as key concepts of this process; a process that initiates coping mechanisms that result in outcomes like "... psychological well-being, functional status and adherence ...". Stress occurs if the demand exceeds the coping resources of the individual (Manderino & Berkey 1997:



## CHAPTER 2

49). According to Lazarus (1976: 58), the individual's psychological state, social and cultural resources will affect this process.

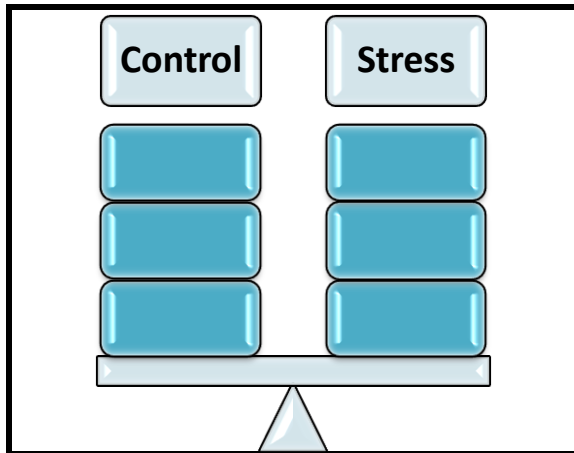
The psychological state of an undergraduate nursing student who has been placed in the clinical learning environment is described by Bond (2009: 135) as one of anxiety. In an attempt to achieve clinical skills, apply knowledge and internalise the values and norms of the profession, undergraduate nursing students look for support to clinical facilitators, nursing colleagues and educators. Hence, the promotion of good interpersonal relationships is important. However, when intra-professional violence is present relationships tend to be negative with associated negative effects (Bond 2009: 136; Levett-Jones & Lathlean 2009: 2874).

Lazarus (1976: 58) points out that social and cultural resources may be a source of support but do not necessarily "... guarantee mastery of potential harm". For example, the individual may look to a fellow undergraduate nursing student, for support, but if this is denied it may cause guilt, depression and stress or may be the source of intra-professional violence.

Glanz et al. (2002: 213) refer to primary appraisal as the judgement that individuals make with regard to the significance of the stressor. The significance will determine the impact that the stressor may have and varies between stressful, positive, controllable, challenging, benign and irrelevant. The ideal situation being that the stress is always controllable as portrayed in Figure 2.3.



## CHAPTER 2

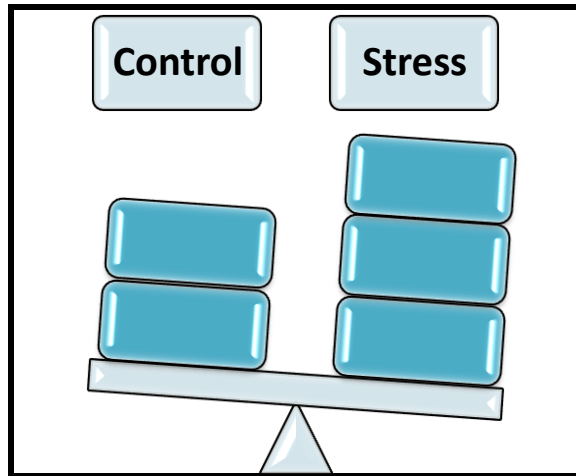


**Figure 2.3 Balance between stress and control**

Secondary appraisal relates to what individuals perceive their abilities to be in terms of changing or managing a stressor (Glanz *et al.* 2002: 216). This reflects on individuals' self-efficacy or belief in their ability to be successful in producing an intended result (*Collins South African dictionary* 2007); the intended result being the ability to control the situation. High self-efficacy results in positive outcomes and low stress and coping mechanisms that involve engaging behaviour. Glanz *et al.* (2002: 217) indicate that low self-efficacy results in disengaging strategies like behavioural distancing and denial that ultimately increase distress (see Figure 2.4).



## CHAPTER 2



**Figure 2.4 Imbalance between stress and control**

Considering that undergraduate nursing students come from an oppressed group and are the most subordinate group in the clinical learning environment, Levett-Jones and Lathlean (2009: 2874) found that intra-professional violence undermines self-efficacy. As a result, disengaging coping mechanisms are preferred, setting in motion the cycle of intra-professional violence (see Figure 1.1).

## 2.6 CONCLUSION

Research has shown that violence is a complex problem with many facets. One of the many facets includes workplace violence, which occurs among individuals in the same profession, also called intra-professional violence. Many names have been given to this disruptive behaviour but they all result in injury to colleagues.

Intra-professional violence, like nursing shortages, is a universal issue in the nursing profession. It is also clear that these are related concepts, with intra-professional violence contributing to attrition rates. Undergraduate nursing students are the solution to nursing shortages; however, in countries like the United States of America, United Kingdom, Australia and New Zealand, researchers have found



## CHAPTER 2

that experiences with intra-professional violence are limiting the number of students that complete their degrees (see Table 2.5). These findings have resulted in concerted efforts to raise awareness and improve conditions.

International studies do not show any statistics with regard to South Africa; therefore it would be appropriate to determine whether oppressed group behaviour and intra-professional violence are experienced by undergraduate nursing students in South Africa.

In chapter 3 the research methodology will be discussed, which will lead to the gathering of information pertaining to intra-professional violence that undergraduate nursing students in South Africa are exposed to in the clinical learning environment.



## CHAPTER 3

# CHAPTER 3 RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

An orientation to the theory base of intra-professional violence was offered in the literature review provided in Chapter 2. Chapter 3 will stipulate the aim and objectives of the research study where after the researcher will elaborate on the research design and the resulting methodology that include the population, sample, data collection and analysis processes. The discussion will include the aspects of validity and reliability implemented to ensure consistent and true measurements. Furthermore the ethical principles considered and adhered to will be discussed.

## 3.2 RESEARCH AIM AND OBJECTIVES

It was the aim of this study to investigate the intra-professional violence that South African undergraduate nursing students are exposed to in the clinical learning environment.

The objectives of this study were to

- determine the presence of oppressed group characteristics in South African undergraduate nursing students
- assess intra-professional violence that South African undergraduate nursing students' are exposed to in the clinical learning environment
- determine South African undergraduate nursing students' primary appraisal of intra-professional violence
- evaluate coping responses that South African undergraduate nursing students implement when confronted with intra-professional violence in the clinical learning environment.



## CHAPTER 3

### 3.3 RESEARCH DESIGN

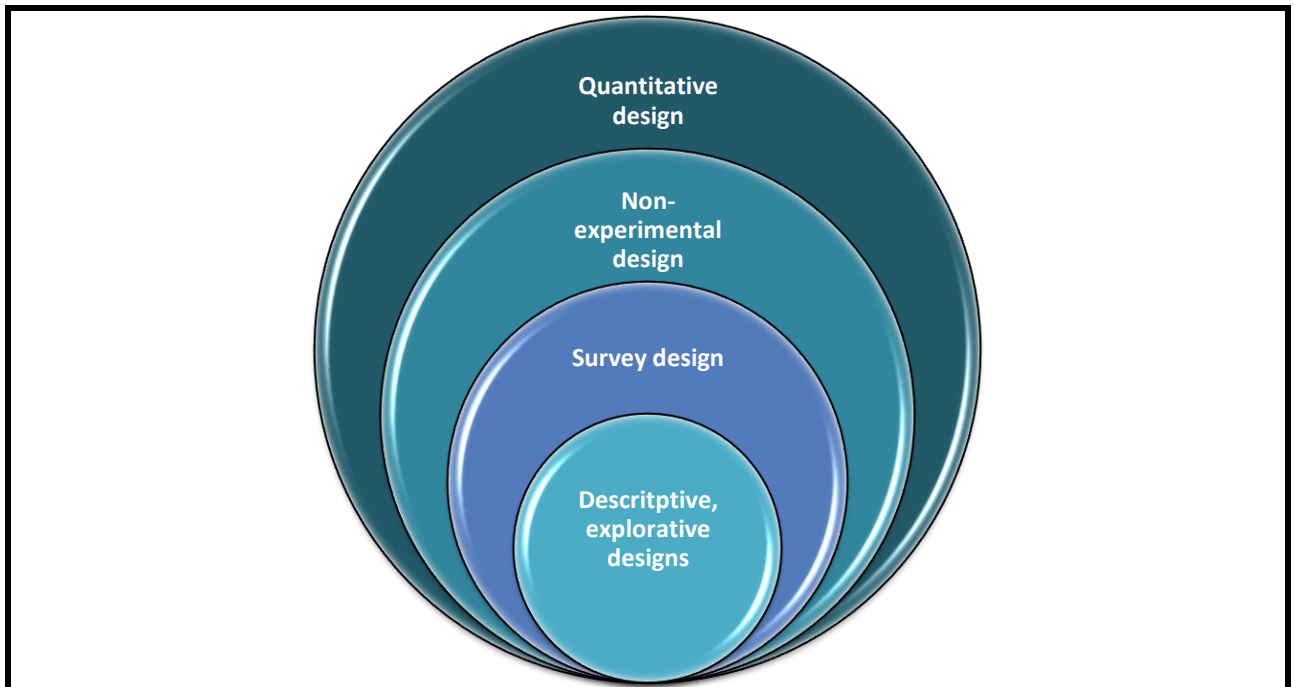
Although the research paradigm provides the philosophical framework of a study, it is the research design that supplies the process plan (Brink 2006: 92; LoBiondo-Wood & Haber 2006: 562). The methodological decisions are then made according to this design, which organises the study into orderly steps and contributes to the integrity and the ability of the research to generalise findings (Brink 2006: 92; LoBiondo-Wood & Haber 2006: 202; Polit & Beck 2010: 74).

Researchers are of the opinion that a choice should be made between a quantitative, qualitative or mixed design (Creswell & Plano Clark 2007: 1). According to Burns and Grove (2009: 33), quantitative research aims to produce knowledge, be it for application in practice or to test a theory. Qualitative research focuses more on understanding the significance of experiences (Burns & Grove 2009: 51), while Creswell and Plano Clark (2007:5) describe mixed methods as a combination of quantitative and qualitative research designs used to answer the same research question.

Figure 3.1 summarises the components of the quantitative research design that was applied to this study. Each component of the research design summarised in Figure 3.1 will be discussed in sections 3.2.1, 3.2.2, 3.2.3 and 3.2.4.



## CHAPTER 3



**Figure 3.1 Components of the quantitative research design applied in this study**  
(Adapted from Lobiondo-Wood & Haber 2006: 239 and Polit & Beck 2010: 223)

### 3.3.1 Quantitative design

Since the philosophical background for this study was positivism, the principles of quantitative design were applied in an attempt to generate more knowledge about intra-professional violence in South Africa. According to LoBiondo-Wood and Haber (2006: 202) a quantitative design enables either hypothesis testing or provides answers to research questions. Accordingly, for the purpose of this study, numerical information was produced to answer the research questions. Table 3.1 depicts the way in which the quantitative design was applied in terms of the positivist paradigm (Polit, & Beck 2010: 16-17).





### CHAPTER 3

**Table 3.1 The quantitative design applied**

Positivist paradigm demands	Quantitative design complies	Application
<b>Systematic procedure</b>	Follows deductive reasoning to identify hypothesis Identifies and defines concepts Tests hypothesis	Deductions made from Theory of Oppressed Group Behaviour and the Transactional Model of Stress and Coping. Concepts will be defined.
<b>Control</b>	Institutes mechanisms to increase validity	Partial control with regard to setting in which data will be collected. Researcher not present during data collection.
<b>Scientific knowledge obtained through measured, quantitative information; statistical analysis</b>	Uses formal measurement tools, thus numeric data analysed using statistical methods.	Questionnaires will be used to collect data, resulting in quantitative data. Statistical analysis will be performed
<b>Generalise findings</b>	Aim to generalise findings	Findings will be generalised to undergraduate nursing students in South Africa

**(Adapted from Polit & Beck 2010: 16-17)**

Polit and Beck (2010: 225) indicate that a quantitative design can be divided into three design types, namely, experimental, quasi-experimental or non-experimental, depending on whether experimental interventions are implemented during the study. Brink (2006: 103) and LoBiondo-Wood and Haber (2006: 240) also indicate that the method of data collection and the purpose for collecting the data play a role in the choice of design. Polit and Beck (2010: 222) call these aspects “design features”. Brink (2006: 103), LoBiondo-Wood and Haber (2006: 240) and Polit and Beck (2010: 222) pose questions with regard to design features; these assisted the researcher in selecting the quantitative design that would be applied in this study. The questions, together with the researcher’s decisions, are summarised in Table 3.2.



CHAPTER 3

**Table 3.2 Researcher’s decision about the design features**

Questions about the design features	Researcher’s decision	Resulting design
Will there be an intervention?	No interventions will be introduced	<b>Non-experimental</b>
How will confounding variables be controlled?	Standardised communication to respondents; homogeneity; statistical control	
Where will the study take place?	Natural setting	
How will the data be gathered?	Questionnaires	<b>Survey</b>
What types of comparison will be made?”	Both within-subject and between-subject comparisons	<b>Descriptive and explorative</b>
What is the purpose of examining the variables?	Describe and explore	

*(Adapted from Brink 2006: 103; LoBiondo-Wood & Haber 2006: 2396; Polit & Beck 2010: 223)*

### 3.3.2 Non-experimental design

Since variables were not manipulated and respondents were not randomly allocated to a control or experimental group (randomisation), this study followed a non-experimental design (Polit & Beck 2010:226). The information was



## CHAPTER 3

gathered for the purpose of knowledge generation and to explore relationships or variations among variables; however, causal relationships were not explored (LoBiondo-Wood & Hader 2006: 239).

### **3.3.3 Survey design**

Polit and Beck (2006: 285) emphasise that surveys are research that relates to the purpose of a study rather than to the design. Accordingly, the purpose of this research was then to acquire information about actions, knowledge, intentions, opinions and attitudes. LoBiondo-Wood and Haber (2006: 239) describe survey studies as the broadest category of non-experimental designs and divide survey studies into descriptive, explorative and comparative designs. Data are obtained either by means of questionnaires or interviews.

The data in this study were obtained through the use of questionnaires and pertained to undergraduate nursing students' behaviours, beliefs and attitudes. The data were collected in order to explore and describe current occurrences in the clinical learning environment and to improve nursing education practices.

### **3.3.4 Descriptive and explorative design**

In line with the descriptive and explorative nature of survey studies, this study yielded information pertaining to the characteristics of undergraduate nursing students, as well as to intra-professional violence in the clinical learning environment (LoBiondo-Wood & Haber 2006: 240). Moreover, using this type of design, a large amount of information could be gathered in a relatively cost-effective manner.



## CHAPTER 3

### 3.4 RESEARCH METHODOLOGY

Polit and Beck (2006:223) state that research methodology refers to the techniques used in the course of the research investigation to structure a study and gather and analyse the data. The process consists of a set of orderly, disciplined procedures designed to acquire information. This set of procedures included defining the population characteristics, determining sample size and allocation, and planning data collection and data analysis (Struwig & Stead 2001: 51-52; Hofstee 2006: 112; Polit & Beck 2010: 75).

#### 3.4.1 Population

“Population” is defined as all the individuals that comply with the inclusion criteria set by the researcher (Brink 2006: 123; Burns & Grove 2009:42; Polit & Beck 2010:306-307). However, these authors point out that it is uncommon for a researcher to have access to the entire population; therefore, a distinction is made between a target population and a study population (or accessible population). A target population refers to the entire group of people that are of interest to the researcher, whereas a study population is the actual group of people that the researcher can approach (Brink 2006: 123; Polit & Beck 2010: 307).

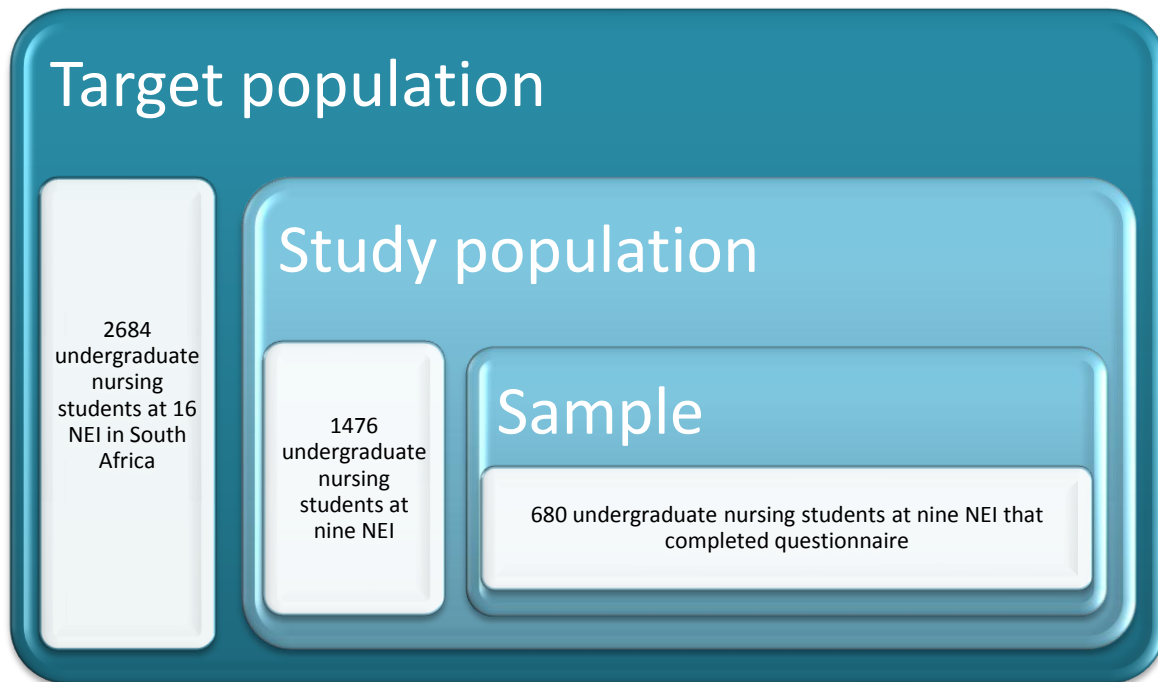
The target population in this study consisted of all the undergraduate nursing students registered for a four-year nursing degree programme at a nursing education institution (NEI) in South Africa. The study population (see Table 4.2) was composed of undergraduate nursing students who were registered at an NEI that had given the researcher permission to access its students. Furthermore, the study population at this NEI met the following inclusion criteria:

- registered full time at a NEI in South Africa
- registered for the four-year degree programme
- had at least six months exposure to the clinical learning environments



## CHAPTER 3

Figure 3.2 gives a representation of the relationship between the target population, the study population and the sample as applicable to this study.



**Figure 3.2 Target population, study population and sample**

### 3.4.2 Sample

Brink (2006: 123), Burns and Grove (2009:42), and Polit and Beck (2010:306-307) agree that a sample is a smaller component of the population (see Figure 3.2) and sampling represents the process of selecting a sample. A key requirement of both the positivist paradigm and quantitative research is that the findings should be generalised to the population; therefore the sample has to be representative of the population (Polit & Beck 2010: 307). Sampling has to be conducted in such a manner to ensure that most of the population's characteristics are present in the sample. Sampling can be conducted using probability or non-probability designs.



## CHAPTER 3

According to Polit and Beck (2010: 312), non-probability designs do not follow random selection and a population is poorly represented with samples of this kind. Probability sampling, on the other hand, increases the representativeness of a sample. Various methods are available for each of these designs and such methods are referred to as the sampling plan. The sampling plan for this study will be discussed in section 3.3.3.

### 3.4.3 Sampling plan

A non-probability sample design was implemented in this study. Accordingly, the sampling methods available to the researcher in terms of this design included convenience sampling, quota sampling, consecutive sampling and purposive sampling (Polit & Beck 2010: 309-312). Convenience sampling was the method chosen for this study, owing to the constraints placed on the study in terms of time and resources. Convenience sampling entails the use of readily available subjects, which, in this study, were the undergraduate nursing students attending lectures on the day scheduled for data collection. The researcher was very aware of the limitations of this sampling method and to ensure that the sample, was as representative as possible, two more criteria were added to the initial inclusion criteria (see section 3.3.1), namely that respondents were to be from both gender groups as well as from each academic year of study.

The two additional criteria were included for the following reasons:

- Although nursing is a predominantly female profession, there are male students in the population. In applying the Theory of Oppressed Group Behaviour, male students will form part of the subordinate group owing to the previously mentioned characteristics of nursing students which place them in an oppressed group. The study by Curtis *et al.* (2007:159) found in the narratives of respondents that intra-professional violence ignores gender. Therefore, the gender stratum ensured that the findings would



## CHAPTER 3

represent the experiences of all undergraduate students, male and female alike.

- Undergraduate nursing students in the target population are either in their first, second, third or fourth year of academic study. The academic year of study stratum was thus included to provide for this.

### 3.4.4 Data collection

“Data collection” refers to the method or technique used to gather the information as it applies to the research variables (LoBiondo-Wood & Haber 2006: 318). Of the three main data collection methods, namely, self-report, observation and biophysiological measures, Polit and Beck (2010: 339) indicate that self-reports are most commonly used in both quantitative and qualitative research.

Within the survey research design, structured self-report data are gathered either verbally through interviewing, or otherwise through formal, written instruments called questionnaires (Polit & Beck 2010: 343). Questionnaires were used in this study, owing to time and personnel constraints, as well as to limit bias as far as possible.

#### 3.4.4.1 Advantages and disadvantages

Questionnaires provide written responses and although the information might have less depth, they do allow for larger samples and consistency during collection. Well-structured questions and response sets yield information on person or subject facts, situational facts, level of knowledge, and the impressions and intentions of the subject (Burns & Grove 2009: 406).



## CHAPTER 3

Questionnaires enable data to be collected from larger samples (that increase representativeness), save time and money, provide numerical data and make analysis easier (LoBiondo-Wood & Haber 2006: 325; Burns & Grove 2009: 406; Polit & Beck 2010: 345).

Brink (2006: 147) and Ferns and Meerabeau (2009: 2683) indicate that questionnaires may be disadvantageous because of the costs involved in mailing, the generally low response rates and incomplete questionnaires. The researcher was aware of the disadvantages of questionnaires, but deemed the advantages to outweigh the disadvantages.

### **3.4.4.2 Data collection instrument**

During the development of the questionnaire, the researcher bore the following principles in mind to ensure a well-designed tool (De Vos 2002: 176):

- Wording of questions and responses must be brief and clear.
- Only one thought per question.
- Questions must be relevant to the purpose of the questionnaire.
- The questions should start with general questions and then move on to more sensitive or personal questions.
- Open-ended questions and close-ended questions may be used, depending on the type of information to be generated. Open-ended questions will provide an opportunity to elaborate on responses, while close-ended questions have fixed responses that range from simple (yes/no) to complex (scales). This type of question makes the completion and analysis of the questionnaire easier (LoBiondo-Wood & Haber 2006: 325; Polit & Beck 2010: 343).

For the purpose of this study, two existing questionnaires were used to develop the study questionnaire, which was intended to measure intra-professional violence in undergraduate nursing students. Firstly, the Nurses Workplace Scale





## CHAPTER 3

(NWS) (see Annexure C1), developed by DeMarco and Roberts (2004), was used to determine the presence of oppressed group behaviour. Secondly, the Bullying in Nursing Education Questionnaire (BNEQ) (see Annexure C1), developed by Cooper *et al.* (2009), was used to determine: (i) whether intra-professional violence had been experienced by the undergraduate nursing students; (ii) the type of behaviour experienced; (iii) who the perpetrators were; and (iv) what coping mechanisms were employed to handle the behaviour. The researcher obtained written permission to adapt and use the tools from the authors (see Annexure A3).

The study questionnaire (see Annexure C3) was divided into five sections:

**Section A:** Demographic information

**Section B:** Behavioural characteristics

**Section C:** Behaviours experienced

**Section D:** Significance of events

**Section E:** Coping mechanisms

**Section A** consisted of four close-ended questions to obtain demographic information relating to the NEI, academic year of study, gender and age.

**Section B** was compiled from the NWS (see Annexure C1) to measure the presence of oppressed group behaviours. This was done by using 12 statements which relate to behaviours, feelings or beliefs that apply to the clinical learning environment. In the original NWS the frequency at which these behaviours, feelings or beliefs occur was measured on a Likert scale from 1 to 5 (DeMarco & Roberts 2004: 297).

**Sections C and E** were developed from the BNEQ (see Annexure C1). According to Cooper *et al.* (2009), the BNEQ is a self-administered Likert scale questionnaire developed from an unnamed nursing student abuse questionnaire by Celik and Bayraktar (2004), and the Negative Acts Questionnaire by Einarsen, Raknes, Mattiesen and Hellesøy (1994). The BNEQ consists of 12 items that



### CHAPTER 3

relate to the sources and frequency of bullying behaviours, 11 items that determine coping responses, and five items that focus on students' perceptions with regard to the nursing school resources available to assist with coping behaviours (Cooper *et al.* 2009). For the purpose of this study, section C contained the 12 items that determine the intra-professional violence behaviours that occur as well as the sources thereof, whereas the 11 items pertaining to coping responses were used as presented in the BNEQ in section E. The five items relating to coping resources in the nursing school were omitted since coping resources are not within the scope of this study.

Table 3.3 outlines the way in which the study questionnaire was compiled by referring to the topics included and the rationale for including them.

**Table 3.3 Outline of study questionnaire**

SECTION A			
Question	Topic	Description	Rationale
1.	NEI	Appropriate box for NEI had to be ticked	To assess representation of NEI in South Africa.
2.	Academic year of study	Appropriate box had to be ticked to indicate academic year of study	Describes the academic year of study to assess representation and enable inferences with oppressed group behaviour
3.	Gender	Appropriate box had to be ticked: Male Female	Describes gender with regard to representation and presence of oppressed group behaviour
4.	Age	Age had to be filled in, in years	Describes the ages of study population to allow for comparison with literature



## CHAPTER 3

SECTION B			
Question	Topic	Description	Rationale
5.1-5.12	Behaviours, feelings or beliefs relating to oppressed group behaviour	Respondents had to indicate by choosing "yes" or "no" which one of the statements relates to them	To determine whether oppressed group behaviour is present in the study population
SECTION C			
Question	Topic	Description	Rationale
6.1-6.12	Behaviours of intra-professional violence Perpetrators of intra-professional violence	Respondents had to indicate the behaviours they have experienced as well as who the perpetrators were. More than one option could be marked	To determine: (i) whether intra-professional violence is experienced in the clinical learning environment (ii) type of behaviour experienced (iii) the perpetrators of the behaviour
SECTION D			
Question	Topic	Description	Rationale
7.1-7.2	Significance of the behaviour	Respondents had to indicate on a scale from 0-4 to what extent do they appraise the behaviour as stressful or controllable	To explore the study population's appraisal of intra-professional violence and determine whether a balance exist between stress and control.



## CHAPTER 3

SECTION E			
Question	Topic	Description	Rationale
8.1-8.12	Different coping mechanisms to manage intra-professional violence	Respondents had to indicate with either "yes" or "no" which coping mechanisms they employ to cope with intra-professional violence	Evaluate the coping mechanisms used to cope with intra-professional violence.

### 3.4.4.3 Pre-test data collection instrument

Both de Vos (2002: 177) and Polit and Beck (2010: 345) indicate that newly constructed questionnaires should be pre-tested to ensure that the correct words are used, that questions are clear and without bias, and that they follow one another sensibly.

Although most of the items that were included in the study questionnaire came from thoroughly tested questionnaires, a draft of the questionnaire was provided for peer review by colleagues of the researcher as well as by the statistician. Suggestions were made with regard to the layout of the questionnaire and the structure of some of the items.

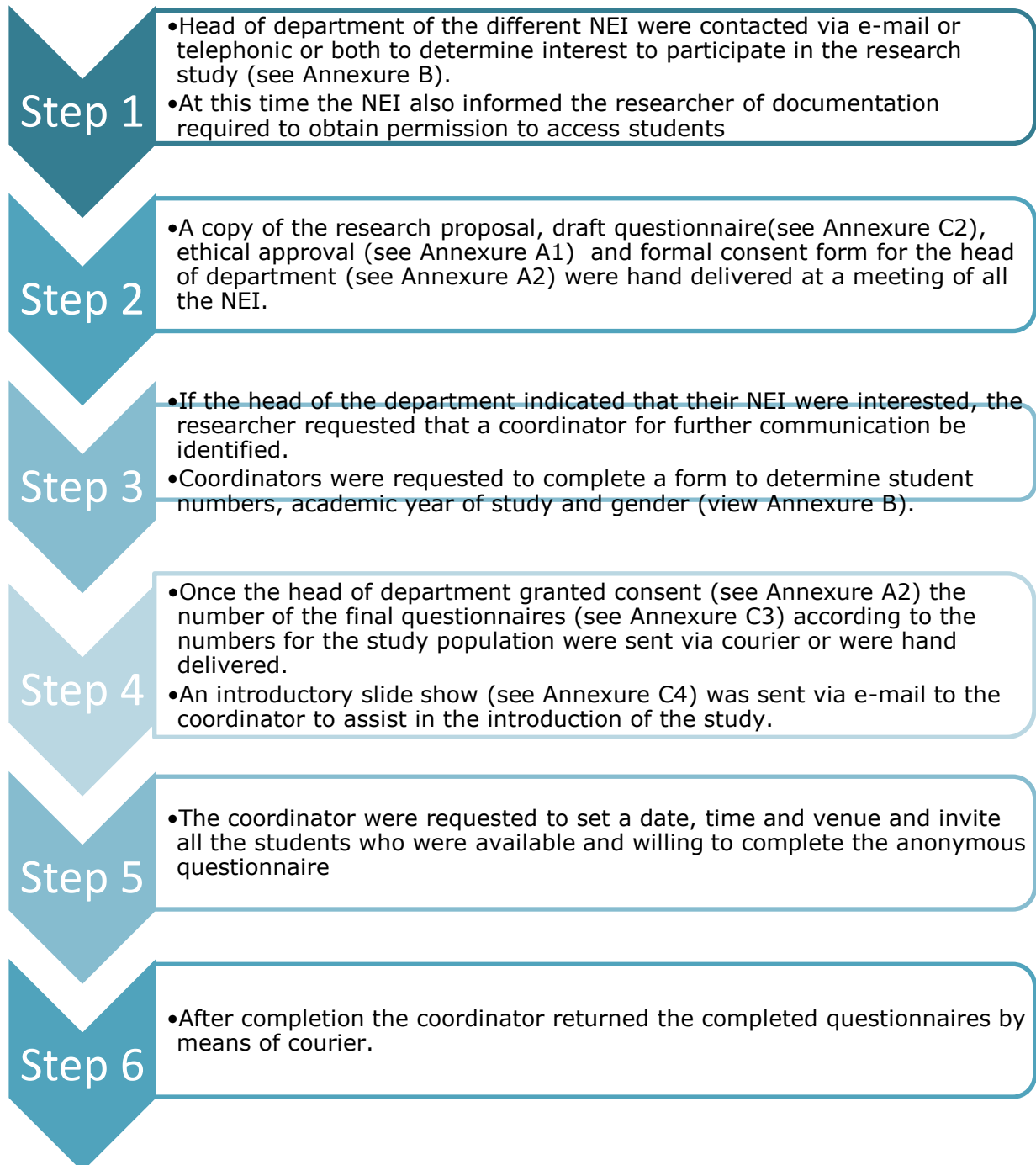
The draft questionnaire (see Annexure C2) was also given to nine students, who had completed their training in 2009 and were working at the time in the clinical learning environment. One important suggestion was to add the statement "treated differently because you are an undergraduate student". The suggestions of both peers and colleagues and the pre-test group were considered and alterations were made to the questionnaire before the data collection process was initiated using the final version of the questionnaire (see Annexure C3).



## CHAPTER 3

### 3.4.4.4 Data collection procedure

The data collection proceeded as is depicted in Figure 3.3



**Figure 3.3 Steps of data collection procedure**



### CHAPTER 3

Difficulties experienced during the data collection process and the actions taken to remedy them, are summarised in Table 4.3.

**Table 3.4 Difficulties experienced during data collection**

Difficulties experienced	Remedial action and result
No response to initial request with regard to interest in participating in the research study. This affected the sampling method (see section 5.6) and the sample size (see sections 4.2 and 4.3).	Departments were contacted by telephone but either there was no answer or else head of department did not return my call. Second and third e-mails were sent. Documents were hand delivered at a meeting of the NEI, but still some did not respond.
Some NEIs required ethical approval from their own ethics committees. Although all the required documents were submitted to these committees, some never responded.	The contact person on the ethics committees was sent a reminder, but to date no response has been received.
Documents were misplaced or lost, thus information were not communicated until very late in the research process.	Documents were re-sent, some responded in time, unfortunately others did not and had to be excluded.
The initial contact person was incorrect and the researcher was informed of this very late in the process.	As soon as the researcher was informed of this she contacted the correct person, but the response was too late for the due date.
No response from coordinator.	Researcher tried to make telephonic contact as well as via e-mail but to no avail.
Form pertaining to student numbers, academic year of study and gender incomplete.	Contacted coordinators again
Slow response from couriers	Researcher had to repeat requests for collection, but procedure was still delayed which affected the time available for analysis.



## CHAPTER 3

The researcher was able to collect data from 680 respondents. All of the respondents complied with the inclusion criteria indicated in sections 3.4.1 and 3.4.3. The data obtained and the quality of the data is discussed in sections 4.2, 4.3 and 4.4.1.

### 3.4.5 Data analysis

For research questions to be answered data has to be analysed. This means that the information has to be coordinated and translated. To assist in this process statistical techniques are incorporated (Bryman & Cramer 1994: 77; Cozby 2005: 229; LoBiondo-Wood & Haber 2006: 359; Polit & Beck 2010: 392). The type of statistical techniques implemented depends on the level of measurement of the variables. According to Polit and Beck (2010: 371), four levels of measurement exist namely, nominal, ordinal, interval and ratio. LoBiondo-Wood and Haber (2006: 359) add that the level of measurement depends on the nature of the object being measured. In this study the following levels of measurement were included which contributed to the type of descriptive statistical techniques (see Table 3.5) implemented:

- **Nominal:** Numeric values were given for a categorical purpose without mathematical meaning to identify gender and academic year of study.
- **Ordinal:** Numeric values to show rank were provided to options in items 7.1 and 7.2 in section D of the questionnaire (see Annexure C3).
- **Interval:** Variables were ranked with equal intervals for items 5.1 to 5.12 (see Annexure C3).

Inferential statistical techniques were also implemented to make deductions from findings. Table 3.5 and Table 3.6 summarise how both descriptive and inferential statistics were applied in this study.



CHAPTER 3

**Table 3.5 Application of descriptive statistics**

<b>Descriptive statistics</b> (To organise, summarise, compare, present and describe data)		
<p><b>Frequency distribution</b> order numeric data and count the number of times a value repeats.</p>	<p><b>Central tendency</b> provide information about the middle of a group or summarise the members through identifying the <i>mode, median or mean</i>.</p>	<p><b>Variability</b> relates to the spread of data and is determined through <i>range, percentile and standard deviation</i>.</p>
<p>This method was used to determine and visually represent:</p> <ul style="list-style-type: none"> <li>• how many respondents participated in the study (see Table 4.2)</li> <li>• the number of respondents per strata (see sections 4.4.1.1 and 4.4.1.2; Figure 4.3 and 4.4)</li> <li>• the number of respondents per age group (see section 4.4.13; Figure 4.5)</li> <li>• frequency of scores out of 12 for behavioural characteristics (see section 4.4.2.1; Figure 4.7)</li> <li>• frequency at which behaviours are experienced (see Table 4.3; Figure 4.12)</li> <li>• how many perpetrators exhibited a specific behaviour (see Table 4.3; Figure 4.13)</li> <li>• how many respondents used a specific coping mechanism (see Figure 4.15)</li> </ul>	<p>Used to summarise:</p> <ul style="list-style-type: none"> <li>• ages per academic year (see Figure 4.6)</li> <li>• score for behavioural characteristics according to gender (see Figure 4.10) and age (see Figure 4.11)</li> <li>• the balance between behavioural significance as stressful or controllable (see section 4.4.4.3)</li> </ul>	<p>Standard deviation were determined for:</p> <ul style="list-style-type: none"> <li>• age distribution per academic year (see Figure 4.5)</li> <li>• scores for behavioural characteristics according to gender (see Figure 4.10) and age (view Figure 4.11)</li> <li>• behavioural characteristics and experience of intra-professional violent behaviour (see section 4.4.3.3; Table 4.6)</li> <li>• the balance between behavioural significance as stressful or controllable (see section 4.4.4.3)</li> </ul>

*Adapted from Brink 1990: 23; Brink 2006: 171-182; LoBiondo-Wood & Haber 2006: 359-367; Polit & Beck 2010: 392-399)*





## CHAPTER 3

**Table 3.6 Application of inferential statistics**

<b><i>Inferential statistics</i></b> <b>(To make generalisations, inferences or estimations from the sample to the target population)</b>	
t-test statistic determines whether two group means are different, thus there are differences between two groups Implemented to determine whether differences exist: <ul style="list-style-type: none"> <li>• between male and female behavioural characteristics of oppressed group behaviour (see section 4.4.2.3)</li> <li>• between high and low behavioural characteristics of oppressed group and experiences of intra-professional violence (see Section 4.4.3.3)</li> </ul>	Analysis of variance (ANOVA) calculates the difference between and within groups. Method implemented to: <ul style="list-style-type: none"> <li>• Determine if difference exist with regard to behavioural characteristics between and in academic years of study (see section 4.4.2.2)</li> </ul>

***(Adapted from Brink 1990: 146-149; Brink 2006: 182-183; LoBiondo-Wood & Haber 2006: 376; Polit & Beck 2010: 413-415)***



## CHAPTER 3

A computer package, namely *Statistical Package for Social Sciences (SPSS)*, was used to analyse the data. Bryman and Cramer (1994: 17) indicate that this program is comprehensive and allows for swift analysis of data. These authors point out that data should be entered accurately and that an individual should know the program well to ensure effective results. Therefore a statistician was consulted to assist in the data analysis process (see Annexure D).

### 3.5 VALIDITY AND RELIABILITY

Research designs and data collection instruments have to be valid and reliable to ensure that accurate conclusions can be made from findings. Researchers have to implement control measures to improve validity and reliability (Brink 2006: 158; LoBiondo-Wood & Haber 2006:337). The validity and reliability of the research design and the study questionnaire will be discussed in sections 3.5.1.1, 3.5.1.2, 3.5.2.1 and 3.5.2.2.

#### 3.5.1 Validity

Validity is concerned with both the research design and the research instrument used to collect the data.

##### 3.5.1.1 Validity of the research design

According to LoBiondo-Wood and Haber (2006:209) and Polit and Beck (2010: 246) the research design has to comply with criteria for internal and external validity.

**Internal validity** determines whether independent variables have an effect on the dependent variable. Threats to internal validity include history, maturation, testing, instrumentation, mortality, and selection bias. LoBiondo-Wood and



## CHAPTER 3

Haber (2006: 213) indicates that these threats are common in experimental designs, but should be considered in all quantitative designs. Since no experimental manipulation, nor pre- and post-testing were performed in this study, the researcher had come to the conclusion that selection bias might hold a potential threat. To address this possibility the researcher provided inclusion criteria that the respondents had to comply with (see sections 3.4.1 and 3.4.3).

**External validity** determines whether findings can be generalised to other populations, thus what should the conditions be for the same results to be repeated (LoBiondo-Wood & Haber 2006: 213). The factors that affect external validity depend on the extent of generalisation to be made. If the generalisation is to a target population, it is important to select a representative sample. As suggested by LoBiondo-Wood Haber (2006: 215), the inclusion criteria (see sections 3.4.1 and 3.4.3) were incorporated to limit selection effects and increase population characteristics. These authors add that if the generalisation is planned for different types of people or settings, new studies might be necessary. Polit and Beck (2010: 249) mention particularly the importance of replication and maintain that multi-site studies contribute to generalisability, especially when findings are replicated. For this reason the researcher included undergraduate students from different NEIs in South Africa.

### 3.5.1.2 Validity of the research instrument

Brink (2006: 158) emphasises that data-collection methods are prone to error. If instruments measure inaccurately, LoBiondo-Wood and Haber (2006: 336) point out that either systematic or random errors occur. Systematic errors may be seen when validity has been affected and systematic errors are indicative of poor reliability.



## CHAPTER 3

Factors that may contribute to error include the respondents, the researcher, the environment, and the instrument (Brink 2006: 159). To limit these effects in this study the following measures were implemented:

- The co-ordinators at each of the NEIs were given clear instructions with regard to when and how data collection should be managed
- The co-ordinators were requested to perform the data collection in a well-lit, well-ventilated venue and to limit noise and interruptions as far as possible.
- the researcher was not present during the data collection process,
- The instrument was pre-tested to avoid ambiguity (see section 3.4.4.3).

A research instrument is valid when it measures what it is intended to measure. Polit and Beck (2010: 377) mention that instruments should be assessed for face validity, content validity, criterion-related validity and construct validity.

**Face validity.** If an instrument looks as though it is measuring the planned construct, face validity is present. Litwin (2003: 33) points out that this validity may be assessed by a lay person, that is, someone who has no knowledge of the subject.

**Content validity** determines whether the sample of items covers the construct sufficiently. A panel of experts ascertains the content validity of a research instrument (Polit & Beck 2010: 378).

**Criterion-related validity** is established to correlate the respondents' performance on the instrument with their actual behaviour (LoBiondo-Wood & Haber 2006: 339) or a criterion (Polit & Beck 2010: 378). Criterion validity may be done concurrently (concurrent validity) or at a time in the future (predictive validity).



## CHAPTER 3

**Construct validity** relates to the extent to which a theoretical construct will be measured (LoBiondo-Wood & Haber 2006: 339-340) and is usually associated with a theoretical perspective (Polit & Beck 2010: 379).

Polit and Beck (2010: 380) call attention to the fact that validity should be supported by evidence. This evidence usually comes from a study conducted by the person that developed the instrument. In order to increase the validity of the study questionnaire, the researcher followed the principles described in sections 3.4.1, 3.4.3, 3.4.4.2 and 3.4.4.3. Findings were also compared to the studies of the original developers of the questionnaires, thus conclusions about validity could be made (see chapter 4).

### 3.5.2 Reliability

Research instruments have to be consistent and accurate in measuring the variables. Polit and Beck (2010: 373) refer to stability, internal consistency and equivalence as factors that contribute to the reliability of the instrument.

When results are the same on two different occasions, high **stability** is indicated. A high coefficient represents more stability (Polit & Beck 2010: 374).

**Internal consistency** is calculated using Cronbach's alpha to signal the extent to which the same trait is being measured.

To ensure **equivalence**, independent coders or observers have to agree about the scoring of the instrument (Polit & Beck 2010: 375).

The Cronbach's alpha for the NWS and the BNEQ (compiled from the Negatives Acts Questionnaire), from which the study questionnaire was compiled, were .81 and .87 to .93 respectively, which indicates high reliability. Table 3.7 depicts the



## CHAPTER 3

reliability of the NWS and the BNEQ and the related sections of the study questionnaire.

**Table 3.7 Application of reliability in study questionnaire**

Study questionnaire (see Annexure C3)	Reliability from existing questionnaires
Section B compiled from NWS	NWS: Cronbach's alpha .81, thus high reliability
Sections C & E compiled from BNEQ (compiled from Negative Acts Questionnaire)	Negative Acts Questionnaire provides Cronbach's alpha of .87 to .93, thus high reliability.

### 3.6 ETHICAL CONSIDERATIONS

LoBiondo-Wood and Haber (2006: 563) define ethics as the theory that addresses moral values and conduct. Polit and Beck (2010: 553) add that the values and conduct refer to the responsibility that the researcher has to the study respondents. These responsibilities have been stipulated in the *Belmont Report* (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (NCPHS) 1979) as (i) respect for the person (ii) beneficence and (iii) justice.

According to the NCPHS (1979), respect for the individual refers to allowing autonomy and providing protection. To comply with the requirements for autonomy and protection in this study, respondents will be informed what the research will entail, and will be free to participate or to withdraw at any point in the research.

Beneficence encompasses freedom from harm and the maximisation of benefit (NCPHS 1979). Since a non-experimental design will be followed, the possibility



### CHAPTER 3

of physical harm is limited. However, as the researcher is aware that psychological harm is more difficult to monitor, she will instruct the coordinators to stop the data-collection process should respondents show any signs of distress as a result of the questionnaire content. The information leaflet states that none of the information will be used against any of the students, but rather will be used to improve their circumstances.

The third principle of the *Belmont Report* relates to justice and entails fair treatment and the right to privacy. To comply with the requirements of fair treatment, the researcher will honour agreements as stated in the information leaflet, will treat respondents that withdraw or refuse to participate in a non-prejudiced fashion, show respect for social, cultural and religious beliefs, and treat respondents with dignity (Polit & Beck 2010: 124). To maintain privacy, the researcher will not be able to identify respondents and questionnaires will be placed in sealed envelopes directly after completion. These principles are also written into the Nuremburg Code and have been summarised in Table 3.8.

**Table 3.8 Summary of the principles of the Nuremburg Code**

Principles of the Nuremburg Code	Application to this study
<b>Voluntary consent is essential</b>	Completion of the informed consent form constitutes voluntary consent for participation in the study.
<b>Study should yield fruitful results for the good of society</b>	The results of the study will be used to inform nurse managers, nurse facilitators, and nurse educators on the extent of intra-professional violence and to make recommendations to improve clinical practice for the nursing profession. The researcher regards this as an opportunity to contribute to nursing practice with the aim of increased patient safety and care.



## CHAPTER 3

Principles of the Nuremberg Code	Application to this study
Previous results should justify the study	The researcher conducted an in-depth literature control on the topic to ensure validity and reliability.
Study should avoid all unnecessary physical and mental suffering and injury	There are no perceived risks of harm to respondents in this study, as there are no planned interventions or potentially harmful activities included.
No study should be conducted if it is believed death or disabling injury will occur	Respondents were given an information leaflet explaining the aims and objectives of this study. No perceived risks that could lead to disability or death.
The degree of risk should never exceed the potential benefits of the study	In this study there were no risks for the respondents involved in the data collection process.
The study should only be conducted by qualified persons	The researcher is a qualified registered nurse, and a qualified nurse educator with twelve years education experience, and has successfully completed a research methodology module. In addition, the supervisors are both recognised researchers.
Respondents should be free to withdraw at any time	It was explicitly explained to respondents that they have the opportunity to uphold consent or to withdraw at any time during the data collection without risk of penalty or prejudice.
The persons undertaking the study must be prepared to stop the study if a continuation is likely to cause harm	Approval for this study was obtained from the Research and Ethics Committee of the University of Pretoria (see Annexure A1).

***(Adapted from Burns and Grove 2009: 186)***

Written permission to use and/or adapt the NWS and BNEQ questionnaires was obtained from the authors. The researcher received the permission along with supporting evidence in e-mail format (view Annexure A3).





## CHAPTER 3

### **3.7 CONCLUSION**

The planned research method provided a structure according to which the researcher planned procedures, time frames and costs that could have affected the process of data collection and analysis. Although the methodology was well thought through, it was necessary to make changes from the original plan owing to time and financial constraints. The empirical data collected were analysed and these findings will be discussed in chapter 4.



## CHAPTER 4

# CHAPTER 4 RESEARCH RESULTS AND DISCUSSION

## 4.1 INTRODUCTION

Chapter 3 provided a comprehensive discussion of the research methodology, and in this chapter, Chapter 4, the results of the data analysis are given. Accordingly, the findings are discussed and compared to relevant literature and recent studies to emphasise similarities and/or differences.

Firstly, an overview of the participating nursing education institutions (NEI) and respondents will be given and, subsequently, a systematic discussion of each of the five sections of the questionnaire will be presented. Results will be elucidated using both descriptive and inferential statistics.

## 4.2 OVERVIEW OF THE PARTICIPATING NEI

At the time of this study, there were 16 NEI presenting the undergraduate training programme in South Africa. Hence, the researcher received permission to collect data from the undergraduate nursing students registered at nine of the 16 NEI. These NEI are situated in five of the nine provinces. However, a number of them were excluded from the study due to the following reasons:

- No response to the initial invitation (see Annexure B) to participate in the study (n = 1)
- Not interested in participating owing to time and resource constraints (n = 1)
- No response from NEI ethical committee or coordinator by deadline date (n = 2)
- Response after deadline date given in final call for participation (n = 3)



## CHAPTER 4

Table 4.1 depicts NEI representation by province, as well as the number of provinces represented in the study.

**Table 4.1 NEI representation by province**

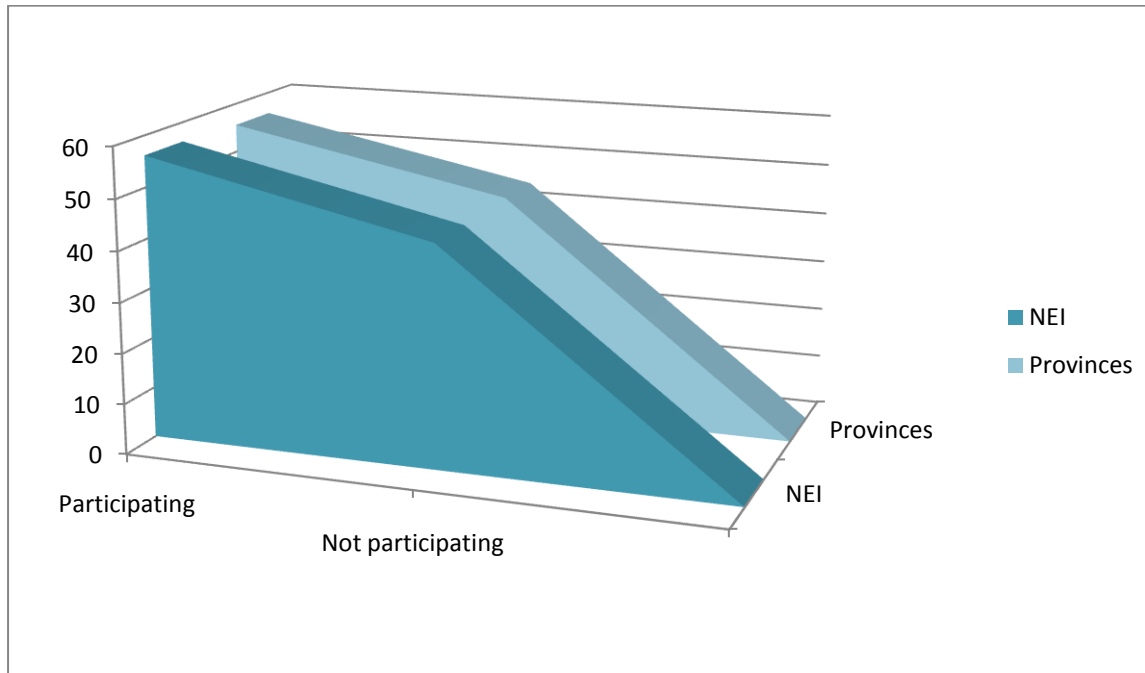
Participating NEI	Province	Representation of NEI in province
<b>I</b> <b>II</b> <b>III</b>	A	100%
<b>IV</b> <b>V</b> <b>VI</b>	B	75%
<b>VII</b>	C	50%
<b>VIII</b>	D	50%
<b>IX</b>	E	33%

NEI I, II and III in province A represent 100% of the NEI for this specific province, and NEI IV, V and VI in province B represent 75% of NEI in the province. Both NEI VII and VIII represent 50% of the NEI in their respective provinces C and D. Only NEI IX represented less than 50% of the NEI in province E. This representation will allow for the generalisation of findings to undergraduate nursing students in provinces A, B, C and D.

It has already been mentioned that nine (56.2%) of the 16 NEI participated in the study and five (55.6%) of the nine provinces in South Africa were represented. Figure 4.1 illustrates a comparison of NEI representation and province representation in this study.



## CHAPTER 4



**Figure 4.1 Comparison of NEI and province representation in this study**

Although Figure 4.1 shows a similar representation in the provinces to the NEI and will allow for generalisation of findings to undergraduate nursing students in these provinces, further analysis of key characteristics and their representation of the target population is necessary and will be discussed later in this chapter (see section 4.4.1).

### 4.3 OVERVIEW OF THE RESPONDENTS

The total number of undergraduate nursing students registered at the South African Nursing Council (SANC) for 2010 amount to 2684<sup>1</sup>. However, the accessible population was 1476; of this accessible population, 680 (n = 680) agreed to complete the questionnaire (see Table 4.2). The statistician indicated that this was

<sup>1</sup> The amount of undergraduate nursing students registered at SANC is an estimated value calculated from statistics pertaining to the output for 2007-2010.



## CHAPTER 4

an acceptable number, but pointed out that, since only nine of the NEI were represented, the results could not be generalised to all undergraduate nursing students in South Africa. 796 undergraduate nursing students of the accessible population were not included, the reasons being that these undergraduate nursing students

- were not available on the day scheduled for data collection
- did not complete a questionnaire, which indicated that they had not given consent
- withdrew during data collection.

*Note:*

A completed questionnaire implied that the undergraduate nursing student gave consent to participate in the study. The undergraduate nursing students were free to withdraw at any point during the data collection process. This was explained in the information leaflet that accompanied the questionnaire (see Annexure C3)

Table 4.2 provides an overview of the accessible population and the number of undergraduate nursing students who agreed to complete the questionnaire.



## CHAPTER 4

**Table 4.2 Overview of accessible population**

NEI	Accessible population	Agreed to complete questionnaire
<b>I</b>	170	143 (84%)
<b>II</b>	175	90 (51%)
<b>III</b>	121	7 (6%)
<b>IV</b>	171	130 (76%)
<b>V</b>	200	82 (41%)
<b>VI</b>	83	65 (78%)
<b>VII</b>	127	76 (60%)
<b>VIII</b>	148	39 (26%)
<b>IX</b>	250	48 (19%)
<b>Total</b>	<b>1476</b>	<b>680 (46%)</b>

### 4.4 RESULTS AND DISCUSSION

The discussion that follows relates to the results of a questionnaire (see Annexure C3) that the researcher compiled in order to collect data from undergraduate nursing students registered at the different NEI in South Africa. In order to obtain specific data that pertain to oppressed group behaviour, intra-professional violence and the transactional model of stress and coping, the questionnaire was divided into five sections:

- **Section A:** Demographic information
- **Section B:** Behavioural characteristics
- **Section C:** Behaviours experienced
- **Section D:** Significance of behavioural events
- **Section E:** Coping mechanisms



## CHAPTER 4

In the discussion of the findings, reference will be made to each section and related items as they appear in the questionnaire (see Annexure C3). Since the respondents were free to withdraw at any time, some respondents returned incomplete questionnaires; therefore for each item completed the number of respondents (n) will be indicated.

### **4.4.1 Section A: Demographic information [V1-V4]**

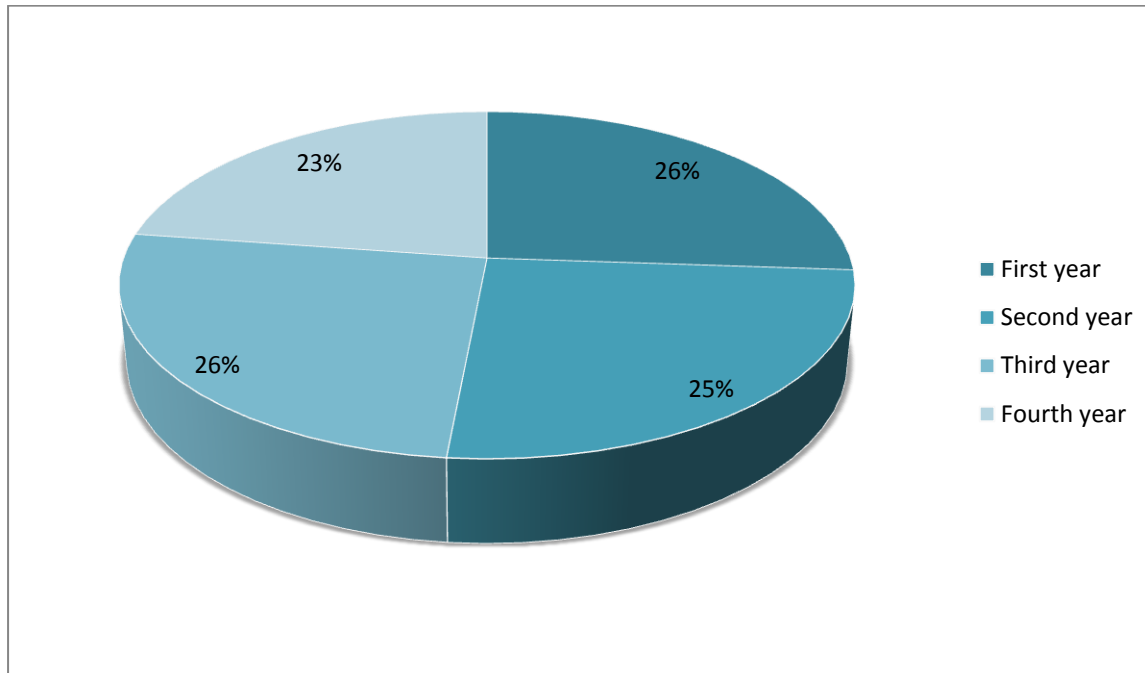
Although demographic information contains generalised data in most research studies, for the purpose of this study certain key items had to be included as they reflect on the susceptibility of the undergraduate students to intra-professional violence. Items included in this section related to the NEI, academic year of study, and the gender and age of the respondents. Of the items mentioned the academic year of study, gender and age have specific relevance to the occurrence of intra-professional violence (see section 2.3.2). Since an overview of the NEI has already been supplied (see section 4.2) it will not be discussed here again.

#### **4.4.1.1 Academic year of study [V2]**

Undergraduate nursing students in this study were either in their first, second, third or fourth academic year of study (n = 679). One hundred and seventy-seven (177 or 26.1%) of the respondents were in their first academic year of study, 173 (25.4%) were in their second academic year of study and 175 (25.8%) were in their third academic year of study. The fourth academic year of study was represented by 154 (22.7%) respondents. Figure 4.2 depicts the distribution of the undergraduate nursing students in this study according to academic year of study.



CHAPTER 4



**Figure 4.2 Representation of academic year of study**

**Literature control:** Jacobs and Kyzer (2010: [1]) point out that the level of experience has a role to play in the occurrence of intra-professional violence. The authors mention that often the “more experienced nurse is the perpetrator...” and that “... the novice nurse is the victim”. Lamontagne (2010: 55) supports this view by indicating that “student nurses and novice nurses” are vulnerable to intra-professional violence. Roche *et al* (2010: 13) report a lower perception of violence in groups with a higher skills mix. Accordingly, the difference in knowledge and experience results in a power differential which contributes to intra-professional violence (Hippeli 2009: 35). These authors, however, concentrate on the power differential that exists between registered nurses and student nurses who are not yet registered or who are newly registered. Studies conducted on undergraduate nursing students by Curtis *et al.* (2007) and Longo (2007) have included the academic year of study, but findings with regard to differences between experiences of intra-professional violence according to the different academic years of study





## CHAPTER 4

have not been reflected. Therefore, the researcher concludes this part of the discussion by referring to the importance of ensuring that the sample is representative of the population so as to enable inferences to be made that would relate to the academic year of study in the sections to follow. Brink (2006: 125) is of the opinion that representativeness not only requires similar variables but also similar proportions, and Polit and Beck (2010: 307) add that the over- or under-representation of characteristics should be prevented.

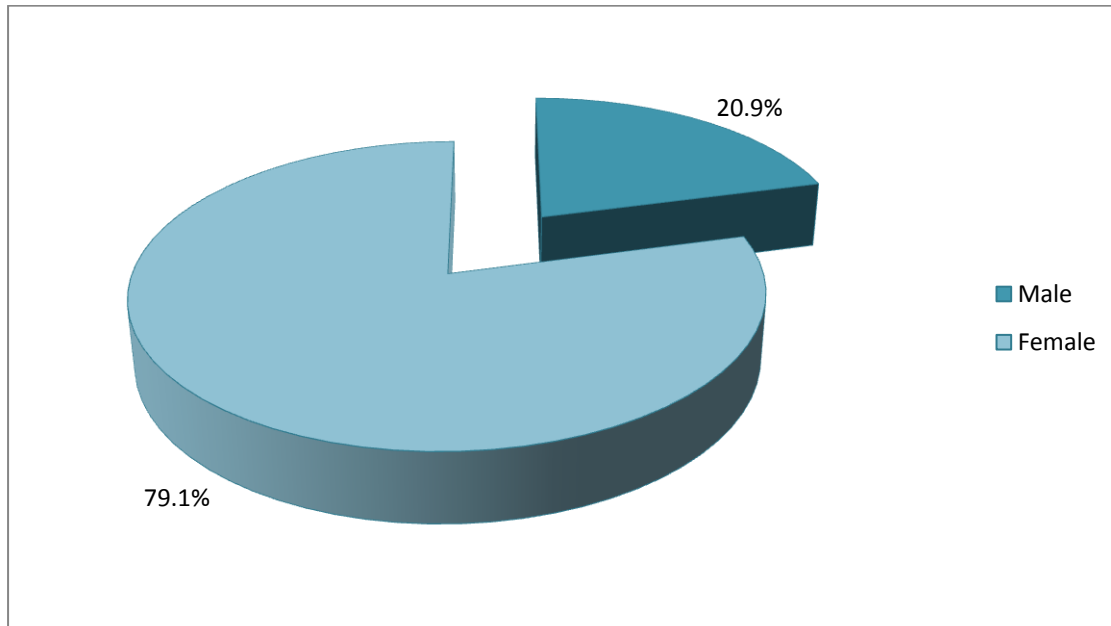
Data were available for the number of undergraduate nursing students in each academic year group. However, since the percentage distribution of the four academic years is so similar it can be concluded that each academic year is represented equally and characteristics of one year group will not over shadow characteristics of the other groups.

### **4.4.1.2 Gender distribution [V3]**

Of the 670 respondents ( $n = 670$ ) who provided this information, 530 (79.1%) were female, with male respondents comprising a total of 140 (20.1%). The gender distribution for the research population ( $n=670$ ) is illustrated in Figure 4.3



CHAPTER 4



**Figure 4.3 Gender distribution**

**Literature control:** In a similar study conducted by Cooper *et al.* (2009: [5]), 73% of the respondents were female. In addition, in two other studies that pertain to undergraduate nursing students specifically, female respondents made up 80 to 90% of respondents (Curtis *et al.* 2007: 158; Longo 2007: 178). Other studies on to intra-professional violence have similar female representation, namely 92% in the case of Hutchinson *et al.* (2008; 22), 95.7% in Dewitty *et al.* (2009: 32), 82% in Johnson & Rea (2009: 86), 92.6% in Pellico, Brewer and Kovner (2009: 195) and 95% in Walrath *et al.* (2010: 107). This reflects the female domination of the nursing profession. As has been discussed in section 2.4.1.1, the feminine gender may contribute to non-verbal violence or, as Dellesaga (2009: 53) puts it, “to tend and befriend” behaviour.

The findings illustrated in Figure 4.3 resemble international trends. The majority of undergraduate nursing students are female, although at two of the NEI a third of



## CHAPTER 4

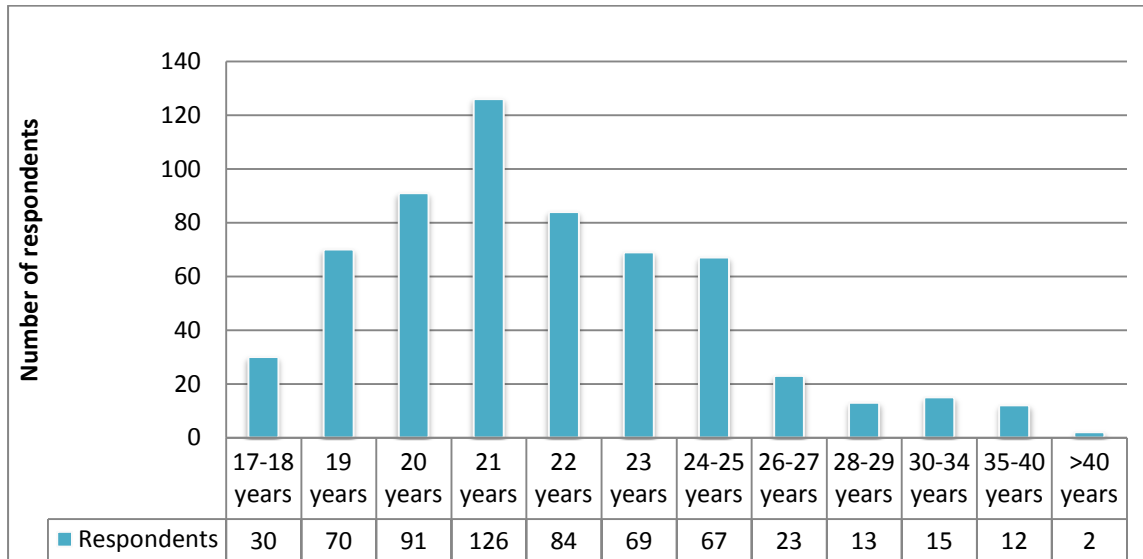
the student population consisted of male students. The effect of the female-to-male ratio will be analysed in section 4.4.2.3.

### **4.4.1.3 Age distribution [V4]**

Six hundred and five respondents gave their age ( $n = 605$ ). The ages of the respondents ranged between 17 and 55 years with the mean age being 22.3 years and the median age being 21.1 ( $SD = 3.8$ ) years. Thirty (5%) respondents were younger than 19 years, 70 (11.6%) respondents were 19 years old, 91 (15%) respondents were 20 years old, 126 (20.8%) respondents were 21 years old, 84 (13.9%) respondents were 22 years old, 69 (11.4%) respondents were 23 years old, 67 (11.1%) respondents were between 24 and 25 years old, 23 (3.8%) respondents were between 26 and 27 years old, 13 (2.1%) respondents were between 28 and 29 years old, 15 (2.5%) respondents were between 30 and 34 years old, 12 (2.0%) respondents were between 35 and 40 years old and two (0.3%) respondents were older than 40. Figure 4.4 indicates the age distribution of the respondents who participated in the study.



## CHAPTER 4



**Figure 4.4 Age distribution of the study population**

Table 4.3 provides a breakdown of the mean and median age by academic year of study for the study population.

**Table 4.3 Mean and median age of study population**

Academic year of study	Mean age	Median age	Standard deviation
First year	20.5	19.0	3.3
Second year	22.0	21.0	3.8
Third year	22.7	22.0	2.8
Fourth year	24.2	23.0	4.3
Study population	22.3	21.0	3.8

**Literature control:** Camerino *et al.* (2008:37) point out that younger staff members are more prone to workplace violence. In studies pertaining to intra-professional violence the ages of the nurses in general range between 33 and 50 years (Stanley *et al.* 2007: 1255; Hutchinson *et al.* 2008: 22; Kisa 2008: 203,



## CHAPTER 4

Barrett *et al.* 2009: 346; Dewitty *et al.* 2009: 32; Vessey *et al.* 2009: 302; Walrath *et al.* 2010: 107), whereas studies that focus on undergraduate nursing students report the ages to be 18 to 29 years (Curtis *et al.* 2007: 158; Ferns & Meerabeau 2007: 440; Kelly & Ahern 2007: 912; Longo 2007: 178; Beech 2008: 97; Cooper *et al.* 2009:[5]; Thomas & Burk 2009: 228). According to the SANC (2010: 4) the mean age of students completing the four-year programme is 30 years, with a minimum age of 20 years and a maximum of 6. However, this relates to both undergraduate and diploma students.

In South Africa tertiary, training is usually initiated directly after completion of secondary training. This results in nursing students being between the ages of 18 and 22 years. Figure 4.5 and table 4.3 show that the respondents, in this study, were between 20 and 25 years of age. This correlates with the studies conducted internationally that relate to undergraduate nursing students.

### 4.4.2 Section B: Behavioural characteristics [V5.1-V5.12]

The 12 statements which represent behavioural characteristics of oppressed groups were completed in full by 607 respondents (n = 607). The findings will be discussed for the total group and then the behavioural characteristics will be compared for academic year of study, gender and age.

**Note:**

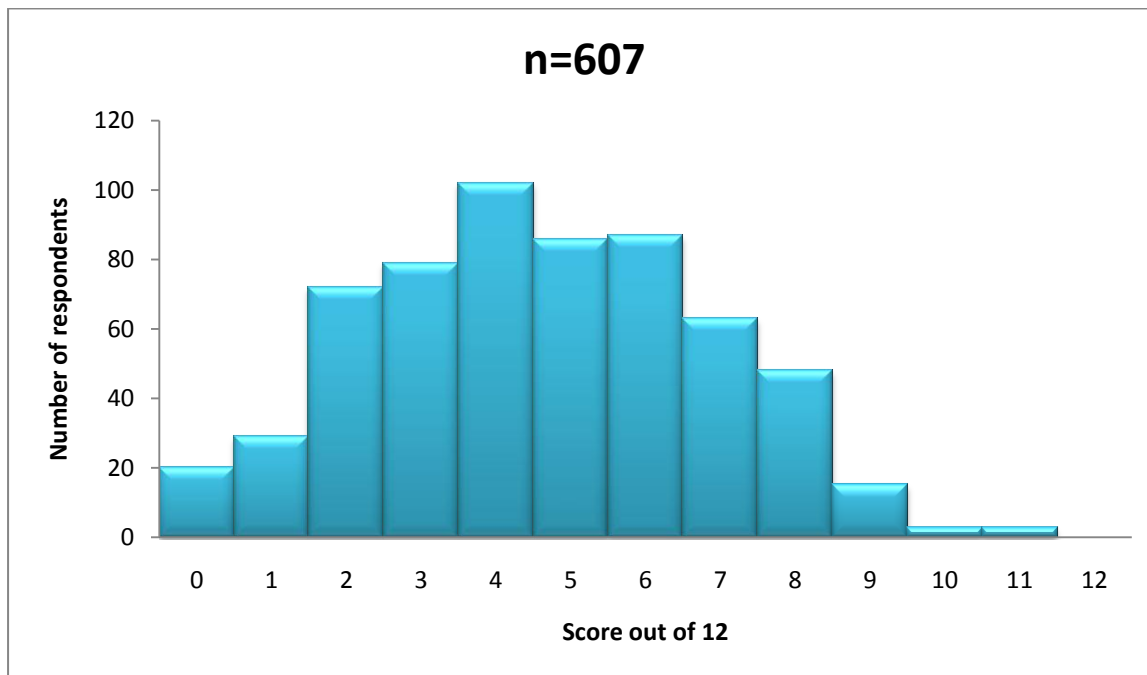
Each respondent obtained a score out of 12. Findings will be reported in the following categories: zero out of 12; 1 to 5 out of 12 and six or more out of 12.



## CHAPTER 4

### 4.4.2.1 Behavioural characteristics for total group

Twenty (3.3%) respondents obtained zero out of 12, 368 (60.6%) respondents obtained scores of 1 to 5 and 219 (36.1%) respondents obtained scores of six and higher out of 12. No respondent obtained 12 out of 12. Figure 4.5 provides the distribution of scores obtained for the behavioural characteristics of oppressed group behaviour.



**Figure 4.5 Scores for behavioural characteristics**

**Literature control:** The tested tool for measuring oppressed group behaviour only became available in 2008, resulting in very few statistics being available. In a study conducted to test this tool, DeMarco *et al.* (2008: 301) concluded that "... oppressed group behaviour do[es] exist in nurses". DeMarco (2010) provides the normative range (mean score) for nurses in Massachusetts as 24.77 out of a possible 60, thus 41.3%. Although Stanley *et al.* (2007: 1251) use constructs from the oppressed



## CHAPTER 4

group theory and Simons (2008: E50) uses oppressed group behaviour as a theoretical framework they do not provide statistical findings on the behavioural characteristics.

Most respondents obtained a score of 4 out of 12, with the mean score for the study population being 4.6 (SD = 2.3). When the mean is calculated as a percentage, the sample obtained 38.3%, which is lower than the normative range found by De Marco. The study population in the study conducted by DeMarco *et al.* (2008: 298) consisted of professional registered nurses, whereas the study population in this study were undergraduate nurses. This difference will be explored further in sections 4.4.2.2 and 4.4.2.4.

Overall, there is a low presence of oppressed group behaviour in the study population, but oppressed group behaviour is present and should be recognised when interventions are planned to address intra-professional violence.

### *Note:*

Matheson and Bobay (2007: 232) found that no measurement tool was available to measure oppressed group behaviours. Subsequently, DeMarco *et al.* (2008) developed and tested the first tool of this kind, thus statistics relating to oppressed group behaviour are limited.

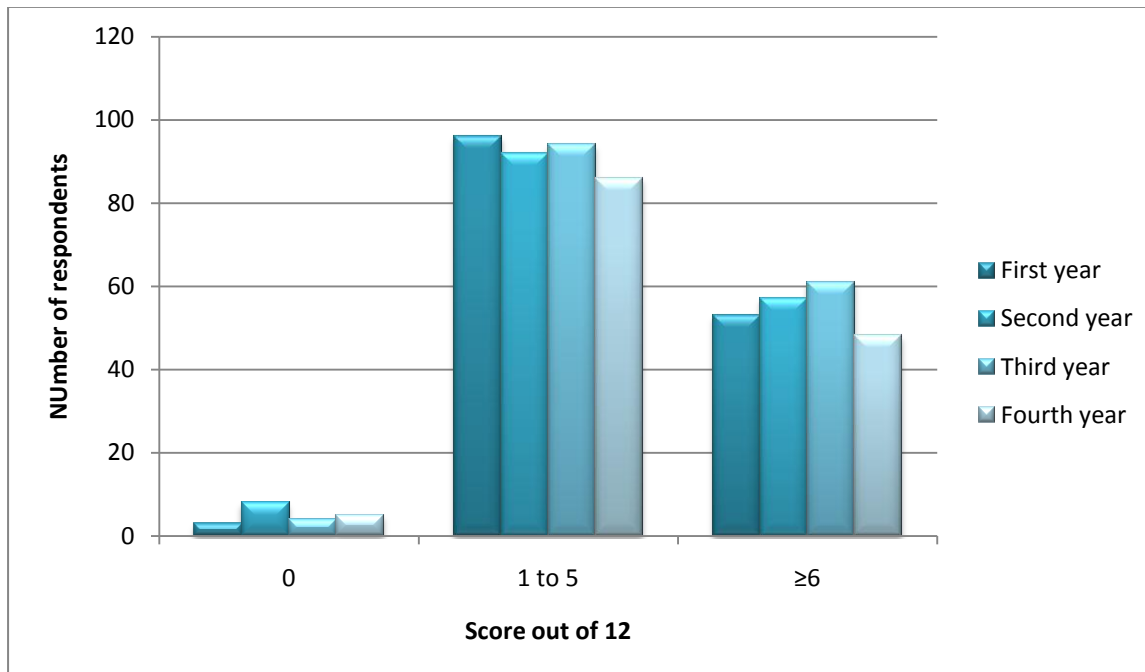
#### **4.4.2.2 Behavioural characteristics versus academic year of study**

Six hundred and seven respondents who completed the items relating to behavioural characteristics in full also gave their academic year of study, thus  $n = 607$  for behavioural characteristics by academic year. The findings for the first year of academic study show that three (2.0%) obtained zero out of 12; 96 (63.2%) obtained 1 to 5 out of 12; and 53 (34.9%) obtained six or more out of 12. The



## CHAPTER 4

scores for the second year of academic study were 8 (5.1%) obtained zero out of 12; 92 (58.6%) obtained 1 to 5 out of 12; 57 (36.3%) obtained six or more out of 12. For the third year of academic study the findings were 4 (2.5%) obtained zero out of 12; 94 (59.1%) obtained 1 to 5 out of 12; 61 (38.4%) obtained six or more out of 12. The fourth year of academic study findings were 5 (3.6%) obtained zero out of 12; 86 (61.9%) obtained 1 to 5 out of 12; 48 (34.5%) obtained six or more out of 12. Figure 4.6 depicts the scores for behavioural characteristics per academic year of study.



**Figure 4.6 Scores for behavioural characteristics according to academic year**

**Literature control:** According to Dewitty *et al.* (2009: 32) and Longo (2010: [3]) power differentials exist within oppressed groups which contribute to intra-professional violence. These power differentials develop as a result of the positions of authority as is seen in the differences between registered and pre-registration groups, where undergraduate nursing students experience intra-professional





## CHAPTER 4

violence perpetrated by registered nurses, staff nurses or nursing managers (Longo: 2007: 178). Being new to the environment also results in being treated differently in some cases to "... to test their abilities" (Stanley *et al.* 2007: 1257). Academic year of study is not mentioned or otherwise not measured, as is seen in the studies by Curtis *et al.* (2007) and Cooper *et al.* (2009). In these studies undergraduate nursing students in different academic years of study were included, but no inferences were made with regard to the behavioural characteristics of oppressed groups across academic year of study.

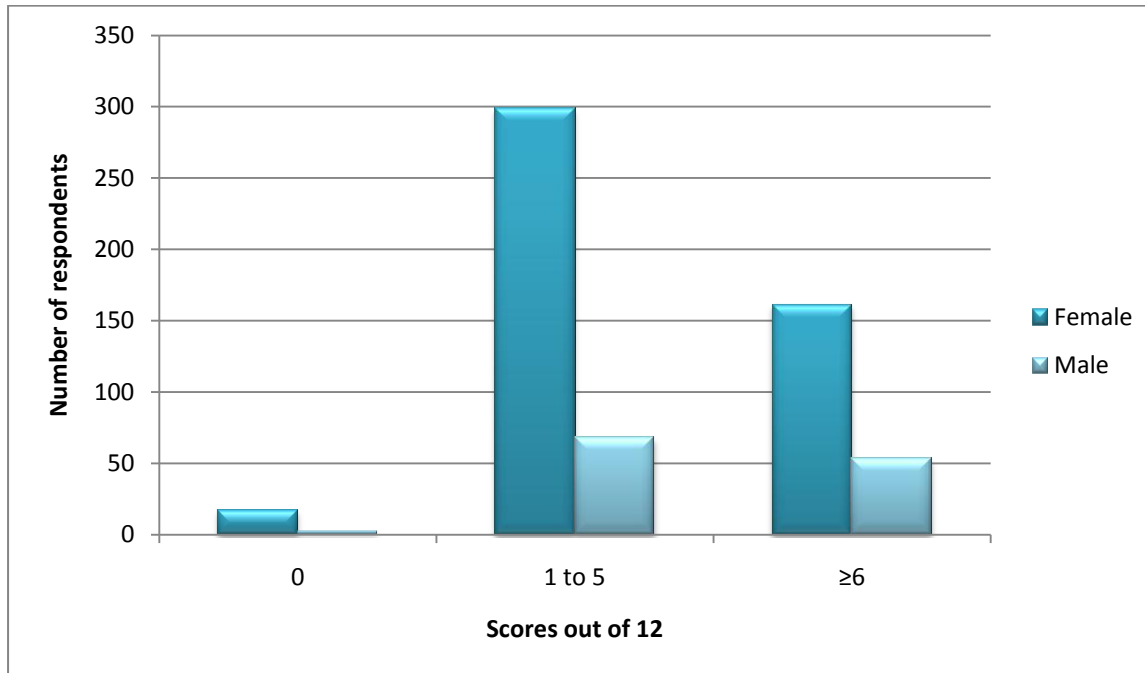
The mean score per academic year was as follows first year 4.55 (SD = 2.18), second year 4.66 (SD = 2.31), third year 4.67 (SD = 2.27) and fourth year 4.53 (SD = 2.34). Although the mean scores per academic year varied, the differences were not significant at the 5% level of significance ( $F=0.156$ ;  $p\text{-value}= 0.926$ ), thus there are no differing degrees of oppressed group behaviour between the different academic years of study. No year group had a mean score of more than six out of 12 and therefore the researcher concludes that oppressed group behaviour is present, but at a low level (see Figure 4.7).

### 4.4.2.3 Behavioural characteristics versus gender

Six hundred respondents completed both the questions relating to gender and the behavioural characteristics of oppressed groups. Of the 600 respondents, 123 (20.5%) were male and 477 (79.5%) were female. The findings for the males were as follow: two (1.6%) obtained zero out of 12; 68 (55.3%) obtained 1 to 5 out of 12; while 53 (43.1%) obtained six or more out of 12. Of the female respondents, 17 (3.6%) obtained zero out of 12; 299 (62.7%) obtained 1 to 5 out of 12; and 161 (33.8%) obtained six or more out of 12. The scores obtained for behavioural characteristics according to gender are depicted in Figure 4.7.



## CHAPTER 4



**Figure 4.7 Scores for behavioural characteristics according to gender**

**Literature control:** The written responses in the study conducted by Curtis *et al.* (2007: 159) indicate that male undergraduate nursing students are exposed to intra-professional violence just like their female counterparts, however, it is not clear to what extent they exhibit the behavioural characteristics of oppressed groups. Neither DeMarco *et al.* (2008: 298) nor Cooper *et al.* (2009: [7]) give any results for comparison of male and female behavioural characteristics in terms of oppressed groups.

In the study, male respondents obtained a mean score of 5.0 (SD = 2.07) out of 12, whereas female respondents scored 4.5 (SD = 2.29) out of 12. The differences between the means were found to be statistically significant at the 5% level ( $t=2.289$ ;  $p\text{-value}=0.022$ ), which prompted further analysis (see section 4.4.2.4.1).



## CHAPTER 4

### 4.4.2.3.1 *Dissection of behavioural characteristics across gender*

According to DeMarco *et al.* (2008: 296), the NWS can be dissected into two components, namely, internal sexism and self-minimisation. The findings made across gender with regard to these two components follow.

**Note:**

Internal sexism was reflected by questions 5.1 to 5.5 (see Annexure C3) and a respondent could obtain a score out of five. Self-minimisation was reflected by questions 5.6 to 5.12 (see Annexure C3) and a respondent could obtain a score out of seven.

One hundred and thirteen male respondents completed question 5.1 to 5.5 (see Annexure C3), which related to *internal sexism* and obtained a mean score of 2.61 (SD = 1.4). The 366 female respondents obtained a mean of 2.1 (SD = 1.6). The differences in the scores were found to be statistically significant at the 5% level of significance ( $t=3.186$ ,  $p\text{-value}=0.002$ ).

One hundred and eleven male respondents completed question 5.6 to 5.12 (see Annexure C3), which related to self-minimisation, and obtained a mean score of 2.4 (SD = 1.2). The 361 female respondents also obtained a mean of 2.4 (SD = 1.6).

**Literature control:** The studies which refer to oppressed group behaviour (Stanley *et al.* 2007: 1257) and explicitly include internal sexism and self-minimisation (DeMarco *et al.* 2008: 289-299) do not provide specific findings for male respondents.



## CHAPTER 4

The study findings indicate that internal sexism measured higher in male respondents than in female respondents, but no difference existed between the two genders for self-minimisation. These findings will be discussed further in section 5.3.3.

### 4.4.2.4 Behavioural characteristics across age

Five hundred and forty-five respondents completed both section B, relating to behavioural characteristics, and Section A, relating to age in full ( $n = 545$ ).

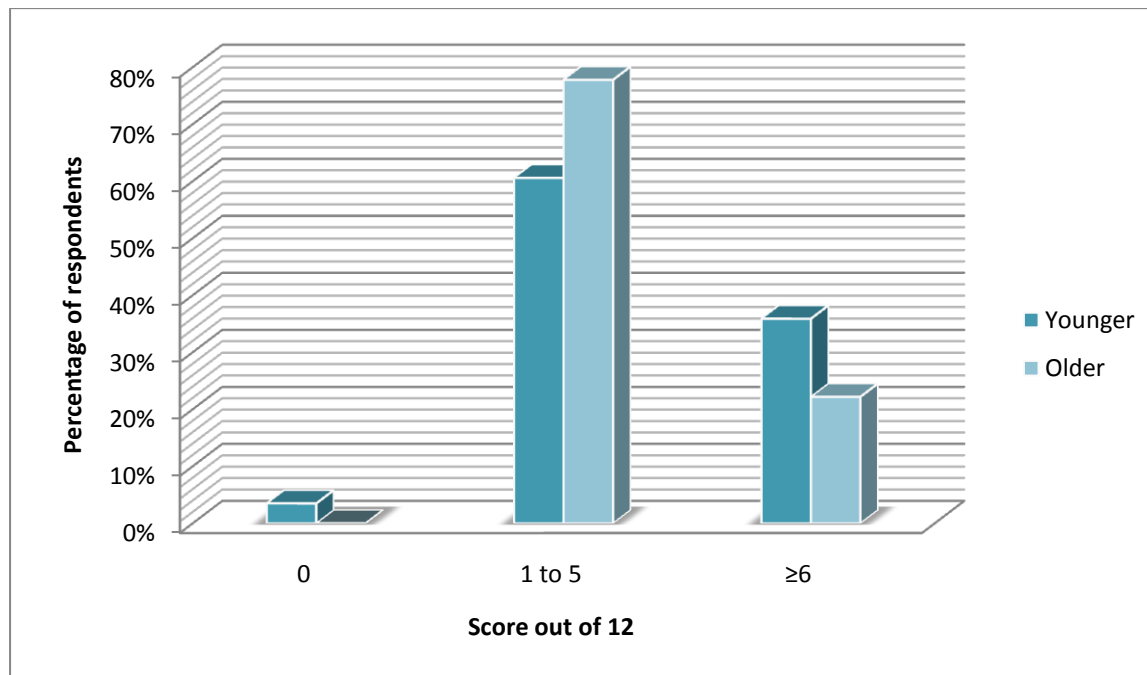
**Note:**

The findings of behavioural characteristics across age were divided into two categories, namely, *younger* (17-29 years) and *older* (30-55 years) undergraduate nursing students.

The younger group's scores for behavioural characteristics of oppressed groups presented as follows: 18 (3.5%) obtained zero out of 12; 314 (60.6%) obtained 1 to 5 out of 12; while 186 (35.9%) obtained six or more out of 12. None of the older group obtained zero out of 12; 21 (77.8%) obtained 1 to 5 out of 12; and 6 (22.2%) obtained six or more out of 12. Figure 4.8 depicts the scores obtained by the two age groups. The younger group obtained a mean of 4.6 ( $SD = 2.3$ ) out of 12 and the older group obtained 3.78 ( $SD = 1.9$ ). Statistically, this was a significant difference at the 10% level ( $t=1.938$ ;  $p\text{-value}=0.053$ ).



## CHAPTER 4



**Figure 4.8 Comparison of scores according to younger and older age groups**

**Literature control:** Stanley *et al.* (2007: 1257) mention situations which serve as oppressors. One such oppressor was described as "... the treatment of new staff and younger nurses by existing staff". DeMarco *et al.* (2008: 300) point out that in their study they had expected that the older group of respondents would have higher scores for oppressed group behaviour, however, they found the contrary to be true: the younger respondents obtained higher scores.

In this study the younger respondents showed higher scores for oppressed group behaviour thus correlating with the findings of DeMarco *et al.* (2008: 300).



## CHAPTER 4

### 4.4.3 Section C: Behaviour experienced [V6.1-V6.12]

Section C focused on the behaviours experienced by undergraduate nursing students in the clinical learning environment. These behaviours constitute intra-professional violence. The discussion that follows will firstly provide the results with regard to the behaviours experienced and this will be followed by the results in terms of who the perpetrators were.

Six hundred and seventy six respondents ( $n = 676$ ) completed this section. Table 4.4 contains the results with regard to undergraduate nursing students' experiences of intra-professional violence behaviours, as well as whom the perpetrators were. The highlighted blocks refer to the behaviours experienced the most, the perpetrator with the highest average and the perpetrator that exhibits a specific behaviour most frequently.

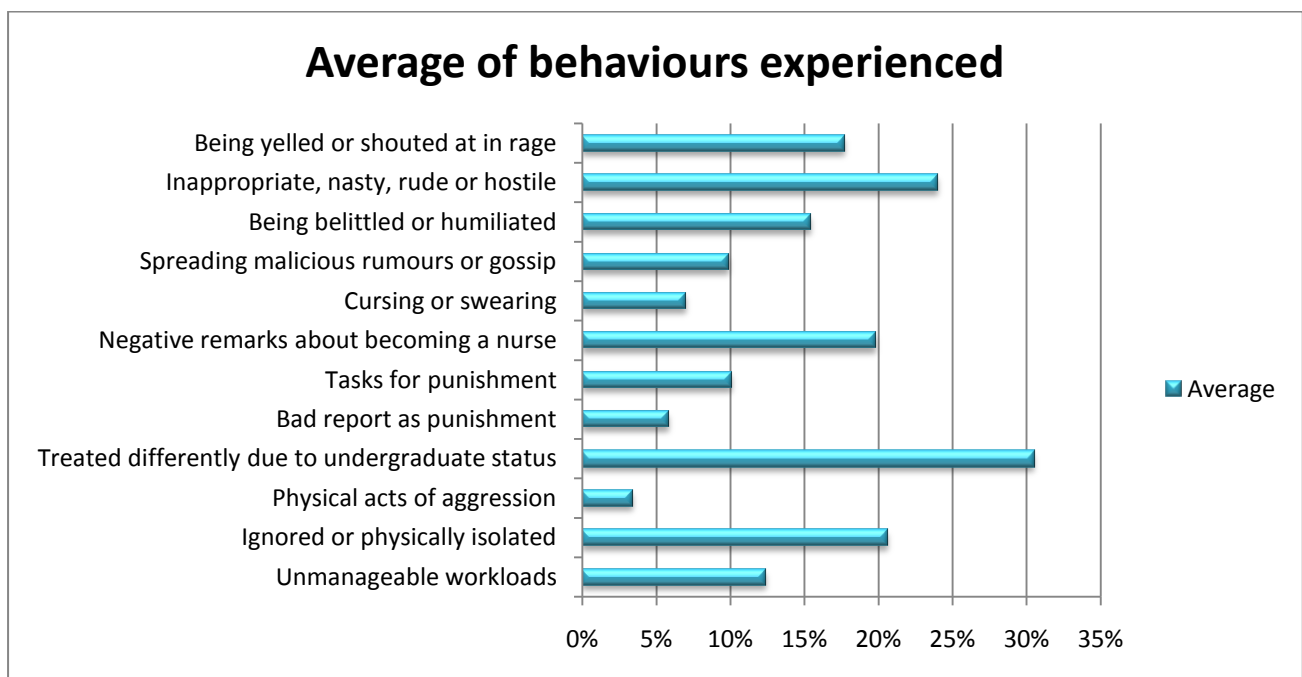




## CHAPTER 4

Thirty-four (5%) of the 676 respondents have never experienced any of the behaviours.

On average a respondent experienced 10.5 events during the course of 12 months. Figure 4.9 presents the average at which the behaviours were experienced.



**Figure 4.9 Average of behaviours experienced**

**Literature control:** Table 4.5 provides the literature control as it relates to experiences of intra-professional violence.





CHAPTER 4

**Table 4.5 Literature control with regard to behaviours experienced**

<b>Researchers</b>	<b>Study description</b>	<b>Behaviours according to incidence</b>
<b>Curtis <i>et al.</i> (2007: 159) Australia</b>	<ul style="list-style-type: none"> <li>• In class survey</li> <li>• 2nd &amp; 3rd year undergraduate students</li> <li>• n = 152</li> </ul>	<ul style="list-style-type: none"> <li>• Humiliation</li> <li>• Treated with arrogance and indifference</li> <li>• Verbal reprimand in public</li> </ul>
<b>Longo (2007:178) United States of America: Florida</b>	<ul style="list-style-type: none"> <li>• In class survey</li> <li>• Senior baccalaureate students</li> <li>• n = 47 (60%)</li> </ul>	<ul style="list-style-type: none"> <li>• Put down</li> <li>• Being humiliated</li> <li>• Sarcastic remark about students</li> <li>• Talked about behind their back</li> </ul>
<b>Stanley <i>et al.</i> (2007:1258) United States of America: South Carolina</b>	<ul style="list-style-type: none"> <li>• Web-based survey</li> <li>• Nursing staff</li> <li>• n=663</li> </ul>	<ul style="list-style-type: none"> <li>• Rudeness</li> <li>• Testing of abilities</li> <li>• Withholding information</li> <li>• Sabotage</li> </ul>
<b>Simons (2008: E52) United States of America: Massachusetts</b>	<ul style="list-style-type: none"> <li>• Mailed questionnaire</li> <li>• Registered nurses</li> <li>• n = 551</li> </ul>	<ul style="list-style-type: none"> <li>• Unmanageable workloads</li> <li>• Being ignored or excluded</li> <li>• Spreading of gossip or rumours about you</li> <li>• Ordered to work below competence</li> <li>• Having your opinions and views ignored (Cont.)</li> </ul>



CHAPTER 4

Researchers	Study description	Behaviours according to incidence
<b>Kisa (2008: 203) Turkey</b>	<ul style="list-style-type: none"> <li>• Survey</li> <li>• Nursing staff</li> <li>• n = 339</li> </ul>	<ul style="list-style-type: none"> <li>• Judging and criticising</li> <li>• Abusive anger</li> <li>• Accusing and blaming</li> <li>• Ignoring</li> <li>• Condescending</li> </ul>
<b>Cooper <i>et al.</i> (2009: [8]) United States of America: Mississippi</b>	<ul style="list-style-type: none"> <li>• Questionnaire</li> <li>• Final-year associate and baccalaureate nursing students</li> <li>• n = 665</li> </ul>	<ul style="list-style-type: none"> <li>• Cursing or swearing</li> <li>• Unmanageable workloads</li> <li>• Being ignored or physically isolated</li> <li>• Inappropriate, nasty, rude or hostile behaviour</li> <li>• Spreading of malicious rumours or gossip</li> </ul>
<b>Johnson &amp; Rea (2009: 87) United States of America: Washington</b>	<ul style="list-style-type: none"> <li>• Mailed survey</li> <li>• Members of Washington State Emergency Nurses Association</li> <li>• n = 249</li> </ul>	<ul style="list-style-type: none"> <li>• Withholding information</li> <li>• Ordered to do work below level of competence</li> <li>• Opinions and views ignored</li> <li>• Pressure not to claim something you are entitled to</li> <li>• Key areas of responsibility replaced with more trivial tasks</li> </ul>
<b>Thomas &amp; Burk (2009: 228) United States of America: Tennessee</b>	<ul style="list-style-type: none"> <li>• Narratives</li> <li>• Junior baccalaureate students</li> <li>• n = 221</li> </ul>	<ul style="list-style-type: none"> <li>• Unwanted and ignored</li> <li>• Distrusted and disbelieved</li> <li>• Unfairly blamed</li> <li>• Publicly humiliated</li> </ul>



## CHAPTER 4

Researchers	Study description	Behaviours according to incidence
<b>Vessey <i>et al.</i> (2009: 303) United States of America</b>	<ul style="list-style-type: none"> <li>• Internet survey</li> <li>• Registered professional nurses in acute care setting</li> <li>• n = 212</li> </ul>	<ul style="list-style-type: none"> <li>• Humiliation in public</li> <li>• Isolation, exclusion, gossiping</li> <li>• Excessive criticism</li> <li>• Unreasonable requests</li> <li>• Name calling</li> </ul>

In the study conducted by Curtis *et al.* (2007: 160), it was mentioned that undergraduate nursing students were singled out and treated differently to other nursing students. However, the “pecking order” still placed the students, no matter the training background, at the bottom.

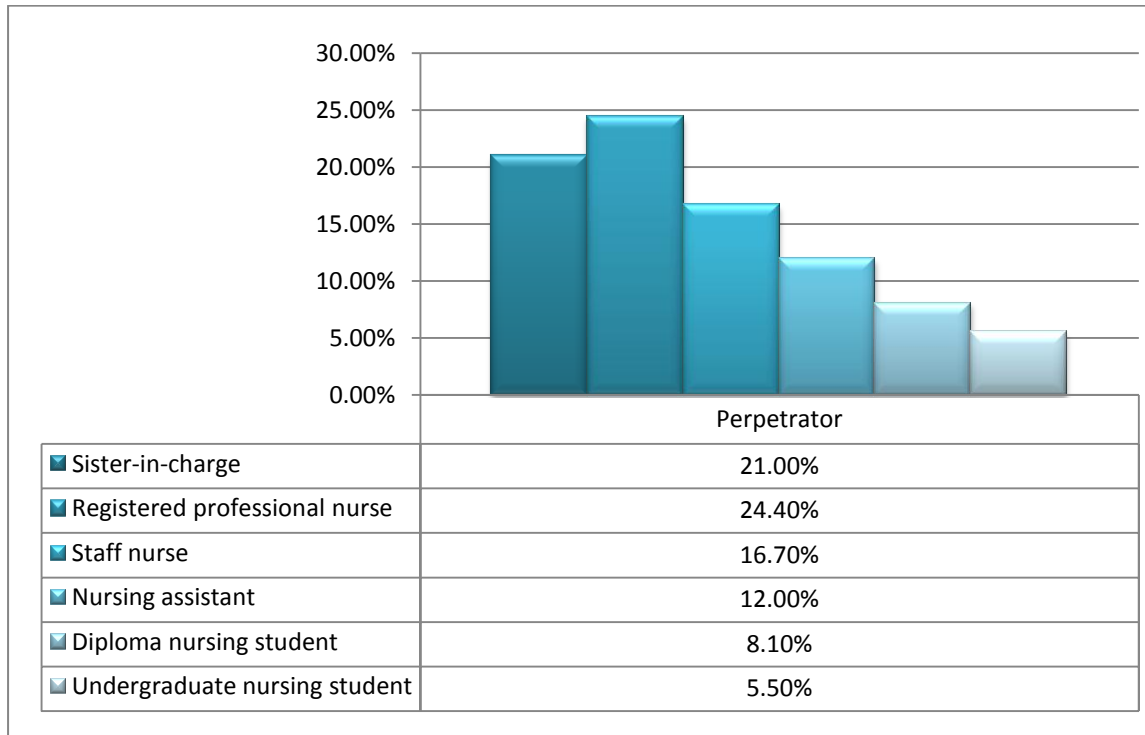
“Being treated differently due to undergraduate status” was the one thing that stood out for the study population; as for the rest, the study population compares very well with those behaviours experienced internationally. Also of note is that registered and pre-registration nurses alike experience the same behaviours, for example rudeness, humiliation and being ignored.

### 4.4.3.2 Perpetrators

The most likely perpetrator has been identified as the registered professional nurse. 24.4% of events were perpetrated by registered nurses, 21% by sisters-in-charge, 16.7% by staff nurses and 12% by nursing assistants. Nursing students registered for a diploma and undergraduate nursing students were indicated as being perpetrators in 8.1% and 5.5% of events, respectively. Figure 4.10 depicts the data relating to the perpetrators.



## CHAPTER 4



**Figure 4.10 Perpetrator frequency**

**Literature control:** Figure 4.10 provides the most frequent perpetrator as described in literature. Included are only those studies that focused on undergraduate nursing students.



CHAPTER 4

**Table 4.6 Literature control with regard to perpetrators**

Researchers	Study population	Most likely perpetrator
Curtis <i>et al.</i> (2007: 160) Australia	<ul style="list-style-type: none"> <li>2nd &amp; 3rd year undergraduate students</li> </ul>	Registered professional nurse
Longo (2007) United States of America: Florida	<ul style="list-style-type: none"> <li>Senior baccalaureate students</li> </ul>	Not determined
Cooper <i>et al.</i> (2009: [8]) United States of America: Mississippi	<ul style="list-style-type: none"> <li>Final-year associate and baccalaureate nursing students</li> </ul>	Students of nursing classmates
Thomas & Burk (2009: 228) United States of America: Tennessee	<ul style="list-style-type: none"> <li>Junior baccalaureate students</li> </ul>	Registered professional nurse

It was also reported that along with student nurses, newly registered nurses are the victims of nursing staff (charge nurses, registered professional nurses, nurse assistants) who have been part of the staff establishment for longer (Stanley *et al.* 2007: 1258; Curtis *et al.* 2007: 160; Thomas & Burk 2009: 228; Vessey *et al.* 2009: 303).

The registered professional nurse has been indicated as the main perpetrator of one or all of the behaviours experienced; a finding that is backed up by Curtis *et al.* (2007: 160) and Thomas and Burk (2009: 228). Contrary to the findings of Cooper *et al.* (2009: [8]), however, both diploma nursing students and undergraduate nursing students were found to be least likely to be the perpetrators which supports the “pecking order” mentioned by Curtis *et al.* (2007: 160).



## CHAPTER 4

### 4.4.4 Section D: Significance of behavioural events [V7.1-V7.2]

Section D refers to the significance of the behavioural events and thus reflects on the undergraduate nursing students' primary appraisal (see section 2.5.2) of the events. The results of this section have a twofold focus: firstly to determine whether the events were viewed as stressful, and secondly, whether the events were viewed as controllable. The significance of each item was compared to evaluate whether a balance exists between stress and control.

#### 4.4.4.1 Behavioural event as stressful

The respondents were required to indicate to what extent the behavioural events were appraised as stressful. A total of 596 respondents responded to this item ( $n = 596$ ). One hundred and sixty-one (28.4%) respondents indicated that the behaviours were moderately stressful, 158 (26.5%) indicated that the behaviours were mostly stressful and 124 (20.8%) indicated that the behaviours were slightly stressful. According to 92 (15.4%) respondents, the events were extremely stressful, whereas 53 (8.9%) appraised them as not at all stressful. Table 4.7 depicts the significance of behavioural events as stressful.

**Table 4.7 Significance of behavioural events as stressful**

Behavioural events as stressful	Not at all (0)	Slightly (1)	Moderately (2)	Mostly (3)	Extremely (4)
Number of respondents	53 (8.9%)	124 (20.8%)	169 (28.4%)	158 (26.5%)	92 (15.4%)



## CHAPTER 4

**Literature control:** Stanley *et al.* (2007: 1257) found that intra-professional violence was the main source of stress and tension. A respondent in the study conducted by Pellico *et al.* (2009: 196) related that her stress resulted in daily vomiting, others meanwhile experienced frustration (Thomas & Burk 2009: 230) and still others mentioned that intra-professional violence left them emotionally exhausted (Kisa 2008: 205). Just about all the respondents in the study by Vessey *et al.* (2009: 303) expressed their stress levels as moderate to severe during the occurrence of intra-professional violence.

Similar to the findings in the literature, the study population indicated that the behavioural events were moderately to mostly stressful. However, the significance as stressful should be related to the respondents' appraisal of the behavioural events as controllable (see sections 4.4.4.2 and 4.4.4.3).

### 4.4.4.2 Significance of behavioural event as controllable

The respondents were required to indicate to what extent the behavioural events were controllable. In total, 577 respondents answered this item ( $n = 577$ ). One hundred and ninety-six (34.0%) respondents indicated that the behavioural events were mostly controllable, 172 (29.8%) indicated them as moderately controllable, while 119 (20.6%) indicated them as slightly controllable. Forty-seven (8.1%) of the respondents felt the behavioural events were not at all controllable against 43 (7.5%) who felt the behavioural events were extremely controllable. Table 4.8 depicts the significance of the behavioural events as controllable.



## CHAPTER 4

**Table 4.8 Significance of behavioural events as controllable**

Behavioural events as controllable	Not at all (0)	Slightly (1)	Moderately (2)	Mostly (3)	Extremely (4)
Number of respondents	47 (8.1%)	119 (20.6%)	172 (29.8%)	196 (34.0%)	43 (7.5%)

**Literature control:** “They were new and did not want to make waves. The person criticizing them was the charge nurse and nobody wanted to go up against her.” This excerpt from the study by Stanley *et al.* (2007: 1258) illustrates the fact that undergraduate nurses feel they do not have the authority or the ability to control intra-professional violence. Vessey *et al.* (2009: 303) found similar responses, “... fear of retaliation ...”, “... fear that career would suffer ...”, “... not wanting to rock the boat ...” In support, Thomas and Burk (2009: 230) and Curtis *et al.* (2007:159) indicate that students believe that they are powerless and not able to confront registered professional nurses about their behaviour.

By contrast, the findings of this study indicate that respondents appraised the behavioural events as moderately to mostly controllable. This might be supported by the fact that low behavioural characteristics of oppressed groups (see section 4.4.2.1) are present.

### 4.4.4.3 Stressful versus controllable

Five hundred and forty respondents responded correctly and fully to allow for a comparison between an appraisal of stressful to an appraisal as controllable. When an event was appraised as “not at all” stressful, 57.8% of respondents indicated that they appraised their ability to control the event as moderate to extreme. If the event was indicated to be “slightly” stressful, 81.7% of respondents indicated that





## CHAPTER 4

they appraised their ability to control the event as moderate to extreme. Eighty-one per cent of respondents indicated that they appraised their ability to control the event as moderate to extreme when the event was appraised as “moderately” stressful and 65.8% indicated that they appraised their ability to control the event as moderate to extreme when the event was appraised as “mostly” stressful. If an event was appraised as “extremely” stressful, 51.2% of respondents indicated that they appraised their ability to control the event as moderate to extreme.

**Literature control:** The Transactional Model of Stress and Coping postulates that the appraisal of an event prompts the type of coping mechanism that individuals implement to manage the stress (Glanz *et al.* 2002: 213). Therefore although an event may create stress, resolution or distress lie in the way the event is managed. Glanz *et al.* (2002: 214) indicate that a behavioural event may cause stress, but is best managed if appraised as controllable. No recent study was found in which the significance of the behavioural event was determined. However, Manderino and Berkey (1997: 52) conducted a study on “Verbal abuse of Staff Nurses by Physicians” and found that the appraisals of the event by the registered nurses were positive, and thus more controllable.

The study findings did not indicate whether appraisals tend to be more stressful or more controllable. However, more respondents appraised their ability to control an event as “moderate to extreme” if their primary appraisal of the event was “slightly to moderately” stressful.



## CHAPTER 4

### 4.4.5 Section E: Coping mechanisms [V8.1-V8.12]

Section E aimed at determining which coping mechanisms students employ to manage the behaviours in section C (see 4.4.3.1). Findings were as follows:

**V8.1:** n = 612 for this question. Four hundred and thirty-four (70.9%) of the respondents indicated that they **"Did nothing"** while 178 (29.1%) respondents did not employ this mechanism.

**V8.2:** n = 615 for this question. Three hundred and fifty-seven (58.0%) of the respondents indicated that they **"Put up emotional barriers"** while 258 (42.0%) respondents did not employ this mechanism.

**V8.3:** n = 616 for this question. Three hundred and sixty-five (59.3%) of the respondents indicated that they **"Pretended not to see the behaviour"** while 251 (40.7%) respondents did not employ this mechanism.

**V8.4:** n = 610 for this question. One hundred and eighty-three (30.0%) of the respondents indicated that they **"Reported the behaviour to a superior"** while 427 (70.0%) respondents did not employ this mechanism.

**V8.5:** n = 616 for this question. Three hundred and eleven (50.5%) of the respondents indicated that they **"Mentioned the behaviour during class"**, while 305 (49.5%) respondents did not employ this mechanism.

**V8.6:** n = 602 for this question. Seventy-six (12.6%) of the respondents indicated that they **"Become ill and consult a doctor"** while 526 (77.4%) respondents did not employ this mechanism.



## CHAPTER 4

V8.7:  $n = 602$  for this question. One hundred and forty one (23.4%) of the respondents indicated that they **“Perceived the behaviour as a joke”** while 461 (76.6%) respondents did not employ this mechanism.

V8.8:  $n = 600$  for this question. Sixty-nine (11.5%) of the respondents indicated that they **“Demonstrated similar behaviour”** while 531 (88.5%) respondents did not employ this mechanism.

V8.9:  $n = 599$  for this question. Fifty-seven (9.5%) of the respondents indicated that they **“Shouted or snapped at the perpetrator”** while 542 (90.5%) respondents did not employ this mechanism.

V8.10:  $n = 602$  for this question. One hundred and forty-two (23.6%) of the respondents indicated that they **“Warned the perpetrator not to do it again”** while 460 (76.4%) respondents did not employ this mechanism.

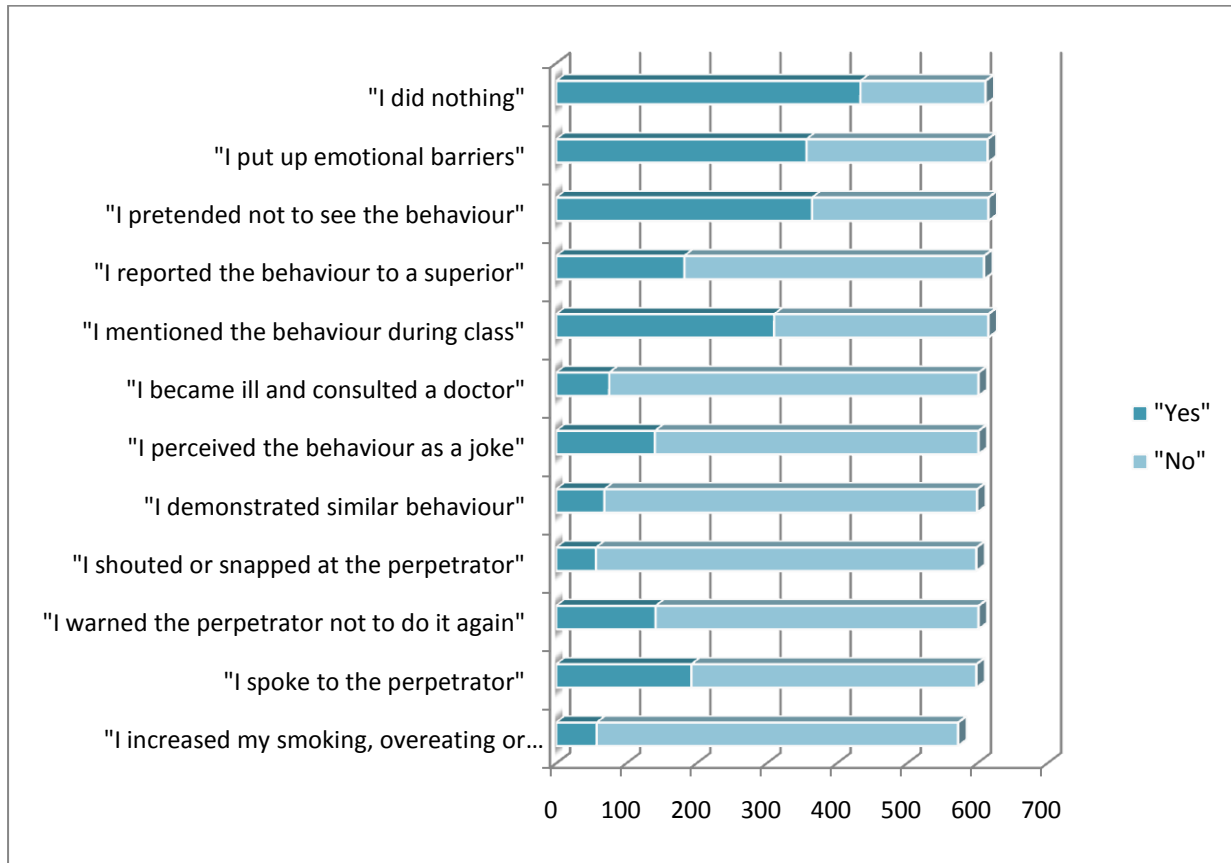
V8.11:  $n = 599$  for this question. One hundred and ninety-three (32.2%) of the respondents indicated that they **“Spoke to the perpetrator”** while 406 (67.8%) respondents did not employ this mechanism.

V8.12:  $n = 573$  for this question. Fifty-eight (67.8%) of the respondents indicated that they **“Increased their smoking, overeating or alcohol consumption”** while 515 (89.9%) respondents did not employ this mechanism.

Figure 4.11 shows the relation between the number of respondents that do employ certain coping mechanisms and the number of respondents that do not employ the same coping mechanisms.



CHAPTER 4



**Figure 4.11 Respondents' indication of coping mechanisms employed**

**Literature control:** Stanley *et al.* (2007: 1258) found that both victims and witnesses choose to *do nothing* and Curtis *et al.* (2007: 160) agree, but explain that students come to accommodate the behaviours and the students advise that "You have to develop a thick skin". Thomas and Burk (2009: 230) also found that the anger is suppressed which then leaves the students with a feeling of being cheated. Longo (2007: 178) and Kisa (2008: 205) provide another mechanism where victims discuss the behaviour with a peer or a significant other. However, *reporting to a superior* is usually the coping mechanism employed least (Kisa 2008: 205). Detrimental habits, like *smoking or alcohol consumption*, may be increased as a coping mechanism (Vessey *et al.* 2009: 301). Similar findings were made by Cooper *et al.* (2009: [8]), with respondents choosing *not to do anything* or else to *put up*



## CHAPTER 4

*barriers* as the main mechanisms of coping. More effective mechanisms of coping were also implemented, namely to *speak to the perpetrator directly* or *reporting the behaviour to a superior*.

In agreement with the literature, most of the study population, 70.9%, indicated that they *did nothing*, pretended not to see the behaviour (59.3%) or *put up emotional barriers* (58.0%). A more effective mechanism employed, which was indicated by 50.5% of respondents, was to mention the behaviour during class.

### **4.5 CONCLUSION**

Chapter 4 provided the research results and analysis of the data collected from 680 respondents. These findings were compared to the available literature and existing research. Chapter 5 will discuss the final conclusions and make recommendations, as well as the researcher's reflections on the findings and the research process.



## CHAPTER 5

# CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

## 5.1 INTRODUCTION

Chapter 5 will provide a brief overview of the study, after which the different themes that formed the basis for the study will be discussed in order to make final conclusions. Furthermore, recommendations will be made for improving current conditions, as well as for future research. Finally, the researcher will reflect on the research study and her experiences.

## 5.2 RESEARCH AIM AND STUDY OBJECTIVES

The aim of this study was to investigate the intra-professional violence that South African nursing students are exposed to in the clinical learning environment.

A questionnaire was compiled according to set objectives to achieve the research aim. The objectives were to

- determine the presence of oppressed group characteristics in South African undergraduate nursing students
- assess intra-professional violence that South African undergraduate nursing students' are exposed to in the clinical learning environment
- determine South African undergraduate nursing students' primary appraisal of intra-professional violence
- evaluate coping responses that South African undergraduate nursing students implement when confronted with intra-professional violence in the clinical learning environment

The questionnaires were distributed to undergraduate nursing students registered at nine of the 16 NEI in South Africa. From the statements given, the



## CHAPTER 5

respondents had to choose those that had applied to them during the previous 12 months. Respondents were also requested to indicate the perpetrators of the events that they had experienced and to specify the type of events they had experienced. What follows is the data analysis of this questionnaire.

### **5.3 CONCLUSIONS AND RECOMMENDATIONS**

Information pertaining to the distribution and return of the questionnaires will be discussed first. Then the researcher will go into the data analysis of each of the five sections of the questionnaire individually. The researcher will also make reference to some of the respondents' comments, which were not included for analysis, but are included here in order for their opinions to be heard.

Section A (view Annexure C3) contained the demographic data and the discussion will consist mainly of descriptive statistical information. Section B to E (view Annexure C3) will include inferential statistics.

Since the objectives are closely related, recommendations will not be discussed by section, but rather, a general discussion will be provided in section 5.3.7.

#### **5.3.1 Distribution and return of questionnaires**

The questionnaires were distributed by courier services, except for four of the NEI, to which the researcher delivered and collected the questionnaires herself. At two of these sites the researcher handed out the questionnaires to the respondents and collected them later since coordinators were not available. In the other cases, the questionnaires were delivered to coordinators who volunteered to assist. These coordinators were responsible for receiving, distributing, collecting and returning the questionnaires and were in contact with the researcher either via telephone, cell phone or e-mail.



## CHAPTER 5

Each participating NEI received the number of copies indicated by the coordinator. However, some of the coordinators did not give the exact number of registered students, resulting in more copies being sent than were needed. One thousand four hundred and seventy-six copies were distributed and 680 (46.1%) completed copies were received back. Table 5.1 depicts the number of copies sent to each NEI and the number of copies returned to the researcher.

**Table 5.1 Number of copies of questionnaire distributed and returned**

<b>Couriered</b>	<b>Distributed</b>	<b>Returned</b>
<b>Site VII</b>	127	76
<b>Site IX</b>	250	48
<b>Site VII</b>	150	39
<b>Site II</b>	175	90
<b>Site I</b>	170	143
<b>Distributed by hand</b>		
<b>Site III</b>	150	7
<b>Site IV</b>	171	130
<b>Site VI</b>	83	65
<b>Site V</b>	200	82
<b>Total</b>	<b>1476</b>	<b>680</b>

### 5.3.2 Section A – Demographical information

Data in this section related to the NEI, academic year of study, and the gender and age of the respondents. In this section the descriptive data relating to these characteristics will be discussed. However, in later sections these data will be used to make inferences to relations between the variables. The researcher specifically included these strata in order to increase sample representation in terms of the population. Other factors that contributed to representation will be pointed out per item.





## CHAPTER 5

The representation of the academic year of study was closely distributed with the first, second and third years ranging between 25.4 and 26.1% and the fourth year being 22.7%. Since the range between the groups was so narrow, it allowed for equal representation of the characteristics of each year group. Furthermore the view points of one group were much less likely to over shadow the viewpoints of another group. The fact that each year group was represented increased the homogeneity of the sample and contributed to representation of the population.

As per strata requirements, both male and female respondents completed the questionnaire. Almost 21% of the respondents were male and 79.1% of the respondents were female, effecting in a 1:4 male to female ratio. This ratio contributes to representativeness since it correlates with the statistics provided by SANC (SANC 2010) for all students registered in 2010.

The age stratum was included since the literature indicated that younger nurses are more prone to intra-professional violence. Only 605 respondents answered this question. The reason for this is not clear, but the researcher speculates that it may be related to the fact that this item was separated from the other demographic items and the respondents may have misread it. However, the ages ranged between 19 and 55 years. The mean age of the respondents were 20 to 24 years (Median 19-23). This means that most of the respondents are very young and accordingly, inferences with other sections will be made.

### **5.3.3 Section B – Behavioural characteristics**

The data in this section related to oppressed group behaviour, but also gave information with regard to two subthemes that are characteristic of oppressed group behaviour, namely internal sexism and self-minimisation. The researcher found the following:



## CHAPTER 5

- Undergraduate nursing students scored 38.3% for oppressed group behaviour -3% lower than the normative range scored by registered nurses.
- Oppressed group behaviour did not differ between academic years of study.
- Oppressed group behaviour did differ slightly between male and female.
- Internal sexism did differ significantly between male and female, whereas self-minimisation did not.
- Oppressed group behaviour was lower in older undergraduate nursing students than in younger undergraduate nursing students.

A score out of 12 could be obtained for oppressed group behaviour. Scores of six and above represented a high presence of oppressed group behaviour and less than six represented low presence. Both the mean (4.4) and the median (5) for oppressed group behaviour were less than six, indicating a low presence of oppressed group behaviour. However, it should be remembered that although the majority of respondents have low scores, relevant behavioural characteristics are present and may contribute to intra-professional violence.

In the different academic years of study no one year group stood out as having more or less oppressed group behaviours than the other groups. This indicates that power differentials do not affect the relationships between different year groups, which allows for group cohesion. It will also contribute to the groups supporting one another and to limiting the occurrence of oppressed group behaviour and intra-professional violence.

Both female and male respondents revealed characteristics of oppressed group behaviour and of the total scores out of 12 it was found that males seemed to have higher scores than females. This result was examined further by breaking down oppressed group behaviour into internal sexism and self-minimisation. It was found that male respondents scored higher on internal sexism. However, it should be said that internal sexism relates to internal dislike within groups of the



## CHAPTER 5

same gender. The questions pertaining to this part focused on females in nursing and therefore the male respondents were reflecting on their female counterparts. There are very few previous studies available for comparing to these results and this finding is in need of more research. With regard to self-minimisation, both the female and the male respondents scored 2.4 out of 7, which indicate that the undergraduate nursing students do not always keep silent or allow perpetrators to mistreat them.

Older respondents presented with less oppressed group characteristics than the younger respondents. This may be related to the life skills that the older undergraduate nursing students have already achieved which result in more self-efficacy being present in these individuals.

Oppressed group behaviour is present in some of the undergraduate nursing students and therefore may contribute to intra-professional violence, but it does not seem to be the only factor. Undergraduate nursing students who had low scores in this part of the questionnaire, still experienced intra-professional violence.

### **5.3.4 Section C – Behaviours experienced**

Section B provided a possible contributing factor for intra-professional violence, but section C provides data that indicate who the perpetrators are, what type of behaviour is experienced and how many of the behaviours are experienced.

Registered nurses are the main perpetrators in the majority of cases (24.4%), with the sister-in-charge (21.0%) second and staff nurses (16.7%) third. This correlates with the researcher's expectations, since the literature indicated that power differences result in the occurrence of intra-professional violence. It should also be noted that fellow undergraduate nursing students (5.5%) and students registered for the diploma (8.1%) are also perpetrators.



## CHAPTER 5

Being treated differently because they are undergraduate students (30.5%) was indicated as being the most frequent behaviour experienced. The comments from the respondents also mention this very pertinently: "They are taking us as degree students to be the most unskilled nurses and when we have learned some skills they leave the work to us. We are being abused by others."; "Nurses feel threatened when they see university students. The[y] don't treat us in a good way." Other behaviour that occurred relates to verbal abuse or isolation. However, intra-professional violence was not experienced by all the respondents, as is evident from the 34 respondents whom indicated that they had never experienced any of the behaviour during the previous 12 months.

Nevertheless, it is evident that many undergraduate nursing students are experiencing intra-professional violence in the clinical learning environment and need assistance in managing it. It is also evident that the perpetrators come from all categories within the nursing profession.

### **5.3.5 Section D – Significance of behavioural events**

Section D reflects on the respondents' evaluation of the event as stressful and their ability to exert control over the event. The data indicated that the respondents do experience stress and they assess it as being moderate (28.4%). It is encouraging to note that the respondents do credit themselves with the ability to control or manage the situations most of the time (34.0%). Respondent comments support this, using phrases like "... I control my destiny ..."; "... I do not let it get me down".

Of note is the fact that an appraisal of slight to moderate stress renders a result of moderate to extreme control. Thus stress should be present but not in too little or too large quantities.



## CHAPTER 5

### 5.3.6 Section E – Coping mechanisms

Although the respondents indicated that they mostly feel that they can control intra-professional violence, the coping mechanism of choice relate to disengaging coping which only result in short term resolution of the stressor. Of the possible statements, “I did nothing” was used by most respondents (70.9%), while an engaging coping mechanism such as speaking to the perpetrator rated fifth. It should be mentioned that both engaging and disengaging mechanisms have a role to play depending on the situation and the outcome to be attained.

The one coping mechanism that does not yield positive outcomes in any situation is when victims become perpetrators. This option was indicated by 10.1% of the respondents. There was also one comment that supported this mechanism “I don’t mind ... because I know next year I will do the same ...”

## 5.4 RECOMMENDATIONS

The following recommendations are aimed at improving the coping mechanisms to ensure positive long-term outcomes that will diminish oppressed group behaviour and break the cycle of intra-professional violence. This entails introducing and enforcing problem-focused coping or engaging coping. Problem-focused coping focuses on three concepts, that is, information seeking, active coping and problem solving. The researcher would like to emphasise that disengaging or emotion-focused coping such as avoidance, denial, seeking social support and venting, have a role to play, especially if the circumstances do not allow for problem-focused coping.



## CHAPTER 5

The research study focused on undergraduate nursing students, but if the problem is to be addressed effectively more role players will have to be included. Thus, the following groups are included in this recommendation:

- undergraduate nursing students
- nurse educators
- nurse facilitators
- nursing managers and administrators

The countering of intra-professional violence will require education and information, improved communication and visible role models.

### **5.4.1 Education and information**

Undergraduate nursing students, nurse educators, nurse facilitators, nursing managers and administrators should all be given information on intra-professional violence. Each group should initially be addressed separately and then together in order to make them aware of the existence of intra-professional violence, what causes and alleviates it, and the fact that everyone is exposed to it, but can also be a perpetrator.

Such educational sessions should consist of an information section and then be followed by practical session using cue cards to change behaviour in situations of intra-professional violence. This method was initiated and tested by Griffin *et al.* (2004) and is called "cognitive rehearsal".

### **5.4.2 Improved communication**

Relations between the different role players should be improved. In addition students should be given the opportunity to be debriefed after being in the clinical learning environment. Structured sessions should be provided during which students are given the opportunity to report (not vent) on events. The



## CHAPTER 5

idea of such a session is not to decide who was wrong or right, but rather to assess the circumstances and to put them in perspective. Once that has been accomplished the coping mechanism which was implemented can be evaluated and if need be the educators can suggest better options. A record of events should be kept to enable educators and managers to identify continuing disruptive behaviour and address it. Should a severe event be reported, an intervention should be planned and the students involved should receive feedback.

Communication between the NEI and the clinical learning environment should be improved. Both of these role players should be involved in planning the learning activities and outcomes for the students. Thus both parties will know what is expected of them and the students; moreover the students' abilities and skill requirements can be addressed more effectively.

### **5.4.3 Role models**

Role models are necessary to ensure that theory becomes practice. When students see their nurse educators and nurse managers in practice they gain confidence and skills are embedded. This is why nurse educators and managers also have to go through the process suggested in section 5.4.1. Nurse educators and managers have to understand intra-professional violence and its effect on the profession; but more importantly they need to know how to counter it and to be able to practise information seeking, active coping and problem solving. Subsequently, it is very important that they share this with the students in the clinical learning environment.



## CHAPTER 5

### 5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

The study focused on obtaining data pertaining to intra-professional violence in South Africa. Since intra-professional violence is becoming even more prevalent in the work environment, more research opportunities are available to build up a larger body of knowledge. Topics could include:

- Intra-professional violence in SA: a qualitative perspective
- Cognitive rehearsal in the SA context
- Nurse educators as perpetrators of intra-professional violence
- Why does intra-professional violence occur between graduates and diplomats?
- Clarification of concepts of internal sexism in nursing
- International collaboration to explore intra-professional violence worldwide

### 5.6 LIMITATIONS

Limitations became evident during the course of the study. The main limitation related to the sample as the researcher had planned to follow a random stratified sample taken from all of NEI in South Africa. This would have ensured optimal representation and the generalisability of the results to all undergraduate nursing students in South Africa. However, time constraints and slow response rates from some NEI resulted in a changed sample plan and only nine of the 16 NEI could be included. However, the researcher still set certain requirements to ensure that the strata within the target population would be represented within the study population.

Another limitation was the fact that the questionnaire content and method of distribution had to be arranged telephonically or via e-mail. Thus the researcher had to assume that the coordinators followed the instructions to ensure that all respondents were treated in the same manner.





## CHAPTER 5

### 5.7 RESEARCHER REFLECTION

The researcher expected that oppressed group behaviour would be low in the undergraduate nursing students, but that intra-professional violence would none the less be present. The researcher also expected that being treated differently owing to undergraduate status would be one of the top five behaviours that is experienced often but not that it would be the behaviour experienced most. The findings also confirmed the expectation that the undergraduate nursing students appraise these events as stressful but within their control and that disengaging coping mechanisms are implemented to manage the events.

As a nurse educator, the researcher had realised that nurse educators have a definite role to play in ensuring that intra-professional violence in the clinical learning environment is addressed. Nurse educators have a responsibility both to the undergraduate nursing students and to the nursing profession. In the classroom, nurse educators focus on teaching the undergraduate nursing students' theory and skills, making sure that they possess these very necessary tools. We also accompany the students in the clinical learning environment, and it is here that we need to make a difference by acting as role models, so the students will learn from our example. Our responsibility to the profession lies in the fact that we should empower our nursing colleagues (sister-in-charge, registered professional nurse, staff and assistant nurses) by reminding them of their role as clinical facilitator and assisting them to identify intra-professional violence and to address it.

From the respondents' written comments, the researcher found that the undergraduate nursing students would like this problem to be addressed and that they themselves are looking for opportunities to verbalise these experiences as well as for solutions.



## CHAPTER 5

Furthermore, the researcher has re-evaluated her relationships not only with the undergraduate nursing students, but also with her colleagues, family and friends, since intra-professional violence, no matter in what form, is still violence and is therefore not limited to specific professions or workplaces.

### **5.8 CONCLUSION**

Undergraduate nursing students at some of the NEI in South Africa are exposed to intra-professional violence in the clinical learning environment. Although oppressed group behaviour is present in some of the undergraduate nursing students it is not the only factor contributing to this violence. Although the undergraduate nursing students appraise intra-professional violence as stressful, they also appraise themselves as being able to control it. It was found that during intra-professional violence disengaging coping mechanisms are implemented. This warrants further research into this topic and the management of such violence in South Africa.



## REFERENCE LIST

### REFERENCE LIST

Anderson, C. 2002. Workplace violence: Are some nurses more vulnerable? *Issues in Mental Health Nursing*, 23(4): 351–366.

Anthony, K. 2006. Overview and summary: The multigenerational workforce: Boomers and Xers and Nets, Oh my! *Online Journal of Issues in Nursing*, 11(2): [1-3].

Barret, A., Piatek, C., Korber, S. & Padula, C. 2009. Lessons learned from a lateral violence and team-building intervention. *Nursing Administration Quarterly*, 33(4): 342-351.

Beech, B. 2008. Aggression prevention training for student nurses: Differential responses to training and interaction between theory and practice. *Nurse Education in Practice*. 8: 94-102.

Bond, M.E. 2009. Exposing shame and its effect on clinical nursing education. *Journal of Nursing Education*, 48(3): 132–140.

Briles, J. 2007. Snakes at the nursing station. *American Nurse Today*. Available from: <http://www.americannursetoday.com/Popups/ArticlePrint.aspx?id=3920> [Accessed: 2 April 2010].

Brink, H. 2006. Fundamentals of research methodology for health care professionals. 2<sup>nd</sup> edition. Cape Town: Juta.

Brink, H.I.L. 1990. *Statistics for nurses*. Pretoria: Academia.



## REFERENCE LIST

- Brown, B., Crawford, P. & Hicks, C. 2003. *Evidence-based research: Dilemmas and debates in health care*. Berkshire: Open University Press.
- Bryman, A. & Cramer, D. 1994. *Quantitative data analysis for social scientists*. London: Routledge.
- Burns, N. & Grove, S.K. 2009. *The research practice of nursing research: Appraisal, synthesis, and generation of evidence*. 6<sup>th</sup> edition. Missouri: Saunders Elsevier.
- Butchart, A., Brown, D., Khanh-huynh, A., Corso, P., Florquin, N. & R Muggah. 2008. *The economic costs of injuries due to interpersonal and self-directed violence*. Geneva: World Health Organisation.
- Camerino, D., Estryng-Behar, M., Conway, P.M., van der Heijden, B.I.J.M & Hasselhorn, H. 2008. Work-related factors and violence among nursing staff in the European NEXT study: A longitudinal cohort study. *International Journal of Nursing Studies*. 45: 35–50.
- Canada Safety Council. 2010. *Bullying in the workplace*. Available from: <http://safety-council.org/workplace-safety/bullying-in-the-workplace/> [Accessed: 23 June 2010]
- Capitulo, K.L. 2009. Addressing disruptive behaviour by implementing a code of professionalism to transform hospital culture. *Nurse Leader*. Available from: [www.nurseleader.com](http://www.nurseleader.com) [Accessed: 6 April 2010]
- Carter, R. 2000. Risk of violence against nurses. *Nursing management*, 6(8): 5.
- Celik, S.S. & Bayraktar, N. 2004. A study of nursing student abuse in Turkey. *Journal of Nursing Education*. 43(7): 330–336.



## REFERENCE LIST

Chan, D.S.K. 2002. Development of the clinical learning environment inventory: Using the theoretical framework of learning environment studies to assess nursing students' perceptions of the hospital as a learning environment. *Journal of Nursing Education*, 41(2): 69–75.

Chan, D.S.K. 2006. Perception of hospital learning environment: A survey of Hong Kong nursing students. *Nursing Education Today*, 27: 677–684.

*Collins South African dictionary*. 2007. Glasgow: HarperCollins Publishers.

Cooper, C.L. & Swanson, N. 2002. Workplace violence in the health sector: State of the art. *International Labour Organisation*. Available from: [www.who.int/violence\\_injury\\_prevention/violence/activities/workplace/WVstateart.pdf](http://www.who.int/violence_injury_prevention/violence/activities/workplace/WVstateart.pdf) [Accessed: 23 June 2010].

Cooper, J.R.M., Walker, J.T., Winters, K., Williams, P. R, Askew, R. & Robinson, J.C. 2009. Nursing students' perceptions of bullying behaviours by classmates. *Issues in Educational Research*, 19(3): 212–226.

Cozby, P.C. 2005. *Methods in behavioural research*. 9<sup>th</sup> edition. New York: McGraw-Hill.

Creswell, J.W. & Plano Clark, V.L. 2007. *Designing and conducting mixed methods research*. California: SAGE Publications.

Crotty, J. 2010. Staff nurses & nursing students: learning from each other. *Nursing 2010*, 51–52.

Curtis, J., Bowen, I. & Reid, A. 2007. You have no credibility; Nursing students' experiences of horizontal violence. *Nurse Education in Practice*, 7(3): 156–163.



## REFERENCE LIST

Daiski, I. 2004. Changing nurses disempowering relationship patterns. *Journal of Advanced Nursing*, 48(1): 43–50.

DeMeo, J. 2005. *Update on Saharasia: New findings since the first printing*. Available from: <http://www.orgonelab.org/SaharasiaNewUpdate.pdf> [Downloaded: 1 July 2010]

Dellasega, C.A. 2009. Bullying among nurses. *AJN*, 109(1): 52–58.

DeMarco, R.F. & Roberts, S.J. 2003. Negative behaviours in nursing. *American Journal of Nursing*, 103(3): 113–116.

DeMarco, R.F. [rdema10519@aol.com]. 2010. Re: NWS Questionnaire. Email to: Engelbrecht, N. [natasjha.engelbrecht@up.ac.za]. 12 April.

DeMarco, R.F., Roberts, S.J., Norris, A. & McCurry, M.K. 2008. Development of the Nurses' Workplace Scale. *Journal of Professional Nursing*, 24(5): 296–301.

Dewitty, V.P., Osborne, J.W., Friesen, M.A. & Rosenkranz, A. 2009. Workforce conflict: What's the problem. *Nursing Management*, 31–37.

Di Martino, V. 2002. Foreword. In: Workplace violence in the health sector. Available from: <http://www.ilo.org/public/english/dialogue/sector/papers/health/stress-violence.pdf> [Downloaded: 30 April 2010]

Duchscher, J.B. & Myrick, F. 2008. The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum*, 43(4): 191–206.

Einarsen, S., Raknes, B., Mattiesen, S. & Hellesøy, O. 1994. *Negative acts questionnaire, revised*. Bergen: Bergen Bullying Research Group.



## REFERENCE LIST

- Fanon, F. 1963. *The wretched of the earth*. New York: Grove Press.
- Farrell, G. A. 2001. From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35(1): 26–33.
- Felson, R.B. 2006. Violence as instrumental behaviour. In Kelloway, E.K., Barling, J. & Hurrell, J.J. *Handbook of workplace violence*. London: Sage, 7–28.
- Ferns, T. & Meerabeau, L. 2007. Verbal abuse experienced by nursing students. *Journal of Advanced Nursing*, 61(4): 436–444.
- Ferns, T. & Meerabeau, L. 2009. Reporting behaviours of nursing students who have experienced verbal abuse. *Journal of Advanced Nursing*, 65(12): 2678–2688.
- Freire, P. 1970. *Pedagogy of the oppressed*. London: Continuum International.
- Giddings, L.S. & Grant, B.M. 2007. A Trojan horse for positivism? A critique of mixed methods research. *Advances in Nursing Science*, 30(1): 52–60.
- Glanz, K., Rimer, B.K. & Lewis, F.M. 2002. *Health behaviour and health education: Theory, research, and practice*. 3<sup>rd</sup> edition. San Francisco: John Wiley & Sons.
- Griffin, M. 2004. Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Education*, 35(6): 257–263.
- Griffin, R.W. & O'Leary-Kelly, A.M. 2004. *The dark side of organizational behavior*. San Francisco: Jossey-Bass.



## REFERENCE LIST

Haddy, P. 2009. Do student midwives experience horizontal violence during their pre-registration programme? *The Plymouth Student Journal of Health and Social Work*, 1: 1-8.

Hader, R. 2008. Workplace violence: Survey 2008. *Nursing Management*, 38(12): 13-19.

Hegney, D., Eley, R., Plank, A., Buikstra, E. & Parker, V. 2006. Workplace violence in Queensland, Australia: the results of a comparative study. *International Journal of Nursing Practice*. 12: 220-231.

Hesketh, K.L., Duncan, S.M., Estabrooks, C.A., Reimer, M.A., Giovannetti, P., Hyndman, K. & Acorn, S. 2003. Workplace violence in Alberta and British Columbia hospitals. *Health Policy*, 63: 311-321.

Hinchberger, P.A. 2009. Violence against female student nurses in the workplace. *Nursing Forum*, 44(1): 37-46.

Hippeli, F. 2009. Nursing: Does it still eat its young, or have we progressed beyond this? *Nursing Forum*, 44(3): 186-188.

Hofstee, E. 2006. *Constructing a good dissertation*. Sandton: EPE.

Huston, C.J. 2006. *Professional issues in nursing: Challenges & opportunities*. Philadelphia: Lippincott Williams & Wilkins.

Hutchinson, M., Wilkes, L., Vickers, M & Jackson, D. 2008. The development and validation of a bullying inventory for the nursing workplace. *Nurse Researcher*, 15(2): 19-29.

International Council of Nursing. 2009. *Nurse matters*. Available from: [http://www.icn.ch/matters\\_violence.htm](http://www.icn.ch/matters_violence.htm) [Accessed: 26 June 2010].





## REFERENCE LIST

- Jacobs, D. & Kyzer, S. 2010. Upstate AHEC lateral violence among nurses project. *South Carolina Nurses' Association*, [1-2]
- Joint Commission. 2008. *Sentinel Event Alert: Behaviors that undermine the culture of safety*. Available from:  
[www.jointcommission.org/SentinelEvents/SentinelEventsAlert/sea\\_40.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventsAlert/sea_40.htm)  
[Accessed: 1 March 2010].
- Jacobson, J. 2007. Violence and Nursing. *American Journal of Nursing*, 107(2): 25-26.
- Kelloway, E.K., Barling, J. & Hurrell, J.J. 2006. *Handbook of workplace violence*. California: Sage Publications.
- Kelly, J. & Ahern, K. 2007. Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing*, 18: 910-918.
- Khalil, D. 2009. Levels of violence among nurses in Cape Town public hospitals. *Nursing Forum*, 44(3): 207-217.
- Kisa, S. 2008. Turkish nurses' experiences of verbal abuse at work. *Archives of Psychiatric Nursing*, 22(4): 200-207.
- Krug, E.G., Mercy, J.A., Dahlberg, L.L. & Zwi, A.B. 2002. The world report on violence and health. *Lancet*, 360: 1083-1088.
- Kuhn, T.S. 1970. *The structure of scientific revolutions*. 2<sup>nd</sup> edition. Chicago: University of Chicago Press.
- Kupperschmidt, B. 2006. Addressing multigenerational conflict: Mutual respect and carefronting as strategy. *Online Journal of Issues in Nursing*, 11(2): [1-10].



## REFERENCE LIST

Lamontagne, C. 2010. Intimidation: A concept analysis. *Nursing Forum*, 45(1): 54–65.

Lanza, M. 2006. Violence in nursing. In Kelloway, E.K., Barling, J. & Hurrell, J.J. *Handbook of workplace violence*. London: Sage, 147–167.

Lazarus, R.S. 1976. *Patterns of adjustment*. 3<sup>rd</sup> edition. New York: McGraw-Hill Book Company.

Levett-Jones, T. & Lathlean, J. 2009. The ascent to competence conceptual framework: an outcome of a study of belongingness. *Journal of Clinical Nursing*, 18: 2870–2879.

Lewis, M.A. 2006. Nurse bullying: organizational considerations in the maintenance and preparation of health care bullying cultures. *Journal of Nursing Management*, 14(1): 52–58.

Litwin, M.S. 2003. *How to assess and interpret survey psychometrics*. 2<sup>nd</sup> edition. California: Sage Publications.

LoBiondo-Wood, G. & Haber, J. 2006. *Nursing research: Methods and critical appraisal for evidence-based practice*. Missouri: Mosby Elsevier.

Longo, J. 2007. Horizontal violence among nursing students. *Archives of Psychiatric Nursing*, 21(3): 177–178.

Longo, J. 2010. Combating disruptive behaviours: Strategies to promote a healthy work environment. *The Online Journal of Issues in Nursing*, 15(1)  
Available from:

<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol152010/No1Jan2010.aspx> [Accessed: 30 April 2010].



## REFERENCE LIST

Longo, J. & Sherman, R.O. 2007. Leveling horizontal violence. *Nursing Management*, 38(3): 34–37, 50–51.

Lynaugh, J. 1980. The “entry into practice” conflict – How we got there and what will happen next. *American Journal of Nursing*, 80(2): 266–270.

Manderino, M.A & Berkey, N. 1997. Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing*, 13(1): 48–55.

Martin, M.M., Stanley, K.M., Dulaney, P. & Pehrson, K.M. 2008. Perspectives in psychiatric consultation liaison nursing. *Perspectives in Psychiatric Care*, 44(1): 58–60.

Matheson, L.K. & Bobay, K. 2007. Validation of oppressed group behaviours in nursing. *Journal of Professional Nursing*, 23(4): 226–234.

Mayhew, C. & Chappell, D. 2005. Violence in the workplace. *The Medical Journal of Australia (eMJA)*. 183(7): 346–347. Available from:

[http://www.mja.com.au/public/issues/183\\_07\\_031005/may10621\\_fm.html](http://www.mja.com.au/public/issues/183_07_031005/may10621_fm.html)

[Accessed: 18 December 2009].

Meissner, J.E. 1986. Nurses are we eating our young? *Nursing*, 16: 51–53.

Mellish, J.M. & Brink, H. 1990. *Teaching the practice of nursing: A text in nursing didactics*. 3<sup>rd</sup> edition. Durban: Butterworths

Merecz, D., Rymaszewska, J., Mościcka, A., Kiejna, A. & Jarosz-Nowak, J. 2006. Violence at the workplace – a questionnaire survey of nurses. *European Psychiatry*, 21: 442–450.



## REFERENCE LIST

Nachreiner, N.M., Hansen, H.E., Okano, A., Gerberich, S.G., Ryan, A.D., McGovern, P.M, Church, T.R. & Watt, G.D. 2007. Difference in work-related violence by nurse license type. *Journal of Professional Nursing*, 23(5): 290–300.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHS). 1979. *The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research*. Available from: <http://ohsr.od.nih.gov/guidelines/belmont.html>

[Accessed: 30 April 2010]

National Research Foundation (NRF). 2010. Available from: [www.nrf.ac.za](http://www.nrf.ac.za)

[Accessed 30 April 2010]

North, D.C., Wallis, J.J. & Weingast, B.R. 2009. *Violence and social orders: A conceptual framework for interpreting recorded human history*. New York: Cambridge University Press.

Pellico, L.H., Brewer, C.S. & Kovner, C.T. 2009. What newly licensed registered nurses have to say about their first experiences. *Nursing Outlook*, 57(4): 194–203.

Petrie, A. & Sabin, C. 2009. *Medical statistics at a glance*. 3<sup>rd</sup> edition. West Sussex: John Wiley & Sons.

Pinker, S. 2007. *A history of violence*. Available from: <http://www.global-mindshift.com/discover/Memebase/A%20HISTORY%20OF%20VIOLENCE.pdf>  
[Downloaded: 1 June 2010]

Polit, D.F. & Beck, C.T. 2006. *Essentials of nursing research: Methods, appraisal, and utilization*. Philadelphia: Lippincott Williams & Wilkins,



## REFERENCE LIST

Polit, D.F. & Beck, C.T. 2008. *Nursing research: Generating and assessing evidence for nursing practice*. 8<sup>th</sup> edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Beck, C.T. 2010. *Essentials of nursing research: Appraising evidence for nursing practice*. 7<sup>th</sup> edition. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Reiss, A.J. & Roth, J.A. 1993. *Understanding and preventing violence*. Washington, DC: National Academy Press.

Republic of South Africa. South African Nursing Council. *Minimum requirements for the education and guide concerning the teaching of students in the programme leading to registration as a nurse (General, Psychiatric and Community) and Midwife*.R. 425. 22 February 1985 as amended 1994. Pretoria: Government Printer.

Republic of South Africa. 1978. *Nursing Act, no. 50 of 1978*. Pretoria: Government Printers.

Republic of South Africa. 2005. *Nursing Act, no. 33 of 2005*. Pretoria: Government Printers.

Roberts, S.J. 1983. Oppressed group behaviour: Implications for nursing. *Advances in Nursing Science*, 5(4): 21–30.

Roberts, S.J., DeMarco, R. & Griffin, M. 2009. The effect of oppressed group behaviours on the culture of the nursing workplace: a review of the evidence and interventions for change. *Journal of Nursing Management*, 17: 288–293.



## REFERENCE LIST

Roche, M., Diers, D., Duffield, C. & Catling-Paull, C. 2010. Violence towards nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1): 13–22.

Rocker, C.F. 2010. Addressing nurse-to-nurse bullying to promote nurse retention. *The Online Journal of Issues in Nursing*. Available from: <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No3Sept08/ArticlePreviousTopic/NursetoNurseBullying.aspx> [Accessed: 6 April 2010]

Rosenstein, A.H. & O'Daniel, M. 2002. A survey of the impact of disruptive behaviours and communication defects on patient safety. *The Joint Commission Journal on Quality and Patient Safety*, 34(8): 464–471.

Rowe, M.M & Sherlock, H. 2005. Stress and verbal abuse in nursing: do burned out nurses eat their young? *Journal of Nursing Management*, 13: 242–248.

Rumsey, M., Foley, E. & Dakin, S. 2007. *National overview of violence in the workplace*. Royal College of Nursing: Australia.

Rutherford, A., Zwi, A.B., Grove, N.J. & Butchart, A. 2007. Violence: a glossary. *Journal of Epidemiology and Community Health*, 61:676–680.

Schat, A.C.H & Kelloway, E.K. 2006. Training as a workplace aggression intervention strategy. In Kelloway, E.K., Barling, J. & Hurrell, J.J. *Handbook of workplace violence*. London: Sage, 579–605.

Sheridan-Leos, N. 2008. Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing*, 12(3): 399–403.



## REFERENCE LIST

Simons, S. 2008. Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, 31(2): E-48–E59.

Simpson, K.R. 2008. Horizontal hostility. *Perinatal PATIENT safety*, 33(5): [1].

Smetzer, J. & Cohen, M. 2005. Intimidation: Practitioners speak up about this unresolved problem. *Journal on Quality and patient Safety*, 31(10): 594–600.

Solidarity Research Institute. 2009. *Nurse shortage in South Africa*. Available from: [www.solidarity.co.za](http://www.solidarity.co.za) [Accessed 26 June 2010].

South African Nursing Council. 1985. *Regulations relating to the approval of and the minimum requirements for the education and training of a nurse (General, Psychiatric and Community) and Midwife leading to registration*. R. 425. 1985 Pretoria: Government Printer.

South African Nursing Council. 2010. [Age Analysis of Persons on the Registers and Rolls, 2010](http://www.sanc.co.za/stats/stat2010/Age%20stats%202010_files/frame.htm). Available from: [http://www.sanc.co.za/stats/stat2010/Age%20stats%202010\\_files/frame.htm](http://www.sanc.co.za/stats/stat2010/Age%20stats%202010_files/frame.htm) [Accessed 13 January 2011].

South African Nursing Council. 2010. *Output 4-year programme (2000–2009) Universities*. Available from: [www.sanc.co.za/stats/stat\\_ts?output%202000-2009%204YP\\_files/slide0030.htm](http://www.sanc.co.za/stats/stat_ts?output%202000-2009%204YP_files/slide0030.htm) [Accessed: 23 June 2010].

South African Nursing Council. 2010. *Output 4-year programme (2000–2010) Universities*. Available from: [www.sanc.co.za/stats/stat\\_ts?output%202000-2009%204YP\\_files/slide0030.htm](http://www.sanc.co.za/stats/stat_ts?output%202000-2009%204YP_files/slide0030.htm) [Accessed: 13 January 2011].



## REFERENCE LIST

Spector, P.E., Fox, S. Domagalski, T. 2006. Emotions, violence, and counterproductive work behavior. In Kelloway, E.K., Barling, J. & Hurrell, J.J. *Handbook of workplace violence*. London: Sage, 29–46.

Stanley, K.M. 2010. Why so many names for bad behaviour? *The South Carolina Nurse*, [1-3].

Stanley, K.M., Martin, M.M., Michel, Y., Welton, J.M. & Nemeth, L.S. 2007. Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing*, 28: 1247–1265.

Struwig, F.W. & Stead, G.B. 2001. *Planning, designing and reporting research*. Cape Town: Maskew Miller Longman/Pearson.

Terre Blanche, M & Durrheim, K. 1999. *Research in practice: Applied methods for the social sciences*. Cape Town: University of Cape Town.

Thomas, S.P. & Burk, R. 2009. Junior nursing students' experiences of vertical violence during clinical rotations. *Nursing Outlook*, 57(4): 226–231.

Twaddle, A. & Hessler, M. 1977. *A sociology of Health*. St. Louis: Mosby.

Underreporting of Violence in the workplace. [s.a] Available from:  
<https://wiki.usask.ca/nursing/images/d/db/Nurse.jpg> [Accessed April 2010]

Vallant, S and Neville, S. 2006. The relationship between student nurse and nurse clinician: impact on student learning. *Nursing Praxis in New Zealand*, 22 (3): 23–33.





## REFERENCE LIST

Vessy, J.A., DeMarco, R.F., Gaffney, D.A. & Budin, W.C. 2009. Bullying of staff registered nurses in the workplace: Preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25(5): 299-306.

Vivar, C.G. 2006. Putting conflict management into practice: a nursing case study. *Journal of Nursing Management*, 14: 201-206.

Walrath, J.M., Dang, D. & Nyberg, D. 2010. Hospital RN's experiences with disruptive behavior. *Journal of Nursing Care Quality*, 25(2): 105-116.

Wieviorka, M. 2009. *Violence: a new approach*. London: Sage.

Woelfle, C.Y. & McCaffrey, R. 2007. Nurse on nurse. *Nursing Forum*, 42(3): 123-131.

World Health Organization (WHO). 1996. *Violence: a public health priority*. Available from: <http://www.who.int/topics/violence/en/> [Accessed 26 June 2010].

World Health Organization (WHO). 2009a. *New research shows workplace violence threatens health services*. Available from: <http://www.who.int/mediacentre/news/releases/release37/en/print.html> [Accessed 18 December 2009].

World Health Organization (WHO). 2009b. *Violence and injury prevention and disability*. Available from: [http://www.who.int/violence\\_injury\\_prevention/violence/activities/workplace/background.html](http://www.who.int/violence_injury_prevention/violence/activities/workplace/background.html) [Accessed 17 December 2009].

Yilidirim, D. 2009. Bullying among nurses and its effects. *International Nursing review*, 56: 504-511.



## ANNEXURES

### **ANNEXURE A**

#### **Ethical approval to conduct the research**

- A1 Faculty of Health Science Ethics Committee
- A2 Nursing Education Institution
- A3 Permission to use NWS and BNEQ



## ANNEXURES

### A1: Faculty of Health Science Ethics Committee



## ANNEXURES

### A2: Nursing Education Institution



## ANNEXURES

### A3: Permission to use NWS and BNEQ



## ANNEXURES

### **ANNEXURE B**

## **Letter of invitation to NEI to participate in the study**



## ANNEXURES

### ANNEXURE C

#### Questionnaire

- C1 Questionnaire from which the questionnaire was derived
- C2 Preliminary questionnaire
- C3 Questionnaire adopted based on feedback following the pre-test
- C4 Printed copy of powerpoint presentation accompanying questionnaire



## ANNEXURES

C1: Questionnaire from which the questionnaire  
was derived





## ANNEXURES

### C2: Preliminary questionnaire



## ANNEXURES

C3: Questionnaire adopted based on feedback  
following pre-test



## ANNEXURES

C4: Printed copy of powerpoint presentation  
accompanying questionnaire



## ANNEXURES

### **ANNEXURE D**

#### **Letter from statistician**



## ANNEXURES

# ANNEXURE E

## Letter from editor