DECLARATION

I declare that Workplace violence experienced by student nurses during clinical placement at Psychiatric institutions in KwaZulu-Natal is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Nomhle Mvunelo

17 December 2013
DEDICATION

This dissertation is dedicated to my late father Sicelo Edward Mtshengu, my living mother Nompucuko Florida Mtshengu, my husband Simthembile Mvunelo, and my children Nolita, Thandeka and Mandisi for encouragement, love and continued support.
ACKNOWLEDGEMENT

I want to thank the following persons for their respective contributions to this dissertation:

- My husband, Simthembile, for his unconditional love, support and encouragement.
- My three children, Nolita, Thandeka and Mandisi; for their support and understanding.
- My Mother, Nompucuko Mtshengu, for support and encouragement.
- A special thank you to my supervisor, Mrs C. Young, for her guidance, support and encouragement.
- My colleague, Miss L. Snell, for encouragement and support throughout.
- Principals of the Campuses, for allowing me to collect data from the student nurses.
- The Kwazulu-Natal College of Nursing ethics committee, for allowing me to use Campuses for data collection.
- The KwaZulu-Natal Province: Department of Health, for giving me the permission to conduct the study.
- Mrs P. Fogg for editing the manuscript.
- Ms Lize Vorster for technical editing of the study
ABSTRACT

Workplace violence directed at student nurses in training in psychiatric institutions is a significant concern as it negatively affects the quality of learning and causes the students to have a negative perception of nursing as a profession. The absence of scientific data describing the perceptions of student nurses about workplace violence and their clinical learning outcome motivated the researcher to conduct the study. Quantitative, descriptive research was conducted to explore the influence that workplace violence will have on clinical learning outcomes of student nurses who are studying psychiatric nursing at psychiatric institutions in KwaZulu-Natal, in South Africa. Data was gathered using a 71 question questionnaire, which was adapted from the one used by Hewett (2010). With the necessary permission from the health authorities, the campus principals and the nursing students, a group of 4th year student nurses (n=163) from 6 campuses of the KwaZulu-Natal College of Nursing (KZNCN) who have worked in psychiatric units for at least 3 months and longer participated in the study. The study highlighted the types of workplace violence encountered by student nurses, the effects of workplace violence on students’ academic performance and the barriers to the reporting of workplace violence encountered by the student nurses. The study revealed that there is a large amount of non-physical, some physical and a few incidents of sexual violence directed towards the student nurses at the psychiatric institutions, and that it has a negative impact on student learning. The recommendations emanating from the study support the idea of a shared responsibility between healthcare and education institutions and the focus is on preparing and equipping the student psychiatric nurses to confront, withstand and break the cycle of workplace violence.

KEY CONCEPTS: Workplace violence, Clinical learning, Clinical environment.
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<th>Description</th>
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<tbody>
<tr>
<td>CCMA</td>
<td>Council for Conciliation, Mediation &amp; Arbitration</td>
</tr>
<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
</tr>
<tr>
<td>KZNcCN</td>
<td>KwaZulu-Natal College of Nursing</td>
</tr>
<tr>
<td>MEC</td>
<td>Member of executive council</td>
</tr>
<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
</tr>
<tr>
<td>UKZN</td>
<td>University of KwaZulu-Natal</td>
</tr>
<tr>
<td>UNISA</td>
<td>University of South Africa</td>
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CHAPTER 1: ORIENTATION OF THE STUDY

1.1 INTRODUCTION

In this first chapter, an overview of the research project is presented. The background, purpose, objectives and the significance of this study are also presented. A brief overview of the research methodology and definitions of the key elements are provided. The ethical considerations underpinning the study and the scope of the study are also discussed.

Health care professionals have a high risk of being attacked at work hence workplace violence experienced by nurses has received increasing global attention (Weisbrod 2007:7).

Lappalainen (2010:1), having encountered violence while working with patients in psychiatric wards states, “the mental health sector has a greater likelihood of staff becoming victims of occupational violence than staff working in general settings”. The author further suggests that there is a need for “risk violence assessment, prevention and management strategies to handle the phenomenon”.

Despite the growing literature focusing on workplace violence experienced by nurses, there are few research studies which focus on the perceptions and experiences of nursing students in relation to workplace violence experiences (Weisbrod 2007:7).

A study conducted by Hewett (2010) in the Western Cape College of Nursing confirmed that nursing students do experience workplace violence during training in clinical settings. This idea was further reinforced by Papastavrou, Lambrinou, Tsangari, Saariskoski and Lieno-Kilpi (2010:177), who claim that clinical settings fail to provide students with positive examples of behaviour; and that they are a source of stress, creating feelings of fear and anxiety which in turn affect the student responses to learning.

Workplace violence has serious consequences, both for those who provide and those who receive health care (Weisbrod 2007:8). Students are recognized as part of the health care provider team when placed in the clinical area to gain practical
experience; therefore they suffer the same consequences as any other health care provider.

The purpose of this study was to examine the types and effects of workplace violence experienced by student nurses when placed in psychiatric clinical environment for clinical learning, to identify barriers to reporting of workplace violence by student nurses and to make recommendations for its prevention by nurse education institutions and nursing services managers. Practical experience is necessary in nursing education as it assists the nurse in training to learn the skill or art of nursing. Papastavrou et al. (2010:177) states, “One of the main features of nursing as a science and a profession is that nursing education is characterised by a close relationship between theory and practice, meaning that nursing cannot be learned through either theory or practice only”. Caka and Lekalakala-Mokgele (2013), in agreement with the above statements, mention that the aim of placement of the students in the clinical area is to afford them the opportunity to practice patient care under the supervision of a qualified clinical nurse, in preparation for being able to provide competent care to the patient upon completion of training.

The objectives of this study were to identify the types of workplace violence encountered by student nurses, the effects of workplace violence on students’ academic performance and the barriers to the reporting of workplace violence encountered by the student nurses. Recommendations to the nursing education institutions and nursing service managers of the psychiatric institutions regarding the prevention and management of workplace violence aimed towards student nurses will be made.

The population under study was student nurses that were registered for the four year comprehensive course leading to registration as a nurse (General, Psychiatric and Community) and Midwifery in a Nursing College of KwaZulu-Natal. The target was the student nurses that were in their fourth year of training, doing the psychiatry module. Psychiatric training in the province of KwaZulu-Natal is done in the second semester of the fourth year, i.e. the last six months of their training in the programme. Psychiatry is a six months module and it requires student nurses to be placed in mental health units in order to be taught psychiatric skills so that they can become competent in psychiatric practical nursing.
With the findings of this study, the researcher aimed to extend the knowledge about the occurrence, type, effect of workplace violence towards student nurses during their psychiatric placement to prevent and/or manage workplace violence in the respective psychiatric units via recommendations to the nurse educator institutions and the nursing service managers of the psychiatric institutions.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Several studies by Lappalainen (2010:4); Weisbrod, 2007; Middleby-Clements (2009:14); Pai and Lee (2010:1410); Jackson, Hutchison, Everett, Mannix, Peters, Weaver and Salamonson (2011:102); Zampieron, Galleazzo, Turra, and Buja (2010:2329); Chapman, Styles, Perry and Combs (2010:479); Child and Mentes (2010:89); Hutchinson, Vickers, Wilkes and Jackson (2010:2319); Chen, Hwu, Lin, Guo, Su and Wang (2010:164); Bimenyimana (2008:2) and Cunniff and Mostert (2012:3) investigated workplace violence in nursing, and they found that occupational violence in the health care sector has been on the rise over the past decades, and out of all health care workers, nurses were at greatest risk of workplace violence. Nurses working in psychiatric settings were also at risk of occupational violence. In support of the above statement, Lappalainen (2010:6) stated, “The risk potential for workplace violence to nurses working in psychiatric settings is higher than their colleagues working in general settings”. Chapman et al. (2010:479) agreed that mental health units were particularly prone to workplace violence events. This statement caused the researcher to become interested in the status of student nurses with regards to their experience of workplace violence in a psychiatric setting.

In many studies there were concerns about the under-reporting of violence within the health care industry. According to Middleby-Clements (2009:18), non-fatal incidents, especially threats, were usually not reported. Among the reasons mentioned for this reluctance in the reporting of workplace violence were the organizational culture, embarrassment, excusing the behaviour of the patient (Middleby-Clements 2009:18), a lack of confidence in the employers, the absence of a reporting system, or empathy for the patient (Zampieron et al. 2010:2331).

In South Africa, studies by Steinman (2003:5); Bimenyimana (2008:53-55) and Engelbrecht (2012:3) also indicated the presence of workplace violence in health
care, including mental health institutions. Hewett (2010:96) conducted her study in the Western Cape College of Nursing and found that 76% of student nurses had frequently encountered acts of non-physical violence in the clinical area and that student nurses suffered grave emotional consequences as a result of this workplace violence. Steinman (2003:8) reported that 90% of the respondents for the research that was conducted by the Medical Research Council on the impact of crime and violence on the delivery of State Health Care Services in the Western Cape have been verbally abused.

Engelbrecht (2012: ii) mentioned that many undergraduate nursing students considered leaving the profession due to their exposure to intra-professional violence. Engelbrecht (2012:115), Hewett (2010:96) and Magnavita & Heponiemi (2011:206), who investigated violence towards student nurses, all agreed that the common types of violence encountered by student nurses included being treated differently due to their undergraduate status, the rudeness of being yelled and shouted at, humiliation, and being ignored.

From the above studies, one could conclude that the problem of workplace violence does not only affect trained nurses, but student nurses as well, and that violence in the health sector was present both nationally and internationally.

1.3 STATEMENT OF THE RESEARCH PROBLEM

A problem statement identifies the nature of the problem that is being addressed in the study and states its context and significance (Polit & Beck 2008:93). A significant problem statement should indicate the importance of the problem to nursing and to the health individuals, families and communities (Burns & Grove 2009:68).

Student nurses registered for the four year comprehensive course, that are placed in clinical units for integration of learned theory to practice during the training period experience several types of workplace violence. These include bullying, being treated differently, being ignored, being physically isolated, receiving negative remarks about becoming a nurse, being yelled or shouted at in rage, having people roll their eyes at them, not receiving acknowledgement for good work, being personally criticised, and receiving inappropriate feedback from co-workers and
supervisors in the clinical area (Engelbrecht 2012:109-112). These experiences could impact negatively on the clinical learning and on the physical and mental wellbeing of the student nurses. Nurses who were trained under such circumstances could view nursing as a dangerous profession and might consider leaving it, leading to a shortage of nurses and difficulty in the recruitment and retention of nurses in South Africa. On the other hand, student nurses could become socialised to the culture of violence in the workplace and could then even practise the same when they qualified as nurses. Such practice could impact negatively on the image of the nursing profession and the possibility of negative implications for patient safety cannot be ruled out (Hewett 2010:116). Families and communities could be exposed to violence when they visited health care facilities or may not have nurses to care for them. The health care sector will then be judged as failing in service delivery by the communities and neighbouring countries.

1.4 RESEARCH PURPOSE

The research purpose is generated from the problem and the research questions / objectives (Brink, Van der Walt & Van Rensburg, 2012:62). The purpose of this study was to examine the types and effects of workplace violence experienced by student nurses when placed in the psychiatric clinical environment for clinical learning, to identify barriers to reporting workplace violence by student nurses and to make recommendations regarding prevention and management of workplace violence towards student nurses via the nurse education institutions and nursing services managers of psychiatric institutions.

1.4.1 Research objectives

Research objectives are clear, concise, declarative statements expressed to direct a study, and they focus on the identification and description of variables (Burns & Grove, 2009:719). The specific objectives of this study with reference to psychiatry clinical placement were:

1. To establish the types of workplace violence incidences experienced by student nurses during their placement in psychiatric units.
2. To determine the effects of workplace violence on student learning in the psychiatry clinical environments.
3. To identify the barriers to the reporting of workplace violence encountered by the student nurses.
4. To make recommendations regarding prevention and management of workplace violence towards student nurses to the nursing education institutions and nursing service managers of psychiatric institutions.

1.5 SIGNIFICANCE OF THE STUDY

Studies (Magnavita & Heponiemi 2011; Lappalainen 2010; Hewett 2010; Engelbrecht 2012 and De Villiers, Khalil & Mayers 2008) highlighted the presence of workplace violence directed at nurses and student nurses in the health sector and its negative effect on the nursing practice. Having noticed the prevalence of workplace violence experienced by nurses in psychiatric institutions, the researcher proposed to investigate the presence of workplace violence directed at student nurses that were practising specifically in psychiatric units, as this area had not been addressed in literature. Not a single study was found during the literature search that specifically investigated psychiatric student nurses’ experiences in South Africa.

The study intended to identify the types of workplace violence encountered by student nurses, the effects of workplace violence on students’ academic performance and the barriers to the reporting of workplace violence encountered by the student nurses and to make recommendations regarding the prevention and management of workplace violence to student nurses by the nursing education institution and nursing service managers.

The findings of this study could be an advantage to all future student nurses, because they would receive the support needed to overcome and effectively deal with difficult workplace scenarios that hold the potential for workplace violence if findings of the study are addressed adequately.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Workplace violence

Workplace violence refers to violent acts directed toward workers, includes physical assault, the threat of assault, and verbal abuse and is widely recognized as having
far reaching consequences for worker’s health and safety (Magnavita & Heponiemi 2011:203).

1.6.2 Student nurse

A student nurse is a person registered as a student with the South African Nursing Council to follow a course of study leading to registration as a nurse (General, Psychiatric and Community) and Midwife (Nursing Act 2005:27). The student nurses registered for the R425 program in KwaZulu-Natal do the psychiatry module in the last six months of the fourth year of training.

1.6.3 Psychiatric units

In this study psychiatric units mean any psychiatric practice unit where the students will acquire psychiatric practical knowledge and skills. Practical placement settings include hospital wards and departments, community health centres, General Practitioner (GP) surgeries, schools, residential homes, industry and day care centres (Quinn & Hughes 2007:341).

1.6.4 Clinical placement

The concept ‘clinical’ comes from the Greek ‘klinikos’ meaning ‘a bed’, the patient receives clinical care while being in the bed (Bruce, Klopper & Mellish 2011:253). Placement is defined as the action of putting something in a certain position (Oxford Paperback English Dictionary 2010:568-569). Clinical placements enable nursing students to learn from clinical encounters with patients, clients, families and communities, and to meaningfully transfer learning from theory into practice, according to Bruce et al. (2011:253).

1.6.5 Staff members

The concept ‘staff’ refers to workers, employees, workforce, personnel, or human resources (Oxford Thesaurus of Current English Dictionary 2006:421).

Member refers to subscriber, associate, supporter, fellow, and representative (Oxford Thesaurus of Current English Dictionary 2006:276).
In this study, staff member refers to professional nurses, enrolled nurses and enrolled nursing assistants working in the same unit of a component where the student nurse is placed.

1.6.6 Learning

Learning refers to gaining knowledge or skill in something through study or experience or being taught (Paperback Oxford English Dictionary 2010:429). In nursing education it involves the correlation between theory learned in college and the direct observation of the patient at the bedside (Meyer, Naude, Shangase & Van Niekerk 2009:132).

1.7 OPERATIONAL DEFINITIONS

An operational definition is the description of how variables or concepts will be measured or manipulated in a study (Burns & Grove 2009:40).

1.7.1 Independent variable: Workplace violence

Workplace violence, for the purpose of this study, included all items listed in Items 5-35 in Section B of the questionnaire. These included non-verbal behaviours (the raising of eyebrows, rolling of eyes, being ignored or neglected, and being left alone in the unit), verbal behaviours (being insulted or sworn at, shouted or yelled at, ridiculed or humiliated, made to feel guilty, harshly judged / criticized, racial slurs, being threatened with physical violence, the lack of acknowledgement for good work done, being denied learning opportunities, given an unfair work allocation and not being treated as part of the team), physical acts (including being pushed or shoved, kicked, slapped or punched, hit with something, having a gun or knife drawn on them, having their arm twisted, their hair pulled, and damage to their property), and finally, sexual harassment (including been inappropriately touched, threatened with sexual assault, having to endure sexist remarks, having suggestive sexual gestures directed at them, and receiving a request for intimate physical contact). All of these impacted negatively on the workplace of the student nurse.
1.7.2 Dependent variable: Learning

Learning is the acquisition of knowledge, skills and attitudes necessary to become an efficient and effective professional nurse. Adequate learning of professional roles can only take place if the environment is free from violence or if the learner possesses effective coping mechanisms to deal with the stress related to workplace violence. Items 58-61 in Section D of the questionnaire addressed the effects of workplace violence on the individual (such as anger, depression, humiliation / embarrassment, anxiety / fear, confusion, feelings of inadequacy, and a negative effect on personal relationships), and ultimately on work performance (such as considering leaving nursing, absenteeism and lower standards of patient care).

1.7.3 Independent variable: Clinical staff

Clinical staff refers to staff members working in the psychiatric environment where student nurses were placed to acquire their psychiatric experience, in order to qualify as registered nurses. Items 40-49 in Section C identified specific members of the clinical staff (such as registered nurses, staff nurses, assistant nurses, clinical facilitators, lecturers, doctors, administrative staff, and housekeeping staff) that the student might meet during their clinical placement in a psychiatric environment.

1.7.4 Independent variables: Patients and patients’ relatives

Patients and patients’ relatives are those individuals upon which the student nurse practices in order to be competent in nursing practice. These two independent variables are listed in items 38 & 39 of Section C of the questionnaire.

1.7.5 Dependent variable: Student nurse

A student nurse is defined as the nursing student who is in the last semester of the fourth year of the comprehensive four year course in nursing (R425) at the College of Nursing of KZN, who has completed their psychiatric clinical placement of three months and more.
1.7.6 Dependant variable: Psychiatric unit

The psychiatric unit includes all of the settings listed under items 36 and 37 in Section C of the questionnaire and includes hospitals and community settings like clinics, rehabilitation centres and schools.

1.8 THEORETICAL/META-THEORETICAL GROUNDING

A theoretical framework is an abstract, logical structure that guides the development of the study and enables the researcher to link findings to the body of knowledge in nursing (Burns & Grove 2009:126). This study was based on the premise of the theory proposed by Hildegard Peplau, which states that nursing is an interpersonal process involving interactions between two or more individuals with a common goal of respect for each other as individuals, both of them learning and growing as a result of the interaction (George 2011:65). Cherry and Jacob (2008) are quoted as having said that the “Interpersonal relations model explores the interpersonal relationships of the nurse and the client and identifies the client’s feelings as a predictor of positive outcomes related to health and wellness. When a client encounters an insult, it renders him or her incapable of moving forward because of existing stressful environmental conditions and anxiety increases”.

In a teacher-student interaction, when a student encounters a stressful negative clinical environment, anxiety ensues and learning in that particular environment is hampered.

The researcher designed the framework below to indicate the outcomes of a negative environment on a student nurse.
1.9 RESEARCH DESIGN

A research design is the plan, recipe or blueprint for the investigation, which provides a guideline according to which a selection can be made of which data collection methods will be the most appropriate to the researcher’s goal, and to the selection of the design (De Vos, Strydom, Fouche & Delport 2011:171). A quantitative-descriptive research has been used in this study.

1.9.1 Research paradigm

A quantitative research paradigm allowed for the formal, objective, rigorous and systematic collection of information (Burns & Grove, 2009:22). Numerical information gathered from the formal measurements was analysed using statistical procedures. The findings of the study were generalized to individuals other than those who participated in the study (Polit & Beck 2008:16).

Utilizing a quantitative descriptive method enabled the researcher to describe the phenomenon of workplace violence in real life, and to explore and explain the relationship between the variables (Brink 2006:102).

Figure 1.1: Conceptual Framework Demonstrating the Effects of a Negative Environment on Student Nurses.
The study complied with the characteristics of a quantitative-descriptive research method to ensure the validity of the information, generalizability of the findings and the appropriate theory development.

1.9.2 Research design

Descriptive research design is used when there is little that is known about the phenomenon, to discover new meaning, describe what exists, to determine the frequency with which something occurs and to categorize information (Burns & Grove 2009:26). Initially the researcher was unsure whether there actually was any violence directed toward student nurses in psychiatric clinical environments. The design allowed the researcher to discover the presence as well as the nature and extent of violent incidents directed at the student nurses in psychiatric units. Information was gathered using a self-reporting questionnaire which was analysed to generate findings.

1.10 RESEARCH METHODS

Research methods refer to the specific steps to be undertaken in a study (Burns & Grove 2009:718).

1.10.1 Sample selection

A non-probability purposive sampling technique was followed in selecting subjects. The researcher based the selection entirely on own judgement to choose subjects that possessed the most characteristic and typical attributes of the population to serve best on the study (De Vos et al.2011:232). The non-probability purposive sampling method is often used productively by qualitative researchers (Polit & Beck 2010:312) but in this study it allowed the researcher to make use of all psychiatric students from all the southern region campuses of KZNCN, whereas other sampling methods would have excluded some members. Choosing the entire group of members from the southern campuses of KZNCN also contributed positively to the sample size as desired by the researcher. Those chosen to take part in the survey met the criteria of selection.
**Population under study:** The population studied by the researcher was the student nurses registered at the KwaZulu-Natal College of Nursing.

**Target population:** Student nurses registered for the comprehensive four year diploma in nursing that were in their fourth year of training and were registered for the psychiatry module at that time.

**Accessible population:** The 6 southern campuses of the KwaZulu-Natal College of Nursing were the accessible sites for this research. The chosen campuses for this study included: Addington, Edendale, Greys, Prince Mshiyeni Memorial, Port Shepstone and the R.K.Khan campuses.

**Criteria of selection:** The study was limited to student nurses who were doing psychiatry nursing science.

- They had been in the psychiatry clinical field for a minimum period of three months.
- They were registered on the R425 program leading to registration as a nurse (General, Psychiatric and Community) and Midwifery.
- They were able to read and speak English.
- They were practicing within the province of KwaZulu-Natal, and were from the southern campuses of the KwaZulu-Natal College of Nursing.
- There was no ethnic limitation.
- There was no age limitation.

**Sample Size:** For quantitative studies there are no simple formulas that can indicate how large a sample will be needed in a given study, but as a general recommendation, the largest sample possible should be used (Polit & Beck 2012:284). The sample size was 177 subjects from 6 different Campuses of the southern region of the KwaZulu-Natal College of Nursing, which included Addington, Edendale, Greys, Port Shepstone, Prince Mshiyeni Memorial and the R.K.Khan campuses.

1.10.2 **Data collection**

The questionnaire was adapted from the one used by Hewett in her study of 'Workplace violence experienced by student nurses during period of placement in
the clinical areas’ (Hewett 2010:131). The reason for using this questionnaire was that it addressed all of the areas that the researcher wanted to focus on. Some changes were made by the researcher to the questionnaire to include the concepts “psychiatric units” before the words clinical areas in sub-sections B and C subheadings to reinforce to respondents that only psychiatric experiences were being evaluated.

The researcher contacted each campus and arranged a convenient date and time for the collection of the data. The researcher requested permission from the Principal of the KwaZulu-Natal College of Nursing and from the Principals of the 6 campuses, to meet with the subjects at the pre-arranged time to explain the purpose of the study. Before any data was collected, the researcher explained the purpose of the study, the procedure for the data collection, allowed the subjects an opportunity to ask questions and then requested them to complete the consent form.

A lecturer assisted the researcher with the handing out of the questionnaires to the subjects on all of the campuses on the pre-arranged dates. The subjects were given time to sign the consent forms, after which the instrument was distributed. The researcher informed the subjects that they would be given 1 hour in which to complete the task. The completed and uncompleted questionnaires were then collected an hour later by the respective campus co-ordinators.

Psychological pain was anticipated from those participants who had encountered some type of workplace violence, as it was thought that their feelings could have been provoked. Any subjects identified as having psychological problems as a result of their experiences would be referred to the hospital psychologists, and fortunately there were none reported.

1.10.3 Data analysis

The researcher made use of descriptive statistics, frequency distributions, measures of central tendency, inferential statistics such as the chi-square test, the independent t-test and Pearson’s r correlation coefficient test to analyse the data.
1.11 DESIGN VALIDITY

Validity is the degree to which an instrument measures what it is supposed to measure (Polit & Beck 2012:336). Aspects for testing validity are face, content, criterion and construct validity.

1.11.1 Face validity

Face validity refers to whether the instrument looks like it is measuring the targeted construct (Polit & Beck 2012:336). The questionnaire was designed such that it had subsections with the subtopics relevant to the topic under study, and the rows and columns made it easy for the participants to know exactly where to place their responses and to see that the questions were related to workplace violence.

1.11.2 Content validity

Content validity is concerned with whether the items contained in the measurement instrument are representative of the content domain that the researcher intends to measure (LoBoindo-Wood & Haber 2010:288). The researcher was guided by the research objectives to ensure that all of the needed content was covered within the questionnaire. The questionnaire was based on the reviewed literature and had been subjected to scrutiny by the supervisor and the ethics committee at the University of South Africa.

1.11.3 Construct validity

Construct validity is based on the extent to which a test measures a theoretical construct underlying the study (LoBoindo-Wood & Haber 2010:290). Section D of the questionnaire included personal and work performance effects of violence on the student nurse. The predicted relationship of this study was between the student learning and the clinical environment as per Peplau’s theory.

1.12 RELIABILITY

The reliability of a questionnaire refers to the consistency with which respondents understand, and respond to all of the questions (Parahoo 2006:300). The researcher had enhanced the reliability by using clear and unambiguous questions for the
respondents to understand and to respond to them in the same manner. The instructions given by the researcher were clear and simple enough to be easily understood by the respondents. The questionnaire was adapted from the one that was developed, used and found to be reliable by Hewett (2010) in the study of workplace violence, which targeted student nurses from the Western Cape College of Nursing.

1.13 SCIENTIFIC INTEGRITY OF THE RESEARCH

There was justice as the subjects were selected fairly in relation to the problem that was studied, and not because the researcher liked them or for ease of availability.

There was honesty in the conducting, reporting, and publication of the study. Quality was maintained as there was no fabrication, falsification, plagiarism or any other practice that deviated from those accepted in the scientific community. The researcher made sure that information was referenced using Harvard’s method, and the correct sources of information were indicated at all times. Data was honestly interpreted and remained free from selective retaining or manipulation of information in favour of desired findings. No non-existent information was utilised.

1.14 ETHICAL CONSIDERATION

Anonymity was guaranteed by the questionnaires that had code numbers instead of the subject’s names. The subjects’ privacy was maintained throughout by ensuring that none of their private information was divulged to anyone who might have connected them with the data received. The subjects were given an opportunity to sign consent as an indication of their willingness to participate in the study and were advised that they could withdraw their participation at any time. Subjects were given the assurance that the consent forms would in no way be associated with the questionnaires. All information obtained from the respondents was kept confidential.

Confidentiality was strengthened by not allowing completed tools to be discussed with other subjects or lecturers. After the study, the researcher ensured that the completed questionnaires were locked away in a safe place for 5 years, during which time only the researcher would have access to them. Beneficence was maintained
as subjects were not subjected to unnecessary harm and a plan was in place to refer those struggling to cope emotionally for psychological services. Another benefit was that the subjects were offered an opportunity to talk about the problem of workplace violence openly.

Permission to conduct the study was obtained from the Ethics Committee of the University of South Africa, the Health Research Committee of the KwaZulu-Natal College of Nursing and from the principals of the southern region campuses of KZNCN that were selected for the study.

1.15 SCOPE AND LIMITATIONS

Six out of eleven campuses of the KwaZulu-Natal College of Nursing were used as a sample. The six southern campuses selected constituted a reasonable sample as they composed 63.6% of the entire college population. The study involved only one programme i.e. R425 learners, and excluded the one year diploma students and advanced psychiatry nursing students.

1.16 DURATION OF THE STUDY

The duration of this study was two years, one year in which the proposal was drawn up and another year of actual research.

1.17 STUDY LAYOUT

The outline of this study is as follows:

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<td>Conclusions and Recommendations</td>
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1.18 CONCLUSION

The study intended to investigate the nature and extent of the workplace violence directed towards student nurses during their clinical placement at the psychiatric
institutions in KwaZulu-Natal using scientific methodology. In this chapter, an overview of the study was presented. The relevant literature and research findings were utilised in drafting the background, problem statement, and significance of the study. An overview of the research methodology and the definitions of key concepts were presented. In the next chapter, an in-depth review of literature that is relevant to the research topic is undertaken and presented.
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is described by Polit and Beck (2012:732) as a critical summary of the research on a topic of interest, often prepared to put a research problem into context.

According to Burns & Grove (2009:93), a review of the existing literature related to a specific study is a critical step that the researcher has to undertake in the research process. It is essential that the researcher’s work be built on the works of others in order to gather what is currently known regarding the topic. This review focused on literature relevant to workplace violence that is directed towards student nurses in psychiatric settings, and aspects relating to the clinical learning environment are included.

The topic of workplace violence in the health sector generally has been extensively studied internationally and to a lesser extent within South Africa, when compared with other countries like Australia, Canada and Taiwan. The majority of these studies focused on workplace violence directed at qualified nurses, and student nurses’ experiences have rarely been investigated. According to Nau, Dassen, Needham and Halfens (2009), as cited by Hewett (2010:13), by 2007 there were only ten articles for the previous fifteen years that were located using multiple search terms which addressed the topic of workplace violence against student nurses.

A search for relevant literature was undertaken with the assistance of the librarians from the University of South Africa (UNISA) and use of the internet. Various keywords relevant to the research topic were used to guide the search for any relevant literature, such as ‘workplace violence, aggression in the health sector, workplace violence directed at nurses/student nurses, clinical learning and learning environment’. Google Scholar, EBSCO host, CINAHL and Curationis databases were used as search engines.
2.2 PURPOSE OF LITERATURE REVIEW

Polit & Beck (2012:170) stated that the literature review is done to inspire new research ideas, and help lay the foundation for the study, suggest appropriate methods and point to a conceptual or theoretical framework. Brink et al. (2012:71) further stated that the review determines what is already known about the topic and helps to obtain a comprehensive picture of the state of knowledge regarding the problem under study. This literature review aimed to explore and understand the issues regarding workplace violence that threatens student nurses in order to increase the body of knowledge regarding the topic.

Notwithstanding the already described purpose, LoBiondo-Wood and Haber (2010:59) have identified the following purposes of a literature review which were also considered by the researcher:

- It determines gaps, consistencies and inconsistencies in the literature about a subject, concept, or problem.
- It discovers conceptual traditions used to examine problems.
- The review generates useful research questions and hypotheses.
- In addition, it determines an appropriate research design, methodology and analysis for answering the research question(s) or hypothesis, based on an assessment of the strengths and weaknesses of earlier works.
- It will enable the researcher to determine the need for replication of a study or refinement of a study.
- And finally, it synthesizes the strengths, weaknesses and findings of available studies on the topic / problem.

2.3 THEORETICAL FRAMEWORK

The study was directed by both nursing and learning theories. The basic concepts of the study were workplace violence, clinical learning and the learning environment.

Peplau’s theory, cited by George (2011), of interpersonal relationships will be utilized to support the study. According to Peplau’s theory, nursing can be viewed as an interpersonal process because it involves interaction between two or more individuals with a common goal. In this interaction, a therapeutic process is
necessary in which the nurse and the patient respect each other as individuals, both of them learning and growing as a result (George 2011:65). In the field of nursing, nurses do not interact with patients alone. There are other sets of individuals such as the patient’s families and friends, members of the multidisciplinary team, community members, their colleagues, those under their supervision like student nurses and support services. All of these individuals stated play a role in the process of the establishment and maintenance of interpersonal relationships in a workplace, and they are crucial elements in the development of a therapeutic process.

Peplau believes nursing to be a learning experience of oneself, as well as of the other individuals involved in the interpersonal action, and that each therapeutic encounter influences the nurses’ and patients’ personal and professional development (George 2011:66). Peplau expanded further and described the treatment settings as the physical and social environment, and viewed the environment as the essential element for human development. Peplau further asserted that the interactional patterns among staff and clients that promote self-knowledge and self-care are critical environmental influencers in a client’s mental health. Fitzpatrick and Whall (2005: 51-52), in their study declared that when interactional patterns threaten the biological or psychological security of the individual, anxiety is produced and this heightens the person’s sensitivity to the environment.

In utilizing this theory, the researcher has developed a picture of the interpersonal relationships between the student nurse and all the stakeholders in the health care setting that will help her/him to develop as a person and as a professional. Any inadequacies in the therapeutic patterns of interaction that may exist between the student nurse and the health care worker and clients will provoke anxiety and can lead to the lack of personal and professional development of the nurse in training. Envisaged from any negative patterns of interaction is the potential risk relating to the standard of nursing care provided to the patients and the passion to become a professional. In essence, the presence of workplace violence directed towards a student nurse in the clinical area will affect the development of that student nurse on a personal and professional basis.
Another theory that supports this study is Rogers’ student-centred approach which emphasizes the creation of a therapeutic learning environment as crucial for student learning. The educator or facilitator should share not only knowledge with students but also feelings and this positive interpersonal relationship will allow people to grow. The goal of education therefore is for the student to develop into a functional person (Bruce et al. 2011:87).

2.4 DEFINITION OF WORKPLACE VIOLENCE

Cherry and Jacob (2008:497) maintain that describing or identifying workplace violence is difficult due to subjective experiences of this occurrence by the recipients. The definition of the concept of workplace violence is a crucial step in this review as it creates common knowledge and understanding about the concept and all of the factors involved for those reading the study. The definition will provide a guide, especially to student nurses, of what constitutes workplace violence.

Workplace violence is defined as incidents where employee(s) are physically or emotionally abused, harassed, threatened or assaulted (overt, covert, direct, indirect) in circumstances related to their work. This includes the periods of commuting to and from work, and involves an explicit or implicit challenge to their safety, well-being or health (Steinman 2003:4). This definition was developed for South Africa by the CCMA (Council for Conciliation, Mediation & Arbitration) trade unions in the health sector, trade union federations and other interested parties and has been found to be applicable to all other workplaces. In defining workplace violence, Wang (2008:1) used the definition by the World Health Organization which defines it as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”.

2.5 TYPES OF WORKPLACE VIOLENCE

The majority of studies conducted regarding workplace violence in the health sector identified three types of violence that are often encountered by nurses in the work environment. These are physical and non-physical violence and sexual harassment.
Physical violence was described by Zampieron et al. (2010:2330) as involving manifestations like pushing, trapping, scratching, kicking, biting, slapping, and even assault with sticks, blades, shoes, or other means.

Pai and Lee (2011: 1405), on the other hand, described non-physical violence as the intentional use of power, including the threat of physical violence, against another person or group that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying / mobbing, harassment and threats.

Sexual harassment refers to unwelcome advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature (Civil Rights Act, 1964). Tamayo (2005:1) expanded on this to add that sexual harassment includes but is not limited to, sexual assaults (e.g. rape), Quid pro quo (conditioning employment opportunities upon the grant of sexual favours), and a hostile work environment that can also include sexual overtures, touching, grabbing, fondling, propositions, pictures and pornography.

All the three types have been found in literature to affect nurses in all health institutions at differing levels.

Different names / words are used interchangeably in literature to describe antagonistic attitudes in the workplace. The researcher found it imperative to describe the different categories of workplace violence that are reflected in the literature:

- **External violence**: Was described by Wang (2008:1) as the type of violence perpetrated by people outside the organization with a criminal intent. This form of violence includes incidents that occur while a nurse is going to or returning from work (Huston 2006:234).

- **Internal violence**: Is the type perpetrated by co-workers, supervisors, and other health care workers, and is often referred to as horizontal violence, according to Wang (2008:1). Thomas and Burk (2009) expanded on the definition of horizontal violence as the abusive behaviours between co-workers in the workplace. They discriminated between vertical violence taking place from supervisor to subordinates and horizontal violence between same level health workers. Huston (2006:233) identified antisocial workplace
behaviours that have the potential to harm another person, such as sending abusive email messages and posters, being verbally abusive, engaging in favouritism, setting a worker up for failure, withholding necessary information and many more. These behaviours are difficult to prove unless there are witnesses, failing which the victim develops low self-esteem and feels worthless and frustrated.

- **Client-initiated violence:** This is violence initiated by patients, or patients’ families against health care providers. Huston (2006:233) agreed by stating that this violence is committed by individuals who have, or had, some form of service relationship with the organization.

- **Overt violence:** The Oxford Dictionary (2010) defines overt violence as that which is done or shown openly.

- **Covert violence:** The Oxford Dictionary (2010) defines overt violence as that which takes place in a secret, non-open way.

- **Direct violence:** The intent to harm is perpetrated directly at the target.

- **Indirect violence:** Aggressive acts are inflicted through rumours (Flanagan 2009:5).

- **Horizontal violence** is considered an act of aggression among nursing professionals (Becher & Visovsky 2012:210).

- **Vertical violence** is defined as any act of violence which occur between two or more persons on different levels of the hierarchical system and prohibits professional performance or satisfaction in the work environment (Cantey 2013: 1).

### 2.6 EXPERIENCES OF WORKPLACE VIOLENCE BY STUDENT NURSES

Various unwelcome experiences in the clinical learning environment were reported by student nurses. Some have encountered horizontal and vertical violence displayed in the form of withholding information, disseminating gossip, criticism in front of other staff, false accusations, the use of menacing body language, bullying, mobbing, intimidation and aggression. Disappointingly, bullies (often staff members) formed alliances and engaged in repeated deliberate acts to destroy the self-confidence of their victims. These bullies were condescending, overbearing, rude, sarcastic, disrespectful, patronizing, and degrading (Thomas & Burk 2009:226-230).
Thomas and Burk (2009) listed other offensive behaviours often displayed by registered nurses (RN) against student nurses. These included:

- Making students feel ignored and unwanted by initially failing to introduce themselves to the new student,
- Displaying dismissive, rejecting behaviour by failing to make eye contact,
- The refusal to answer simple questions asked by the student nurse when the clinical facilitator was not around,
- Going back and re-doing all work previously done by the student and charting over the students handwriting,
- Responding to student’s explanations by rolling their eyes without any verbal response,
- Using students as scapegoats and making pejorative comments where the senior nurse blames the student nurse for not carrying out duties that are actually not their responsibility, and
- Publicly criticizing and humiliating the student nurse. The senior nurse screams, yells, chastises or shouts at the student in the presence of patients or other nurses claiming that students do not want to do duties without asking for explanation first.

In addition to this, Jackson et al. (2011:103-105) and Engelbrecht (2012:127) identified some types of workplace violence similar to the ones reported by Thomas and Burk (2009), and added to the list of offensive behaviours: being undervalued, made to feel invisible, ignored, physically isolated by staff not speaking to or showing any interest in the students, experiencing verbal abuse, enduring negative remarks about becoming a nurse, being yelled or shouted at in rage and encountering nasty, rude or hostile behaviour.

Hinchberger (2009:37), who studied violence against student nurses, found that one hundred percent of those surveyed admitted to experiencing some type of workplace violence and that the perpetrators were most often other staff members, followed closely by patients. Moreover, students felt unsupported in the clinical area, according to the findings of Magnavita and Heponiemi (2011:206). Indonesian student nurses who participated in the study done by Nelwati Mckenna and Plummer (2012:59-60) reported feeling pressurized and challenged by their relationships with
unpleasant and unfriendly ward nurses who expected them to know everything. Regrettably, Caka and Lekalakala-Mokgele (2013:8) found that the student nurses from a military hospital reported feeling as if they did not belong in public hospitals because they were marginalized there, blamed for all the wrongs done and were referred to as ‘soldiers’ or ‘securities’. Much unwelcoming attitude and disrespect by qualified staff nurses for students when beginning their clinical placements was noted by Hathorn (2006:4), who further commented that when there were staff shortages, students were exploited as a convenient pair of hands for tasks required and that their learning objectives were not considered to be important.

Contrary to the above mentioned statements, Baglin and Rugg (2009:149), in their study of student experiences of community-based practice placement learning, found that students felt supported, confident in voicing their concerns, and felt that their learning was enhanced by the team spirit in the clinical environments where they were allocated.

2.7 PERPETRATORS OF WORKPLACE VIOLENCE

The most commonly identified perpetrators of violence are patients, relatives, volunteers, housekeepers, nurses, medical doctors and other health care workers, as evidenced by the findings of Zampieron et al. (2009:2330), Hegney, Tuckett, Parker and Eley (2009:189); Flanagan (2009:5) and Oostrom and Mierlo (2007:321). According to Pai and Lee (2011:1414) and Spector, Zhou, and Che (2013:72), patients are responsible for physical violence whereas members of the hospital staff perpetrate psychological violence. The patients implicated are usually mentally ill as they quite often experience mood disturbances and display sudden, unexpected and ostensibly irrational behaviours (Chapman et al. 2010:480). In agreement with this are Spector et al. (2013:7) who reported physical violence to be the most prevalent in psychiatric units, emergency departments, and geriatric facilities. Hewett (2010: 98) studied student nurses’ experiences of violence and found the perpetrators to be staff nurses (76%), assistant nurses (75%), and registered nurses (67%), patients (59%), and other categories presenting with lower percentages.
2.8 RISK FACTORS FOR WORKPLACE VIOLENCE

Flanagan (2009:10) is of the opinion that certain features that are characteristic with a particular occupation have a risk potential for workplace violence.

She identified common risk factors to all work sectors to include:

- Working night time hours, fewer team members working alone in small numbers, late night and very early morning shifts increases the chances of being a victim,
- Periods of increased activity and less surveillance such as visiting times or mealtimes,
- A lack of security, and
- Where one person is solely responsible for assessment and treatment of the patient.

2.8.1 Risk factors in the abuser

The commonly identified abusers in the health care sector are the patients / clients, family members and the nurses according to Zampieron et al. (2010:2330); Huston (2006:233); Hahn, Muller, Needham, Dassen, Kok & Halfens (2010: 3535); Binyeminama (2008:44); Bock (2011:17) and Thobaben (2007:82).

2.8.1.1 The patient as abuser

The risk factors for the patient as the abuser include the presence of cognitive dysfunction and alcohol, drug and substance abuse. Wang (2008:4) added that a prior record of violence, history of drug or alcohol abuse, mental disorder, and poor coping skills add to the patient risk factors. According to Huston (2006:233), client initiated attacks are not personal and occur rather because the perpetrators are acting out their aggression, possibly because of stress, illness, or they are feeling vulnerable and the nurse happens to be in the wrong place at that time. In a nurse-patient relationship, the issue of a power struggle often ensues, leading to conflict as a result of an unequal distribution of power, especially where the victims are unable to defend themselves (Cunniff & Mostert 2012:2).

The regulations of the Mental Health Care Act, No.17of 2002, regarding admissions of patients into psychiatric institutions poses a risk of violence in itself. This act
classifies the patients (mental health care users) into different categories. The involuntary patients (Section 34), the assisted mental health care user (section 33), and the state patient (section 42) are admitted on the basis of being a danger to themselves, to others, and to the property of others. When nurses provide services to these clients / patients like administration of medication, it is likely that they will respond in a violent manner in an attempt to leave the long-walled buildings and seek freedom outside. Some of the clients may have been aggressive at home and as a result their families had sought the assistance of the South African Police Services. This denotes their violence levels and provides an indication of the risk that nursing staff are exposed to daily during their duty hours.

2.8.1.2 The family member as abuser

Zampieron et al. (2010:2330) states that family members become angry because of the long waiting times, the enforcement of hospital policies, the patient's condition / situation and the health care system in general. Family members and friends account for more physical violence than non-physical violence (Spector et al. 2013:5), and their attacks are mainly directed towards nursing staff (Huston 2006:233). Health care settings are located in communities and therefore factors leading to the destabilization of the community can spill over into the health care sector causing distrust, suspicion and confrontation between patients and health care workers. Examples of these factors include high levels of crime, drug use, gang activity, low levels of community resources or high poverty rates (Wang 2008:5). Other reasons for aggression by family members could include the worsening of the patients' condition, changes in treatment especially if it produces side effects, a loss of hope for the recovery of their loved one, and a lack of knowledge of how the system works, where they may think that their loved one is being neglected.

2.8.1.3 The nurse as abuser

With regard to abuse by nurses, verbal expressions of violence were mainly due to personal problems in the nurse's relationships with doctors and co-workers (Zampieron et al. 2010:2330). Cunniff and Mostert (2012:8), from their study of workplace bullying, found that bullying by supervisors was more prevalent than by colleagues, and they regarded supervisor bullying as having devastating effects in maintaining trust. Likewise, colleagues in the workplace were found not to be exempt
from bullying and they often used humiliation, sarcasm, rudeness, practical jokes, isolation, and gossiping about others as tools.

Complementary to the above views, Konstantinos and Christina (2008:184) highlighted other common stressors to nursing in mental health institutions as including demanding communication and relationships with patients and relatives, the added stress of emergency cases, high workload, understaffing and a lack of support or positive feedback from senior nursing staff. The aspect of marginalizing where others are perceived as different (Jackson et al. 2011:103), and clique formation where “in” groups and “out” groups are developed ultimately promotes competition within groups of employees (Cunniff & Mostert 2012:3). In such instances, the powerful group usually abuses the less recognized group.

2.8.2 Risk factors in the learner

Many factors have been identified that contributed to the learner being abused in the clinical area such as anxiety and stress, age, gender, qualifications, supervisory issues and minority status of the learner.

2.8.2.1 Anxiety and stress in the learner

Learners may experience feelings of uncertainty and anxiety in the clinical environment as it is a new area to them. Anxiety is produced when communication with others threatens the biological or psychological security of the individual (Fitzpatrick & Whall, 2005:51). A high level of anxiety can be a precedent for violence (Chen, Hwu, Kung, Chiu & Wang 2008:291). Added to this is the statement by Zampieron et al. (2010:2333) who reports that episodes of violence are directed more towards nurses who reported being stressed at work.

Magnavita and Heponiemi (2011:204) found that student nurses are vulnerable to patient-nurse violence because of their relative inexperience as they work in potentially risky areas early on in their careers, have high client contact time, and change frequently from ward resulting in the challenge of encountering a new environment every month with patients with whom they need to develop a relationship.
2.8.2.2 The age of the learner
The age factor has an influence on the risk potential for abuse. Cunniff and Mostert (2012:10), following their study of bullying in the workplace, found younger employees experiencing higher levels of workplace bullying than their older counterparts. To support their findings they mentioned that young entrants to organizations have low status in terms of pay, job security and experience creating a power imbalance that is conducive to bullying. Nelwati et al (2013:1926) support the idea by stating that novice nursing students view clinical placement to be stressful because of their lack of previous clinical experience. Pai and Lee (2011:1410) justify the age factor by stating that a younger age may be a reflection of a lack of job experience, resulting in a nurse’s inability to identify or prevent potentially abusive situations.

2.8.2.3 Gender
Gender has also been identified as a risk factor. Zampieron et al. (2010: 2333) explained that male patients more frequently display characteristics of aggression towards female staff. This placed female student nurses at a higher risk for workplace violence. Huston (2010:198) concurred that violence against female nurses was greater than that reported by male nurses and this could also be related to the findings of Engelbrecht (2012:106), who regarded female nurses as an oppressed group. Contrary to this, Cunniff and Mostert (2012:11) reported males as more abused than females. Likewise, Child and Mentes (2010:90) agreed that male nurses were more likely to be assaulted than female nurses, but this finding applied to psychiatric settings only. Zampieron et al. (2010:2330) subsequently reported that when violence was perpetrated against male staff, the violence and aggression was focused more often on male nurses with less work experience. It is therefore not clear which gender of student nurse is more likely to be affected by workplace violence in the South African work environment, and specific research regarding this is required.

2.8.2.4 Qualifications
The attitude related to future qualification is another fact for concern. Student nurses commonly become victims of vertical violence from the nurses who have not engaged in further studies to improve themselves. According to Nelwati et al. ’s
findings (2013:1930), ward nurses assumed that student nurses knew everything as they had academic degrees, thus allocating all of the work to them even though they had no clinical experience. This perception makes it difficult for student nurses to establish relationships with the ward nurses. In addition to this, ward nurses are threatened by the qualification that the student nurses receive upon completion of the four year comprehensive diploma in nursing, as they ultimately qualify in four specialties.

2.8.2.5 Supervisory factors
Subordination and a lack of skill and competence also play a role as junior student nurses are required to work under the supervision of senior nurses who feel it is an added responsibility to supervise the learners. Hathorn (2006:2) viewed the teaching and nurturing of nursing students while maintaining the highest standards of practice in the wards as an added role that placed additional stress on the staff nurse and fostered negative attitudes toward nursing students.

2.8.2.6 Minority factor
Another aspect that places student nurses at risk is differing from the majority of the population in the clinical setting, leading to ‘othering’, where this minority group then becomes marginalized and is taken as less worthy by the larger population (Jackson et al., 2011:103). In all clinical health care settings, student nurses are a minority because fewer students are allocated so as not to overcrowd the professional nurses, thereby affording the students the best opportunity to learn.

2.8.3 Risk factors in the environment
An environment characterized by unavailability or inaccessibility of staff, conflict between the expectations of the nursing school and clinical nursing personnel, and a lack of awareness among senior professionals of the needs and problems of learners in the clinical health care environment is a risk factor for workplace violence, according to a study conducted by Meyer et al. (2009:112).

2.8.3.1 Lack of resources in community: Buildings and staffing
It is an undeniable fact that staff shortages remain a problem in the province of KwaZulu-Natal (KZN), especially in mental health care settings (Bimenyimana, 2008:4), leading to nursing students being seen as an additional pair of hands, and
the goal of learning regarded as not important by staff nurses (Hathorn, 2006:2). The trend observed in mental health nursing is that with fewer nurses, the existing staff becomes more overworked, thus more stress is experienced and the likelihood of violence becomes eminent (Bimenyimana, 2008:44). Burns (2010) revealed that in KZN, as is the case in South Africa as a whole, the psychiatry and mental health care services are historically and currently disadvantaged in terms of funding, infrastructure development and staffing. The study revealed that inequalities existing between mental health care and general health care services in KZN result in:

- Psychiatric hospitals remaining outdated,
- An extremely serious shortage of professionals including nurses, psychiatrists, psychologists, social workers, occupational therapists etc. The ratio of psychiatrists is 0.38 per 100 000 of the population in the upper KZN regions.
- The inability to provide vitally important tertiary services such as child and adolescent services, psychogeriatric and neuropsychiatric services, and
- The community mental health care psychosocial rehabilitation services remain underdeveloped.

### 2.8.3.2 Inequalities in services

Another pattern in the service provision of mental health care identified by Uys and Middleton (2010:10) is that inequalities in the provision of mental health care services refer back to the Apartheid era where urban and white dominated areas had better services than the black rural settlements. South Africa has a dual health care system with the public sector comprising of government institutions which serves the predominantly indigent populations, while the private sector comprising of profit making organizations serves the insured population or those who can afford the treatment (Pillay 2009:1). The mental health care services are mainly provided by the public sector but there are private institutions that offer services of a high standard to those individuals who have medical aid and those who can afford treatment.

The MEC for health in KZN, Dr. S. Dhlomo, in the provincial mental health summit that was held on 19 March 2010, indicated his awareness of the disparities in the mental health system, such as an inadequate infrastructure, a lack of human
resources and compliance with the 72 hour assessment period, and finally the lack of integration of mental health into the primary health care system. He called for the collaboration and co-operation of different sectors and stakeholders in order to succeed. Improving the work environments so that they align with the aspirations and value systems of health professionals is more likely to increase the satisfaction of nurses and consequently have a positive effect on individual, organizational, and health outcomes (Pillay 2009: 9).

2.8.3.3 Policies for a safe working environment

An environment characterized by poor work organization (like inadequate staffing causing an increased waiting time and delays in care delivery) increases the odds of hostility from patients. A poor work climate (management style that is authoritarian, restrictive and impersonal) frustrates patients and increases co-worker conflicts (Wang 2008:10).

Of concern is the lack of policies in the workplace that promote a safe working environment. The presence and dissemination of a policy lets the employees know that management is committed to reducing violence in the workplace, asserts Wang (2008: iii). Beech and Bowyer (2004:32) also reported the lack of policies and protocols in the workplace as an aggravating factor for workplace violence. The supporting study by Hewett (2010:101) revealed that 72% of the student respondents were unaware of the existence of a policy regarding workplace violence. Lanza, Rierdan, Forester and Zeis (2009:746) reported, however, that if policies and programmes regarding zero tolerance for violence against staff are in fact in place, that these documents and systems are not adequate for the prevention and reduction of violence by patients, as they often target only physical abuse, whereas verbal violence against nurses produces more disruptive psychological effects. Notwithstanding the insufficiency of the policies, Bimenyimana (2008:66), who studied workplace violence towards psychiatric nurses, recommends a comprehensive orientation approach for newly appointed psychiatric nurses regarding the challenges and problems related to their work environments, so that they can use a variety of skills to overcome such challenges. The orientation program should compel unit managers to discuss with the new employees,
especially novice nursing students, the contents of the policies regarding prevention and reporting of workplace violence on arrival to the unit.

The Department of Health in KZN has issued three policies to be used by institutions as guidelines if an incident of workplace violence takes place. These are:

- The Health and Productivity Management Policy for Public Service (South Africa 2012/13): Section 7.7 of this policy deals with injury on duty and incapacity. Section 7.8 deals with occupational health education and promotion, involving the dissemination of information and communication to catalyse and reinforce behaviour change, aiming to improve individual health and productivity.
- The Policy for Sexual Harassment (South Africa 1984, section 20), which defines the concept and discusses the procedure to be followed by victims.
- The Policy for Injury on Duty (South Africa 2012/13), which explains where and how to report incidents.

2.8.3.4 Conflict in expectation of the nursing education institution and clinical nursing service personnel

Muller (2009:330) states that when a clinical nursing unit is accredited by the SANC for providing formal educational nursing programmes, in collaboration with an accredited nursing education institution, the unit manager accepts responsibility for the clinical training of students in partnership with the clinical facilitators/preceptors within the health care organization. Papastavrou et al. (2009:177), following their study in Cyprus, concluded that the ward manager’s educational role became neglected due to workloads, insufficient time, inadequate staff levels, primary patient care responsibility and lack of coherent training and support. Added to the above statement is the lack of recognition for the role of mentorship and time allocated for performing it (Baglin & Rugg 2009:147).

Complementary to the above is the findings by Hathorn (2006:133-134) that qualified nurses from Louisiana complained that the method of communication between them and lecturers was predominantly one way with the lecturers or students sending messages to them.
2.8.3.5 Lack of awareness of the needs and problems by senior personnel in the clinical area.

The unit professional nurse has a moral duty to teach, mentor and supervise students to ensure that the patient / client in her care receives the best possible healthcare. To achieve this duty, the unit manager must be familiar with the clinical learning requirements including clinical learning objectives / outcomes for each student allocated in the unit (Bruce *et al.* 2011:257). To bridge the gap, Hathorn (2006:135) suggested in Louisiana that the nurse education administrator should inform the faculty of education of their obligations of what to offer to clinical facilities according to contractual agreement including empowerment of staff nurses who work with students.

The above factors implied that there is a problem with nurse training because the student nurses need support from health care professionals who are a scarce, severely challenged resource in KZN. Training is required to take place in under-resourced, overcrowded environments which hamper productivity in the workplace. The sample in this research study was a combination of both rural and urban student nurses. The majority of four were urban-based, and two institutions were from rural areas, and this will impact on the findings at the end.

2.9 CONSEQUENCES OF WORKPLACE VIOLENCE

Various consequences resulting from workplace violence committed against nurses have been reported in the literature.

2.9.1 Physical consequences

Flanagan (2009:12-13) and Nelwati *et al.* (2013:1930) mentioned that nurses reported sleep disturbances, loss of appetite, headaches and even symptoms of post-traumatic stress disorder following the acts of violence. Lappalainen (2010:8) reported some physiological symptoms experienced by nurses like shaking, perspiration and a lack of strength as the consequences of violence.
2.9.2 Emotional consequences

Zampieron et al. (2010:2331) and Lappalainen (2010:8) reported that qualified nurses presented with a vast number of emotional feelings included fear of patients, feeling angry following the act of verbal and physical aggression, hatred, guilt, anxiety, feelings of tiredness, irritability, lack of confidence in their own skills, decrease in work motivation, helplessness, numbness and despair.

Some of the above experiences were also shared by student nurses in the workplace. Magnavita and Heponiemi (2011:204-206) together with Hume et al. (2006:68) mentioned that students commonly experience verbal violence during clinical placements, rather than physical or sexual violence and that nonphysical abuse can produce even more severe psychological effects than other forms of abuse, including anger, anxiety and guilt that can persist for months or years after the original event.

2.9.3 Relational consequences

Workplace violence hampers the therapeutic process that is meant to take place between patients and the health workers. Some nurses resorted to hiding their identity from patients during work shift, colleagues avoid the victim with the fear of being involved and this further silence the victim and the case remain unreported to the management team (Zampieron et al. 2010:2331; Flanagan 2009:12-13)


These negative interactions included being frozen out, destructive innuendo, resentment, humiliation in front of others, undervaluation of their efforts, unwelcome teasing, embarrassment, disempowerment, being made to feel unwelcome, and difficulty in establishing relationships with clients and staff.
2.9.4 Consequences for the future

The health care institutions may need to increase their effort in recruiting and training of new nurses as a result of workplace violence (Child & Mentes 2010:90) as occupational dissatisfaction experienced by nurses might result in a fast turnover of staff (Flanagan 2009:12-13).

2.9.5 Consequences for psychiatric faculty

According to Lanza et al. (2009:745), high violence rates in acute psychiatric settings discourage potential nurses from entering nursing and current nurses from staying in nursing. Zampieron et al. (2010:2331) and Child and Mentes (2010:90) reported that nurses presented with impaired job performance for the rest of the shift / week, some developed a fear of the patients, they experienced a decline in job satisfaction, and absenteeism increased. Some of the nurses requested transfers or resigned, and there were increased claims for workers’ compensation.

To conclude, nurses and student nurses experience physiological and psychological reactions as a result of encountering violence in the workplace, which ultimately affect their level of work performance. From the above mentioned responses reported, it can be seen that workplace violence also interferes with the legal provisions of the country. According to the Batho Pele principles (http://www.kznhealth.gov.za/bathopelez.pdf), a customer is supposed to be kept informed of the level of care they should anticipate, including the knowledge of who is providing the services. The principle of redress requires the service provider to apologize if proper care was not provided, and to provide the reasons for the occurrence. Lastly, service providers are to maintain service standards. The presence of this practice is questionable when nurses hide their identities, fear communicating with the patients and report impaired job performance as a result of workplace violence.

2.10 REASONS FOR UNDER-REPORTING OF WORKPLACE VIOLENCE

Despite the incidence of violence and its debilitating consequences, qualified nurses together with the nursing students demonstrate a reluctance to report violence that has been encountered in the workplace. Various reasons for this have been
identified in different studies (Flanagan 2009:9; Beech & Bowyer 2004:32 & Chapman et al. 2010:481). These include the lack of a clear definition of workplace violence, the fear of being blamed for the incident or the incident somehow being attributed to the victim’s negligence, a belief that workplace violence is a normal occupational hazard, fear that the perpetrator might retaliate, a fear of jeopardizing their job or position, dissonance between the service provider’s professional role and being a victim, being too busy, too much paper work required, the frequency of low level incidents, a lack of policies and protocols, a reluctance to elevate incidents because of a possible negative response by management, a concern that the number of incidents could be associated with staff effectiveness, and the desire to defend patients and make allowances for their behaviour.

Pai and Lee (2011:1410), who studied risk factors for clinical registered nurses, reported that respondents complained that after reporting an incident, no investigation was undertaken, thus indicating insufficient post-incident support. Some nurses mentioned a lack of confidence in their employers and the absence of a reporting system (Zampieron et al. 2010: 2331).

An interesting point was mentioned by Chapman et al. (2010:484), that 70% of the nurse respondents maintained that they would report an incident of workplace violence if a nurse was injured or if there was a chance that they would be laying charges against the offender or making a claim for worker’s compensation. This finding tallied with the responses that the researcher obtained from the two professional nurses that were interviewed regarding the policies in place for the prevention and management of workplace violence in two different psychiatric hospitals of KwaZulu-Natal. Nurses were found to be uninterested in reporting verbal violence, but physical and sexual violence was highly reported and the management system encouraged employees to complete the ‘injury on duty’ forms available so that evidence was on hand if the nurse wanted to make a claim.

Hewett (2010:100) found that student nurses were reluctant to report violence to the authorities because of the fear of victimization, ignorance about where or how to report it, and the perception or feeling that nothing would get done about it, while Stockhausen (2004:8) and Nelwati et al. (2013:1926) revealed that student nurses often engaged in various coping strategies like over-eating, smoking, relaxation,
trying to forget, sharing with family and peers, and sleeping following a stressful encounter from the clinical environment.

2.11 CLINICAL LEARNING ENVIRONMENT

In this section clinical environments will be described in detail as they are the platform for workplace violence that is experienced by nurses and student nurses.

2.11.1 Description

This is an environment (also called practice setting) where students can learn and develop clinical nursing skills in relative safety, according to Bruce et al. (2011:255).

The clinical learning environment is identified by Quinn and Hughes (2007:341) as including hospital wards and departments, community health centers, general practitioner surgeries, schools, nurseries, day centers, residential homes, and industry. Psychiatry students are placed in designated psychiatry hospital wards and outpatient departments, community health care centers, nursing homes and hospitals for intellectually challenged persons. The aim of the placement of student nurses into the clinical learning environment is to afford them the opportunity to practice care under the supervision of a qualified clinical nurse, in preparation for being able to provide competent care to the patient upon completion of their training (Caka & Lekalakala-Mokgele 2013:4).

The clinical learning environment allows for a correlation between theory and practice. The learners develop critical reasoning ability and use theoretical knowledge to generate options for problem solving and to intelligently discriminate between new ideas (Meyer et al. 2009:132). Clinical learning is described by Nelwati et al. (2013:1925) as the provision of teaching in health sciences in the form of lectures, demonstrations, individual instructions and the supervision and assessment of practical application of therapeutic and patient care techniques. From this description we can recognise the components involved in clinical teaching and learning as being:

- Teaching / instruction,
- Demonstration,
- Supervision, and
• Assessment

This distinction is important as it is often missed out by managers and nurses in the clinical area as they feel that teaching only takes place in the classroom, therefore students are sent to the clinical area to practice what they have already learned. This is true, but only to a certain extent, and it has to be borne in mind that student nurses come to the clinical area with no practical experience, so they need guidance and supervision in the area.

Meyer et al. (2009:100) feels it is the duty of the nursing unit manager to provide a safe, friendly and professional environment for learners. The factors that may help the unit manager in the creation of a psychological environment conducive to clinical learning include: mutual respect and trust, collaboration, support, openness and authenticity and humaneness.

2.11.2 Characteristics of a workplace environment conducive to learning

Various studies have identified characteristics of a ‘good’ clinical learning environment that promotes effective learning for student nurses. The views of Morrison, Boohan, Jenkins and Mountray, quoted in Caka and Lekalakala-Mokgele (2013:4), are that an ideal clinical learning environment is the one that encourages students to be part of the team, student learning is supported by members of the clinical learning environment, and students are afforded an opportunity for learning with a view of developing their competence and expertise.

Papastavrou et al. (2009:177) suggested the following characteristics for an effective clinical learning environment:

• A ward atmosphere that incorporates items like how easy the staff members are to approach, a spirit of solidarity among nursing staff, and the encouragement of students to participate in discussions.

• The ward premise including the nature of care delivery, the nursing philosophy, individualized delivery of care, flow of information related to patient care and documentation of nursing.
• The leadership style referring to attitude of the ward manager towards staff, his or her appreciation of the efforts of individual employees and the leader behaving as a team member.

• The mentor’s attitude towards supervision, individualized approach and feedback for the student.

Quinn and Hughes (2007:345-346) identified the perceptions of students with regards to a good clinical learning environment.

2.11.2.1 A humanistic approach to the student

The staff is to treat students with kindness and understanding and should try to show interest in them as people. The staff should be approachable and helpful, provide the necessary support to the student, try to foster student self-esteem and must be sensitive to the students study needs.

2.11.2.2 Team spirit

Qualified staff should make students feel part of the team and should create a good atmosphere.

2.11.2.3 Management style

Teaching must have its place in the overall organization of the unit. Students are to be given responsibility and encouraged to use their initiative.

2.11.2.4 Teaching and learning support

Qualified staff should provide students with opportunities to ask questions, attend medical staff rounds, observe new procedures and have access to patient’s records.

Non-nursing staff (e.g. doctors, psychologists, occupational therapists, social workers etc.) must be encouraged to see themselves as a resource in relation to student learning.

2.11.3 Advantages of a clinical environment conducive for student learning

In a learner conducive clinical environment, the learner will feel free to ask for explanations, participate in activities and be eager to learn and gain skill and knowledge. They are able to make decisions and take responsibility for their
decisions; they feel that they are part of the professional team and go on to become a safe and accountable nursing practitioner (Meyer et al., 2009:100).

If the attitudes of staff are positive, student nurses will feel free to ask questions, apply their creativity, and self-expression becomes possible with the support from the unit manager and staff. According to Hathorn (2006:12), a facilitating clinical placement allows the nursing student to take responsibility, have opportunities to practice tasks and receive feedback, collaborate with staff, gain an overview of the setting, and gain a sense of control.

A number of strategies are employed by the KZN College of Nursing in the promotion of a learner friendly clinical environment:

- All health institutions utilized for student training are provided with learning objectives, specific to a particular unit and which specifies student needs.
- In each health institution there is a permanent student liaison nurse who is a qualified nurse.
- Evaluation of a facility by student nurses when they leave the institution is implemented.
- Once a year there is a clinical facilities meeting which acts as a platform for clinical facilitators, lecturers and student liaison officers to meet and discuss issues relating to student issues and clinical learning.

2.12 CAUSES OF VIOLENCE IN PSYCHIATRIC SETTINGS

2.12.1 The community-based approach to mental health services

The advent of this approach to mental health services has resulted in psychiatric wards having a higher concentration of patients with more severe forms of illness and symptoms, and this has increased violence within psychiatric inpatient services. With this approach only individuals presenting with acute symptoms of mental illness are admitted in the hospitals, and the chronic cases are attended to in the community. There is a strong link between severe psychopathology and in-patient aggression.

According to the mental Health Care Act (South Africa 2002) the criterion for admission of psychiatric patients to a designated psychiatric institution requires that
they should be a threat to themselves, to others or to their property or the property of others, or have caused damages.

2.12.2 Staff attributes

Lappalainen (2010:6-7) identified the following staff factors that may contribute to workplace violence in psychiatric settings:

- Lack of staff experience and job dissatisfaction – workers who are dissatisfied are likely to be angry and display aggressive behaviour as a defence mechanism.
- Ineffective listening skills more so by nurses provokes anger from patients who feel they are not regarded as important.
- Power disparities between nurses and patients contribute to increased violence in mental health nursing where a nurse is perceived as superior to the patient.
- Lack of any possibility for negotiations as patients are acutely ill and therefore unable to express themselves,
- Unit related matters like privacy and space, the type of regime and ward design, and
- Substance abuse.

2.12.3 Patient and patient’s relatives

Patients become violent when not satisfied with the service provision or delays in care, when they have received bad news. Relatives may be violent following the loss of their family member and impatience with the system of health care delivery. Health workers’ violence is the result of relational and managerial problems (Zampieron et al. 2010:2333).

2.12.4 Environmental factors

Zampieron et al. (2010:2337) reported that psychiatric units are characterized by work stress which is triggered by working overtime and fatigue as a result of shortages of staff.
Richards, Bee, Barkham, Gilboy, Cahill and Glanville (2005:34) and Konstantinos and Christina (2008:183) have identified violence in in-patient psychiatric hospitals as being caused by problems in poor environmental design, inadequate staffing, overcrowding, substance misuse, patient boredom and non-therapeutic systems of care, demanding communication and relationships with patients and relatives, and a lack of support or positive feedback from senior nursing staff.

Acute in-patient mental health facilities are busy, understaffed and under-resourced. They are recognized to be fraught with tension and that nurses working there are in the front line dealing with a sometimes aggressive and unpredictable environment, where patients often make physical threats and are suicidal and demanding (Ward 2011:77).

2.13 PREVENTION OF WORKPLACE VIOLENCE IN THE CLINICAL AREA

Many stressors encountered in the workplace are beyond the individual practitioner’s power to change. The organization carries a responsibility for the health and safety of its employees (Quinn & Hughes 2007:349-350). The two important organizations that are involved in student training are the training institution and the clinical institution where the student is placed for practice. Therefore the key figures that play a major role in ensuring an adequate clinical learning are the nurse educator and the clinical manager. Engelbrecht (2012:134), who investigated violence towards undergraduate nurses, recommends improved relations between the different role players, the debriefing of students, an evaluation of the coping mechanisms used by students, that a record of events should be kept, that students should be involved in the reporting of severe events and be given feedback, that communication between the nursing education institution and the clinical learning environment be improved and that there should be role modelling by nurse managers and nurse educators.

2.13.1 The role of the nurse education institution

According to Thomas and Burk (2009:230) the preparation of student nurses for workplace abuse should be included in nursing curricula to prepare them for the inevitable. The faculty should teach students assertive responses and effective
techniques to discharge their lingering anger such as exercise, journaling, meditation, or confronting the abusers.

2.13.2 The role of the health institution

The critical step in the prevention of workplace violence is staff education. It would provide the nurse with clear knowledge that they can utilize to prevent the occurrence of violence and protect themselves against violent acts. According to Hood (2010:342); Harding (2011:256); Anderson, FitzGerald and Luck (2010:2528); Flanagan (2009:17-19); Beech and Bowyer (2004:36) and Zampieron et al. (2010:2331), aspects that are vital in staff education, including that of student nurses are:

- The definition of what constitutes an act of violence,
- Triggers of violent acts,
- Causes of violent behaviours,
- Assessment of potentially violent situations,
- Signs and symptoms of anger,
- Phases of the assault cycle,
- Conflict resolution strategies,
- Techniques to disrupt escalating violent behaviours,
- Strategies for effective intervention for potentially violent situations,
- Procedures for reporting acts of violence, and
- Techniques for medical and physical restraints as the last resort.

Lanza et al. (2009:746) and Chen et al. (2008: 292) have suggested prevention strategies for workplace violence which include:

- Flagging the charts of patients with a history of violence,
- Utilizing physical or chemical restraints, and engaging potentially violent patients in treatments such as group therapy, social skills, or anger management training,
- Training the potential nurse victim in assessing violence potential and in non-violent methods of de-escalation and intervention including those nurses with high levels of anxiety, and
• The involvement of institution-wide policies and programs such as zero tolerance of violence against staff.

2.13.3 Partnership to the student nurses

Thomas and Burk (2009:230) suggested that ‘zero tolerance’ must become the policy in all institutions where students engage in clinical work because:

• Early clinical placements are stressful enough without the addition of abusive treatment,
• Physiological and psychological consequences of suppressed anger and rumination such as elevated blood pressure, overeating and substance misuse, depression, burnout etc. may ensue, and
• Patient care and students’ academic achievement may be compromised.

A study by Spirichyakan, Thangpunkum, and Suparifitpatana (2003: iv), however, revealed that policies and procedures for violence prevention and control had not yet been established in the health organizations featuring in their study.

Nursing leadership must become engaged in efforts to eradicate vertical violence towards student nurses and encourage student nurses to report abusive incidents. Hospitals have to institute day-long workshops for nursing supervisors and anti-bullying policies as strategies to reduce vertical workplace violence. An annual roundtable discussion involving managers from the hospital and instructors who supervise the clinical rotations of student nurses is recommended. What would be of mutual benefit is a partnership between the schools of nursing and hospitals, where clinical staff nurses serve as positive role models, mentors and clinical instructors (Thomas & Burk, 2009:230-231).

2.14 CONCLUSION

This chapter highlighted critical issues relating to workplace violence affecting nurses and student nurses. Clinical environments have been discussed in relation to student learning and a picture of an ideal clinical learning environment was drawn.

Workplace violence in the health sector is a world-wide problem that affects nurses, both qualified and those still undergoing training. Psychiatric institutions are sites
with high rates of violence directed towards workers and this is due to the nature of the illnesses being treated and the environmental structure. The nature of the clinical environment in a psychiatric institution needs a lot of support in order to facilitate effective clinical learning for student nurses. This can be envisaged through effective collaboration between nursing schools and hospital management. The inclusion of workplace violence training in the curriculum may assist student nurses when confronted with violent attacks during their placement in clinical environments. The next chapter presents the research methodology undertaken by this study.
3.1 INTRODUCTION

Discussing the research design and methodology is a crucial step in any research process, as it spells out the plan and process undertaken by the researcher in conducting the study.

The literature review in the previous chapter revealed that nurses working at psychiatric health care settings are at risk of workplace violence, more particularly non-physical violence than any other type. Noticeably, there is lack of studies investigating the risk of violence directed towards student nurses, and attempts to eliminate any threats of violence that may contribute to the difficulty in the recruitment and retention of nurses in the nursing profession. The researcher conducted this study in an attempt to address this issue. The study's focus point was to determine the presence or absence of workplace violence that is directed at student nurses and to gain an understanding of the student nurses’ experiences and how it affects their learning when allocated in the psychiatry clinical environments. The research design, methodology including target population and sampling, the data collection method, data analysis and the internal and external validity of the study will be discussed in this chapter. Explanations will be provided with regards to particular methods or strategies employed in the study.

3.2 METHODOLOGY

The research methodology refers to the steps, strategies and procedures used for data gathering and analysis in research (Polit & Beck 2008:758). The methods of data collection are the tools (e.g. questionnaires or scales) and techniques (e.g. interviews or observations), according to Parahoo (2006:183-184).

The decision regarding the tools for data collection was influenced by the questions identified in the study, which are:

- What type of workplace violence do student nurses experience during their placement in psychiatric units?
• What effect does workplace violence have on the clinical learning of the student nurses who are placed in psychiatric units?
• What are the barriers to the reporting of workplace violence encounters by student nurses during their period of clinical placement in psychiatric units?
• What would be the recommendations for prevention and management of workplace violence towards student nurses to the nursing education institutions and nursing service managers of psychiatric institutions?

3.3 RESEARCH SETTING

According to Polit and Beck (2008:57), the research setting refers to the specific places where information is gathered. This definition is consistent with the definition provided by Burns and Grove (2009:722), who state that a setting is a location for conducting research. In this study, data was collected from the participants at the selected campuses of a Nursing College in the province of KZN. The participants were student nurses that were in their fourth year of nurse training and who were doing the psychiatry module and had exposure to the psychiatric clinical environments for a minimum of three months.

The KZN College of Nursing (KZNCN) has got eleven campuses doing the comprehensive nursing diploma, and is divided into the northern region with five campuses and the southern region with six campuses. The researcher selected the southern region campuses which were able to be reached, as KZN is a large province and the campuses are widely distributed. The venue used for data collection was the classrooms on the selected campuses. Data was collected at times agreed upon by the researcher and the relevant campus principals. Five days were set aside for data collection because of the geographical distribution: the selected campuses were in three different districts (Ugu, Ethekwini and Umgungundlovu). During this time period all of the student nurses had returned from the clinical area for examinations (although one campus had already completed the examinations), and the researcher utilised the times agreed upon with the principals of the campuses to collect the required data. Two campuses from the Ethekwini district were visited on the same day and the other four were visited on separate dates. Data was collected during the months of May and June 2013. During this
period student nurses had completed the three months clinical experience required for the study, and were about to complete the diploma in June 2013. In KZNCN, the psychiatry module is done during the second semester of the fourth year of training. The researcher had to collect the data while the students were still in training.

3.4 RESEARCH DESIGN

The research design is the blueprint for maximizing control over factors that could interfere with the study’s desired outcome and it directs the selection of a population, sampling procedure, methods of measurement, and a plan for data collection and analysis (Burns & Grove, 2009:41). Thus it is a plan that describes how, when and where data are to be collected and analysed (Parahoo 2006:183). The objectives that have been identified for the study guided the researcher in deciding on the design. A quantitative descriptive and exploratory design was followed to identify the types of workplace violence encountered by student nurses, the effects of workplace violence on students' academic performance and the barriers to the reporting of workplace violence encountered by the student nurses and to make recommendations regarding the prevention and management of workplace violence towards student nurses to the nursing education institutions and nursing service managers of psychiatric institutions. The objectives that have been identified for the study guided the researcher in deciding on the design.

3.4.1 Quantitative design

Quantitative design, according to Brink (2006), has the following characteristics:

- Focuses on a relatively small number of concepts,
- Begins with preconceived ideas about how the concepts are interrelated,
- Uses structured procedures and formal instruments to collect information,
- Collects information under conditions of control,
- Emphasizes objectivity in the collection and analysis of information,
- Analyses numeric information through statistical procedures,
- The investigator does not participate in the events under investigation – is most likely to collect data from a distance, and
- Incorporates logistic, deductive reasoning.
The quantitative design was appropriate for this study because it explored and described numerical data on the incidence of workplace violence as viewed by student nurses in psychiatric institutions.

### 3.4.1.1 Descriptive design

Descriptive design is described by Botma, Greef, Mulaudzi and Wright (2010:110) as a non-experimental design used if the researcher wants to describe the variable of interest as it naturally occurs, where there is little that is known about the topic. The researcher was interested in the prevalence of workplace violence directed at student nurses, specifically in psychiatric settings, and its influence on the students’ clinical learning. Brink et al. (2012:112) further explains that descriptive designs may be used to identify problems with current practice. The problem with regard to current practice that concerned the researcher was the presence of violence in the psychiatric institutions that was possibly interfering with the clinical learning of student nurses.

### 3.4.1.2 Exploratory designs

Polit and Beck (2008:21) state that exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related. Burns and Grove (2009: 359) compliment the above description by saying that exploratory studies are designed to increase the knowledge of the field of study. In this study, the researcher’s intention was to gain an understanding of whether or not student nurses experienced workplace violence in psychiatric institutions and the related effect that it had on the student’s psychological wellbeing and clinical learning.

### 3.5 POPULATION

According to Brink et al. (2012:131), a population is the entire group of persons or objects that is of interest to the researcher and that meets the criteria that the researcher is interested in studying. The population for this study were student nurses that were registered for the comprehensive four year course in nursing with the KZN College of Nursing and were doing the psychiatry module. The researcher had decided to identify the target population as the entire population was widespread in terms of geographical distribution. The target population has been described by
Burns and Grove (2009:724) as a group of individuals who meet the sampling criteria and to which the study findings will be generalized. The target population is located at all of the southern region campuses of the KZN College of Nursing.

**Table 3.1: Population of student nurses according to campuses where they are training**

<table>
<thead>
<tr>
<th>NAME OF CAMPUS</th>
<th>NUMBER OF STUDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addington</td>
<td>39</td>
</tr>
<tr>
<td>Benedictine</td>
<td>21</td>
</tr>
<tr>
<td>Charles Johnson Memorial</td>
<td>23</td>
</tr>
<tr>
<td>Edendale</td>
<td>39</td>
</tr>
<tr>
<td>Greys</td>
<td>44</td>
</tr>
<tr>
<td>Madadeni</td>
<td>25</td>
</tr>
<tr>
<td>Ngwelezane</td>
<td>32</td>
</tr>
<tr>
<td>Port Shepstone</td>
<td>14</td>
</tr>
<tr>
<td>Prince Mshiyeni Memorial</td>
<td>15</td>
</tr>
<tr>
<td>R.K.Khan</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>278</strong></td>
</tr>
</tbody>
</table>

Table 3.1 illustrates the number of student nurses at each campus. During the period of data collection there were 278 student nurses that were doing the psychiatry module at the KZNCN. The campuses in the table above were arranged in an alphabetical order and not according to regions or districts. The target population is listed in Table 3.2 below and it comprises of 177 student nurses, or 63.6 % of the entire student population.
Table 3.2: Target Population of Student Nurses According to Campuses Where They are Training

<table>
<thead>
<tr>
<th>NAME OF CAMPUS</th>
<th>NUMBER OF STUDENTS (N=177)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addington</td>
<td>39</td>
</tr>
<tr>
<td>Edendale</td>
<td>39</td>
</tr>
<tr>
<td>Greys</td>
<td>44</td>
</tr>
<tr>
<td>Port Shepstone</td>
<td>14</td>
</tr>
<tr>
<td>Prince Mshiyeni Memorial</td>
<td>15</td>
</tr>
<tr>
<td>R.K. Khan</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>177</strong></td>
</tr>
</tbody>
</table>

3.6 SAMPLING

Brink et al. (2012:132) stated that "sampling is the researcher’s process of selecting the sample from a population in order to obtain information regarding a phenomenon, in a way that represents the population of interest". This statement was supported by Burns and Grove (2009:343), when they stated that sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study. Having identified the population of psychiatry students in KZNCN, the sample was decided upon by the researcher, namely the students that were registered in the six southern region campuses of the KZN College of Nursing. According to Burns and Grove (2009:343), sampling is necessary as the entire population may not be accessible to the researcher for various reasons which could include refused entry permission by an authority, a widely distributed geographical area, availability of funds etc. Four campuses from the northern region of KZNCN were excluded from the study due to the widely distributed geographical area.

3.6.1 The criteria for inclusion in the study

- The participant had to be registered for a four year comprehensive diploma programme in one of the selected nursing campuses of the KZN College of Nursing. The KZN College of Nursing has eleven campuses and fourteen sub-campuses of which six campuses, namely Addington, Edendale, Greys, Port
Shepstone, Prince Mshiyeni, and the R.K. Khan campuses were selected for the study.

- The participants from the Addington, Edendale, Greys, Port Shepstone, Prince Mshiyeni, and R.K. Khan campuses had to be in the fourth year, second semester of their training.
- The participants should have been exposed to psychiatry clinics, hospitals and rehabilitation centres as clinical learning environments for a period of not less than three months.
- They had to be willing to participate in the study.

3.6.2 Exclusion criteria

- Student nurses who were registered for the four year degree in nursing with the University of KwaZulu-Natal. These students were following a similar programme but the difference was that they were studying at the university. They were also placed in the same psychiatric institutions as the diploma students and were also doing the psychiatry module over six months.
- The one year psychiatry diploma students were also excluded from the study. This was due to the fact that they had more clinical experience which they had acquired in general nursing before they registered for the one year diploma course, and the fact that they were already wearing distinguishing devices which made them different from students and were therefore treated like professional staff.
- The campuses from the northern region of the KZN College of Nursing which includes Benedictine, Charles Johnson Memorial, Madadeni, and Ngwelezane campuses were excluded because they were not proximal to the researcher.

3.7 SAMPLING METHOD

A purposive non-probability sampling method was used by the researcher. This sampling method allows the researcher to deliberately choose who to include in the study on the basis that those selected can provide the necessary data (Parahoo 2006:268). Brink et al. (2012:141) supports this understanding by describing purposive sampling as the technique based on the judgement of the researcher regarding the participants that are typical or representative of the study or
knowledgeable about the question at hand. As purposive sampling allows the researcher to use his or her knowledge of the population and its elements to handpick the cases to be included in the sample (LoBiondo-Wood & Haber 2010:228), the researcher chose this method because of knowledge that the block periods were equal and that the period for clinical placement was similar for all campuses of the KZNCD. As they all followed the same syllabus and all of the campuses did the psychiatry module during the last six months of the fourth year of training, this guaranteed the representativeness of the sample that was selected. Out of ten campuses that were doing the comprehensive four year diploma, the researcher deliberately selected participants from six campuses which were believed to have the knowledge that was required with regards to the study topic. The other four campuses from the northern region were excluded deliberately by the researcher as it would be difficult to access them due to their wide geographic distribution.

3.7.1 Sample size

The total sample size was 92.09% (n=163). The researcher had prepared 177 questionnaires according to numbers obtained from the campuses. At Addington campus 39 questionnaires were handed out, thirty completed and nine uncompleted ones were returned. Greys campus had four uncompleted questionnaires because these four students had opted to go and work back owing clinical hours. Port Shepstone had one student that was absent due to ill health. The response rate was as follows:

<table>
<thead>
<tr>
<th>PARTICIPANTS</th>
<th>TOTAL NUMBER</th>
<th>OUTPUT</th>
<th>RESPONSE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addington</td>
<td>39</td>
<td>30</td>
<td>77%</td>
</tr>
<tr>
<td>Edendale</td>
<td>39</td>
<td>39</td>
<td>100%</td>
</tr>
<tr>
<td>Greys</td>
<td>44</td>
<td>40</td>
<td>90.9%</td>
</tr>
<tr>
<td>Port Shepstone</td>
<td>14</td>
<td>13</td>
<td>92.8%</td>
</tr>
<tr>
<td>Prince Mshiyeni</td>
<td>15</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>R.K.Khan</td>
<td>26</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>177</strong></td>
<td><strong>163</strong></td>
<td><strong>92.09%</strong></td>
</tr>
</tbody>
</table>
3.8 DATA COLLECTION

Burns and Grove (2009:43) assert that data collection is the precise, systematic gathering of information relevant to the research objectives of the study. The researcher used a self-reporting approach using a structured questionnaire. The data collection instrument enabled the researcher to address all of the questions of the study and allowed for more objective comparison of the findings.

3.8.1 Design of the questionnaire

The questionnaire was divided into five sections from A to E. Section A requested the demographic data of the participants. Section B comprised of types of workplace violence that may be experienced by the participants. Section C addressed the issue of perpetrators of violence and sites where violence was encountered. Section D was about the effects of violence on individual participants and Section E was about the reporting of the violence. Pretesting of the questionnaire was not done because it had been borrowed from D. Hewett, whom has used it before and granted permission to use it for this study. Screening of the questionnaire was done by the ethical committee of the University of South Africa. Data collection took place between the months of May and June 2013. Permission to access the students was granted by the KZN College of Nursing, the KZN Department of Health and the Campus Principals.

3.8.2 Administration of the questionnaire

De Vos et al. (2011:186) and Burns and Grove (2009:406) describe a questionnaire as a document designed to solicit information appropriate for analysis, in a consistent manner for all respondents, with less opportunity for bias. All of the respondents were required to respond to the same questions no matter which campus they were from and the questionnaire allowed the researcher to include all of the desired aspects of the phenomenon under study.

The researcher met face to face with the students and highlighted the purpose and objectives of the research. Those who agreed to participate were made to sign
informed consent forms. A lecturer at each campus served as a coordinator and was responsible for the distribution and collection of the completed questionnaires.

3.8.2.1 Advantages of questionnaires

The following advantages of a questionnaire were favoured by the researcher:

- Enables the researcher to gather a large amount of data in a relatively short period of time.
- Having ensured validity and reliability, the researcher has confidence of the quality of the data produced.
- Offers anonymity which improves the honesty with which the participants answer the questions (Botma et al. 2010:135).
- They minimise researcher bias and enable a more objective comparison of the results.
- They are less expensive in terms of time and money.
- The format is standard for all participants and not dependant on the mood of the interviewer (Brink et al. 2012:153).
- They enable the researcher to ensure that all items of the questionnaire are considered without omissions (Brink et al. 2012:153).

3.8.2.2 Disadvantages of a questionnaire

Certain disadvantages of a questionnaire may discourage the researcher from using it, including:

- The response rate may be low and those who did respond may not be representative of the population.
- The manner in which the participants responded may be flawed, the answers may be subject to social desirability bias.
- Not all questions may be answered.
- If a misunderstanding of the question arose, there is no way of clarification and the responses will be made in absence of full understanding of the question (Botma et al., 2012:135)
- The participants are unable to elaborate on responses.
- The researcher cannot use probing strategies.
- There is the possibility that the participants may provide socially acceptable answers rather than true answers.
• Non-verbal behaviours and mannerisms cannot be observed.

For this study it was anticipated that the participants would be unable to elaborate on their responses, the researcher could not use probing strategies, and non-verbal behaviours and mannerisms could not be observed.

3.9 DATA ANALYSIS

According to Polit and Beck (2008:751), data analysis is the systematic organisation and synthesis of research data. It reduces, organizes and gives meaning to the data collected (Burns & Grove 2009:44). A statistician was consulted for assistance with the statistical analysis plan. Basic descriptive statistical analysis was done by using the SPSS version 21 computer programme. Descriptive statistics were used in order to allow the researcher to organise the data in ways that gave meaning and insight and to examine the phenomenon from a variety of angles. Frequency distributions were determined from descriptive statistics to describe the numerical data. Inferential statistics were subsequently utilised to estimate the probability that the statistics in the sample accurately reflected the population parameter (LoBiondo-Wood & Haber 2010:318). The Chi-square and Pearson r tests were conducted to test the associations between the variables. The data was presented in the form of graphs and tables. The problems encountered during data analysis were that some students had more exposure to the clinical area than others. Some had had three months and others four months of clinical exposure, but all had had the minimum requirement of three months before the questionnaire was distributed. It was difficult for the researcher to interpret numbers as it was the first exposure to such an exercise but it became possible with the aid of a statistician and books on statistics in research. There was a large amount of data to be analysed as the questionnaire had seventy one items.

3.10 VALIDITY AND RELIABILITY

The utilisation of research cannot be separated from the concepts of validity and reliability. Different types of validity and reliability are discussed below as they apply to this study.
3.10.1 Validity

According to Polit and Beck (2008:768), validity in measurement is the degree to which an instrument measures what it is intended to measure. The four types of validity include face, content, and construct and criterion validity.

3.10.1.1 Face validity

Polit and Beck (2008:458) state that face validity refers to whether the instrument looks as though it is measuring the appropriate construct. Face validity is still an important aspect of the usefulness of the instrument, because the willingness of the subjects to complete the instrument relates to their perception that the instrument measures the content that they agreed to provide (Burns & Grove 2009:381). Strategies that were utilised to ensure face validity included designing the questionnaire in a tabular format, using English language which was understood by all participants, having subsections to group specific content needed, and sticking to required content. Short and simple, unambiguous sentences were added to make the tool attractive to respondents. In this study all the questions were answered by all the participants, indicating their willingness to partake and complete and thus adding to face validity.

3.10.1.2 Content validity

Burns & Grove (2009:381) explained that content validity examines the extent to which the method of measurement includes all of the major elements relevant to the construct being measured. De Vos et al. (2011:173) expanded on this to add that it focuses on whether the full content of a conceptual definition is represented in the measure. To determine content validity, the researcher has to ensure that the instrument that is used should really measure the concept we assume it is measuring and it should provide an adequate sample of items that represent the concept being measured (De Vos et al.2011:173). The research questions utilised ensured that all needed content was covered within the questionnaire. The questionnaire was based on the reviewed literature and had been subjected to scrutiny by the supervisor and analysis by the statistician who assisted in excluding the extraneous variables that could undermine the study findings. The researcher bias was avoided by requesting one lecturer from each campus to assist with the distribution and collection of the questionnaires from the student nurses. The
psychiatry student nurses were only allowed to participate in the study if they have completed a minimum of three months of exposure in a psychiatric clinical area.

### 3.10.1.3 Construct validity

Construct validity is the degree to which the instrument measures the construct under investigation, according to Polit and Beck (2008:750). An intensive literature review was conducted by the researcher to support coverage of the entire content and construction of the questionnaire. Although the instrument was borrowed, it was assessed to see if it covered all of the required information. The strategy used involved examination of relationships based on theoretical predictions. Following the literature study, it became evident that student nurses were violated in the workplace by other categories of workers and that this could have a negative impact on their performance. Such experiences reinforce Peplau’s view that nursing is a process of interpersonal interactions and that its outcome will depend on the type of interactions that have taken place. A positive interaction will lead to positive outcomes of respect, learning and growth of both partners (George 2011:65), and the opposite is possible.

### 3.10.2 Reliability

Polit and Beck (2008:196) asserted that reliability refers to the accuracy and consistency of information obtained in a study. This means that a valid measuring instrument, when applied to different groups under various circumstances, should produce the same results. Botma et al. (2010:177) concurred with this assertion. The same questionnaire was distributed to different students from different campuses of the KZNCN, and the responses were similar. All of the students from the campuses followed the same instructions regarding completing the questionnaire and all responded to the questions in an expected manner.

### 3.11 ETHICAL CONSIDERATIONS

According to Burns and Grove (2008:184), nursing research requires not only expertise and diligence but also honesty and integrity. Ethical implications arise at every stage of the research process, including the choice of the topic, selection of the design and the publication of the findings (Parahoo 2006:111). Polit and Beck (2008:167) add that when humans are used as study participants, care must be
exercised in ensuring that the rights of those humans are protected. To ensure that ethical considerations were observed in this study, the proposal was submitted for approval to the Research and Ethics Committee at the Department of Health Studies of the University of South Africa (UNISA), as well as to the Provincial Research Ethics Committee of the Department of Health in KZN. Permission to conduct the research was also granted by the Research Committee of the KwaZulu-Natal College of Nursing and consent was obtained from the principals of the six different campuses involved in the study. The Belmont Report, cited in Polit and Beck (2008:170), articulated three primary ethical principles upon which the standards of ethical conduct in research are based, namely beneficence, respect for human dignity, and justice.

3.11.1 Beneficence

This principle imposes a duty on the researchers to minimize harm and to maximize benefits (Polit & Beck 2012:152). The principle covers two rights of human beings, the right to freedom from harm and discomfort, and the right to protection from exploitation.

3.11.1.1 The right to freedom from harm and discomfort

The possible harm or discomfort in this study would be psychological, as the participants might be reminded of the painful past which can provoke negative emotional feelings in them. The researcher, during data collection, had verbally addressed the issue with the participants and had provided them with the contact details of a psychologist if they needed referrals for psychological interventions. The same information was included in the consent form. The research itself was conducted in safe environments as it was done in a classroom in each campus.

3.11.1.2 The right to protection from exploitation

The participants were given the reassurance that the information they provided would not be used against them. The benefits of the study were explained to the participants, namely that the findings would be used in influencing the creation of learner conducive clinical environments and that students would be better prepared for going to the clinical area. Staff would be made aware of what to watch out for regarding workplace violence and would be aware of what to do.
3.11.2 Respect for human dignity

This principle holds that humans are capable of controlling their own destiny, and that they should be treated as autonomous agents who have the freedom to conduct their lives as they choose, without external controls (Burns & Grove 2009: 189).

3.11.2.1 Right to self determination

According to this right, prospective participants have the right to decide voluntarily whether to participate in a study, without risking any penalty or prejudicial treatment (Polit & Beck 2008:171-172). The researcher informed the participants that they were not forced to participate, and that there was no punishment or victimization that would take place as a result of not participating in the study. The researcher further explained to the participants that they could withdraw from the study and offered them the opportunity to ask questions. The researcher had encouraged participation by explaining the benefits of the study and asked the participants to sign an informed consent form. There were no rewards that were used to influence the participants. Some students did not complete the questionnaire and were not asked the reason for not completing it. No investigation was carried out to determine who had completed the task and who had not.

3.11.2.2 Right to full disclosure

Full disclosure means that the researcher has fully described the nature of the study; the person’s right to refuse participation, the researcher’s responsibilities, and likely risks and benefits (Polit & Beck 2008:172). A written consent form which indicated the topic of the study, the purpose, objectives, benefits and possible risks of the study was presented to the participants and was explained before they could sign the declaration section of the form. This was a strategy by the researcher to ensure that participants had made an informed, voluntary decision about study participation.

3.11.3 Justice

The principle of justice holds that each person should be treated fairly and should receive what he or she is due or owed (Polit & Beck 2008:174).
3.11.3.1 Right to fair treatment

The selection of participants was fair because all students doing psychiatry in the Southern Region of the KZN College of Nursing were invited to participate in the study. Participants were selected on the condition that they must have worked in the psychiatric institutions for a minimum of three months, because the study's focus was workplace violence directed at student nurses during their placement in psychiatric institutions. A selection criteria was used that was in line with the purpose and the objectives of the study. During data collection no one was forced to partake and all participants received the same explanations when the questionnaires were applied. All of the questionnaires were distributed at the same time, and at the same venue according to the campuses, and all were to complete and hand it in at the same time. Students were allocated one hour to complete the questionnaire on all of the campuses, and no one asked for an extension of time. It was explained that they should use the one hour allocated and that they could not take the questionnaire away to be completed in their own time, as that was not allowed. The researcher was conscious of the fact that the students from the northern campuses were denied the opportunity to voice their thoughts on their workplace experiences as they were excluded from the study for the reasons explained in section 3.7 above.

3.11.3.2 The right to privacy

According to Polit & Beck (2008:174), researchers should ensure that their research is not more intrusive than it needs to be and that the participant's privacy is maintained throughout the study. The researcher decided to keep the data collection instruments anonymous and the completed ones were kept under lock and key. Data collected was within the scope of this research, and no unnecessary questions were included in the questionnaire. The findings of the study will be published without linking the findings to the individual participants.

3.12 CONCLUSION

In this chapter the research methodology, research design, population and sampling methods, data collection, data analysis and ethical considerations were discussed. In the following chapter, data analysis and presentation of the findings will be discussed.
CHAPTER 4: ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter focus on the presentation and description of the results. The purpose of this study was to identify the types of workplace violence that were experienced by student nurses during their clinical placement in psychiatric units, to determine the effects that these incidents had on the nursing aspirations of the student nurses, identify the reasons for not reporting workplace violence encountered by student nurse and to make recommendations regarding the findings. The questionnaires were handed out to 63.6% of the total population (n=177), namely the fourth year psychiatry nursing students registered with the KwaZulu-Natal College of Nursing for the R425 diploma leading to registration as a nurse (general, community and psychiatric) and midwifery.

Data collection and analysis was based on the following objectives:

- To establish the types of workplace violence incidents experienced by student nurses during their placements in psychiatric units.
- To determine the impact of workplace violence on the learning of the student nurses in the clinical area.
- To identify barriers to the reporting of workplace violence encountered by the student nurses.
- To make recommendations regarding the prevention and management of workplace violence towards student nurses.

4.2 DATA COLLECTION

The data for the student nurses was collected by means of a structured questionnaire that consisted of a Likert scale 1 – 4 as follows:

- Never,
- Seldom (1-2 times),
- Frequently (3-4 times), and
- Always (5 and more)
Cited in De Vos et al. (2011:172) is Salkind (2006), who describes measurement as the assignment of numerical to objects or events according to rules. In section A, age and period of psychiatric placement were measured at a nominal level, whereas in section E all variables had only two measurements, yes or no.

The questionnaire contained five sections which were:

- SECTION A: Biographical Data
- SECTION B: Types of Violence exposed to
- SECTION C: Settings and Sources of Abuse
- SECTION D: Effects of Workplace Violence on performance of students
- SECTION E: Reporting of Violence

The population in this study consisted of students who had enrolled for an undergraduate diploma in nursing at a Nursing College in KwaZulu-Natal. To qualify for inclusion in this study they had to be doing the psychiatry module, with a minimum of three months experience in the psychiatric clinical area. The KZNCN had a total population of 278 student nurses that were registered for the psychiatry module during the period of data collection. A sample of 63.6% (n=177) from the total population registered was used for data collection. The questionnaires were handed out at selected campuses (Addington - 39, Edendale - 39, Greys - 44, Port Shepstone -14, Prince Mshiyeni -15, and R.K. Khan - 26), according to the number of students that were registered for psychiatry at the time of data collection. A total of 92.6% (n= 163) of the 177 questionnaires were completed and returned by the respondents, and fourteen were returned uncompleted. All of the items on completed questionnaires were answered in full and this contributed positively to the analysis of the data.

4.3 ANALYSIS OF DATA AND PRESENTATION OF FINDINGS

The findings will be presented in the same order as they appeared on the questionnaire.

Data analysis refers to the techniques used to reduce, organize and give meaning to data (Burns & Grove 2009:695). Data gathered from all the questions were measured at a nominal and ordinal level. A spreadsheet on Microsoft Excel was
used to capture the raw quantitative data per computer and was then analysed using IBM SPSS version 21 software. Descriptive statistics were used to describe and summarise the data and frequency distributions were used to organize the descriptive data. The data was then represented in tables and graphs. The measures of central tendency were used to describe the pattern of responses among the sample as they yield a single number that describes the middle of the group and summarize the members of the sample, as reported by LoBiondo-Wood and Haber (2010:314). The measures of central tendency that were measured in this study were the mean, which is the average of all of the scores and is obtained by adding all of the scores together and dividing the total by the total number of scores (Brink et al., 2012:185). The median determined the midpoint where one half was above and one half was below the middle point in the distribution, and the mode which identified the most frequently occurring number in the distribution (Neuman 2012:236). Measures of variability describe how widespread the values or scores are in a distribution. The measures of variability utilised included the standard deviation to indicate how scores varied about the mean of the distribution. A measure of Kurtosis was undertaken to measure the extent to which the scores were bunched around the mean to form a tall peak or else spread to form a flat hill. A measure of skewness established the asymmetry of the distribution as a normal distribution is symmetric, according to Argyrous (2011:214).

Inferential statistics were used to compare the relationships between the variables under study. The relationships between the variables were analysed using an appropriate analysis of variance (ANOVA). The Analysis of Variance is the parametric procedure for testing differences between means when there are three or more groups, and is reported in an F-ratio (Polit & Beck 2012:416). The Chi-square test of independence is a nonparametric statistic that was used to determine whether the frequency in each category was different from what would be expected by chance (LoBiondo-Wood & Haber 2010:326). The Pearson correlation coefficient was used to measure the correlation or the degree of association between two or more variables. This is expressed as either a perfect positive or a perfect negative, or no relationship according to LoBiondo-Wood and Haber (2012:327).
4.3.1 Section A - Biographical data

Biographical data refers to the information about the person that identifies the person differently from others. The demographic data required from the student nurses included gender, ethnicity, age, and the period of their psychiatric placements indicated in months.

4.3.1.1 Gender distribution

The population of student nurses has both male and female representation and that makes it necessary to distinguish between the genders in the study. This study had 130 (79.8%) females as compared to 33 (20.2%) males.

The figure above shows that females constituted 79.8% (n=130) and males 20.2% (n=33) of the respondents in the study. This reflects the statistics released by the South African Nursing Council for age analysis of student nurses registering in nursing for the first time (SANC 2012), which showed that of the student nurses who were registered for the four year comprehensive programme in 2012, 16076 were females as compared to 4844 males, with the total number of student nurses being 20920. In the province of KZN, of the total of 3009 student nurses registered for the four year comprehensive programme, 2274 were females against 735 males for the year 2012. These results indicated that in South Africa, the nursing profession is still dominated by females. MacWilliams, Schmidt and Bleich (2013: 38) showed that males make up less than 10% of the nursing profession in the United States. An annual survey conducted by the National League of Nursing (NLN) in the United States of America revealed that 85% of females were registered for a diploma in nursing as opposed to 15 % of males that were registered for the same program in the year 2013. The same pattern was noticed with the baccalaureate students, with
85% of females as opposed to the 15% of males registered for nursing in the USA (NLN org 2013).

One would hypothesize that with a majority of females in the field of nursing more reports of incidences of workplace violence would occur. Steinman (2003:28) reported no significant difference between the percentages of male and female health workers subjected to workplace violence. Surprisingly, Cunniff and Mostert (2012:10), in their study of workplace bullying in South Africa, found that men reported statistically significantly higher levels of workplace bullying than women did, and that more direct and indirect bullying was received from supervisors as well as colleagues. Engelbrecht (2012:130) had similar findings of males having higher scores of being the oppressed group than females. These findings are of interest as males are generally viewed as stronger, more powerful and influential and are more respected by public.

4.3.1.2 Ethnicity
The representation of ethnicity indicates that a larger amount of student nurses are black (75.5%, n=123). Indians were the second largest population in the study at (17.1%, n = 28), followed by Coloureds at 7.4% (n=12).

![Figure 4.2: Ethnicity (n = 163)](image-url)
Table 4.1: Comparison of racial distribution of population of KZN and SA with students in study

<table>
<thead>
<tr>
<th>RACE</th>
<th>NATIONAL</th>
<th>KWAZULU NATAL</th>
<th>STUDENTS INCLUDED IN THE STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African</td>
<td>79.2%</td>
<td>86.8%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Coloured</td>
<td>8.9%</td>
<td>1.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Indian/Asian</td>
<td>2.5%</td>
<td>7.4%</td>
<td>17.1%</td>
</tr>
<tr>
<td>White</td>
<td>8.9%</td>
<td>4.2%</td>
<td>NIL</td>
</tr>
</tbody>
</table>

Looking at Table 4.1 above, a racial population distribution at national and provincial level is compared with the respondents of the study. The study revealed that the black African student nurses are the majority racial group, and this could be attributed to the fact that the black African population is the majority in KZN, and nationally (Statistics SA, 2011). The question that now came to mind was whether the findings of the study will represent more of the experiences of black nurses. Cunniff and Mostert (2012:10) found that blacks experienced the highest level of workplace bullying, and they related their findings to the fact that blacks are the largest race group in South Africa.

It is surprising to see that there were no white students nurses among the participants, given the white population figure of 4.2% in the province of KZN and 8.9% nationally. Training in the private sector and at graduate level might include this ethnic group.
4.3.1.3 Age distribution

Table 4.2: Age distribution

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>14</td>
<td>8.6</td>
</tr>
<tr>
<td>23</td>
<td>20</td>
<td>12.3</td>
</tr>
<tr>
<td>24</td>
<td>15</td>
<td>9.2</td>
</tr>
<tr>
<td>25</td>
<td>15</td>
<td>9.2</td>
</tr>
<tr>
<td>26</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>27</td>
<td>9</td>
<td>5.5</td>
</tr>
<tr>
<td>28</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>29</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>30</td>
<td>9</td>
<td>5.5</td>
</tr>
<tr>
<td>31</td>
<td>10</td>
<td>6.1</td>
</tr>
<tr>
<td>32</td>
<td>6</td>
<td>3.7</td>
</tr>
<tr>
<td>33</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td>34</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>35</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>36</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>37</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>38</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>39</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>40</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>42</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>43</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>44</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>47</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>163</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The mean age was 28 years. The youngest was 22 years old (8.6%, n = 14) and the eldest was 47 years old (0.6%, n= 1). The majority of the participants, 12.3% (n= 20), were 23 years old and this corresponds with the estimation by the Department of Education that a learner passes grade 12 at the age of 18 years and enters into tertiary education at 19 years of age (SA 2008:49-51). The nurses participating in this study are in their fourth year of tertiary education, therefore the age of 23 years
is relevant. According to the SANC (2012), the average age of students who commenced training in 2012 was 25 years, with a minimum of 17 and a maximum age of 55 years. The mean age was 28.3, the mode was 23, median 27 and the standard deviation was 5.51.

4.3.1.4 Period of psychiatric placements

The diagram below illustrates that the majority of the participants (66%, n=108) had four months of clinical experience and 34% (n=55) of the participants had three months of clinical experience. The figures were rounded off to the nearest whole month, as some student nurses had had an added week or two in the clinical environment, but no one had had less than three months of experience. The study required that the participants should have a minimum of three months exposure in the clinical area.

![Figure 4.3: Period of psychiatric placements](image)

4.3.2 Section B: Types of violence exposed to

The literature review revealed that student nurses, like qualified nurses, were exposed to various types of violence such as non-verbal, verbal, physical, and sexual violence, with non-physical forms being the most common one. The types of non-verbal abuse were listed in items 5-35 of the questionnaire. The respondents had to indicate their level of exposure to the various types of violence. Items 8, 20, 29, and 35, entitled “other”, were designed for the respondents to identify and report on any types of non-verbal abuse which they had experienced and that might not have been listed on the questionnaire. The student nurses were informed by the researcher to respond to the questionnaire strictly according to their experience in
psychiatric settings and not to include their experiences from any other field of nursing. The respondents answered all the items in this section.

### 4.3.2.1 Types of non-verbal abuse

There were three items listed under this subsection which the participants had to respond to.

#### 4.3.2.1.1 Raised eyebrow, rolling of eyes

This diagram below illustrates that 47.9% (n=78) of the participants had not had someone raise their eyebrows or roll their eyes at them, followed by 41.1% (n=67) who reported this as a seldom occurrence, 8.6% (n=14) who reported frequent exposure to this behaviour, and 2.5% (n=4) who indicated that this happened all of the time.

![Figure 4.4: Raised eyebrow, rolling of eyes](image)

#### 4.3.2.1.2 Ignored or neglected

Figure 4.5 shows that the majority of the participants, 48.5% (n=79), had never been ignored or neglected in the clinical area, 12.3% (n=20) had frequently experienced this behaviour, 35.6% (n=58) had seldom experienced it, and 3.7% (n=6) of the student nurses reported having always been either ignored or neglected in the workplace.
4.3.2.1.3 Left alone in the Unit

The majority of the participants, 71.8% (n=117), have never been left alone in the unit, while 19% (n=31) reported seldom being left alone, 8.0% (n=13) had frequently been left alone, and 1.2% (n=2) were always been left alone, as shown in Figure 4.6 above.

4.3.2.2 Verbal abuse

Items 9-19 were listed under this subsection for participants to report on their experience of verbal abuse.
4.3.2.2.1 Insulted or sworn at

Figure 4.7 indicates that 0.6% (n=1) of the participants have always been exposed to insults and swearing, 5.5% (n=9) frequently experienced this, and 19.6% (n=32) seldom experienced this, while 74.2% (n=121) reported not to have been exposed to insults and swearing during their clinical exposure.

![Figure 4.7: Insulted or sworn at (n=163)](image)

4.3.2.2.2 Shouted or yelled at

In Figure 4.8, 58.9% (n=96) of the participants have never been shouted or yelled at, 31.3% (n=51) were seldom shouted and yelled at, 9.2% (n=15) reported this as a frequent occurrence and 0.6% (n=1) reported that they had always been shouted or yelled at.

![Figure 4.8: Shouted or yelled at (n=163)](image)
4.3.2.2.3 *Ridiculed or humiliated*

Of the participants, 78.5% (n=128) were never ridiculed or humiliated, 14.1% (n=23) seldom had this happen to them and 7.4% (n=12) were frequently ridiculed and humiliated during their clinical placement in the psychiatric institutions.

![Figure 4.9: Ridiculed or humiliated (n=163)](image)

4.3.2.2.4 *Made to feel guilty*

An amount of 65.05% (n=106) of the respondents had never been made to feel guilty in the workplace, 25.2% (n=41) reported seldom exposure, and 9.8% (n=16) had frequently been made to feel guilty in the workplace.

![Figure 4.10: Made to feel guilty (n=163)](image)
4.3.2.2.5 *Harshly judge/criticized*

About 8% (n=13) of the respondents reported that they had frequently been harshly judged or criticized, and 26.4% (n=43) indicated that this had seldom occurred, while 65.6% (n=107) reported that they had never experienced this.

![Figure 4.11: Harshly judged / criticized (n=163)](image)

4.3.2.2.6 *Had a racist remark directed to you*

According to this figure, only one student nurse 0.6% (n=1) always had racist remarks directed at him/her, for 3.7% (n=6) this was a frequent occurrence, 19.6% (n=32) seldom received these remarks and the majority of the participants, 76.1% (n=124), never had racist remarks directed at them.

![Figure 4.12: Had a racist remark directed to you (n=163)](image)
4.3.2.2.7 Threatened with physical violence

Threats of physical violence are still present in the clinical area as the evidence indicated that 0.6% (n=1) of the student nurses reported that they were always threatened, 3.7% (n=6) reported frequent threats, and 16% (n=26) had seldom been threatened. Of the respondents, 79.8% (n=130), had never been exposed to threats of physical violence.

Figure 4.13: Threatened with physical violence (n=163)

4.3.2.2.8 Not received acknowledgement for good work

Figure 4.14 shows that 46.0% (n=75) of the participants never had their good work acknowledged, 36.8% (n=60) reported that such acknowledgment seldom took place, 11.0% (n=18) were frequently denied any acknowledgement for their good work, and 6.1% (n=10) reported that they have never received acknowledgment for good work done.

Figure 4.14: Not received acknowledgement for good work (n=163)
4.3.2.2.9 Denied learning opportunity

It was unfortunate to observe that some student nurses were denied the opportunity to learn during their placement in psychiatric settings. Figure 4.15 indicates that 0.6% (n=1) of the student nurses has always been denied learning opportunities, 34.4% (n=56) were seldom denied, 7.4% (n=12) had frequently been denied, and 57.7% (n=94) had fortunately never been denied the opportunity for learning.

![Figure 4.15: Denied learning opportunity (n=163)](image)

4.3.2.2.10 Given unfair work allocation

Some of the students 2.5% (n=4) felt that they were always allocated duties unfairly, 27.6% reported that this was seldom the case, 16% (n=26) reported a frequent unfair allocation of work, but 54% (n=88) denied having ever been subjected to an unfair allocation of work.

![Figure 4.16: Given unfair work allocation](image)
4.3.2.2.11 Not been treated as part of the team

Some student nurses felt they had not been treated as part of the team. A total of 5.5% (n=9) felt that they had always been treated as strangers, 36.8% (n=60) of the students seldom experienced this feeling, 15.3% (n=25) had frequent experience of this, and 42.3% (n=69) stated that they have never been treated as though they were not part of the team.

![Bar chart showing the distribution of responses](chart.png)

Figure 4.17: Not been treated as part of the team (n=163)

Table 4.3 is an illustration of the means and standard deviations for the variables related to non-physical violence. A confidence interval of 0.95% was established for the mean of each variable. The mean of each variable of non-physical violence varied between 1.2 and 1.7. The small difference in the means of the fourteen variables for non-physical violence indicates the little difference in the frequency of the behaviours. The standard deviation for the non-physical violence is between 0.5 and 0.8. The small difference in standard deviations indicates that there was little deviation from the mean.
Table 4.3: Means and standard deviations of variables regarding types of non-physical violence

<table>
<thead>
<tr>
<th>Types of Non-Physical Abuse</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised eyebrow, rolling of eyes</td>
<td>1.66</td>
<td>0.740</td>
</tr>
<tr>
<td>Ignored or neglected</td>
<td>1.71</td>
<td>0.822</td>
</tr>
<tr>
<td>Left alone in the unit</td>
<td>1.39</td>
<td>0.688</td>
</tr>
<tr>
<td>Other</td>
<td>1.02</td>
<td>0.135</td>
</tr>
<tr>
<td>Insulted or sworn at</td>
<td>1.33</td>
<td>0.607</td>
</tr>
<tr>
<td>Shouted or yelled at</td>
<td>1.52</td>
<td>0.688</td>
</tr>
<tr>
<td>Ridiculed or humiliated</td>
<td>1.29</td>
<td>0.595</td>
</tr>
<tr>
<td>Made to feel guilty</td>
<td>1.45</td>
<td>0.668</td>
</tr>
<tr>
<td>Harshly judged / criticized</td>
<td>1.42</td>
<td>0.637</td>
</tr>
<tr>
<td>Racist remark directed at them</td>
<td>1.29</td>
<td>0.564</td>
</tr>
<tr>
<td>Threatened with physical violence</td>
<td>1.25</td>
<td>0.548</td>
</tr>
<tr>
<td>Not received acknowledgement for good work</td>
<td>1.77</td>
<td>0.877</td>
</tr>
<tr>
<td>Denied learning opportunity</td>
<td>1.51</td>
<td>0.661</td>
</tr>
<tr>
<td>Given unfair work allocation</td>
<td>1.67</td>
<td>0.832</td>
</tr>
<tr>
<td>Not been treated as part of the team</td>
<td>1.84</td>
<td>0.881</td>
</tr>
<tr>
<td>Other</td>
<td>1.00</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Confidence Interval=0.95%

4.3.2.3 Physical abuse

The respondents were expected to identify and report on items (21-29) relating to physical abuse.

4.3.2.3.1 Pushed or shoved

Very few of the respondents 4.3% (n=7) admitted to have been seldom pushed or shoved. The majority of the participants 95.7% (n=156) have never been pushed or shoved, as shown in Figure 4.18.
4.3.2.3.2 Kicked
A large percentage of student nurses 98.2% (n=160) reported that they had never been kicked and 1.8 % (n=3) of the students were seldom kicked in the clinical area.

4.3.2.3.3 Slapped or punched
The figure below indicates that 0.6% (n=1) of the student nurses were frequently slapped or punched in the clinical area, 1.8% (n=3) seldom had this happen and 97.5% (n=159) have never experienced it.
4.3.2.3.4 *Hit with something*

A small number (1.2%, n=2) of the student nurses reported that they were seldom hit with something, whereas 98.8% (n=161) indicated that they had never been hit with anything in the psychiatric clinical area.

4.3.2.3.5 *Had your arm twisted*

This figure demonstrates that only 1.8% (n=3) of the student nurses had had their arm twisted at times. The rest of them, 98.2% (n=160), had never had their arm twisted.
4.3.2.3.6 Had your hair pulled

Figure 4.23 indicates that 1.8% (n=3) of the participants had their hair pulled and 98.2% (n=160) never had their hair pulled during their placement in a psychiatric clinical area.
4.3.2.3.7 Had something of yours damaged

Some of the student nurses reported having had something of theirs damaged, with 0.6% (n=1) reporting this as a frequent event, 1.8% (n=3) indicated that this happened seldom and 97.5 (n=159) reported that this had never happened to them.

![Figure 4.24: Had something of yours damaged (n=163)](image)

The scores of mean and standard deviations of the variables regarding physical violence indicate a close distribution since there is less difference noted within the scores. The mean scores ranges between 1.00 and 1.04 and the standard deviation is between 0.1 and 0.2. These findings indicate that there were no outliers; all of the respondents were exposed to similar experiences of physical abuse. It is noted from the mean scores above that none of the participants were exposed to violence involving guns and knives. The most common behaviour that occurred was being pushed or shoved, although the scores for the two were not dissimilar.
Table 4.4: Means and standard deviations of variables regarding physical abuse

<table>
<thead>
<tr>
<th>Types of Physical Abuse</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pushed or shoved</td>
<td>1.04</td>
<td>.203</td>
</tr>
<tr>
<td>Kicked</td>
<td>1.02</td>
<td>.135</td>
</tr>
<tr>
<td>Slapped or punched</td>
<td>1.03</td>
<td>.206</td>
</tr>
<tr>
<td>Hit with something</td>
<td>1.01</td>
<td>.110</td>
</tr>
<tr>
<td>Had a gun or knife drawn at you</td>
<td>1.00</td>
<td>0.000</td>
</tr>
<tr>
<td>Had your arm twisted</td>
<td>1.02</td>
<td>.135</td>
</tr>
<tr>
<td>Had your hair pulled</td>
<td>1.02</td>
<td>.135</td>
</tr>
<tr>
<td>Had something of yours damaged</td>
<td>1.03</td>
<td>.206</td>
</tr>
</tbody>
</table>

Confidence interval: 0.95%

4.3.2.4 Sexual abuse

The five items of sexual abuse listed for reporting were all attended to by the respondents.

4.3.2.4.1 Been inappropriately touched

An amount of 1.2% (n=2) of the participants reported that they had always been inappropriately touched, 6.1% (n=10) had frequent encounters of this nature, 19.6% (n=32) reported that this occurred seldom and 73% (n=119) had never been inappropriately touched.
4.3.2.4.2 **Been threatened with sexual assault**

According to the figure below, 0.6% (n=1) of the participants indicated that they were always threatened with sexual assault, 2.5% (n=4) indicated that this was a frequent occurrence, 6.7% (n=11) seldom experienced this and 90.2% (n=147) had never been threatened with sexual assault.

4.3.2.4.3 **Had sexist remarks directed at you**

Although 71.2% (n=116) of respondents had no experience of sexist remarks directed at them, 23.9% (n=39) and 4.9% (n=8) reported this as having happened seldom and frequently respectively.
4.3.2.4.4 Had suggestive sexual gestures directed at you

The findings indicate that 66.9% (n=109) of study participants had never had suggestive sexual gestures directed at them, 27.0% (n=44) had seldom experienced the behaviour and 6.1% (n=10) had frequently experienced the behaviour.

4.3.2.4.5 Had a request for intimate physical contact

About 0.6% (n=1) of the participants always received requests for intimate physical contact, 5.5% (n=9) reported this as a frequent event, 12.3% (n=20) reported that they had seldom experienced this kind of behaviour and 81.6% (n=133) had never had a request for intimate physical contact.
4.3.2.4.6 Other

A single participant 0.6% (n=1) of the study reported that they had experienced other forms of sexual abuse but did not state the nature of this abuse and 99.4% (n=162) indicated that there were no other forms of sexual abuse experienced.

Table 4.5 indicates a fair distribution of scores and there were no extreme differences noted. The mean scores ranged between 1.1 and 1.3 and the standard deviations scores were between 0.035 and 0.051. The little differences in the mean scores are significant of the respondents that were more or less equally exposed to the same circumstances. No outliers were noted.
Table 4.5: Means and standard deviations of variables regarding sexual abuse

<table>
<thead>
<tr>
<th>Types of Sexual Abuse</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been inappropriately touched</td>
<td>1.36</td>
<td>.654</td>
</tr>
<tr>
<td>Been threatened with sexual assault</td>
<td>1.13</td>
<td>.452</td>
</tr>
<tr>
<td>Had sexist remarks directed at you</td>
<td>1.34</td>
<td>.569</td>
</tr>
<tr>
<td>Had suggestive sexual gestures directed at you</td>
<td>1.39</td>
<td>.603</td>
</tr>
<tr>
<td>Had a request for intimate physical contact</td>
<td>1.25</td>
<td>.581</td>
</tr>
<tr>
<td>Other</td>
<td>1.01</td>
<td>.078</td>
</tr>
</tbody>
</table>

4.3.3 Section C: Settings of workplace violence

This section required the respondents to report on settings in which violence had taken place and the sources of the violence. The settings were listed in items 36 and 37, followed by sources in items 38 to 48. Item 49 entitled ‘Other” was designed to afford the respondents an opportunity to identify and report on the source of workplace violence not included on the list. To answer this section, the respondents were guided by a statement saying “During the period of clinical placement in psychiatric units, identify the area / areas where the abuse took place and the source/s of the abuse”. All questions were answered by the respondents.

4.3.3.1 Settings for workplace violence (n=163)

Two settings were identified for workplace violence, including hospitals (item 36) and community settings e.g. clinics, rehabilitation centres, schools (item 37).

Table 4.6 illustrates that 3.1% of the participants always experienced workplace violence in the hospital settings compared to 0.6% in the community setting. 52.1% (n=85) of the respondents had never experienced workplace violence while in the community setting, compared to the 33.7% (n=55) from the hospital settings. Upon comparing the two settings, it is apparent that there is more violence directed at student nurses in the hospital settings than in the community settings.

These findings correlated with Lappalainen (2010:6), who explained that higher levels of violence in the psychiatric in-patient settings resulted because some of the
patients admitted to the psychiatric hospitals were acutely ill and displayed high levels of violence and aggression.

<table>
<thead>
<tr>
<th>Settings</th>
<th>Never</th>
<th>Seldom</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Hospital</td>
<td>55</td>
<td>33.7</td>
<td>80</td>
<td>49.1</td>
</tr>
<tr>
<td>Community</td>
<td>85</td>
<td>52.1</td>
<td>66</td>
<td>40.5</td>
</tr>
</tbody>
</table>

The mean scores for settings were 1.56 for community settings and 1.87 for those in the hospital, and the standard deviations are 0.649 for community and 0.766 for the hospital. A confidence interval of 0.95% was established to calculate the scores.

Table 4.7: Means and standard deviations of variables regarding settings for workplace violence

<table>
<thead>
<tr>
<th>Settings</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1.87</td>
<td>.766</td>
</tr>
<tr>
<td>Community settings e.g. clinics, rehabilitation centres, schools.</td>
<td>1.56</td>
<td>.649</td>
</tr>
</tbody>
</table>

4.3.3.2 Sources of workplace violence

In this section, eleven categories of people with the potential for perpetrating violence were listed for the respondents to indicate the source and the level of workplace violence that they had experienced.
Table 4.8 shows that staff nurses and assistant nurses always rated highly as perpetrators of violence at 6.7% (n=11), followed by patients at 4.9% (n=8). The majority of sources that were reported to frequently perpetrate violence against the students were patients 16% (n=26), registered nurses 11% (n=18), staff nurses and assistant nurses, both with 7.4% (n=12). The categories reported to create less violence were the clinical facilitators, lecturers, administration staff and student nurses. This statement was based on the rating these categories had for “never”: clinical facilitators 93.9% (n=153), lecturers 151% (n=92.6), administration staff 90.8% (n=148), and student nurses 87.7% (n=143).

It was interesting to the researcher that the registered nurses, who were supposed to nurture new staff members and who knew better than the staff nurses and auxiliary nurses, were revealed to be the most frequent perpetrators of violence. Generally, the findings from this section indicated that worker on worker violence was present in nursing. A study by Wilson, Diedrich, Phelps and Choi (2011) found that 61.1% of the surveyed nurses reported horizontal violence observed between co-workers in their units. Becher and Visovsky (2012:232) asserted that horizontal and vertical
violence created a negative work environment, impairing team work and compromising patient care. These authors concluded that it was their belief that the failure to address horizontal violence could discourage students and new graduate nurses, and result in their leaving the profession.

Another cause for concern was the trend of categorizing other people into ‘in’ or ‘out’ groups, which often resulted in older employees exhibiting hostility towards younger employees, or those with a higher education feeling superior to unskilled employees and engaging in bullying behaviours (Cunniff & Mostert, 2012:3). In the workplace, especially in psychiatric settings, enrolled nurses and assistant nurses are usually older, with long service, and they often feel bitter knowing that the student that they were guiding and mentoring would be promoted to a supervisory position soon after completing their training. Students reported a common comment of “You are here so that in no time you can become our boss”. Such comments confirm that staff does not always see students as information seekers but rather as competitors, particularly the R425 students.

Vertical violence towards students can originate from persons who work closely with them including physicians and staffing supervisors, state Becher and Visovsky (2012:211). They reported forms of this behaviour also from non-professional categories of staff, like housekeepers.
Table 4.9: Means and standard deviations of variables regarding sources of workplace violence

<table>
<thead>
<tr>
<th>Sources</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1.84</td>
<td>0.867</td>
</tr>
<tr>
<td>Patient's relatives/friends</td>
<td>1.21</td>
<td>0.515</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>1.55</td>
<td>0.713</td>
</tr>
<tr>
<td>Staff nurses</td>
<td>1.55</td>
<td>0.897</td>
</tr>
<tr>
<td>Assistant nurses</td>
<td>1.55</td>
<td>0.897</td>
</tr>
<tr>
<td>Student nurses</td>
<td>1.18</td>
<td>0.532</td>
</tr>
<tr>
<td>Clinical facilitators</td>
<td>1.06</td>
<td>0.241</td>
</tr>
<tr>
<td>Lecturers</td>
<td>1.09</td>
<td>0.322</td>
</tr>
<tr>
<td>Doctors</td>
<td>1.23</td>
<td>0.466</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>1.11</td>
<td>0.385</td>
</tr>
<tr>
<td>Housekeeping staff</td>
<td>1.24</td>
<td>0.565</td>
</tr>
<tr>
<td>Other</td>
<td>1.01</td>
<td>0.078</td>
</tr>
</tbody>
</table>

Confidence interval: 0.95%

The scores for the mean range from 1.0 to 1.8 and standard deviations scores were between 0.2 and 0.8. A confidence interval of 0.95 was established for the mean of each variable. The differences in the mean scores demonstrates that the distribution was widespread, thus indicating that the respondents were exposed to different sources of violence. This may be as a result of the many sources listed for the participants to respond to, which could be favourable for a better understanding of the topic under study.

4.3.4 Section D: Effects of workplace violence on performance of students

Respondents were required to report on the personal and work performance consequences of workplace violence to them. Items 57 and 61 entitled ‘Other’ were provided for the respondents to identify and report on personal and work performance effects of violence respectively. The respondents were guided by the statement: “Identify the emotional feelings of abuse to you and on your work performance”. During orientation to the questionnaire, the respondents were instructed to report strictly on their experiences from the period of psychiatric
placement only. All participants attended to this section and there were no missing responses.

### 4.3.4.1 Personal effects

There were seven items that the respondents had to report on with regards to the personal consequences of workplace violence that they had experienced during their psychiatry clinical placement.

#### 4.3.4.1.1 Anger

Exposure to workplace violence had provoked anger in student nurses. They reported the frequency of the feelings as follows: 1.2% \((n=2)\) always, 12.9% \((n=21)\) frequently, 40.5% \((n=66)\) seldom, and 45.4% \((n=74)\) never.

![Figure 4.31: Anger (n=163)](image)

#### 4.3.4.1.2 Depression

The majority of the student nurses indicated that they were not depressed as a result of their exposure to violence in the workplace, 8.0% \((n=13)\) reported that they frequently became depressed, 22.7% \((n=37)\) seldom got depressed and 69.3% \((n=113)\) have never experienced depression in the workplace as a result of violence.
4.3.4.1.3 Humiliation/Embarrassment

Figure 4.33 indicates that 51.1% (n=84) of the student nurses have never been humiliated nor embarrassed, 34.4% (n=56) seldom experienced this, 12.3% (n=20) frequently felt this way and 1.8 (n=3) were always humiliated and embarrassed by workplace violence taking place in psychiatric institutions.

4.3.4.1.4 Anxiety/Fear

Figure 4.34 illustrates that only one respondent was always anxious and fearful in the workplace as a result of violence, otherwise 15.3% (n=25) reported frequent
anxiety and fear, 38.7% (n=63) seldom experienced this and 45.4% (n=74) had never experienced any anxiety or fear.

Muschalla (2009:46), described workplace anxiety as a phobic reaction with symptoms of panic occurring when thinking of or approaching the workplace. This can lead to people avoiding the workplace, thereby elevating the absenteeism rate in the workplace.

![Figure 4.34: Anxiety / Fear (n=163)](image)

**4.3.4.1.5 Confusion**

Only one student (0.6%, n=1) reported always experiencing confusion in the workplace, 10.4% (n=17) frequently experienced confusion, 27.6% (n=45) were seldom confused and 61.3% (n=100) have never been confused.
4.3.4.1.6 **Feelings of inadequacy**

Figure 4.36 demonstrates that some students felt inadequate in the workplace, 1.8% (n=3) had always felt this way, 10.4% (n=17) frequently had the feelings and 26.4% (n=43) seldom felt inadequate. Other students 61.3% (n=100) never had feelings of inadequacy as a result of violence in the workplace.

4.3.4.1.7 **Negative effect on personal relationships**

Some student nurses reported that the presence of workplace violence in the psychiatric clinical areas created a negative relationship between them and other
people at work. The majority of them (73%, n=119) had not developed any negative effects regarding their personal relationships, 20.2% (n=33) indicated that they were seldom affected, 6.1% (n=10) of them frequently and 0.6% (n=1) always experienced negative effects regarding their personal relationships as a result of violence encountered in the workplace.

![Figure 4.37: Negative effect on personal relationships (n=163)](image)

4.3.4.1.8 Other

One student nurse 0.6% (n=1) reported that he/she had seldom experienced other negative personal effects of workplace violence that were not covered by the questionnaire but did not indicate the actual effects whereas 99.4% (n=162) had never experienced any other effects.

![Figure 4.38: Other (n=163)](image)
The mean scores ranged from 1.3 to 1.7 and standard deviations scored between 0.6 and 0.7. The scores were established at a confidence interval of 0.95%. Although anger, anxiety and fear appear to be the most prevalent personal effect experienced, the difference within the mean scores is small indicating that these consequences occur at a similar rate.

Table 4.10: The mean and standard deviations of variables regarding personal effects of workplace violence

<table>
<thead>
<tr>
<th>Personal Effects of Workplace Violence</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>1.70</td>
<td>.738</td>
</tr>
<tr>
<td>Depression</td>
<td>1.39</td>
<td>.632</td>
</tr>
<tr>
<td>Humiliation/embarrassment</td>
<td>1.64</td>
<td>.767</td>
</tr>
<tr>
<td>Anxiety/fear</td>
<td>1.71</td>
<td>.743</td>
</tr>
<tr>
<td>Confusion</td>
<td>1.50</td>
<td>.706</td>
</tr>
<tr>
<td>Feelings of inadequacy</td>
<td>1.53</td>
<td>.756</td>
</tr>
<tr>
<td>Negative effect on personal relationships</td>
<td>1.34</td>
<td>.622</td>
</tr>
<tr>
<td>Other</td>
<td>1.01</td>
<td>.078</td>
</tr>
</tbody>
</table>

Confidence interval: 0.95%

4.3.4.2 Effects on work performance

The respondents were expected to report on the extent to which the workplace violence affected their work performance. Three items were listed in this subsection, and all of the participants responded to them. A provision was made for any other effect that might have been experienced by the learner to be plotted on the space written ‘Other’ on the table.
Table 4.11: Effects on work performance (n=163)

<table>
<thead>
<tr>
<th>Effects</th>
<th>Never</th>
<th>Seldom</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>n%</td>
<td>n%</td>
<td>n%</td>
<td>n%</td>
<td>n%</td>
</tr>
<tr>
<td>Made you consider leaving nursing</td>
<td>135</td>
<td>82.8</td>
<td>19</td>
<td>11.7</td>
</tr>
<tr>
<td>Caused you to be absent</td>
<td>146</td>
<td>89.6</td>
<td>10</td>
<td>6.1</td>
</tr>
<tr>
<td>Negatively affected standard of patient care</td>
<td>112</td>
<td>68.7</td>
<td>38</td>
<td>23.3</td>
</tr>
<tr>
<td>Other</td>
<td>161</td>
<td>98.8</td>
<td>2</td>
<td>1.2</td>
</tr>
</tbody>
</table>

This table (table 4.11), indicates that the presence of violence in the workplace has a negative effect on the standard of work performance of the student nurses. Some respondents reported that workplace violence made them consider leaving nursing. 1.8% (n=3) always felt this way, 3.75 (n=6) frequently felt this way, 11.7% (n=19) seldom did, and 82.8% (n=135) never felt the desire to leave. There was only one student 0.6% (n=1) who reported that violence in the workplace always caused her/him to be absent as opposed to 89.6% (n=146) who have never been absent as a result of violence. The reported responses regarding the negative effects on the standard of patient care were 8.0% (n=13) for frequently and 23.3% (n=38) for seldom.

Table 4.12: Means and standard deviations of variables regarding effects on work performance

<table>
<thead>
<tr>
<th>Effects on Work Performance</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made you consider leaving nursing</td>
<td>1.25</td>
<td>.610</td>
</tr>
<tr>
<td>Caused you to be absent</td>
<td>1.15</td>
<td>.492</td>
</tr>
<tr>
<td>Negatively affected your standard of patient care</td>
<td>1.39</td>
<td>.633</td>
</tr>
</tbody>
</table>

Confidence interval: 0.95%.
The distribution of scores for the effects on work performance was fair since there were small differences in the scores. The mean scores ranged between 1.15 and 1.39, and standard deviation scores were between 0.4 and 0.6. A confidence interval of 0.95% was established for the mean of each variable.

4.3.5 Section E: Reporting of workplace violence

This section was for respondents to indicate if they had ever reported workplace violence to the authorities and if not, their reasons for not doing so. They were also asked if they were aware of any policies in the clinical area addressing workplace violence. Item 70 entitled ‘Other’ was intended for respondents to indicate the reasons that could have discouraged them from reporting the violence. An instruction was given below item 62 which said: “If yes in question 62, then proceed to question 71, if no then continue with question 63”. This instruction was not followed accurately by most of the student nurses because even those who indicated “yes” to question 62 continued with question 63 onwards. Some respondents placed a tick on item 63 although they had already indicated experiences of violence in other sections above. This practice by the respondents was disappointing to the researcher as the findings in this section might not be a true reflection of what is actually happening in the clinical area. The respondents were to report by placing a tick on either the “Yes” or “No” options, according to their experiences.

4.3.5.1 Reporting of workplace violence

Figure 4.39 illustrates that only 7.4% (n=12) of the student nurses had reported workplace violence and 92.6% (n=151) have never reported the occurrence of this violence to authorities. The mean score for the reporting of the workplace violence was 1.93 and the standard deviation was 0.262.
4.3.5.2 Reasons for not reporting workplace violence

The respondents were expected to indicate only the reasons that applied to them. During the process of data recording on the computer, all of the reasons that were ticked were regarded and counted as ‘yes’ and those that were left blank were regarded as ‘no’ because there were only two measurements. Table 4.13 indicates only the responses that were ticked by the respondents.

Table 4.13: Reasons for not reporting workplace violence (n=163)

<table>
<thead>
<tr>
<th>Reasons for Not Reporting Workplace Violence</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>63. I have never experienced workplace violence.</td>
<td>58</td>
<td>35.6</td>
</tr>
<tr>
<td>64. I do not know where and how to report.</td>
<td>41</td>
<td>25.2</td>
</tr>
<tr>
<td>65. I feel it is part of the job.</td>
<td>38</td>
<td>23.3</td>
</tr>
<tr>
<td>66. I think nothing will be done because I am a student.</td>
<td>73</td>
<td>44.8</td>
</tr>
<tr>
<td>67. I am afraid I will be victimized.</td>
<td>59</td>
<td>36.2</td>
</tr>
<tr>
<td>68. I wanted to finish the required hours and leave.</td>
<td>95</td>
<td>58.3</td>
</tr>
<tr>
<td>69. It is not important to report.</td>
<td>24</td>
<td>14.7</td>
</tr>
<tr>
<td>70. Other: please write down and make a tick in the appropriate space.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.13 indicates that student nurses, for various reasons, fail to report workplace violence experienced in the clinical area. The researcher had listed seven common reasons that were mentioned in literature for the failure to report workplace violence. The most common reason that was mentioned by student nurses (58.3%, n=95) was that they wanted to finish their studies and leave and 44.8% (n=73) thought nothing would be done about the matter because they were student nurses. This indicated that the student nurses regarded themselves as inferior to the other members of the multidisciplinary team in the workplace. Other reasons given by students were that (25.2%, n=41) of them did not know where and how to report the incidents, 23.35% (n=38) felt that it was part of the job, and 14.7% (n=24) thought it was not important to report workplace violence.

Table 4.14: The mean and standard deviation for variables regarding reasons for not reporting workplace violence

<table>
<thead>
<tr>
<th>Reason for not reporting</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have never experienced workplace violence</td>
<td>1.64</td>
<td>.480</td>
</tr>
<tr>
<td>I do not know where and how to report</td>
<td>1.75</td>
<td>.435</td>
</tr>
<tr>
<td>I feel it is part of the job</td>
<td>1.77</td>
<td>.424</td>
</tr>
<tr>
<td>I think nothing will be done because I am a student</td>
<td>1.55</td>
<td>.499</td>
</tr>
<tr>
<td>I am afraid I will be victimized</td>
<td>1.64</td>
<td>.482</td>
</tr>
<tr>
<td>I wanted to finish the required hours and leave</td>
<td>1.42</td>
<td>.495</td>
</tr>
<tr>
<td>It is not important to report</td>
<td>1.85</td>
<td>.355</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>1.96</strong></td>
<td><strong>.203</strong></td>
</tr>
</tbody>
</table>

Confidence interval: 0.95%

The mean scores ranged between 1.4 and 1.9, and standard deviation scores were between 0.3 and 0.4. A confidence interval of 0.95% was established for the mean of each variable. The difference between the mean scores was not much, which indicated that the respondents had almost similar reasons for not reporting. The small difference in standard deviation scores indicated that there was little deviation from the mean.
4.3.5.3 Awareness of workplace violence policies

The figure below depicts that only 37.4% (n=61) of the students were aware of the policies, and 62.6% (n=102) were not aware of any policies in the clinical area addressing workplace violence. A discrepancy was noticed between knowledge of the policies and the reporting of the workplace violence. In relation to 37.4% (n=61) of the students that were aware of the policies, only 7.4% (n=12) had reported workplace violence. The dissonance in responses made the researcher consider whether the available policies were communicated appropriately to the learners so as to promote their effectiveness. The mean score for the awareness of the policies was 1.63, and the standard deviation was 0.485.

![Figure 4.39: Awareness of workplace violence policies](image)

4.4 MEASURES OF RELATIONSHIPS BETWEEN DEMOGRAPHIC DATA AND STUDY VARIABLES

The statistics regarding the relationships between the demographic variables (gender, ethnicity, age, and period of psychiatric placement) and the study variables were measured and analysed to understand any existing correlations. A Pearson correlation coefficient (r) determines whether the value obtained is likely to have occurred by chance whereas the Chi-square statistic determines whether the frequency in each category is different from what would be expected by chance (LoBiondo-Wood & Haber, 2010:326-327).
4.4.1 Relationships of gender

The correlation tests were run to ascertain whether there are any relationships between gender and the study variables.

4.4.1.1 Gender and variables regarding types of violence

The three types of violence that were analysed by the researcher were non-physical (non-verbal and verbal), physical, and sexual violence.

4.4.1.1.1 Gender and non-physical violence

An independent t-test was conducted to determine the relationship between gender and the prevalence of non-physical violence. The probability value (p=0.303) exceeded 0.05, indicating a statistically insignificant relationship between age and the prevalence of non-physical violence (F=1,070) (p=0.303).

4.4.1.1.2 Gender and physical violence

An independent t-test was conducted to establish whether there was any relationship between gender and the prevalence of physical violence. The probability value (p=0.020) did not exceed 0.05, indicating a statistically significant relationship between gender and the prevalence of physical violence (F=5,549) (p=0.020). More females reported physical violence than males. This finding requires further research as to why females are more prone to physical assault than males in psychiatric clinical environments.

4.4.1.1.3 Gender and sexual violence

An independent t-test was done to examine the relationship between gender and the prevalence of sexual violence. The probability value (p<0.001) did not exceed 0.05, indicating a statistically significant relationship between gender and the prevalence of sexual violence (F=23.302) (p=0.001). The females rated higher than males on experiences of sexual abuse. This may be related to cultural beliefs by the majority of South Africans that males are usually the ones that initiate intersexual conversation with the females.

4.4.1.2 Gender and variables regarding sources of violence

An independent t-test was conducted to establish whether any relationship existed between gender and the sources of violence. The probability value (p=0.001) did not
exceed 0.05, indicating a statistically significant relationship between gender and the sources of violence (F=11.613) (p=0.001). The finding shows that females reported more on the positive side of the measurement (frequent and always) than males did towards all sources of violence mentioned. This finding indicates that females were exposed to higher levels of violence than males were.

### 4.4.1.3 Gender and variables regarding effects of workplace violence

An independent t-test was conducted to establish whether there was any relationship between gender and the effects of violence. The probability value (p=0.034) did not exceed 0.05, indicating a statistically significant relationship between gender and the prevalence of physical violence (F=5,549) (p=0.020). The females reported more effects of violence than males. This requires further research as to why females were so much more affected by workplace violence than males in psychiatric clinical environments. There is a general belief that females are emotionally more sensitive and find it difficult to control their emotions than males, they respond emotionally to most of their experiences.

### 4.4.1.4 Gender and variables regarding reporting of violence to authorities

A Chi-square test of independence was conducted to determine the relationship between gender and the behaviour of reporting violence to authorities. The probability value (p=0.070) exceeded 0.05, indicating a statistically insignificant relationship between age and the behaviour of reporting violence to the authorities.

### 4.4.1.5 Gender and variables regarding reasons for not reporting violence

A Chi-square test of independence was conducted to determine the relationship between gender and reasons for not reporting violence. A statistically significant relationship was established between gender and the question “have you ever experienced violence in the workplace”, with a probability value (p<0.001) that failed to exceed 0.05. The majority of male respondents had never experienced violence in the workplace. Secondly, a statistically significant relationship was established between gender and the question of “is it important to report workplace violence”, the probability value (p=0.005) did not exceed 0.05. Females felt it was more important to report workplace violence than males. From the total of seven reasons for not reporting violence that were examined, only the two above had a significant relationship, the other five showed a statistically insignificant relationship.
4.4.1.6 Gender and variable regarding awareness of policies in the psychiatry clinical areas addressing workplace violence

A Chi-square test of independence was conducted to determine the relationship between gender and an awareness of policies in the clinical areas addressing workplace violence. The probability value (p=0.001) did not exceed 0.05, indicating a statistically significant relationship between gender and the awareness of policies in the psychiatry clinical areas addressing workplace violence. Male respondents were more aware of the availability of the policies than females. Research is needed to investigate the reasons for the difference in knowledge between both genders.

4.4.2 Relationships of ethnicity

The correlation tests were run to ascertain whether there were any relationships between ethnicity and the study variables. The ethnic groups that participated in the study were Blacks, Coloureds and Indians.

4.4.2.1 Ethnicity and variables regarding types of violence

The three types of violence that were analysed were non-physical (non-verbal and verbal), physical and sexual violence.

4.4.2.1.1 Ethnicity and non-physical violence

A one-way ANOVA test was conducted to determine the relationship between ethnicity and the prevalence of non-physical violence. The probability value (p=0.571) exceeded 0.05 indicating a statistically insignificant relationship between ethnicity and the prevalence of non-physical violence. A post hoc Tukey HSD test was run and the probability value (p=0.996) exceeded 0.05, indicating a statistically insignificant relationship among the three race groups (Blacks, Coloureds & Indians) that participated in the study.

4.4.2.1.2 Ethnicity and physical violence

A one-way ANOVA test was conducted to determine the relationship between ethnicity and the prevalence of physical violence. The probability value (p=0.654) exceeded 0.05, indicating a statistically insignificant relationship between ethnicity and the prevalence of physical violence.
4.4.2.1.3 Ethnicity and sexual violence

A one-way ANOVA test was conducted to determine the relationship between ethnicity and the prevalence of sexual violence. The probability value (p=0.265) exceeded 0.05, indicating a statistically insignificant relationship between ethnicity and the prevalence of sexual violence.

4.4.2.2 Ethnicity and variables regarding sources of violence

A one-way ANOVA test was conducted to determine the relationship between ethnicity and the sources of violence. The probability value (p=0.326) exceeded 0.05, indicating a statistically insignificant relationship between ethnicity and sources that perpetrated violence.

4.4.2.3 Ethnicity and variables regarding effects of workplace violence

A one-way ANOVA test was conducted to determine the relationship between ethnicity and the prevalence of non-physical violence. The probability value (p=0.553) exceeded 0.05 indicating a statistically insignificant relationship between ethnicity and the effects of violence.

4.4.2.4 Ethnicity variables regarding the not reporting of violence to authorities

A Chi-square test of independence was conducted to determine the relationship between ethnicity and the behaviour of not reporting violence to authorities. The probability value (p=0.588) exceeded 0.05 indicating a statistically insignificant relationship between ethnicity and the behaviour of not reporting violence.

4.4.2.5 Ethnicity and variables regarding reasons for not reporting violence to authorities

A Chi-square test of independence was conducted to determine the relationship between ethnicity and variables regarding reasons for not reporting violence to authorities. The probability value (p=0.045) did not exceed 0.05 for the variable “I feel it is part of the job”, indicating a statistically significant relationship between ethnicity and the behaviour of not reporting violence to the authorities. The coloured participants were more inclined to feel that violence was part of the job whereas more Black and Indian respondents felt the opposite.
4.4.2.6 Ethnicity and variables regarding awareness of policies in psychiatry clinical areas addressing workplace violence

A Chi-square test of independence was conducted to determine the relationship between ethnicity and the awareness of policies in psychiatry clinical areas addressing workplace violence. The probability value (p=0.559) exceeded 0.05 indicating a statistically insignificant relationship between ethnicity and awareness of policies in psychiatry clinical areas addressing workplace violence.

4.4.3 Age relationships

The correlation tests were run to ascertain whether there were any relationships between age and the study variables.

4.4.3.1 Age and variables regarding types of violence

The three types of violence that were analysed by the researcher were non-physical (non-verbal and verbal), physical and sexual violence.

4.4.3.1.1 Age and non-physical violence

A Pearson correlation coefficient test was conducted to determine the relationship between age and the prevalence of non-physical violence. The probability value (p=0.539) exceeded 0.05 indicating a statistically insignificant relationship between age and the prevalence of non-physical violence (r=-0.048, p=0.539).

4.4.3.1.2 Age and physical violence

A Pearson correlation coefficient test was conducted to examine the relationship between age and the prevalence of physical violence. The probability value (p=0.449) exceeded 0.05 indicating a statistically insignificant relationship between age and the prevalence of physical violence (r=-0.060, p=0.449).

4.4.3.1.3 Age and sexual violence

A Pearson correlation coefficient test was conducted to determine the relationship between age and the prevalence of sexual violence. The probability value (p=0.001) did not exceed 0.05 indicating a statistically significant relationship between age and the prevalence of sexual violence. A negative relationship is demonstrated by the r-value (r= -0.258) indicating that the two variables goes into different directions. The
interpretation is that the greater the age, the lesser is the likelihood of one being sexually violated. The younger ones are more often sexually violated.

4.4.3.2 Age and variables regarding sources of workplace violence
A Pearson correlation coefficient test was conducted to examine the relationship between age and the sources of violence. The probability value (p=0.039) did not exceed 0.05, indicating a statistically significant relationship between age and the sources of violence. A weak negative relationship (r=-0.162) was established indicating that age has an effect on the perpetration of violence by different sources.

4.4.3.3 Age and variables regarding effects of workplace violence
A Pearson correlation coefficient test was conducted to determine the relationship between age and the effects of violence. The probability value (p=0.902) exceeded 0.05 indicating a statistically insignificant relationship between age and the effects of violence (r=-0.010, p=0.902).

4.4.3.4 Age and variables regarding reporting of violence to authorities
A Chi-square test of independence was conducted to determine the relationship between age and the behaviour of reporting violence to authorities. For purposes of correlation, the age was categorized into two groups, 22 to 30 and 31 to 50 years. The probability value (p=0.313) exceeded 0.05 indicating a statistically insignificant relationship between age and the behaviour of reporting violence.

4.4.3.5 Age and variables regarding reasons for not reporting violence
A Chi-square test of independence was conducted to determine the relationship between age and the behaviour of reporting violence. For purposes of comparison, age was categorised into two groups, 22 to 30 and 31 to 50 years. All the reasons signified an insignificant relationship. A statistically significant relationship was established between age 22-30 and wanting to finish the required hours and leave with a probability value (p=0.037) not exceeding 0.05.

4.4.3.6 Age and variables regarding awareness of policies in the psychiatry clinical areas addressing workplace violence
A Chi-square test of independence was conducted to determine the relationship between age and the awareness of policies in the clinical areas addressing workplace violence. The probability value (p=0.713) exceeded 0.05 indicating a
statistically insignificant relationship between age and the awareness of policies in the psychiatry clinical areas addressing workplace violence.

4.5 DISCUSSION OF FINDINGS

In this chapter student nurses’ experiences of workplace violence was investigated. The findings indicated that student nurses were exposed to various types of violence when placed in psychiatric environments for clinical learning, which ultimately impacted negatively on themselves and their work performance. The issue of the reporting of violence by student nurses was also included in the investigation. In this section the findings from the above analyses are discussed and related to the outcomes of the literature review. The order of discussion will be according to the objectives of the study.

Objective One: Establish the types of workplace violence incidences experienced by student nurses during their placement in the psychiatric units.

The findings of the study revealed that student nurses had frequently encountered acts of violence in psychiatric units, with the non-physical violence occurring more frequently than physical and sexual abuse. The most commonly reported acts of non-physical violence included:

- Not being treated as part of the team (figure 4.16),
- Not receiving acknowledgement for good work (figure 4.13), and
- Being ignored or neglected (figure 4.4).

The types of non-physical violence that were least experienced by student nurses included: Being threatened with physical violence (figure 4.12), ridiculed or humiliated (figure 4.8), and having racist remarks directed at them (figure 4.11).

The findings of this study regarding high incidences of non-physical violence in nursing are not exceptional and can be related to the findings by Chen et al. (2009:2818), Child and Mentes (2012:89), Hahn et al. (2010:3535), Hutchinson et al. (2010: 2321), Khalil (2009:217), Rowe and Sherlock (2005:242-248), and Wang (2008:2). These authors all investigated the prevalence of violence among qualified staff in general and psychiatric hospitals. On a similar note, student nurses were also challenged by the presence of violence in the clinical areas, as supported by

The types of physical violence that were more frequently experienced included being pushed or shoved, slapped or punched, and having personal property damaged (Table 4.4). The type of physical violence that was not reported by student nurses at all was being confronted with a gun or knife. Comparatively, physical violence appeared to be more evident and lethal in psychiatric hospitals than in general hospitals. Cook (2013) reported that mental health nurses have been punched in the face, bitten and had their car tyres slashed in a string of violent attacks.

Incidents of sexual abuse were reported more frequently than incidents of physical violence but far less frequently than those of non-physical violence. The increase in reporting of sexual violence contradicted the findings of Hewett (2010:96); Talas, Kocaoz and Akguc (2011:3) and Chen et al. (2009:2818), who found sexual violence to be the least reported type of workplace violence. Huston (2006:230), however, raised an important point that sexual violence at work was not normally included within definitions of occupational violence and this could explain why most studies concentrated on physical and non-physical violence.

**Objective Two:** Determine the effects of workplace violence on student learning in psychiatric clinical environment.

The aim of placing psychiatry student nurses in the clinical area is to allow them to learn the required high quality nursing skills. The students in the psychiatric institutions of KZN found themselves exposed to unwelcome, traumatic acts of violence in their work areas, leading to the development of emotional suffering among them. The most prevalent emotions experienced included anxiety / fear, anger, humiliation / embarrassment, and feelings of inadequacy and confusion. The resultant effects on their work performance were:

- The standard of patient care was negatively affected,
- Students considered leaving nursing, and
- They resorted to absenteeism.

Some respondents also mentioned that they were denied opportunities for learning (Table 4.3).
The findings of this study corresponded with those of Muschalla (2009); Bimenyimana (2008) and Jeffrey (2010), who had also reported on the psychological effects of violence on mental health nurses. Nelwati et al. (2013); Hewett (2010); Engelbrecht (2012); Baglin and Rugg (2009) and Caka and Lekalakala-Mokgale (2013) also found that negative interpersonal relationships in clinical environments hampered the students’ clinical learning.

Stockhausen (2004) and Papastavrou et al. (2010:182) had also investigated students’ experiences in the clinical learning environment, but their studies found that student nurses respected and appreciated the experiences that they had had with the patients and registered nurses who had illuminated the practice of nursing for them.

**Objective Three:** Identify barriers to the reporting of workplace violence encountered by student nurses.

The findings of this study showed that the majority (92.6%) of the respondents failed to report incidents of violence (Detailed in Figure 4.38). This may have resulted from a combination of factors, namely that 62.6% of the respondents were unaware of policies available in the workplace regarding violence, and/or the reasons students gave for not reporting violence.

The common reasons raised by respondents for not reporting violence were:
- It was not important enough to report,
- They felt that it was just part of the job, and
- They did not know where and how to report.
- Students were afraid that they might be victimized if they report violence incidents encountered in the workplace,
- Some students felt nothing would be done because of their student status,
- They wanted to finish the required hours and leave the place.

Similar reasons were found by Beech and Bowyer (2004:32) and Jackson et al. (2010:103), in their studies of violence in workplace.

The rate of under reporting was found by Hewett (2010:100) to be much higher among the students (85%) than among the qualified staff (approximately 50%).
agreement with this are the findings by Hume et al. (2006:70) who postulated that students taking action against bullying accounted for a less significant percentage compared to qualified staff.

4.6 CONCLUSION

Descriptive statistics have been utilised to determine the frequencies of the occurrence of the variables, and non-parametric tests have been run and analysed to infer the findings to the population. An analysis of the relationship between the demographic data (gender, ethnicity, and age) had been carried out.
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the significant conclusions of this research study, the limitations experienced by the researcher, as well as the recommendations made for nursing management, nursing education, and further research.

The purpose of the study was to examine the types and effects of workplace violence experienced by student nurses when placed in psychiatric clinical environments for clinical learning, to identify the barriers to reporting of workplace violence. The research questions that guided the study were the following:

- What types of workplace violence did student nurses experience during their placement in psychiatric units?
- What effect did workplace violence have on the clinical learning of the student nurses who were placed in psychiatric units?
- What are the barriers to the reporting of workplace violence encounters by student nurses during their period of clinical placement in psychiatric units?
- What recommendations can be made to prevent and manage workplace violence towards student nurses?

In Chapter 1, the researcher described the background, purpose and significance of the study to nursing. The specific research objectives were formulated based on reviewed literature. In Chapter 2, an extensive review of literature pertaining to the study was presented. From the reviewed literature, the researcher established that most studies carried out regarding workplace violence in psychiatric institutions focused on qualified nurses. Bearing in mind the exploratory nature of this study, a theoretical framework, outlining the outcome of workplace violence to student nurses was described and later utilized in the discussion of the research findings. In Chapter 3, the research methodology was presented in detail, and the data was analyzed, interpreted and discussed in Chapter 4.

In this final chapter, the conclusions, study limitations, and recommendations arising from the study are presented.
The conclusions are discussed in relation to the research objectives and the theoretical framework used in this study, as well as to the literature and previous studies on the perceptions of workplace violence experienced by nurses in various clinical environments.

5.2 CONCLUSIONS OF RESEARCH

Conclusions are drawn from the findings of the study discussed in Chapter 4, subsection 4.7, and will be discussed with reference to each study objective. The overall purpose of the study, which was to establish the extent and effect that workplace violence has on student nurses’ psychiatric learning was achieved. The conclusion for study objectives 1-3 is now presented. Objective 4 which dealt with recommendations to prevent and manage workplace violence will be discussed under heading 5.3: Recommendations.

5.2.1 Objective one

To establish the types of workplace violence incidences experienced by student nurses during their placement in psychiatric units.

The three subgroups, as per the analysis, of the types of violence (non-physical, physical and sexual abuse) are discussed.

5.2.1.1 Non-physical violence

The findings indicated that psychiatry student nurses are not excluded from the workplace violence that is experienced by qualified staff in mental health nursing. It can be concluded that in the psychiatric institutions of KZN, student nurses:

- Often encounter active and passive manifestations of non-physical violence,
- Seldom encounter manifestations of physical violence, and
- Frequently encounter sexual violence. The frequency of sexual abuse aimed at the psychiatry student nurses (Figure 4.24 – Figure 4.28) is frightening and warrants appropriate interventions.

It should also be mentioned that most of the workplace violence was encountered in psychiatric hospitals (66.3%) and to a lesser degree in the community clinics.
Nurses and patients are the main perpetrators of workplace violence in the mental health care setting.

### 5.2.2 Objective two

To determine the effects of workplace violence on student learning in the psychiatry clinical environments.

Many respondents acknowledged suffering debilitating psychological consequences after episodes of workplace violence. It can be concluded that workplace violence has a harmful effect on the work performance of the psychiatry students of the KZN College of Nursing, as evidenced in Table 4.2:

- The standard of patient care is negatively affected,
- Students consider leaving the nursing profession, and
- Students resort to absenteeism.

### 5.2.3 Objective three

To identify the barriers to the reporting of workplace violence encountered by student nurses.

It can be concluded that student nurses of the KZN College of Nursing are particularly reluctant to report episodes of workplace violence to their authorities. The reasons for not reporting workplace violence were similar to those revealed in the literature review:

- Students wanted to complete the required number of hours and leave the work area,
- Students think that nothing will be done because they are just students,
- They are afraid of being victimized,
- They feel that this violence is part of the job, and
- They do not realize that it is important to report the incidents.

In addition to the above barriers, the findings of this study indicated that ignorance related to the procedure for reporting workplace violence further contributed to non-reporting of workplace violence. This was evidenced by the majority of the
respondents (62.6 %, n=102) indicating a lack of knowledge regarding the policies in place to address violence in the workplace.

5.3 RECOMMENDATIONS

Objective 4 was to make recommendations regarding the prevention and management of workplace violence directed towards student nurses in the psychiatric clinical environment to nursing education institutions and nursing service managers of psychiatric institutions.

Studies by Magnavita and Heponiemi (2011:203) and Zampieron et al. (2010:2339) on violence and aggression in the workplace have recognized that urgent preventive and management action is needed to control worker-to-worker and worker-to-patient violence in the clinical settings. Hewett (2010:110) acknowledges that the successful prevention and management of workplace violence depends on a multidisciplinary team, encompassing shared responsibility by organizational, community, government, professional, and union interventions (Huston 2006:243).

The recommendations emanating from this study are mainly focused on preparing and equipping the psychiatry student nurses to confront, withstand and break the cycle of workplace violence. According to Weisbrod (2007:8), advancing the knowledge of students’ perceptions and experiences of workplace violence in health care settings is critical in breaking the cycle of workplace violence and transforming the culture of violence in health care workplaces. Hewett (2010:111) adds that breaking the cycle is important but that it is profoundly dependent upon how the trained nursing staff treat the students in the clinical areas.

Based on the findings of the study, the following recommendations have been made for nursing education, nursing management and further research.

5.3.1 Nursing education

The Department of Nursing Education is responsible for ensuring the adequate clinical learning of student nurses. From the inception of nursing training the Nursing College allocates students to various clinical environments for clinical experiential training in order to meet the regulations of the South African Nursing Council whilst
taking into consideration the type of training and the courses followed by the nurses. The aim of placing students in the clinical learning environments is to afford them the opportunity to practice patient care under the supervision of a qualified clinical nurse in preparation for being able to provide competent care to the patients upon completion of their training (Caka & Lekalakala-Mokgele 2013:2).

Prior to a student’s clinical placement, and on a continuous basis, exploration of the environment is ideal to gain insight into the educational functioning of the clinical area and allows nurse teachers to enhance the student’s opportunities for learning (Papastavrou et al. 2009:1). With the plethora of violence in the workplace, student nurses encounter difficulties in achieving the desired goal of clinical learning. Nurse educators are positioned to play a significant role in reducing nursing student abuse, thereby promoting healthier work environments in both clinical and academic settings (Bradley & McGregor 2008). Nurse educators can achieve this by:

- Giving information to student nurses about workplace violence, its causes and guidelines on the prevention and reporting of abusive incidents before they are placed in clinical area.
- Continuously updating the clinical staff on the student’s learning needs during their placement in the clinical area and, together with the clinical personnel, identifying the expected roles to be played by staff with regards to student support.
- Greater visibility and advocacy from lecturers and clinical educators.
- Providing students with the opportunity to be debriefed after being exposed to incidents of workplace violence in the clinical learning environment.
- Debriefing of student nurses upon their return to the Nursing Colleges from the clinical learning environment, to determine if any abusive behaviour had occurred, and conducting a prompt follow up without implicating the student nurses.

5.3.2 Nursing management

A student nurse enters the clinical area with great expectations related to the acquisition of practical skills, in order to help the patient to recover from their illnesses. The unit manager and other personnel are invested with the responsibility of the establishment of a positive learning climate in the unit and the creation of an
environment that is conducive to learning and free from prejudice and threats (Muller 2009:334). Nurse leaders are expected to hold themselves and their peers accountable for modelling acceptable professional behaviour (Becher & Visovsky 2012:212). It is unfortunate that supervisors are sometimes found to be perpetrators of violence in the workplace (Cunniff & Mostert 2012:13). Student nurses rotate through the various clinical placements in order to meet their clinical needs, and disappointingly, they sometimes find themselves confronted with challenging relationships with staff, patients, peers and the community, according to Nelwati et al. (2013:60). Such experiences hinder the intention of clinical placement i.e. clinical learning. Further to the above statements, Cunniff and Mostert (2012:13) postulate that organizations need policies to regulate the workplace conduct. The policies are to be communicated to everyone including the student in training. Hewett (2010:111), found that preventive and management measures addressing workplace violence in the clinical settings are largely unknown to the student nurses, and are therefore ineffective in safeguarding them. Bimenyimana (2008:66), who studied workplace violence towards psychiatric nurses, recommends a comprehensive orientation approach for newly appointed psychiatric nurses regarding the challenges and problems related to their work environments so that they can use a variety of skills to overcome these challenges.

Nursing management has an obligation to prevent any types of workplace violence in their work areas, protect their subordinates and expose violence targeting student nurses (Hewett 2010:111).

The researcher recommends that:

- Nurse managers hold debriefing sessions every day, where they check the student nurses’ experiences for each day in a therapeutic, calm atmosphere.
- Student nurses must be encouraged to report any incident that has occurred immediately to whoever is senior in the unit at that time, and that all nurses should be sensitive to student’s grievances.
- Nurse managers communicate to the education institution any incidents of workplace violence that were reported by student nurses, and the steps that have been undertaken after report of the incident.
5.3.3 Further research

The following recommendations are suggested following the experience gathered from this study:

Further research can be conducted on:

- The impact of the clinical learning environment on student nurses’ training in psychiatric institutions. This study has proved that there is violence directed at student nurses in the clinical area. A qualitative study would allow the student nurses the best opportunity to explain how psychiatric clinical environments promote or hinder their practical learning.

- Another topic would be the role of a nurse educator in counteracting workplace violence directed at student nurses. Such a study would provide an opportunity for nurse educators to extend their understanding of what constitutes workplace violence and how it affects student nurses, as well as their role to improve the situation.

5.4 CONTRIBUTIONS OF THE STUDY

This study has provided important information regarding the types and effects of violence that are experienced by student nurses who are placed in psychiatric institutions for clinical learning. It is the first study of its kind where the influence of the psychiatry environment on student learning is investigated, as most research concentrated on workplace violence towards trained nurses in psychiatry settings. The SANC requires student nurses to be competent in both theory and practice. The students felt unsupported and vulnerable in the mental health clinical areas. The recommendations made in this study aim to equip student nurses, lecturers from nurse education institutions and health services management with information regarding prevalence and effects of workplace violence and to reduce the culture of workplace violence which the student nurses can be indirectly socialized to.

5.5 LIMITATIONS

The limitations of this study included those aspects of research methodology that had to do with sampling and data collection. The following limitations were identified:
The study involved only one programme, the four year comprehensive nursing diploma (R425), and had excluded the one year diploma students, the BA Curationis university students and the advanced psychiatry nursing students.

Other campuses (the northern region campuses of the KZNCN), who qualified according to the inclusion criteria of this study were excluded from the study due to time, financial and geographical constraints.

The use of a structured questionnaire limited the students from elaborating on responses which has probably resulted in a superficial view of the problem.

In spite of the above limitations, this study has provided important information regarding workplace violence in psychiatric settings and its impact on student nurses’ clinical learning.

5.6 CONCLUSION

A quantitative, descriptive exploratory study was conducted to investigate the experience of workplace violence directed towards student nurses during their psychiatry clinical placement. The study took place at Nursing Colleges in the province of KwaZulu-Natal and the population was the psychiatry student nurses who were registered for the four year comprehensive course (R425 program) at a college.

The overall conclusion is that student nurses are victims of violence in the workplace and they commonly encounter non-physical violence. The common perpetrators of violence towards student nurses are nurses, particularly enrolled nurses, assistant nurses, and professional nurses, followed by patients. Workplace violence has negative effects on emotions and the standard of patient care is jeopardized.

The nursing profession is facing a challenge of staff shortages and staff burnout, especially in psychiatric settings. To overcome such shortcomings, the nursing profession has to produce effective and capable nurses through effective training. This could be possible if factors that negatively affect nurse training, like workplace violence, can be eradicated through improved clinical learning and working environments.
LIST OF REFERENCES


Bimenyimana, E. 2008. *The lived experience of aggression by nurses in a Gauteng psychiatric institution*. In partial fulfilment of the requirements for the Degree of Magister Curationis in the Department of Nursing Science, Faculty of Health Sciences at the University of Johannesburg. South Africa.


Cook, H. 2013. *Mental health nurses are punched, bitten as work violence rises.* Victoria state political news report: 30 September 2013: (1).


Appendix A: Questionnaire

TITLE: Workplace violence experienced by student nurses during clinical placement in Psychiatric institutions of KwaZulu-Natal.

Researcher: Mvunelo, N. – 3167 566 2

QUESTIONNAIRE

SECTION A.

1. Gender

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
</table>

2. Ethnicity

<table>
<thead>
<tr>
<th>Black</th>
<th>Coloured</th>
<th>Indian</th>
<th>White</th>
</tr>
</thead>
</table>

3. Age in years


4. Period of psychiatric placement in months


SECTION B.

Data related to types of violence that may have been experienced by student nurse during his/her placement in Psychiatric units.

<table>
<thead>
<tr>
<th>During your period of allocation in Psychiatric units have you experienced any of the following forms of abuse:</th>
<th>Never</th>
<th>Seldom (1-2 times)</th>
<th>Frequently (3-4 times)</th>
<th>Always (5 and more)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-verbal abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Raised eyebrow, rolling of eyes etc</td>
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<tr>
<td>6. Ignored or neglected.</td>
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<td>7. Left alone in the unit</td>
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<tr>
<td>8. Other: please write down and make a tick in the appropriate box.</td>
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<tr>
<td><strong>Verbal abuse</strong></td>
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<tr>
<td>9. Insulted or sworn at.</td>
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<tr>
<td>10. Shouted or yelled at.</td>
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<tr>
<td>11. Ridiculed or humiliated.</td>
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<tr>
<td>12. Made to feel guilty.</td>
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<tr>
<td>14. Had a racist remark directed to you.</td>
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<tr>
<td>15. Threatened with physical violence.</td>
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<tr>
<td>16. Not received acknowledgement for good</td>
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</tbody>
</table>
work.  
17. Denied learning opportunity.  
18. Given unfair work allocation.  
19. Not been treated as part of the team.  
20. Other: please write down and make a tick in the appropriate box.  

**Physical abuse**  
21. Pushed or shoved  
22. Kicked.  
23. Slapped or punched.  
24. Hit with something.  
25. Had a gun or knife drawn at you  
26. Had your arm twisted.  
27. Had your hair pulled.  
28. Had something of yours damaged.  
29. Other: please write down and make a tick in the appropriate box.  

**Sexual abuse.**  
30. Been inappropriately touched.  
31. Been threatened with sexual assault.  
32. Had sexist remarks directed to you.  
33. Had suggestive sexual gestures directed to you.  
34. Had a request for intimate physical contact.  
35. Other: Please write down and make a tick in the appropriate box.  

**SECTION C.**  
Data relating to settings and sources of abuse in psychiatry clinical areas.  

<table>
<thead>
<tr>
<th>Settings</th>
<th>Never</th>
<th>Seldom (1-2 times)</th>
<th>Frequently (2-5 times)</th>
<th>Always (5 and more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community settings e.g. clinics, rehabilitation centers, schools.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sources</th>
<th>Never</th>
<th>Seldom (1-2 times)</th>
<th>Frequently (2-5 times)</th>
<th>Always (5 and more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient’s relatives/friends.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Registered nurses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff nurses.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Assistant nurses.</td>
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<tr>
<td>Student nurses.</td>
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</tr>
<tr>
<td>Clinical facilitators.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lecturers</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Doctors.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Administrative staff.</td>
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<td></td>
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<tr>
<td>House keeping staff.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: please write down and tick in the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SECTION D.**
Data related to effects of workplace violence on individual and work performance.

Identify the emotional feelings of abuse to you and on your work performance.

<table>
<thead>
<tr>
<th>Personal effects</th>
<th>Never</th>
<th>Seldom (1-2 times)</th>
<th>Frequently (2-4 times)</th>
<th>Always (5 and more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50. Anger.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>51. Depression.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>52. Humiliation/ embarrassment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>53. Anxiety/fear.</td>
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<tr>
<td>54. Confusion.</td>
<td></td>
<td></td>
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<tr>
<td>55. Feelings of inadequacy.</td>
<td></td>
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</tr>
<tr>
<td>56. Negative effect on personal relationships.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>57. Other: please write down and tick on the appropriate box.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effects on Work performance

| 58. Made you consider leaving nursing. | | |
| 59. Caused you to be absent. | | |
| 60. Negatively affected your standard of patient care. | | |
| 61. Other: please write down and make a tick in the appropriate box. | | |

**SECTION E.**
Data related to reporting of violence that takes place in the work environment.

62. Have you ever reported workplace violence to the authorities?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, proceed to question

If no, continue with the question 63, (You may tick more than one box).

I have never reported an episode of workplace violence to the authorities because:

63. I have never experienced workplace violence.
64. I do not know where and how to report.
65. I feel it is part of the job.
66. I think nothing will be done because I am a student.
67. I am afraid I will be victimized.
68. I wanted to finish the required hours and leave.
69. It is not important to report.
70. Other: please write down and make a tick in the appropriate box.
71. Are you aware of any policy in the clinical areas addressing workplace violence?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Thank you for taking your time to complete this questionnaire.
N. Mvunelo: 2012.
Annexure B: Consent Form

CONSENT FORM

STUDY TITLE: Workplace violence experienced by student nurses during clinical placement in psychiatric institutions of KwaZulu-Natal.

You are invited to take part in the above mentioned study. The aim of the research is to investigate the forms of workplace violence experienced by student nurses, establish the effects of workplace violence on student clinical learning, and make some recommendations regarding prevention and management for nurses. You have been chosen because you have been allocated in psychiatric institutions for your clinical learning.

Your participation in this research is voluntary; you can withdraw at any time without giving a reason. Confidentiality and anonymity will be maintained and no one will be able to match the completed questionnaire with any specific individual. What you will need to do is to sign the consent form and complete the questionnaire and hand it in.

The information that the researcher get from this study will improve insight into extent and management of workplace violence targeting student nurses in the clinical area. The results of the study will be presented to the Principal of KwaZulu-Natal College of Nursing, your Campus Principal and to specific clinical facilities.

When you answer the questions and experience some distress you should contact me so that necessary interventions can be organized. If you have any concerns or other questions about this study, contact me in the following numbers.

Tel: 031-7054048(H), 031-4596187 (W), 0827076869 (Cell).

________________________
N. Mvunelo

Declaration by student:
I declare that by signing below, I……………………………………………..agree to take part in the above mentioned research project by completing the questionnaire. I have been given an opportunity to ask questions and all my questions have been adequately answered. I understand that participation is voluntary and I have not been forced to take part.

_______________________     ____________________
Signature of participant       Date
Appendix C: Permission to use the questionnaire from D. Hewett

P.O.BOX 1307
NEW GERMANY
3610
02 JULY 2012

Miss D Hewett
University Of Western Cape
Contact: 084 230 3294
Email: dehewett@pgwc.gov.za

Dear Madam

RE: PERMISSION TO USE YOUR RESEARCH QUESTIONNAIRE.

Following our telephonic conversation I would like to thank you for allowing me to use your data collection tool, to adapt mine from it. My study topic is: workplace violence experienced by student nurses during period of clinical placement in Psychiatric units of KwaZulu-Natal.

Kindly email permission to me and my supervisor.
My supervisor is Mrs. C. Young, her email address is cornelle@medinet.co.za. My email address is nomhle.mvunelo@yahoo.com

Kind Regards
Nomhle Mvunelo
Contact: 0827076869

Re: PERMISSION TO USE YOUR RESEARCH QUESTIONNAIRE
Monday, July 2, 2012 6:39 AM
From: "Deidre Hewett" <Dehewett@westerncape.gov.za>
Add sender to Contacts
To: "Nomhle Mvunelo" <nomhle.mvunelo@yahoo.com>
Cc: cornelle@medinet.co.za

Dear Nomhle

You are welcome to adapt the questionnaire that I used in my study. Good luck with your research.

Kind regards

Deirdre Hewett

>>> Nomhle Mvunelo <nomhle.mvunelo@yahoo.com> 2012/07/02 03:14 PM >>>
Appendix D: Approval from the University of South Africa

UNISA

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/136/2013

Date: 6 February 2013  Student No: 3167-566-2

Project Title: Workplace violence experienced by student nurses during clinical placement in psychiatric units of KwaZulu Natal health institutions.

Researcher: Nomhle Mvunelo

Degree: Masters in Public Health

Code: MCHS94

Supervisor: Ms C Young
Qualification: M Cur
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [✓]  Conditionally Approved [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES
Appendix E: Approval from the KwaZulu Natal College of Nursing

Principal Investigator:
Ms Mxunelo Nomhle
C/O UNISA

Dear Madam,

RE: PERMISSION TO CONDUCT RESEARCH AT THE KZN COLLEGE OF NURSING

TITLE: WORKPLACE VIOLENCE EXPERIENCED BY STUDENT NURSES DURING CLINICAL PLACEMENT IN PSYCHIATRIC UNITS OF KWAZULU-NATAL HEALTH INSTITUTIONS

I have the pleasure in informing you that permission has been granted to you as per the above request by the Acting Principal of the KZN College of Nursing.

Data Collection sites:

- RK Khan Campus  
- Greya Campus  
- Prince Mshiyeni Campus

Please note the following:

1.1 Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
1.2 This Research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
1.3 Please ensure this office is informed before you commence your research.
1.3.1 Permission is therefore granted for you to conduct this research at the Identified Campuses of the KZN College of Nursing.
1.4 The KwaZulu-Natal College and its NEI’s will not provide any resources for this research.
1.5 You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thanking You,

Ms JT Makhathini
Acting Principal: KwaZulu-Natal College of Nursing

uMnyungo Wezempilo, Departement van Gesondheid  
Fighting Diseases, Fighting Poverty, Giving Hope.
Appendix F: Consent from Department of Health: KwaZulu Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 044/13
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms N. Mvunelo

Subject: Approval of a Research Proposal

1. The research proposal titled ‘Workplace violence experienced by student nurses during clinical placement in psychiatric units of KwaZulu Natal health institutions’ was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at Addington, Edendale, Grey’s, RK Khan, Port Shepstone and Prince Mshiyeni campuses of the KZN College of Nursing. Data collection is scheduled for two weeks.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lütge
Chairperson, Health Research Committee
Date: 11/03/2003

____________________________________
uMnyango Wezempilo, Departement van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope
Appendix G: Letters granting permission from the campuses.

Dear Ms. N. Mvumelo

Re: Permission to Conduct a Research Study at R.K. Khan Campus

I have pleasure in informing you that the permission to conduct research at this campus has been granted. The project title is: "Workplace violence experienced by student nurses during clinical placement in psychiatric institutions of KwaZulu Natal".

Please make sure that you adhere to the policies, procedures and protocols of the department of health, and do not disturb the functioning of the campus when collecting data.

The campus wishes you all the best in your studies.

Thank You

Ms. J. Reddy
Campus Principal
Dear Ms N Mvunelo,

Re: Permission to Conduct a Research Study at Prince Mshiyeni Campus

I have pleasure in informing you that the permission to conduct research at this Campus has been granted. The title of the study is: "Workplace violence experienced by student nurses during clinical placement in psychiatric institutions of KwaZulu-Natal".

Please make sure that you:
- Adhere to the Department of Health policies, procedures and guidelines.
- Do not disturb the functioning of the campus or academic activities when collecting data.
- Make prior arrangements with the relevant staff members and/or group coordinators.

The campus wishes you all the best of luck in your studies. It will be appreciated that you share the findings or provide feedback on your findings.

Thank you,

Dr SZ Mthembu
Campus Principal
RE: PERMISSION TO CONDUCT RESEARCH PROJECT

This is to inform you that permission is granted to you to conduct your research project in our institution. The topic is "Workplace violence experienced by student nurses during clinical placement in Psychiatric institutions of KwaZulu Natal.

Kindly ensure you follow the policies of KwaZulu Natal College of Nursing and of the Department of Health.

Good luck with your studies.

M.A. SIssing (Mrs)
CAMPUS PRINCIPAL
ADDINGTON CAMPUS
MAS/mvt
Date: 25 April 2013

Attention: Mrs N. Mwunelo

P.O. Box 1207
NEW GERMANY
3510

Dear Mrs Mwunelo

RE: REQUEST FOR PERMISSION TO CONDUCT STUDY

Your letter dated 17 April 2013 is hereby acknowledged and refers:

Permission is hereby granted for you to conduct your study at Port Shepstone Nursing Campus. Please take note of the conditions as stated by the KwaZuluNatal College of Nursing.

Best wishes

MR N.B. GWALA
CAMPUS PRINCIPAL
PORT SHEPSTONE NURSING CAMPUS

uMyengo Wezeempilo . Departement van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope
Ms. N. Mvunelo
Ofo R.K. Khan Campus
Private Bag X 004
Chatsworth
4030

Dear Ms. Mvunelo

Re: Request to conduct research at Grey's Campus

Your letter dated 17th April 2013 is received and acknowledged.

Permission is granted for you to interview the learners on 23rd May 2013 from 13h00 to 16h00 at Grey's Campus.

Kindly liaise with Miss. N. Royan – H.O.D. Psychiatric Nursing Science and Social Sciences on 033 897 3617 to make the necessary arrangements.

You are wished all the best with your research project.

Yours Faithfully

E.N. Hlongwa (Kwa)
Campus Principal
18 April 2013

Ms. N. Mvunelo (3167-566-2)
P.O. BOX 1307
NEW GERMANY

Dear Ms Mvunelo

REQUEST TO CONDUCT RESEARCH AT EDENDALE NURSING CAMPUS
Protocol: “Workplace violence experienced by student nurses during clinical placement in psychiatric units of KwaZulu-Natal health institutions”

Your letter dated 17.04.13 refers.

We are pleased to inform you that the permission is granted provided:

- Confidentiality is maintained at all times
- Your research does not interfere with smooth running of the Campus
- Proper consent is obtained from the participants

Thank you
Yours sincerely

Dr N.V. Mkhize
(Chairperson Research committee)

Mrs N.C. Majola
(Campus principal)