VIOLENCE AND RACISM EXPERIENCED BY NURSING STUDENTS

PREVALENCE, ASSOCIATED FACTORS, AND IMPACT OF VIOLENCE AND RACISM EXPERIENCED BY NURSING STUDENTS IN CLINICAL PLACEMENTS

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TITLE: Prevalence, Associated Factors, and Impact of Violence and Racism Experienced by Nursing Students in Clinical Placements

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Lay Abstract

Nursing students pay a critical role in addressing Canada's healthcare crisis and sustaining the nursing workface. As part of their training, they participate in clinical placements to translate theoretical knowledge into practice. However, these settings often expose nursing students to violence and racism leading to trauma and attrition, which has been documented globally. Despite its universal recognition as a growing concern, there is a notable lack of quantitative data on this phenomenon within the Canadian context. This study addresses this gap by using a descriptive cross-sectional design and an anonymous online survey to collect relevant data on the prevalence, associated factors, and impacts of violence and racism experienced by nursing students within clinical placements in Southwestern Ontario. Findings reveal alarmingly high rates of such incidents, perpetrated by various individuals, with significant psychological and physiological consequences. Additional findings indicate that most students respond with inaction, and incidents are rarely reported. Currently, nursing students rely on personal resilience, though they express a need for professional and organizational reform to mitigate this issue in the future.

Abstract

Background: Amidst a growing crisis in the Canadian nursing workforce, nursing students serve as a crucial component in strengthening and sustaining the healthcare system. As part of education, nursing students are required to complete clinical placements in healthcare settings where violence and racism often persist. Previous research has found that such incidents can result in significant psychological and physiological harm, including disrupted learning and increased rates of attrition. Within the Canadian context, there is a gap in understanding the depth and severity of this issue due to a lack of quantitative data.

Aim: The aim of this study was to obtain current quantitative data on the prevalence of violence and racism experienced by nursing students in clinical placements, the associated factors, and impacts of these experiences. The research questions that guided this study were (1) What are the types and frequency of violence and racism experienced by nursing students, and who are the perpetrators? (2) How do nursing students respond to and report violence and racism? (3) What negative outcomes do students report after experiencing violence and racism? (4) What protective factors do students report that mitigate the negative impacts of violence and racism? and (5) What recommendations do students report that address violence and racism on the individual, professional, and organizational levels?

Methods: This study utilized a descriptive cross-sectional design and an anonymous online survey to collect data. Participants were nursing students currently enrolled in either the basic or accelerated stream of a nursing program who were currently engaged

in, or had completed, at least one clinical placement in Southwestern Ontario. Data were analyzed using IBM® SPSS software to compute frequencies and counts for the study variables.

Results: 82 out of 485 nursing students responded to the study survey yielding a response rate of approximately 17%. The mean age of participants was 22 years (*SD*=±2.80), with 87% identifying as female. Approximately 61% of participants reported experiencing at least one form of violence within the last twelve months. The most prevalent form of violence was verbal violence (43%), followed by racism (30%), physical violence (18%), and sexual violence (12%). Patients were identified as the primary perpetrators across all forms of violence; however, multiple sources, including staff nurses, patients' visitors, and preceptors, were also reported for verbal violence and racism. The most frequently reported negative outcomes were anxiety, disrupted learning, and anger. Participants commonly reported taking no action in response to experiences of violence and racism. Overall, incidents were underreported with verbal violence being the most frequently reported (26%), followed by physical violence (13%), racism (12%), and sexual violence (10%). Family and friends were often identified as the individuals to whom incidents were disclosed. Participants who chose not to report incidents cited reasons such as the belief that nothing will get done about it, the incident was not important enough to them, or that they did not know how to report it. Participants frequently reported personal resilience and supportive clinical learning environments as key protective factors against negative outcomes. To mitigate violence and racism, participants commonly

recommended education and training for both clinical placement staff and clinical teachers.

Implications: This study emphasizes the urgent need for clearly defined, trauma-informed, and anti-oppressive policies to address violence and racism experienced by nursing students in clinical placements. It outlines the importance of implementing structured reporting mechanisms, zero-tolerance policies with appropriate language to address the severity of the issue, as well as collaborative partnerships between educational institutions and clinical organizations to promote safe learning environments. Clinical and educational staff should receive targeted, trauma-informed training that is grounded in anti-oppressive and anti-racist principles, while changes to curricula should be implemented to prepare students for the realities of clinical environments before their placements. This study also advocates that the responsibility for addressing violence and racism should not fall solely on students, recognizing their vulnerable position within clinical hierarchies. Finally, this study calls for further research to better understand the psychological and educational impacts of these experiences and to develop evidence-based, trauma-informed strategies for prevention and response.

Dedications

This thesis is dedicated to all nursing students—past present and future—whose strength and perseverance shape the future of healthcare.

Acknowledgements

Words will fall short of fully capturing the depth of gratitude I feel for the many inspiring individuals who supported me over the past two years, as this journey does not happen alone. Despite this, I will attempt to provide an overview of those who made this possible.

I want to begin by thanking the 82 nursing students that took time out of their busy lives to participate in this study. Your willingness to share your experiences and support this research is something that cannot be thanked enough. It is no exaggeration to say that this would not have happened without you. Because of you, I am deeply inspired and committed to continuing the fight for justice and equity for nursing students, ensuring that your experiences lead to meaningful change. Thank you.

To Dr. Carter, you are one of the few people who have helped shatter my imposter syndrome through your consistent acknowledgment and unwavering support of my ideas, goals, and aspirations. From day one, you have heard me, seen me, and provided the tools I needed to grow beyond what I would have imagined when I first started this journey. Because of your mentorship I have accomplished many things, even those that were not on my original list. It is truly an understatement to say how fortunate I am to have you as my supervisor. I look forward to continuing this wonderful journey with you in future endeavours. Thank you.

To Dr. Henry and Dr. Pierazzo, I could not have asked for a more well-rounded and exceptionally positive committee. Your guidance and involvement in my academic journey have made these past two years among the most enjoyable of my life. Your

support extended beyond academics, with Dr. Henry equipping me with essential coping skills that I desperately needed (I now have my own worry stone!), and Dr. Pierazzo continually reminding me of the warmth and dedication a leader should embody. As a committee, you also taught me what can be achieved when we work together within supportive learning environments where power is shared and knowledge creation is grounded in mutual respect. Thank you.

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To my parents, I owe you the world.

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List of Abbreviations

BScN	Bachelor of Science in Nursing
BWT	Broken Window Theory
CASN	Canadian Association of Schools of Nursing
CFNU	Canadian Federation of Nurses Unions
CI	Confidence Interval
CIHI	Canadian Institute for Health Information
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CNA	Canadian Nurses Association
IBM®	International Business Machines
ICN	International Council of Nurses
ILO	International Labour Office
MEDLINE	Medical Literature Analysis and Retrieval System Online
PRISMA	Preferred Reporting Items for Systemic Reviews and Meta-Analyses
PSI	Public Services International
PTSD	Post Traumatic Stress Disorder
QR	Quick Response
REB	Research Ethics Board
RNAO	Registered Nurses' Association of Ontario
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

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Declaration of Academic Achievement

This thesis presents original research conducted by me, the student investigator, under the supervision of Dr. Nancy Carter, with the support of committee members Dr. Shaunattonie Henry and Dr. Joanna Pierazzo.

Dr. Carter played a central role in the conception and development of the study. Her mentorship was instrumental in shaping the research design and guiding me toward meaningful graduate-level research opportunities. Dr. Shaunattonie Henry contributed her expertise in quantitative methods, offering critical analysis and a scholarly perspective that significantly strengthened both the research methodology and the academic rigor of the writing. Dr. Joanna Pierazzo offered essential support in the implementation of the study and played a key role in shaping the interpretation of the research findings, drawing on both her academic and clinical expertise.

All contribution have been acknowledged, and the final thesis represents my own work and interpretation of the research, grounded in current literature.

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Chapter 1: Introduction and Background

The nursing profession is the largest workforce within the global healthcare sector, and within Canada, it exceeds all other disciplines for the most regulated healthcare professionals (Health Canada, 2024; World Health Organization [WHO], 2020). Despite this, the nursing workforce is facing difficulties meeting the growing demands of the aging population in Canada (Canadian Institute for Health Information [CIHI], 2024). According to CIHI, the ratio of nurses working in direct care fell from 59 to 52 nurses per 1,000 older adults over the past decade (2024). To add to the strain of the thinning nursing workforce, the COVID-19 pandemic escalated this enduring crisis, leading to various physical and psychological impacts, as well as a mass exodus of nurses from acute care settings and from the profession as a whole (Registered Nurses' Association of Ontario [RNAO], 2021). The growing gap in the nursing workforce is destined to manifest in the Canadian population through decreased quality of care as well as adverse patient outcomes (Reichert, 2017).

To offset the impending collapse of the nursing workforce, RNAO (2021) put forth retention strategies as a result of their 2021 Ontario-based *Work and Wellbeing Survey*, which included (1) "[increasing] support for early and mid-career nurses" and (2) "[bolstering] admissions to nursing baccalaureate programs by 10 percent in each of the next four years" (pp. 20-21). In addition to this, in the RNAO's *Nursing Through Crisis: A Comparative Perspective* report (2022b), approximately 37% of Canadian participants reported that their workplace recruited students to help relieve the pressures of the pandemic. These reports place nursing students on the frontlines of the workforce

emergency and emphasize the importance of recruiting and supporting nursing students during this critical point in the nursing profession. However, framing nursing students as the ideal solution to the nursing workforce crisis carries significant risk if the long-standing issues of violence and racism in clinical settings are overlooked.

A 2005 national survey on the health and wellbeing of nurses conducted by Health Canada, Statistics Canada, and the CIHI revealed that one third to half of the 19,000 nurses surveyed had experienced some form of violence in their workplace (Shields & Wilkins, 2006). In 2017, the Canadian Federation of Nurses Unions (CFNU) built on this report and released a discussion paper titled *Enough is Enough* which outlined the urgent need to address violence in the nursing workplace (Reichert, 2017). The paper revealed the detrimental effects of violence, including physical injury leading to increased lost time claims and increased mental health impacts such as Post-Traumatic Stress Disorder (PTSD) (Reichert, 2017). In 2020, CFNU shared the results from a pre-COVID survey of 7,153 regulated Canadian nurses which revealed that 21% experienced daily verbal violence, and 8% experienced daily physical violence in their workplace (Hall & Visekruna, 2020). Of the nurses surveyed, approximately 60% planned to leave their job in the next year, while 27% planned to leave the nursing profession altogether due to the deteriorating working conditions (Hall & Visekruna, 2020). A recent *CFNU Member Survey Report* in 2024 revealed that nurses who experienced several forms of violence were more likely to leave their current job and less likely to rate their mental health as excellent (CFNU, 2024). The survey also reported that nurses who faced more than one form of violence were more likely to be in a workplace that was overcapacity and more

likely to say that their quality of healthcare in their workplace had deteriorated (CFNU, 2024). In 2020, a survey by the RNAO Black Nurses' Task Force of 200 Black nurses and nursing students in Ontario revealed that close to 88% of all participants experienced racism and discrimination in their workplace which contributed to negative impacts on their mental health (2022a). Violence and racism experienced by nurses not only contributes to the loss of millions of dollars annually from absenteeism and lost time injuries but also results in long lasting trauma that continues to diminish the nursing workforce (Reichert, 2017). These effects are not isolated to nurses in the current workforce; in fact, the impacts of violence and racism begin as soon as nursing students enter into clinical settings.

As part of Canadian nursing programs, students complete clinical placements in the same settings as nurses; they therefore face similar rates of violence and racism while lacking the skills or experience to manage the consequences of those encounters (Canadian Association of Schools of Nursing [CASN], 2015; Hallett et al., 2023; Lu et al., 2024). Due to their inexperience and the dual burden of academic and clinical demands, nursing students are particularly vulnerable to traumatization and attrition, with violence and racism in clinical settings being the most critical and preventable contributing factors (Dafny, Cooper, et al., 2024; Dafny, Waheed, Snaith, et al., 2024; Hopkins et al., 2018a; Martinez, 2017; Tee & Valiee, 2020; Zhu et al., 2022). The success of Canadian nursing students is essential to address the worsening situation faced by the nursing workforce; therefore, exploring the issue of violence and racism that nursing students experience during their clinical placements is vital.

Background

To effectively understand and address the scope and complexity of violence and racism experienced by nursing students in clinical settings, it is essential to first critically examine the multifaceted structural, historical, and professional dynamics that have contributed to these conditions. This section will explore (1) the landscape of nursing, (2) racism in nursing, (3) nursing education in Canada, (4) the current state of nursing, and (5) defining violence and racism.

The Landscape of Nursing

The nursing profession in Canada can be traced back to the seventeenth century, where informal care for the sick began as a religious endeavor heavily influenced by the Christian virtue of charity (Baker et al., 2012). These religious foundations and further subservient curriculum in the Nightingale era have led to the expectation of nurses to be obedient and compliant regardless of working conditions (Baker et al., 2012; Emerson, 2017; Kallio et al., 2022; Lim & Bernstein, 2014). When nursing is viewed as a *calling* instead of paid labour or evidence-based practice, it allows for self-sacrificing and unnecessary hardship that is not appropriate in modern professional workplaces (Emerson, 2017; Kallio et al., 2022). This misconception in modern nursing normalizes the violence experienced by nurses, as the public accepts the notion that nurses are willing to prioritize their patient's needs above their own well-being and are willing to perform their duties under adverse conditions (Emerson, 2017; Kallio et al., 2022). In the mixed-method study by Kallio et al. (2022), participants shared that nurses that viewed nursing as a calling were tolerant of poor working conditions as well as low pay and were

not likely to advocate for their rights. Participants expressed that this perspective of the nursing profession was oppressive as it reinforces the ideal image of nurses as altruistic servants rather than paid professionals (Kallio et al., 2022). When individuals view nursing as a calling, advocating or complaining about better working conditions may be seen as contradictory, or even as an insult to the selfless perception of the profession (Emerson, 2017). This tendency toward self-silencing has not only enabled violence to fester in clinical settings but has also normalized it as an expected aspect of the profession. As a result, healthcare organizations and society at large have weaponized this tolerance and religious legacy to resist systemic change aimed at addressing this internalized issue (Kallio et al., 2022). This is further illustrated by the tendency to label nurses as *heroes* or *angels* during times of crisis, a narrative that reinforces the self-sacrificial norms historically embedded within the nursing profession (E. Smith et al., 2023). Rather than acknowledging nurses' unwavering commitment to fundamental human rights through tangible supports, such as fair compensation or safe working conditions, the profession continues to be marginalized with superficial forms of recognition. The historical entanglement of religious servitude and charitable labour within nursing has contributed to the normalization and tolerance of violence against nurses, allowing it to persist largely unchallenged across all levels of society.

The intersection of nursing and violence can also be analyzed through the critical lens of feminist theory, particularly the tenet that systemic oppression of women reinforces gendered labour hierarchies and the normalization of violence in female-dominated professions (Chinn & Wheeler, 1985; Dong & Temple, 2011; Roberts, 1983;

Roberts et al., 2009). Since its inception in Canada, the nursing profession has been, and continues to be, a female-dominated workforce (Canadian Nurses Association [CNA], 2021; Chinn & Wheeler, 1985). In 2021, CIHI reported that 91% of regulated nurses in Canada identified as female and in 2024 the *Workforce Census Survey* conducted by College of Nurses of Ontario (CNO) reported similar findings, with approximately 91% of nurses in Ontario identifying as a woman (CNA, 2021; CNO, 2024). The oppression of women within a patriarchal system is relevant to the nursing profession not only because it is a female-dominated workforce, but also because it occupies a lower position within the fabricated healthcare hierarchy (Chinn & Wheeler, 1985; Dong & Temple, 2011; Roberts, 1983). The history of the medical profession provides necessary context to examine the oppression of nurses within this so-called healthcare hierarchy. With the advancement of medicine, healthcare became institutionalized, nursing knowledge came to be perceived as inferior, and physicians found themselves at the top of the healthcare hierarchy (McPherson, 2003; Roberts, 1983). By the early twentieth century, the establishment of a patriarchal medical system dominated by male physicians marginalized the professional expertise of nurses, reinforcing their image as altruistic caregivers whose role was to support the intellectual authority of physicians (Dong & Temple, 2011; McPherson, 2003; Roberts, 1983; Roberts et al., 2009). This control and power over nursing identity within the healthcare hierarchy imposed an additional layer of oppression on an already marginalized group, contributing to internalized self-hatred and diminished professional pride (Roberts, 1983). These oppressed group behaviours which were initially outlined by Paulo Freire's model of oppression in 1970, led to violence in the

nursing profession through the *submissive-aggressive syndrome* (Matheson & Bobay, 2007; Roberts, 1983). As nurses assumed a subordinate position, they were unable to express their frustration toward the dominant group of physicians, leading to the internalization of this tension which ultimately manifested as self-destructive violence within the profession (Matheson & Bobay, 2007; Roberts, 1983). Meissner (1986) famously highlighted this phenomenon of intra-professional violence in nursing through the phrase "nurses eat their young," drawing attention to the cyclical nature of hostility experienced by nursing students as well as novice nurses within the profession. A literature review by Matheson and Bobay (2007) found that oppressed group behaviours remain underexplored in nursing, suggesting that the phenomenon will persist until the profession collectively acknowledges and rejects the internalized oppression. Roberts (1983) cites Freire's assertion that "freedom is acquired by conquest not by gift"; thus, the nursing profession can only liberate itself from internal violence through critical awareness and emancipation from the constraints of the patriarchal healthcare hierarchy (p. 25).

Racism in Nursing

Since the establishment of formal training programs, the nursing profession in Canada has been shaped by systemic racism and White supremacy: a belief that White identity and culture are superior to those of non-White groups (Beagan et al., 2023; Hamzavi & Brown, 2023; Louie-Poon et al., 2022; McPherson, 2003; Muray et al., 2023; National Collaborating Centre for Determinants of Health, 2018). This is linked to the colonization of Indigenous Peoples by European empires, and the enslavement of people

of African descent from 1629 to 1834 on what is now Canadian territory (Government of Canada, 2020; Muray et al., 2023). Discriminatory immigration policies and legislation have contributed to deeply entrenched historical racism in Canada as well, a pattern that has been reflected within the nursing profession (Government of Canada, 2025; Muray et al., 2023). Nursing programs in Canada began in 1874, during a period when Black and Indigenous Canadians were systemically excluded from admission (Cooper Brathwaite et al., 2023; Muray et al., 2023). As a result of these racist exclusionary practices, the formation of the "Whiteness of nursing" has led to the gatekeeping of nursing knowledge and curricula through a Eurocentric lens (Beagan et al., 2023; Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin, Jefferies, Bradley, Campbell, Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, Punia, et al., 2022; Hamzavi & Brown, 2023; Louie-Poon et al., 2022; Muray et al., 2023). A well-known example of this is the elevation of Victorian ideals of womanhood in nursing, specifically Florence Nightingale as the central figure in nursing history; this led to the erasure of racialized nurses and their contributions to the profession (Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin, Jefferies, Bradley, Campbell, Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, Punia, et al., 2022; Hamzavi & Brown, 2023). Systemic racism has led to underrepresentation of racialized nurses in leadership positions, a diminished sense of belonging within the profession, and the normalization of oppression and discrimination as part of their daily experience (Beagan et al., 2023; Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin, Jefferies, Bradley, Campbell, Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, & Grinspun, 2022; Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin,

Jefferies, Bradley, Campbell, Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, Punia, et al., 2022; Cooper Brathwaite et al., 2023; Hamzavi & Brown, 2023; Louie-Poon et al., 2022; Prendergast et al., 2024). This experience can be critically analyzed through Black feminist theory, specifically the concept of intersectionality, in which multiple socially constructed identities overlap to form unique experiences (Jefferies et al., 2021). Racialized nurses have been subjected to multiple intersecting forms of oppression based on their gender as a woman, their race as a non-White person, and their subordinate position as a nurse within the healthcare hierarchy (Jefferies et al., 2021).

Nursing Education in Canada

The delivery of nursing education has undergone multiple transformations throughout the history of the profession, evolving from a practice-based discipline to one grounded in praxis (Baker, 2022; Baker et al., 2012). *Praxis*, a term that describes the unity of theory, research, and practice, encapsulates the essence of the nursing profession and underscores the critical importance of knowledge translation from the classroom to the clinical setting (M. C. Smith, 2024). In Canada, nursing education was initially based on an apprenticeship model and primarily took place in dedicated hospital settings. Nurses who were trained through this model were well-prepared to manage patient caseloads and demonstrated strong clinical judgement (Baker, 2022; Baker et al., 2012). As health issues became more complex, patient acuity increased, and the scope of nursing expanded; more emphasis was therefore needed on theoretical knowledge in nursing (Baker, 2022; Baker et al., 2012). In 1965, a national health care system emerged in Canada as a result of the Hall Commission Report which advocated for the separation of

nursing education from the service sector (Baker, 2022). As nursing education transitioned to diploma and baccalaureate programs within academic institutions, nurses gained a stronger theoretical foundation but often faced challenges in developing clinical judgement and hands-on skills (Baker, 2022). This difficulty in transitioning to practice was conceptualized by Kramer in 1974 as *reality shock* (Baker, 2022). Clinical placements were subsequently introduced earlier in nursing programs, with a consolidation period at the end to help integrate academic learning with practical experience in the profession (Baker, 2022; Baker et al., 2012). Clinical placement is now a necessary and mandatory component of nursing education designed to support students in bridging the gap between theoretical knowledge and practical judgement as they develop their own praxis.

Students are no longer solely acquiring practical skills through a traditional apprenticeship model; instead, they enter clinical settings equipped with complex theoretical knowledge that requires critical reflection and the capacity to recall and integrate this knowledge into their practice (Baker, 2022). Due to this nuanced learning process, a supportive and safe environment is essential to facilitate the effective translation of theory into practice (Levett-Jones & Lathlean, 2009). The *Ascent to Competence* framework developed by Levett-Jones and Lathlean (2009) draws on Maslow's hierarchy of needs to emphasize the importance of safe learning environments. According to this framework, students need to feel both physically and psychologically safe in order to progress toward achieving their full potential as a competent nurse (Levett-Jones & Lathlean, 2009). Violence and racism directly impede the learning

process and progression through the hierarchy by compromising basic needs, thereby diminishing the focus on higher-level needs that are essential for effective learning (Levett-Jones & Lathlean, 2009). Therefore, addressing violence and racism in clinical settings is essential to supporting the professional development and overall well-being of nursing students.

Current State of Nursing

Violence and racism have been experienced within the nursing profession since its foundation, and their persistence in the modern day can be attributed to multiple factors, one of which may be understood through the lens of the Broken Window Theory (BWT) (Ellis et al., 2020; Schulz-Quach et al., 2025; Zhou et al., 2017). Wilson and Kelling developed this theory (1982) to explain how environmental cues, both physical and social, can contribute to the tolerance and normalization of disruptive behaviour and incivility, leading to further decline (Ellis et al., 2020; Zhou et al., 2017). In contemporary healthcare settings, environmental cues such as prolonged wait times in emergency rooms due to understaffing and the persistence of interprofessional violence among healthcare personnel serve to perpetuate disruptive behaviours and sustain a cycle of ongoing violence (Ellis et al., 2020; Zhou et al., 2017). The COVID-19 pandemic, in recent years, has exacerbated these environmental factors, adding to the violence within healthcare settings as a result of increasingly deteriorating working and care conditions (Hall & Visekruna, 2020; Schulz-Quach et al., 2025). A recent publication by Schulz-Quach et al. (2025) identified several contributing factors to the escalation of workplace violence in the aftermath of the COVID-19 pandemic. These contributing factors include: (1)

organizational risk factors, (2) societal risk factors, (3) clinical risk factors, (4) environmental risk factors, and (5) economical risk factors (Schulz-Quach et al., 2025). The cumulative impact of these factors has led to increased patient trauma, compromised quality of care, heightened levels of trauma and burnout among healthcare providers, and elevated operational costs for healthcare organizations (Schulz-Quach et al., 2025). As the BWT suggests, a systemic upstream approach is necessary to effectively address the issue, rather than relying exclusively on reactive, individual-level interventions (Wilson & Kelling, 1982; Zhou et al., 2017). Addressing violence and racism in healthcare settings necessitates the implementation of comprehensive, multi-level strategies which must be mobilized across individual, organizational, and systemic levels to effectively mitigate harm and foster a safe working environment.

Environmental cues are especially influential during clinical placements, where nursing students initiate their professional socialization and begin to learn and internalize the norms of the profession (Henderson et al., 2012; Holmes, 2022; J. Thomas et al., 2015). An environment that tolerates and normalizes violence and racism perpetuates a cycle in which nursing students become desensitized and increasingly likely to accept such behaviours as inherent to the profession (Crawford et al., 2019). In alignment with the Broken Window Theory, this acceptance contributes to the progressive deterioration of the clinical environment, reinforcing harmful behaviours unless a comprehensive, systemic intervention is implemented to address the issue (Wilson & Kelling, 1982).

Defining Violence and Racism

A contributing factor to the persistence of violence and racism in the nursing profession is the lack of a universally accepted definition of these phenomena within clinical settings, which then impacts recognition, reporting, and intervention (Dafny et al., 2024; Hopkins et al., 2018; International Labour Office [ILO], International Council of Nurses [ICN], WHO, & Public Services International [PSI], 2002). Although multiple definitions of workplace violence exist, these frameworks often fail to capture the unique experiences of nursing students in a clinical setting, as these environments are not considered their formal workplaces but rather experiential learning sites during clinical placements (ILO, ICN, WHO, & PSI, 2002). The rhetoric used to describe interpersonal violence within the nursing profession can inadvertently contribute to the perpetuation of the problem. This is exemplified by the use of the term *bullying*, which is frequently associated with juvenile or school-aged children, rather than adults in professional settings (Clarke et al., 2012; Rutherford et al., 2019). The use of such rhetoric may diminish the perceived severity of the issue among systems and organizations, resulting in ineffective, individual-focused interventions, or in some cases, a complete neglect of the problem. To add to the issue of terminology, the use of varied and inconsistent language to describe violence further obscures the nature of the problem, thereby hindering effective identification, and therefore intervention. This is demonstrated by the use of terms such as *lateral violence*, *horizontal violence*, *vertical violence*, *bullying*, and *incivility*, each reflecting different facets and perspectives on violence but collectively contributes to conceptual ambiguity within the discourse (Clarke et al., 2012; Rutherford

et al., 2019). While it is important to explore the depth and breadth of this phenomenon, an overly fragmented understanding may diminish clarity around the broader systemic issue, resulting in disjointed interventions or interpretive confusion when examining the problem.

For the purpose of this thesis, a broader definition of *workplace violence* and *racism* will be used to encompass the diverse dimensions and manifestations of these phenomena. The Joint Programme on Workplace Violence in the Health Sector comprised the ILO, ICN, WHO, and PSI, defines workplace violence as "incidents where staff are abused, threatened, or assaulted in circumstances related to their work […] involving an explicit or implicit challenge to their safety, well-being or health" (ILO, ICN, WHO, & PSI, 2002, p.3). The National Commission to Address Racism in Nursing (2021, p. 1) defines racism as "assaults on the human spirit in the form of actions, biases, prejudices, and an ideology of superiority based on race that persistently cause moral suffering and physical harm of individuals and perpetuate systemic injustices and inequities." While these definitions offer a valuable conceptual foundation for understanding the issues at a general level, they remain limited in capturing how these phenomena are specifically experienced by nursing students within clinical placements; this is an area which requires further exploration.

Purpose Statement

Given the pervasiveness of violence, racism and their detrimental impacts within the nursing profession, alongside the urgent need to retain a sustainable nursing workforce, it is thus essential to examine how these issues affect nursing students within

their clinical learning environments. The purpose of this research study is to investigate the prevalence, associated factors, and impacts of violence and racism experienced by nursing students in clinical placements. Clinical placements are a mandatory component of nursing education in Canada which provide a space where nursing students connect their theoretical knowledge with clinical judgement and build professional skills (Baker, 2022). A safe environment is required to optimize learning and build professional identity, which is compromised by violence and racism (Hallett et al., 2023; Levett-Jones & Lathlean, 2009). Further details on the study, including research questions and study methodology, is discussed in Chapters 3.

Chapter Summary

This chapter outlined the issues of violence and racism within the context of the nursing workforce, emphasizing the critical role of nursing students in addressing the ongoing nursing shortage. A historical and structural context was presented to deepen an understanding of the violence and racism that is embedded within the profession through various theoretical lenses. Broad definitions were outlined to frame the scope and focus of this thesis. Finally, a purpose statement is provided that describes the intent of the study to explore the violence and racism experienced by nursing students in clinical placements. The next chapter explores the theoretical framework underpinning this study.

Chapter 2: Theoretical Framework

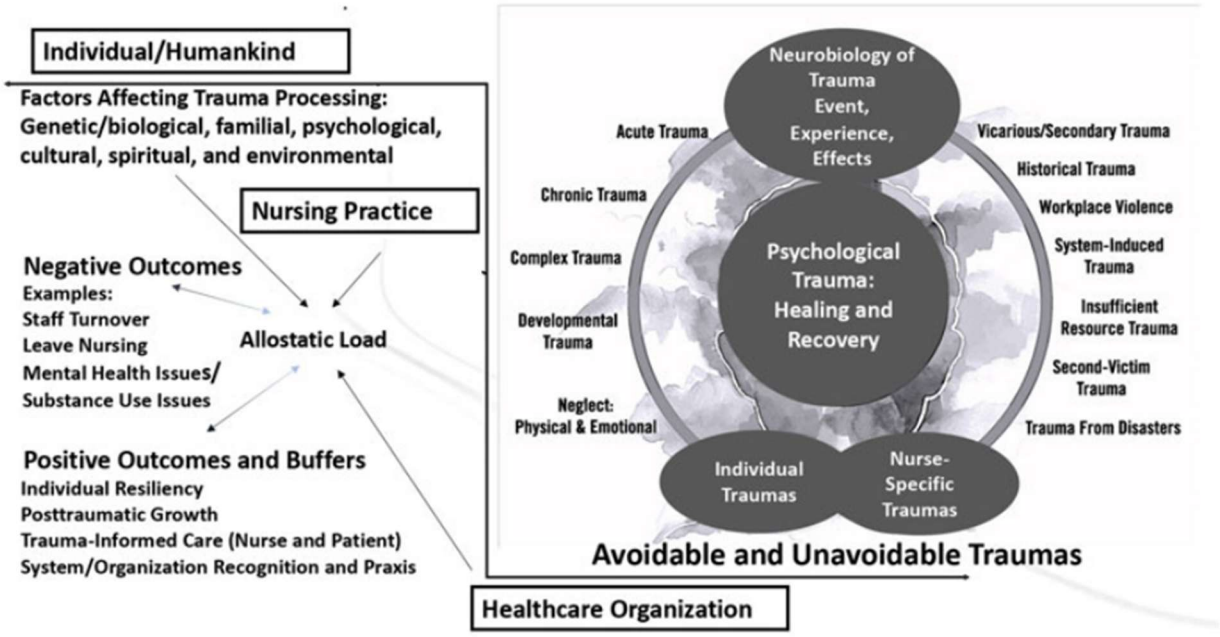
This chapter provides a comprehensive description of Foli's (2022) Theory of Nurses' Psychological Trauma which serves as the theoretical foundation for this study. The chapter begins with a detailed description of the theory, followed by its application to the study's purpose and methodology.

Theoretical Framework

Foli's middle-range Theory of Nurses' Psychological Trauma (2022) offers a critical lens for understanding the multifaceted trauma that is experienced by nurses. It outlines key concepts such as types, responses, and impacts of trauma both individually and within the nursing profession. This theory underpins the current study by providing a conceptual framework to examine how violence and racism are interwoven with the practice of nursing, and that there are negative outcomes of avoidable forms of trauma, such as workplace violence, that can be mitigated through multi-level interventions (Foli, 2022; Foli & Thompson, 2019). Figure 1 presents a visual representation of the Theory of Nurses' Psychological Trauma (Foli, 2022).

Figure 1

Theory of Nurses' Psychological Trauma



Theory Overview

In this theory, the concept of psychological trauma is grounded in the Substance Abuse and Mental Health Administration's 3Es model, which conceptualizes trauma through three key components: (1) event, (2) experience, and (3) effects (Foli, 2022).

The *event* within the 3Es model refers to the occurrence or incident that initiates a trauma response, which may be physical, psychological, or both. According to the theory, these events may stem from broad humankind traumas or nurse-specific traumas (Foli, 2022). Humankind trauma encompasses forms of trauma that are universally experienced by human beings; these include acute, chronic, complex, and developmental trauma, as well as trauma resulting from neglect (Foli, 2022; Foli & Thompson, 2019). Examples of events associated with humankind trauma include adverse childhood experiences, assault,

or motor vehicle accidents (Foli & Thompson, 2019). Nurse-specific trauma refers to forms of trauma that are inherently embedded within the nursing profession and are uniquely experienced through the caregiver role (Foli, 2022; Foli & Thompson, 2019). Within the theory, there are seven nurse-specific traumas: (1) vicarious and secondary trauma, (2) historical and intergenerational trauma, (3) workplace violence, (4) system/treatment-induced trauma, (5) insufficient resource trauma, (6) second-victim trauma, and (7) trauma from disasters (Foli, 2022). Events associated with nurse-specific trauma may include medication errors, witnessing patient death, and the exposure to physical violence perpetrated by patients. Both humankind and nurse-specific traumas can be either avoidable or unavoidable, occurring across individual, professional, and organizational levels, and are not mutually exclusive of one another. Therefore, effective strategies to address trauma must be comprehensive and multi-level, aiming not only to prevent avoidable events but also to support and protect individuals following exposure to unavoidable events (Foli, 2022).

The *experience* refers to an individual's subjective interpretation and internal processing of the traumatic event, influenced by a range of factors including genetic predisposition, cultural background, and environmental context (Foli, 2022). This suggests that individuals experience each traumatic event differently, and that a complex interplay of psychological, physiological, and contextual elements shapes one's response to trauma (Foli, 2022; Foli & Thompson, 2019). Since each experience is exclusive to the individual, trauma cannot be comprehensively understood without the subjective account of the person who has endured it. This indicates that a singular event may be experienced

in fundamentally different ways due to diverse factors inherent to each individual; therefore, assumptions regarding how individuals process traumatic events cannot be universally applied.

The final component of the 3E model addresses the *effect*, which encompasses both positive and negative outcomes resulting from the event and experience. Similar to subjective experiences, these effects are unique to each individual. According to the theory, trauma can lead to positive outcomes, including individual resiliency, post-traumatic growth, and trauma-informed care (Foli, 2022; Foli & Thompson, 2019). Resilience is defined as a "positive adaptation following a potentially traumatic event that can manifest as a trait, a process, a defense mechanism, or an outcome" (Foli & Thompson, 2019, p. 214). In this context, resilience may represent a positive outcome, as it enables individuals to endure adverse circumstances. This capacity can also contribute to post-traumatic growth, wherein the traumatic experience and its processing is perceived as contributing meaningful value to the individual's life (Foli, 2022). Another positive outcome of experiencing trauma is the development of trauma-informed care, in which individuals who have navigated their own traumatic events may demonstrate greater empathy and sensitivity toward the trauma of others. Conversely, and perhaps more significantly, trauma can result in a range of negative outcomes, including PTSD, professional attrition, as well as alcohol and substance use (Foli, 2022). According to the theory, chronic exposure to unresolved nurse-specific trauma can lead to an accumulation of allostatic load, resulting in adverse effects on both mental and physical health, as well as a decline in the quality of delivered nursing care (Foli, 2022). Positive and negative

outcomes of trauma may occur simultaneously; however, negative outcomes necessitate coordinated, multi-level interventions to ensure the safety and well-being of nurses (Foli, 2022; Foli & Thompson, 2019).

Theoretical Application to the Study Purpose

The Theory of Nurses' Psychological Trauma identifies several forms of trauma that are directly relevant to the purpose of this study, including workplace violence and historical traumas that are specific to the nursing profession (Foli, 2022; Foli & Thompson, 2019). According to the theory, workplace violence is defined as "verbal, written, or physical abuse/assault from patients and visitors directed toward nurses. Workplace violence also includes nurse-to-nurse horizontal violence (incivility)" (Foli & Thompson, 2019, p. 217). Historical trauma is defined as "trauma passed down to future generations so that the offspring are vulnerable to the original trauma" (Foli & Thompson, 2019, p. 213). Thus, workplace violence encompasses traumas associated with the various forms of violence inflicted by multiple categories of perpetrators, while historical trauma positions nursing as an oppressed group, shaped by a legacy of racial exclusion that continues to impact the profession today (Foli, 2022).

The theory emphasizes that the processing and impact of traumatic events are highly individualized and suggests that chronic exposure to trauma creates an allostatic load which leads to negative outcomes such as mental health issues, and leaving the profession entirely (Foli, 2022). Considering these concepts, it is evident that experiences of violence and racism are subjective; this necessitates the development of effective reporting and response mechanisms to mitigate the accumulation of allostatic load and

reduce the risk of negative outcomes (Foli, 2022). This further underscores the reality that assumptions about the severity of traumatic impacts cannot be generalized, and an overreliance on individual resilience is insufficient as a sole strategy for addressing trauma (Foli, 2022; Foli & Thompson, 2019).

According to the theory, certain forms of trauma are avoidable, such as the trauma associated with workplace violence (Foli, 2022). This suggests that workplace violence is not an inherent aspect of the nursing profession, challenging its normalization and highlighting the need for multi-level interventions and system change. Thus system-level and organizational trauma-informed strategies, including safe working environments and enhanced resources, are essential for mitigating the impact of trauma experienced by nurses (Foli, 2022).

Theoretical Application to the Methodology

In addition to serving as the theoretical foundation for the study, Foli's Theory of Nurses' Psychological Trauma will inform the methodology of this study in multiple ways, including the interpretation of the literature review in the following section, the refinement of the data collection instrument detailed in Chapter 4, and the discussion and implications of the research findings explored in Chapter 6.

Chapter Summary

This chapter provided an overview of Foli's (2022) Theory of Nurses' Psychological Trauma, with a focus on the 3Es model—event, experience, and effect—as a framework for understanding psychological trauma. The discussion included several types of traumas, their impacts, and potential mitigation strategies. The chapter also

examined workplace violence and historical trauma as forms of nurse-specific trauma relevant to this study and emphasized the need for multi-level interventions to effectively address these issues. Finally, the chapter outlined how the theory will inform subsequent chapters including the literature review, methodology, and interpretation of research findings. The following chapter presents a comprehensive review of the literature related to this study.

Chapter 3: Literature Review

This chapter critically examines current literature relevant to the purpose of this study, which is to explore the prevalence, associated factors, and impacts of violence and racism experienced by nursing students in clinical placements. The chapter includes a detailed description of the search strategy used for the literature review, followed by an overview and synthesis of the findings from the existing literature, and concludes with identifying gaps in the current literature that the present study aims to address.

Search Strategy

To initiate the literature review process, a comprehensive consultation was conducted with a health sciences librarian who offered guidance on effective search strategies, relevant databases, and research procedures that were subsequently implemented in this study. The databases used to find relevant publications were Ovid Medical Literature Analysis and Retrieval Systems Online (MEDLINE), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed. Based on the consultation, these databases were selected for their extensive coverage of literature relevant to healthcare, with a particular focus on the nursing profession. Initial searches were conducted on Ovid MEDLINE and CINAHL as they are specific to the nursing profession; a more general search was conducted on PubMed afterwards to capture any single studies that may have been missed. Search terms were created with the support of the health sciences librarian for both Ovid MEDLINE and CINAHL databases. For search terms used for each database search, see Appendix A.

Studies were included if they were (1) in the English language, (2) were specific to nursing students, (3) addressed violence or racism, and (4) were relevant to the clinical setting. No time limit was applied to the Ovid MEDLINE or CINAHL searches in order to capture all literature on the topic, whereas a 5-year limit was applied to the PubMed search, as it was a complimentary search to include any missed studies in addition to the other database searches. Ovid MEDLINE included publications from 1946 (inception) to 2025, CINAHL included publications from 1981 (inception) to 2025, and finally PubMed included publications from 2020 to 2025.

The database searches yielded 205 results from Ovid MEDLINE, 135 from CINAHL, and 45 from PubMed. All search results were imported into the Covidence software platform for screening and review. To review the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRSIMA) flow diagram, see Appendix B. There were 16 duplicate studies identified by Covidence which resulted in 369 total studies that were screened. Study titles and abstracts were screened according to predefined inclusion criteria, resulting in the exclusion of 240 studies and the inclusion of 129. All 129 included studies were successfully retrieved and underwent a full-text review to assess eligibility for final inclusion. Of the 129 studies reviewed, 29 were excluded due to the following reasons: wrong setting (*n*=2), wrong outcomes (*n*=20), and wrong patient population (*n*=7). This resulted in a final total of 100 studies included in the literature review. The primary researcher conducted the search strategy.

Literature Overview

The literature review included studies published between 1996 to 2025, encompassing a diverse range of publication types: discussion papers (*n*=11), mixed-method studies (n=12), qualitative studies (*n*=28), quantitative studies (*n*=35), instructional papers (*n*=2), and reviews (*n*=12). The studies included in the review originated from several countries including: Australia (*n*=9), Canada (n=14), China (*n*=14), Germany (*n*=1), Iran (*n*=6), Ireland (*n*=1), Israel (*n*=1), Italy (*n*=2), Jordan (*n*=1), Netherlands (*n*=1), New Zealand (*n*=1), Saudi Arabia (*n*=1), Scotland (*n*=1), South Africa (*n*=1), South Korea (*n*=1), Tanzania (*n*=1), Turkey (*n*=5), United Kingdom (*n*=7), United States of America (*n*=17), and multi-country studies (*n*=15).

Although 100 publications were included in the literature review process, a high-level synthesis is presented to highlight the key findings that informed the current research, including insights from reviews that incorporate many of the individual studies. Common themes identified in the literature and selected for further exploration include: (1) prevalence of violence and racism, (2) perpetrators, (3) responding and reporting behaviours, (4) impacts and protective factors, (5) recommendations.

Prevalence of Violence and Racism

Findings from the literature review confirm the absence of a universally accepted definition of violence and racism, as evidenced by the diverse terminology and rhetoric used across studies to describe various forms of violence (Dafny et al., 2023; Hallett et al., 2023; Hopkins et al., 2018a; Lu et al., 2024). The terminology used to describe forms of violence varied across studies, including terms such as psychological violence,

aggression, bullying, harassment, physical violence, and threats, among others. This variation, as mentioned before, presents challenges for analysis and synthesis, potentially hindering a comprehensive understanding of the global nature of violence in the clinical setting (Dafny et al., 2023; Hallett et al., 2023; Hopkins et al., 2018a; Lu et al., 2024). Despite this, several reviews conducted in recent years have attempted to analyze the issue. These reviews encompass many of the individual studies that were included in this literature review, thereby contributing to a more comprehensive overview of the available data.

In a systematic review and meta-analysis of nursing student's experiences of workplace violence conducted by Hallett et al. (2023) which included 71 international studies, including two from Canada, types of violence were categorized into five groups for analysis: (1) verbal, (2) physical, (3) sexual, (4) bullying, and (5) racism. The prevalence of any form of violence was reported to be approximately 38%. The most prevalent type of violence identified was bullying with a rate of approximately 59% (95% Confidence Interval (CI) [44, 74]), followed by verbal violence (56%; 95% CI [45, 67]), sexual violence (26%; 95% CI [16, 38]), physical violence (17%; 95% CI [9, 26]), and racism (16%; 95% CI [7, 26]). In another systematic review and meta-analysis, Lu et al. (2024) included 57 international studies, only two of which were Canadian, and used multiple categories to analyze the data: (1) physical violence, (2) emotional violence, (3) threats, (4) verbal sexual harassment, (5) physical sexual harassment, and (6) sexual harassment. A pooled prevalence analysis revealed that approximately 45% of nursing students had experienced some form of violence during clinical placements, with

psychological violence being the most prevalent type reported at 65% (95% CI [41, 83]) (Lu et al., 2024). This was followed by emotional violence (32%; 95% CI [24, 42]), threats (16%; 95% CI [11, 21]), physical violence (8%; 95% CI [5, 13]), sexual harassment (6%; 95% CI [3, 14]), verbal sexual harassment (6%; 95% CI [3, 13]), and physical sexual harassment (4%; 95% CI [2, 8]). A qualitative systematic review by Dafny et al. (2023) which synthesized findings from 18 international studies identified five categories of violence, including (1) physical violence, (2) verbal violence, (3) psychological violence, (4) sexual violence, and (5) racism. Notably, no Canadian studies were included in the review. Psychological violence was presented in a majority of the papers (*n*=17), followed by verbal violence (*n*=13), physical violence (*n*=7), sexual violence (*n*=5), and racism (*n*=3). While the findings of most reviews were consistent with those of individual studies included in this literature review, there were some individual studies that suggested higher prevalence of racism. One single study conducted in Iran with 150 nursing students reported a racial harassment prevalence rate of approximately 41% (Samadzadeh & Aghamohammadi, 2018). However, the authors suggested that their findings may be attributed to the elevated levels of social violence in the Ardabil region where the study was conducted, which reportedly exceeded the national average. Another single study conducted in Ontario, Canada involving Black registered nurses (*n*=157), nurse practitioners (*n*=7), registered practical nurses (*n*=7), and nursing students (*n*=34), reported a notably high prevalence of discrimination and racism, with 88% of participants experiencing it at both individual and institutional levels (Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin, Jefferies, Bradley, Campbell,

Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, & Grinspun, 2022). This study suggests that when controlling for race, a higher prevalence of racism may be observed among non-White participants. However, it is important to note that the sample comprised a majority of registered staff compared to nursing students; this may have influenced the findings, as registered staff are likely to have greater exposure to racism due to their extended time in clinical settings.

The literature on the prevalence of violence and racism experienced by nursing students indicates that the most commonly reported forms of violence are described as psychological, verbal, or bullying, with considerable overlap in the nature of the experiences that these terms represent. Physical violence, sexual violence, and racism are also prevalent, though reported to varying degrees, and are generally characterized by more clearly defined experiences.

Perpetrators

The term *perpetrator* generally carries a negative connotation, given its predominant association with acts of intentional criminality, which may limit its suitability in contexts involving violent acts committed without malice or intent (Merriam-Webster, n.d.). Despite this, the term is frequently used in the literature to describe individuals who engage in acts of violence against nurses, whether intentional or not, including those involving patients and their family members (Al-Qadi, 2021). Consistent with the existing literature and discourse, the term perpetrator is used in this literature review and research study, with acknowledgement of its inherent limitations.

Although findings on perpetrators vary across studies, certain trends are evident. Patients, as well as their visitors, are frequently identified as the primary perpetrators of all forms of violence, particularly for verbal, physical, and sexual violence (Alsharari & Kerari, 2024; Cheung et al., 2019; Dafny et al., 2023; Ferns & Meerabeau, 2008; Hallett et al., 2023; Hambridge et al., 2025; Hopkins et al., 2018a; Johnston et al., 2024; Kurtgöz & Koç, 2025; Liao et al., 2025; Lu et al., 2024; Qian et al., 2023; E. Smith et al., 2023; Zhu et al., 2022). In the meta-analysis conducted by Hallett et al. (2023), relatives or visitors were the most prevalent sources of verbal violence with a mean percent exposure rate of approximately 47 % (95% CI [34, 59]), followed by patients (24%; 95% CI [13, 37]), nurses (23%; 95% CI [13, 33]), and doctors (21%; 95% CI [12, 33]). Patients were identified as the most frequent perpetrators of physical violence with a mean percent exposure rate of approximately 10% (95% CI [3, 21]), followed by nurses (9%; 95% CI [3, 19]), and relatives/visitors (7%; 95% CI [0, 20]). Patients were also the main source for sexual violence (67%; 95% CI [28, 98]), followed by doctors (19%; 95% CI [8, 33]), and nurses (1%; 95% CI [0, 1]). Nurses were identified as the primary source of bullying with a mean percent exposure rate of approximately 39% (95% CI [26, 52]), followed by clinical tutors (21%; 95% CI [8, 38]), patients (13%; 95% CI [10, 17]), student nurses (9%; 95% CI [2, 19]), doctors (9%; 95% CI [4, 15]), and relatives/visitors (6%; 95% CI [3, 9]). The review did not provide information regarding the specific perpetrators of racism (Hallett et al., 2023). In the meta-analysis conducted by Lu et al. (2024), a general analysis was undertaken to identify the primary perpetrators of violence across various contexts. Patients and their relatives had the highest prevalence rate at approximately

51% (95% CI [16, 85]), followed by clinical nursing instructors (39%; 95% CI [20, 61]), patient relatives or friends (33%; 95% CI [17, 55]), other nurses (32%; 95% CI [18, 50]), patients (32%; 95% CI [22, 43]), doctors (11%; 95% CI [5, 22]), nurse managers (10%; 95% CI [6, 17]), other staff (8%; 95% CI [3, 17]), and other nursing students (6%; 95% CI [2, 15]). In the qualitative systematic review by Dafny et al. (2023), multiple perpetrators of violence were also identified including patients, patients' relatives, nurses, staff, physicians, peers, and clinical educators. Patients were identified as the common perpetrators of several forms of violence, including physical violence, harassment, racism, and sexual violence. In contrast, bullying and verbal violence were frequently perpetrated by nurses, clinical educators, other staff, and physicians (Dafny et al., 2023). In other individual studies, incidents of racism experienced by nursing students were frequently attributed to faculty members, clinical educators, and peers (Dafny, Snaith, McCloud, et al., 2025; Dhari et al., 2025; Kim et al., 2022; Luhanga, Maposa, Puplampu, & Abudu, 2023; Luhanga, Maposa, Puplampu, Abudu, et al., 2023; Waddell-Henowitch et al., 2022).

Findings from the literature indicate that the perpetrators of violence and racism vary across different contexts. However, patients are most frequently identified as the source of various forms of violence, particularly physical and sexual violence. It is important to note that violence perpetrated by patients may be unintentional, as documented in literature, with contributing factors including medical conditions, mental illness, or substance misuse, among others (Hallett et al., 2023; Hopkins et al., 2018; Lu et al., 2024; Pagnucci et al., 2022). More obscure forms of violence such as verbal

violence and racism are perpetrated not only by patients, but also by nurses, clinical educators, physicians, and peers. This underscores the complex nature of nursing students' vulnerability, as they may be exposed to violence and racism from multiple sources, not solely from patients, and they may lack the necessary skills or support to effectively navigate such incidents.

Responding and Reporting Behaviours

A concerning response observed across multiple studies was that nursing students often remained silent, used avoidance, or took no action when faced with violence or racism (Cheung et al., 2019; Gungor & Tosunoz, 2024; Hallett et al., 2023; Johnston et al., 2024; Kim et al., 2022; Kurtgöz & Koç, 2025; Liao et al., 2025; Lu et al., 2024; Luhanga, Maposa, Puplampu, & Abudu, 2023; Qian et al., 2023; E. Smith et al., 2023; Tee & Valiee, 2020; S. P. Thomas & Burk, 2009; Younas et al., 2024; Zanchetta et al., 2021; Zhang et al., 2024; Zhu et al., 2022). In the meta-analysis conducted by Lu et al. (2024), approximately 65% of nursing students reported remaining quiet and taking no action after experiencing violence. In several individual studies, nursing students reported taking no action in response to violence, citing uncertainty about how to respond and a perceived obligation to maintain a professional relationship when the perpetrator was a patient (Dhari et al., 2025; Johnston et al., 2024; E. Smith et al., 2023; Younas et al., 2024). When violence or racism was perpetrated by nurses or clinical educators, students often felt unable to respond due to a sense of powerlessness associated with their student status, and feared that speaking out might compromise their academic or professional success (Aliafsari Mamaghani et al., 2022; Dafny, Waheed, Snaith, et al., 2024; Kurtgöz

& Koç, 2025; Lim & Bernstein, 2014; S. P. Thomas & Burk, 2009; Walker et al., 2024; Zhang et al., 2024).

In terms of reporting, the meta-analysis conducted by Hallett et al. (2023) revealed a mean precent of reporting for verbal violence and bullying. Verbal violence had a mean percent reporting rate of approximately 64% (95% CI [18, 99]) and bullying had a rate of 43% (95% CI [7, 83]) (Hallett et al., 2023). When interpreting these findings, it is important to consider the wide 95% confidence intervals, which indicate substantial uncertainty regarding the true extent and nature of reporting. The review also did not specify the reporting channels utilized by nursing students following incidents of violence. Nursing students were also noted to seek support from peers and clinical educators in the aftermath of such experiences (Hallett et al., 2023). Reasons for not reporting incidents included fear of reprisal, a belief that reporting would not lead to meaningful change, and a perception that such behaviour were too pervasive to warrant reporting (Hallett et al., 2023). In the meta-analysis conducted by Lu et al. (2024), it was found that about 74% of nursing students did not report an incident after experiencing violence. In the qualitative systematic review conducted by Dafny et al. (2023), findings also revealed that reporting incidents of violence was infrequent by nursing students. Commonly cited reasons for underreporting included fear of backlash, concerns about jeopardizing professional or academic success, a belief that nothing would change, and the perception that violence is an expected aspect of the clinical placements (Dafny et al., 2023). When nursing students did choose to report these incidents, they most commonly directed their reports to clinical educators, or mentors from their educational institutions

(Dafny et al., 2023). In other individual studies, friends and family members were common sources for support for nursing students following incidents of violence (Dafny, Snaith, Cooper, et al., 2025; Gungor & Tosunoz, 2024; Hambridge et al., 2025; Kim et al., 2022; Liao et al., 2025).

Overall findings from the literature review emphasized the lack of adequate responses to violence and racism encountered by nursing students in clinical placements. When confronted with incidents of violence or racism, nursing students often remain silent, refrain from taking action, or choose to avoid the perpetrators. A persistent issue identified is the underreporting of such incidents, often attributed to fears that reporting may negatively affect students' academic and professional progression, as well as perceptions that nothing will get done to mitigate the violence, and that violence is an inherent part of the nursing profession. Additionally, nursing students frequently experience a sense of disempowerment linked to their student status, accompanied by the fear of reprisal, further discouraging them from reporting these incidents.

Impacts and Protective Factors

Nursing students have reported a range of detrimental impacts resulting from experiences of violence and racism in clinical placements, encompassing both psychological and physiological effects. In the systematic review by Hallett et al. (2023), these impacts included anxiety, feelings of hopelessness, diminished self-esteem, fear associated with learning, and compromised patient care. Additionally, such experiences led some students to question their choice of nursing as a profession and, in some cases, to consider leaving the field altogether (Hallett et al., 2023). This was further supported

by the systematic review conducted by Lu et al. (2024), which found that exposure to violence negatively impacted the professional practice of nursing students and, in severe cases, contributed to student attrition. This review also highlighted that exposure to violence prompted professional growth among nursing students, including increased vigilance in practice and the development of advanced knowledge and skills aimed at preventing future incidents (Lu et al., 2024). Themes such as anxiety, impaired learning, and intentions to leave the profession were also identified in the qualitative systematic review by Dafny et al. (2023), along with effects on academic success and feelings of worthlessness. In the integrative review on sexual violence experienced by nursing students during clinical placements, E. Smith et al. (2023), identified a range of consequences including emotional responses such as anger, guilt, and shame, as well as physical symptoms such as nausea and sleep disturbances. Other severe consequences of sexual violence included loss of motivation, increased absenteeism and eventual attrition from nursing programs (E. Smith et al., 2023). In their mixed-methods study, Dhari et al. (2025) found that nursing students who experienced discrimination during their programs began to anticipate similar treatment in their future professional roles. This anticipation was accompanied by fears of negative treatment by employers and concerns about difficulties integrating into the workplace, particularly due to their intersecting identities including race (Dhari et al., 2025). Hambridge et al. (2025) found that approximately 15% of nursing and midwifery students in their study exhibited signs of PTSD related to exposure to violence. Similar findings were reported by Johnston et al. (2024), where nursing students described experiencing PTSD symptoms of varying severity, including

recurrent distressing memories and hypervigilance. Liao et al. (2025) identified suicidal thoughts as a severe consequence of bullying, reported by 3% of participants in their study. In a grounded theory developed by Chachula et al. (2015), exploring factors influencing newly graduated nurses in Western Canada to leave the profession, it was found that violence experienced during clinical placement, such as bullying, often persisted into their professional roles, ultimately contributing to attrition. A concerning trend observed in the literature is the normalization of violence experienced by nursing students, particularly in the form of bullying. This normalization contributes to the perpetuation of a harmful cycle, wherein affected students may later replicate bullying behaviours towards future cohorts of nursing students within the clinical setting (Aliafsari Mamaghani et al., 2018; Clarke et al., 2012; Hallett et al., 2023).

Protective factors against negative outcomes identified in the literature include personal resilience, education and training, positive interpersonal relationships, and welcoming clinical environments. Personal resilience emerged as a common protective factor in the literature, with nursing students often relying on their individual capacity to cope with experiences of violence (Kim et al., 2022; Qian et al., 2023; Tian et al., 2019). Education and training including the identification of violence, response strategies, and coping mechanisms were associated with nursing students feeling better prepared to manage incidents of violence in clinical placements (Liao et al., 2025; Lyng et al., 2012; Martinez, 2017; Meng et al., 2025; E. Smith et al., 2023; M. Wang et al., 2023; Zhao et al., 2025). However, in a study by Hambridge et al. (2025), only 35.8% of participants reported receiving sufficient education and training from their programs on how to

manage violence. Positive interpersonal relationships such as those with family, friends, peers, and clinical educators played a key role in mitigating the negative effects of violence experienced by nursing students (Aliafsari Mamaghani et al., 2018; Bakker et al., 2021; Chachula et al., 2015; Dafny, Cooper, et al., 2024; Dafny, Waheed, Snaith, et al., 2024; Kim et al., 2022). Finally, a welcoming environment accompanied by strong organizational support was identified as a protective factor that fosters learning and well-being among nursing students (Johnston et al., 2024; Liao et al., 2025).

Overall, it is evident that experiences of violence and racism contribute to a range of negative outcomes for nursing students, spanning from psychological distress to physiological impacts, as well as program attrition. Nevertheless, several protective factors have been identified that help mitigate these adverse effects including personal resilience, supportive interpersonal relationships, and inclusive learning environments.

Recommendations

Across the literature, several multi-level recommendations have been proposed to address the prevalence of violence and racism experienced by nursing students during clinical placements. A common recommendation involved enhanced preparation by educational institutes to equip nursing students with skills necessary to identify, manage, and report violence and racism during clinical placements (Alsharari & Kerari, 2024; Dafny, Waheed, Snaith, et al., 2024; Dhari et al., 2025; Hallett et al., 2023; Hamzavi & Brown, 2023; Hopkins et al., 2018a; Johnston et al., 2024; Johnston & Fox, 2020; Kurtgöz & Koç, 2025; Liao et al., 2025; Lu et al., 2024; Luhanga, Maposa, Puplampu, & Abudu, 2023; Martinez, 2019; Meng et al., 2025; Montague et al., 2024; Qian et al.,

2023; Sanner-Stiehr & Ward-Smith, 2017; Shen et al., 2020; E. Smith et al., 2023; Solorzano Martinez & De Oliveira, 2021; Stephen et al., 2022; S. P. Thomas & Burk, 2009; M. Wang et al., 2023; Xu et al., 2023; Zhao et al., 2025; Zhu et al., 2022). Specific interventions included targeted course content, resilience training, communication and conflict resolution strategies, and integrating curriculum on managing violence which can be delivered through various learning modalities including simulation, role-playing, and problem-based learning (Celebioglu et al., 2010; Curtis et al., 2007; Johnston & Fox, 2020; Liao et al., 2025; LoGiudice & Phillips, 2018; Martinez, 2019; Meng et al., 2025; Sanner-Stiehr & Ward-Smith, 2017; Shen et al., 2020; Stephen et al., 2022; M. Wang et al., 2023; Xu et al., 2023; Zhao et al., 2025). Education and training for clinical educators and staff were also recommended to strengthen their ability to support nursing students experiencing violence and racism (Clarke et al., 2012; Del Prato, 2013; Dhari et al., 2025; Qian et al., 2023; Tee & Valiee, 2020; L. Wang et al., 2022; Younas et al., 2024). Policies and procedures for reporting violence and racism were also recommended across several studies, with two specifically advocating for the appointment of a designated individual to manage and support with such cases reported by students (Alsharari & Kerari, 2024; Clarke et al., 2012; Dhari et al., 2025; Hambridge et al., 2025; Johnston & Fox, 2020; Luhanga, Maposa, Puplampu, & Abudu, 2023; Meng et al., 2025; S. P. Thomas & Burk, 2009; Walker et al., 2024; Zhu et al., 2022). Organizational strategies identified in the literature include the implementation of a zero-tolerance policy toward violence and racism, as well as the promotion of a welcoming and inclusive learning environment for nursing students (Chang et al., 2023; Dafny, Snaith, Cooper, et al., 2025; Dafny, Snaith,

McCloud, et al., 2025; Kurtgöz & Koç, 2025; Lu et al., 2024; Pagnucci et al., 2022; Shen et al., 2020; S. P. Thomas & Burk, 2009; L. Wang et al., 2022; Zhang et al., 2024).

The literature review underscored the importance of coordinated multi-level mitigation strategies, with recommendations spanning individual, professional, and organizational levels. These recommendations move beyond placing sole responsibility on nursing students, instead emphasizing the critical role of clinical educators, educational institutes, and clinical placement environments in addressing violence and racism.

Literature Gap

Despite the substantial body of literature on violence and racism experienced by nursing students during clinical placements, there remains a notable lack of quantitative data addressing this issue within the Canadian context. Among the Canadian studies included in this literature review, only a limited number collected quantitative data, primarily focusing on bullying, discrimination related to intersecting identities, and racism, though not specifically in the context of nursing students. The majority of Canadian studies included in the literature review employed qualitative methodologies, largely exploring the experiences of discrimination and racism among nursing students. While qualitative research offers valuable insight into the nuances and lived experiences of nursing students regarding this issue, it does not adequately capture the prevalence or scope of the issue and its associated factors. To understand the magnitude of this issue within the Canadian context, and to explore its interrelated dimensions, the collection of quantitative data is essential. Accordingly, the literature gap this research study seeks to

address is the limited availability of quantitative data on the prevalence of violence and racism, the associated factors, and the resulting impact on nursing students in the Canadian context. The research questions that guide this study will be presented in Chapter 4.

Chapter Summary

This chapter provided a critical examination of the existing literature relevant to the purpose of this study, which is to investigate the prevalence, associated factors, and impact of violence and racism experienced by nursing students in clinical placements. It began by outlining the search strategy used for the literature review, followed by a synthesis of key findings encompassing the prevalence of violence and racism and their perpetrators, responding and reporting behaviours, impacts and protective factors, as well as recommendations for mitigating the issue. The chapter concluded by identifying a significant gap in the current literature, specifically the lack of quantitative data within a Canadian context, which this study aims to address. The research questions guiding this study, along with the methodology will be presented in the subsequent chapter.

Chapter 4: Methodology

This chapter presents the research aim and the guiding questions for the study, followed by a detailed description of the study design, participant selection, recruitment procedures, research instrument, data collection methods and analysis techniques, as well as ethical considerations.

Research Aim & Questions

The aim of this study was to obtain current quantitative data on the prevalence of violence and racism experienced by nursing students in clinical placements, the associated factors, and impacts of these experiences. The research questions that guided this study were:

1. What are the types and frequency of violence and racism experienced by nursing students, and who are the perpetrators?
2. How do nursing students respond to and report violence and racism?
3. What negative outcomes do students report after experiencing violence and racism?
4. What protective factors do students report that mitigate the negative impacts of violence and racism?
5. What recommendations do students report that address violence and racism on the individual, professional, and organizational levels?

Design

This study employed a descriptive cross-sectional design to address the limited availability of quantitative data on violence and racism experienced by nursing students in

clinical placements within the Canadian context. It aimed to collect preliminary objective data on the prevalence, associated factors, and impacts of these experiences. A descriptive cross-sectional study design was used as it is commonly used to assess the prevalence of variables, such as health outcomes, within a population, and to gather preliminary data that can inform the design of more advanced future research (Wang & Cheng, 2020).

Participants

In consultation with the research committee, an appropriate study sample was determined based on considerations of feasibility and the study's time limit. The inclusion criteria for participants were: (1) currently enrolled in either the basic or accelerated stream of the Bachelor of Science in Nursing (BScN) program at a university in Southwestern Ontario, and (2) current participation in, or completion of, at least one clinical placement. A sample size calculation was conducted using the most up-to-date data available at the time to generate an informed estimate of the required sample for the study population. The calculated minimum sample size was 215. See Appendix C for the sample size calculation.

Recruitment

A convenience sampling approach was employed to recruit participants for the study. Recruitment was conducted between February and April 2025 through multiple channels, including email communication via the university BScN administrative account, social media announcements, poster distribution, outreach by the university's nursing students' society and in-class recruitment efforts by faculty and staff. The assistant dean of undergraduate nursing programs provided guidance and authorization to

utilize the university BScN administrative email account for recruitment communications. Weekly email communications were distributed containing information about the study's purpose, the extent of participant involvement, the survey link and Quick Response (QR) code, and contact details for both student and faculty researchers. See Appendix D for the initial recruitment email template, Appendix E for subsequent reminder email template, and Appendix F for the study poster which was also attached in the recruitment emails. Study posters were printed and displayed on designated campus bulletin boards, as well as in strategically identified locations, such as outside simulation labs, based on recommendations from the research committee to optimize recruitment. The study poster was also disseminated via the primary researcher's LinkedIn account and the nursing students' society Instagram account, accompanied by supplementary text to support recruitment efforts (see Appendix G for Additional Text with Ad). The study poster and accompanied text were also distributed to faculty and staff teaching in the BScN and accelerated streams at the university. They were instructed to share the study information in person during class sessions and to post the materials on their online teaching platform for students to access voluntarily.

A confidential survey link hosted on LimeSurvey, a free online survey platform, was distributed to potential participants via email communications and a QR code displayed on the study poster. Upon accessing the survey link or scanning the QR code, participants were presented with detailed information about the study and prompted to voluntarily provide informed consent by selecting a checkbox before proceeding to the survey (see Appendix H for the survey invitation and consent information). Participation

was anonymous and based on self-referral, with students able to withdraw their consent at any point during the data collection phase by opting not to submit their survey responses.

Instrument

The instrument used in this study was adapted from a survey originally developed and validated by Hewett (2010), which was administered to 218 undergraduate nursing students in South Africa. The original survey consists of five sections: (1) demographic data, (2) data related to workplace violence, (3) non-physical violence settings, perpetrators, and impacts, (4) reporting behaviours, and (5) open-ended question inviting participant recommendations for managing violence in the clinical setting. The survey primarily consists of closed-ended questions employing a 4-point Likert scale to assess the frequency of experiences, along with dichotomous response options (e.g. Yes/No or Agree/Disagree) to evaluate actions taken and levels of agreement with relevant statements.

The primary researcher initially modified the original survey to align with the objective of the current study. A pilot test of that initial draft of the modified survey was conducted to assess face validity with three individuals from the School of Nursing, including a faculty member, a staff member, and a graduate student. Each reviewer was provided with a feedback form (see Appendix I), which was completed and returned to the primary researcher. Revisions were made to the survey based on the feedback received, resulting in the final version of the instrument.

The original survey was adapted through the following modifications: (1) including a non-binary gender identity option, and a “prefer not to answer” option; (2)

including a demographic question regarding participants' race/ethnicity; (3) addition of "racism" as a distinct type of violence; (4) addition of responding behaviours for all types of violence; (5) addition of reporting behaviours for all types of violence; (6) addition of a section on protective factors against negative outcomes for all violence types based on Foli's (2022) Theory of Nurses' Psychological Trauma; (7) modification of the "suggestions to manage workplace violence" section from open-ended to close-ended questions addressing individual, professional, and organizational strategies also grounded in Foli's (2022) theory; and (8) adding a 5-point Likert agreement scale for selected questions. The final survey was titled *Nursing Students' Experiences with Violence and Racism Survey* (see Appendix J). The modified survey took approximately 10 to 20 minutes to complete.

The final modified survey employed in this study included four sections: (1) demographic information including age, gender identity, ethnicity/race, and program level; (2) violence type, including frequency, perpetrators, responding behaviours, reporting behaviours, and negative impacts; (3) protective factors; and (4) recommendations. The survey contained four distinct types of violence: (1) verbal, (2) physical, (3) sexual, and (4) racism. These sections included frequency of specific examples of each type of violence, the identified perpetrators, responding behaviours, reporting behaviours, and negative impacts. The frequency of experiences, perpetrators, responding and reporting behaviours, as well as negative outcomes were measured using a 4-point Likert scale with the following response options: (1) "Never," (2) "Occasionally (1-2 times)," (3) "Sometimes (3-5 times)," and (4) "Often (more than 5 times)." These

frequencies reflect experiences within clinical placements over the past twelve months. A total frequency was calculated by summing the number of responses marked as "Occasionally," "Sometimes," and "Often" for the select variables. Reasons for not reporting incidents were assessed using a 5-point Likert scale measuring levels of agreement: (1) "Strongly disagree," (2) "Disagree," (3) "Neutral," (4) "Agree," and (5) "Strongly agree." The remaining sections included a list of protective factors against negative outcomes, and recommendations to mitigate violence and racism on an individual, professional, and organizational level which were also measured using the 5-point Likert scale measuring levels of agreement.

Data Collection & Analysis

Data collection was conducted between February and April 2025, following approval from the Research Ethics Board. Data were collected using the LimeSurvey platform and securely stored in encrypted form on password-protected university sanctioned Cloud based storage (OneDrive). The data, which are anonymous and pose minimal risk, will be retained indefinitely on these servers for study-related purposes (McMaster University, n.d.). Participant anonymity was maintained by excluding the collection of identifying information, such as names or student numbers. Additionally, data were aggregated at the program level to enhance confidentiality and further protect participant anonymity.

Data were analyzed using IBM® Statistical Package for the Social Science (SPSS), employing descriptive statistical methods to organize and interpret the dataset. Demographic characteristics of the study participants are summarized in a comprehensive

table, providing important contextual information about the composition of the sample. Frequencies, including both counts and percentages, were calculated for all relevant variables to offer a clear representation of participant responses. Percentages were specifically applied in sub-variable analyses to identify which items were reported more frequently than others, thereby revealing patterns and variations in responses. Additionally, frequencies for variables are displayed in both tabular and graphical formats to enhance interpretability and support the identification of trends within the data. The findings of the analysis are elaborated in detail in Chapter 5.

Ethical Considerations

Given the study's focus on potentially traumatic experiences, several ethical considerations were addressed, including the risk of re-traumatization, informed consent, and the protection of participant anonymity. The potential for re-traumatization was acknowledged due to the exploratory nature of the survey questions which addressed participants' experiences of violence and racism in clinical placements. To mitigate the risk of re-traumatization, the study's purpose was explicitly outlined in the survey invitation and consent information, enabling participants to anticipate the nature of the questions before commencing the survey. Participants were permitted to pause the survey at any time and resume later if they found the content overwhelming. Additionally, a link to the university's student wellness services was included in the survey invitation to offer participants access to support resources. Participants were able to withdraw their consent and discontinue participation at any point prior to submitting their survey responses. No

identifying information such as names or student numbers was collected, and participant anonymity was maintained through aggregation of data at the program level.

Chapter Summary

This chapter presented the research aim and the guiding research questions. It also outlined the study design, participant selection criteria, recruitment procedures, instrument modifications, data collection and analysis methods, and ethical considerations. The subsequent chapters will present the collected data and provide an in-depth discussion of the findings.

Chapter 5: Results

This chapter presents the findings of the research study, beginning with the response rate and a demographic overview of the sample. It then addresses each category of violence, detailing frequencies of perpetrators, associated negative outcomes, responding and reporting behaviours, protective factors, and recommendations to mitigate violence and racism.

Response Rate

The research survey was directly distributed to approximately 485 students via the university's BScN administrative email account. The target population included students from a university in Southwestern Ontario, encompassing both basic and accelerated streams who were currently participating in or had completed at least one clinical placement. Of the 485 students contacted, 82 completed the survey, yielding a response rate of approximately 17%.

Demographic Overview

Demographic data collected included participants' age, gender identity, race or ethnicity, and program level. The mean age of participants was approximately 22 years with a Standard Deviation (*SD*) of 2.80 years, with the majority identifying as female (87%). Participants reported a range of racial and ethnic identities; however, the most commonly represented groups were individuals of East and Southeast Asian origins (*n*=25), White (*n*=23), and South Asian origins (*n*=21). A substantial proportion of participants were in Level 3 (*n*=37), followed by Level 4 (*n*=25), and Level 2 (*n*=20). A summary of these findings is presented in Table 1.

Table 1

Sample demographic characteristics (n=82)

Variables	Frequency	Percentage	Mean (*SD*)
Age (years)			21.72 (±2.80)
Gender Identity[1]			
Female	71	86.59	
Male	11	13.41	
Non-binary	1	1.22	
Race/Ethnicity[2]			
First Nation or North American Indian	1	1.22	
White (Caucasian)	23	28.05	
Other European origins	4	4.88	
Black/African American/African Canadian	4	4.88	
Latin, Central and South American origins	3	3.66	
African origins	5	6.10	
West Central Asian and Middle Eastern origins (e.g., Turkish, Iranian)	7	8.54	
South Asian origins (e.g., Indian, Sri Lankan)	21	25.61	
East and Southeast Asian origins (e.g., Chinese, Filipino)	25	30.49	
Program Level			
Level 2	20	24.39	
Level 3	37	45.12	
Level 4	25	30.49	

Note: [1]More than one gender identity selected (*n*=1); total percentage greater than 100%. [2]More than one race/ethnicity selected (*n*=11); total percentage greater than 100%. *SD*= Standard Deviation.

It is important to note that one participant selected more than one gender identity resulting in a total of 83 counts which resulted in a total percentage greater than 100%.

Similarly, several participants selected multiple options for race/ethnicity, resulting in 93 counts.

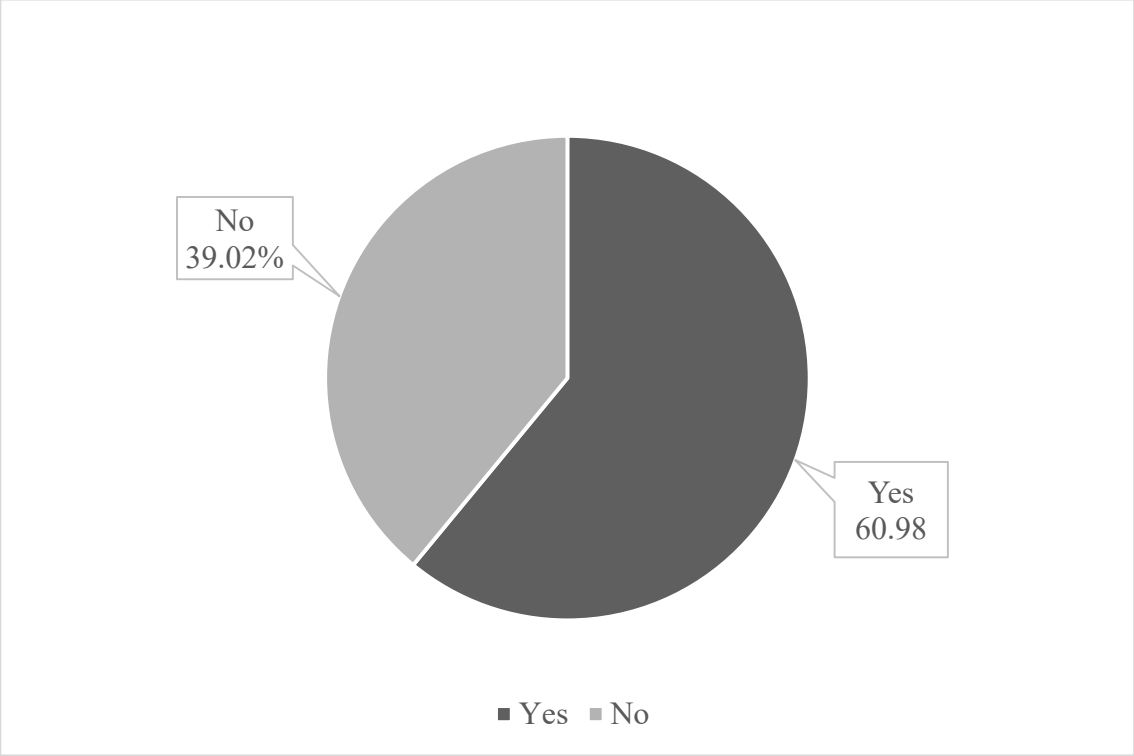
Prevalence of Violence and Racism

Data on the prevalence of violence encompassed four distinct types: (1) verbal, (2) physical, (3) sexual, and (4) racism. Frequency data for specific examples within each category were collected using a 4-point Likert scale: (1) "Never," (2) "Occasionally (1-2 times)," (3) "Sometimes (3-5 times)," (4) "Often (more than 5 times)." For each example, a total frequency score was calculated by aggregating the number of responses reported as "Occasionally," "Sometimes," and "Often."

Of the 82 participants, 50 reported experiencing at least one type of violence, resulting in an overall prevalence rate of approximately 61% (95% CI [71.54, 50.42]). This is illustrated in Figure 2 as a pie chart.

Figure 2

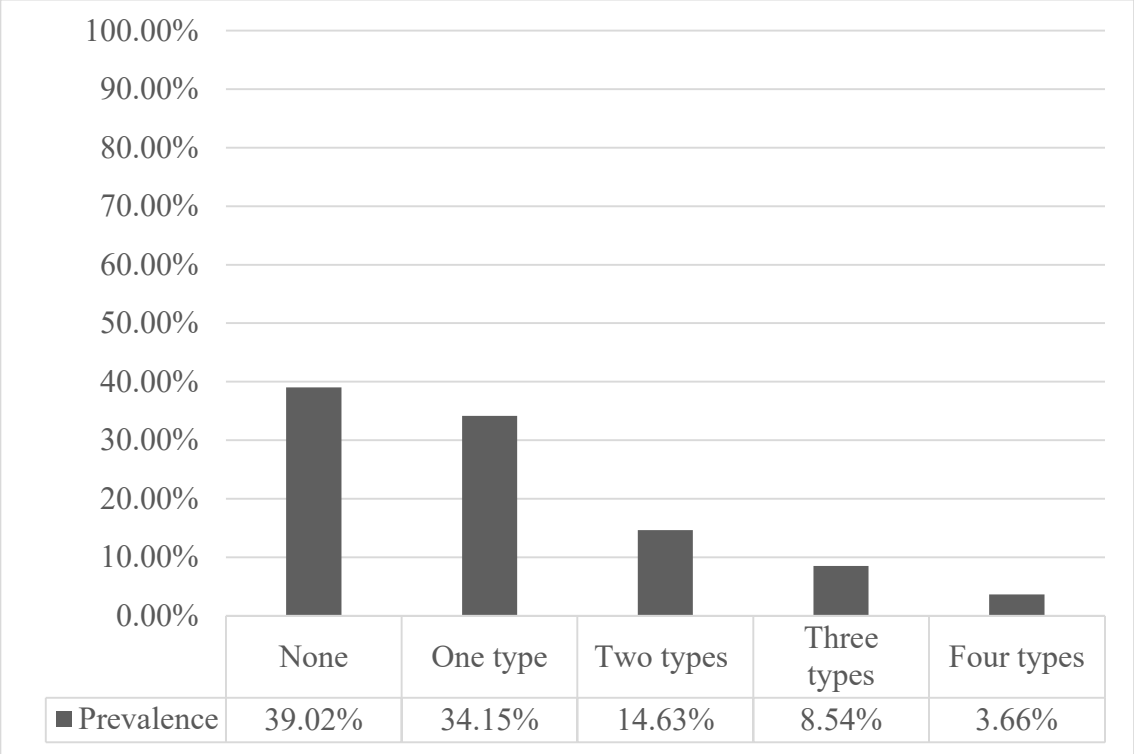
Overall Prevalence of Violence- Pie Chart



A majority of participants, 32 out of 82, reported experiencing no violence (39.02%; 95% CI [49.58, 28.46]), followed by 28 participants who reported experiencing one type (34.15%; 95% CI [44.41, 23.88]), 12 who reported experiencing two types (14.63%; 95% CI [22.28, 6.98]), 7 who reported experiencing three types (8.54%; 95% CI [14.58, 2.49]), and 3 who experienced all four types of violence (3.66%; 95% CI [7.72, -0.40]). Figure 3 presents this data as percentages in a bar graph format.

Figure 3

Number of Types of Violence Experienced- Bar Graph



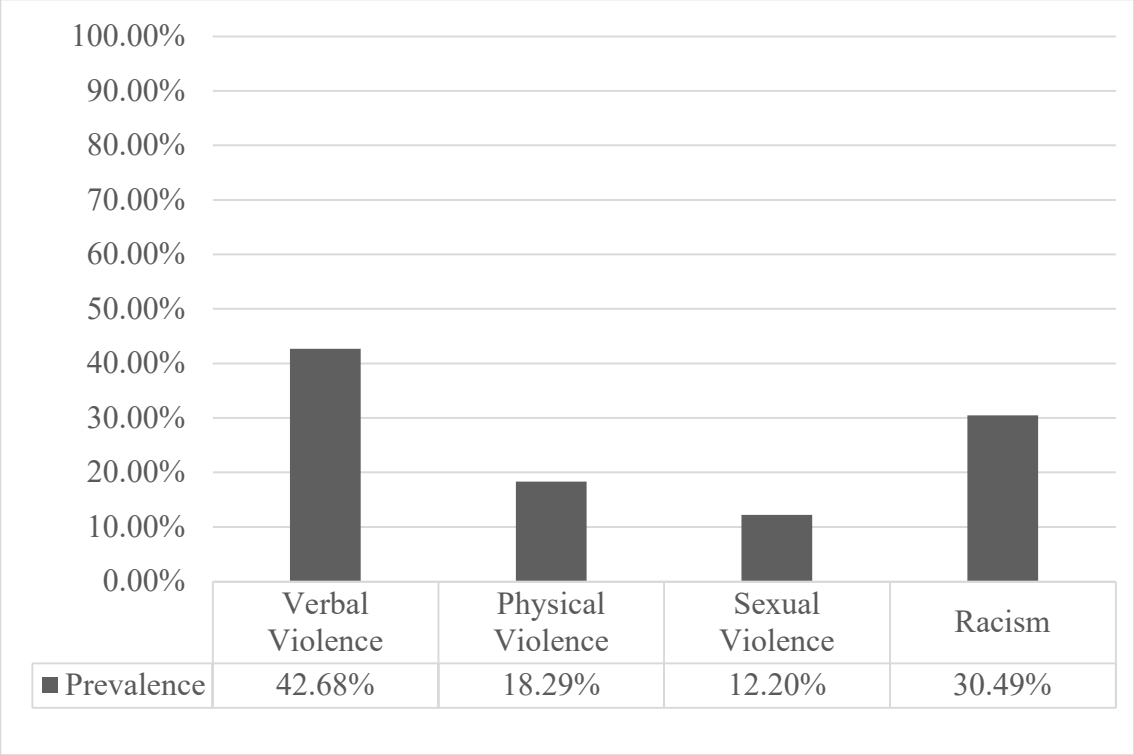
Exploration of overall prevalence of violence by gender identity indicated that participants who identified as female (including a participant that identified as female and non-binary) reported a prevalence rate of 65% (46 of 71), compared to 36% among those who identified as male (4 of 11). An analysis of violence prevalence by program level revealed that Level 2 reported the highest rate with 65% of participants (13 of 20) reporting an experience of at least one type of violence, followed by Level 3 (62%; 23 of 37), and Level 4 (56%; 14 of 25)

Verbal violence was the most frequently reported type of violence (*n*=35; 42.68%; 95% CI [53.39, 31.98]), followed by racism (*n*=25; 30.49%; 95% CI [40.45, 20.52]),

physical violence (*n*=15; 18.29%; 95% CI [26.66, 9.92]), and sexual violence (*n*=10; 12.20%; 95% CI [19.28, 5.11]). The prevalence of each type, expressed as a percentage, is illustrated in Figure 4 using a bar graph.

Figure 4

Prevalence of Violence and Racism- Bar Graph



An analysis of sexual violence by gender identity revealed that all participants who reported experiencing sexual violence identified as female (*n*=10). When examined exclusively among participants who identified as female, the prevalence of sexual violence increased from 12% (10 of 82) to 14% (10 of 71).

In examining experiences of racism, the exclusion of participants who identified as White (*n*=23) from the analysis resulted in an increase in the reported prevalence of racism from approximately 30% to 39% among the remaining participants (*n*=59).

Among participants who reported experiencing verbal violence (*n*=35), the three most commonly cited examples were "non-verbal" (*n*=32), followed by "sworn, shouted, or yelled at" (*n*=26), and "harshly judged/criticized" (*n*=24). Table 2 provides a comprehensive list of all examples and frequencies of verbal violence while Figure 5 presents a stacked bar graph illustrating the frequencies of these examples.

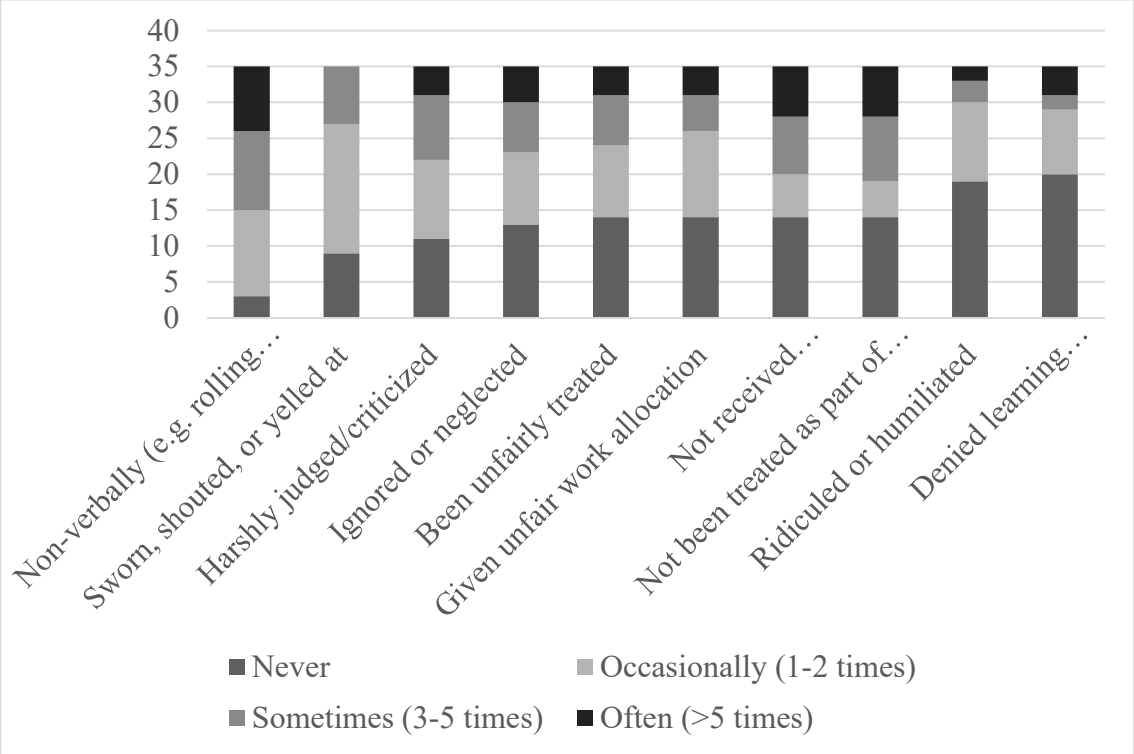
Table 2

Frequency of Verbal Violence Examples

	Verbal Violence (*n*=35)				
In the past 12 months in my clinical placement, I have experienced verbal violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Non-verbally (e.g. rolling eyes)	3	12	11	9	32 (91.43)
Sworn, shouted, or yelled at	9	18	8	---	26 (74.29)
Harshly judged/criticized	11	11	9	4	24 (68.57)
Ignored or neglected	13	10	7	5	22 (62.86)
Been unfairly treated	14	10	7	4	21 (60)
Given unfair work allocation	14	12	5	4	21 (60)
Not received acknowledgment for good work	14	6	8	7	21 (60)
Not been treated as part of the multidisciplinary team	14	5	9	7	21 (60)
Ridiculed or humiliated	19	11	3	2	16 (45.71)
Denied learning opportunities	20	9	2	4	15 (42.86)

Figure 5

Frequency of Verbal Violence Examples- Stacked Bar Graph



Of the participants who experienced physical violence (*n*=15), the most commonly reported example was "been threatened with physical violence" (*n*=10). Appendix K provides a list of examples and frequencies of physical violence, along with a stacked bar graph illustrating this data.

For sexual violence (*n*=10), the most frequently reported example was "had inappropriate sexual comments said to me" (*n*=10). A detailed frequency list of these examples, accompanied by a stacked bar graph representation is provided in Appendix L.

Among participants that experienced *racism* (*n*=25), the two most reported examples were "felt uncomfortable, excluded, or isolated because of my race" (*n*=22) and

"had an inappropriate comment directed at me in relation to me race" (*n*=22). Table 3 presents the frequency data reported by participants who experienced racism, while Figure 6 illustrates this data in the form of a stacked bar graph.

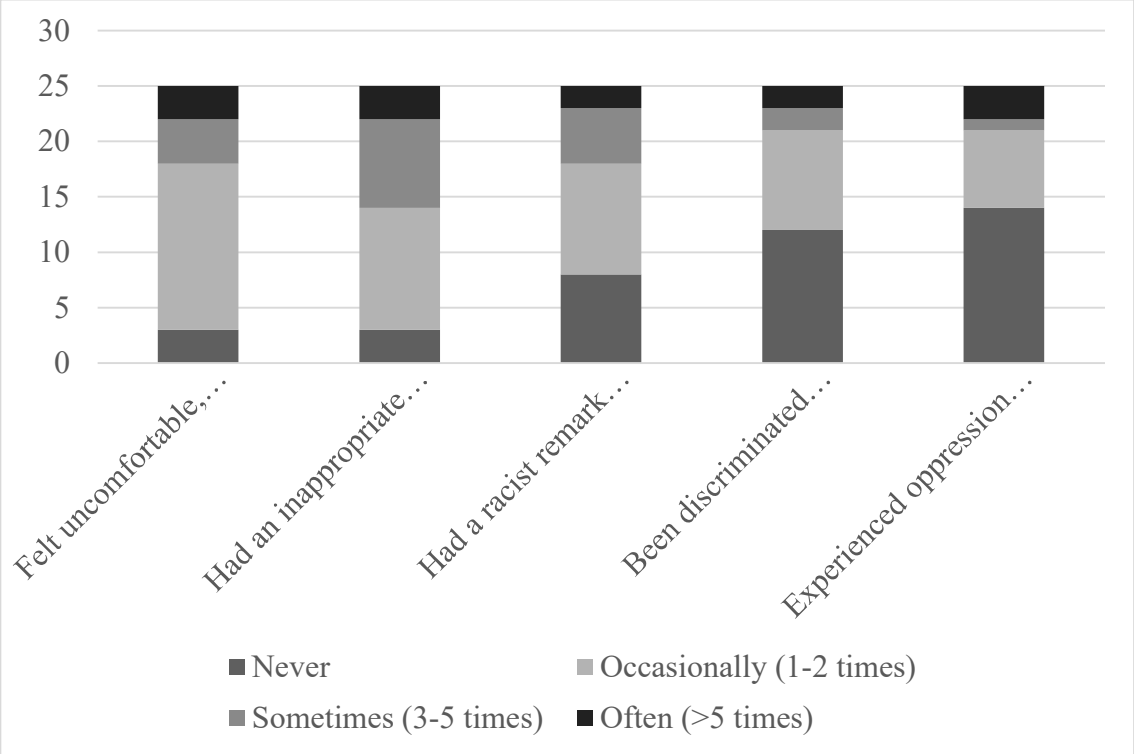
Table 3

Frequency of Racism Examples

	Racism (*n*=25)				
In the past 12 months in my clinical placement, I have experienced racism in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Felt uncomfortable, excluded, or isolated because of my race	3	15	4	3	22 (88)
Had an inappropriate comment directed at me in relation to my race	3	11	8	3	22 (88)
Had a racist remark directed at me	8	10	5	2	17 (68)
Been discriminated against because of my race.	12	9	2	2	13 (52)
Experienced oppression based on my race	14	7	1	3	11 (44)

Figure 6

Frequency of Racism Examples- Stacked Bar Graph



Perpetrators

Across all types of violence, patients were the most frequently reported perpetrators and were the sole perpetrators of physical violence. For sexual violence, only patients and patients' visitors were identified as perpetrators. In cases of verbal violence and racism, staff nurses were the second most reported perpetrators, followed by patients' visitors and preceptors.

Table 4 provides a comprehensive list of perpetrators for verbal violence while Figure 7 illustrates this data in a stacked bar graph format. Table 5 presents the frequencies of perpetrators for racism while Figure 8 displays this data as a stacked bar

graph. Appendix M presents frequency tables detailing the perpetrators of physical and sexual violence.

Table 4

Frequency of Verbal Violence Perpetrators

	Verbal Violence (*n*=35)				
In the past 12 months in my clinical placement, I have experienced verbal violence from the following sources:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Patients	5	9	13	8	30 (85.71)
Staff nurses	8	18	5	4	27 (77.14)
Patients' visitors	15	13	6	1	20 (57.14)
Preceptor	25	6	2	2	10 (28.57)
Clinical teacher	29	4	1	1	6 (17.14)
Allied health providers and staff	29	5	1	---	6 (17.14)
Physicians	31	3	---	1	4 (11.43)
Peers	33	1	---	1	2 (5.71)

Figure 7

Frequency of Verbal Violence Perpetrators- Stacked Bar Graph

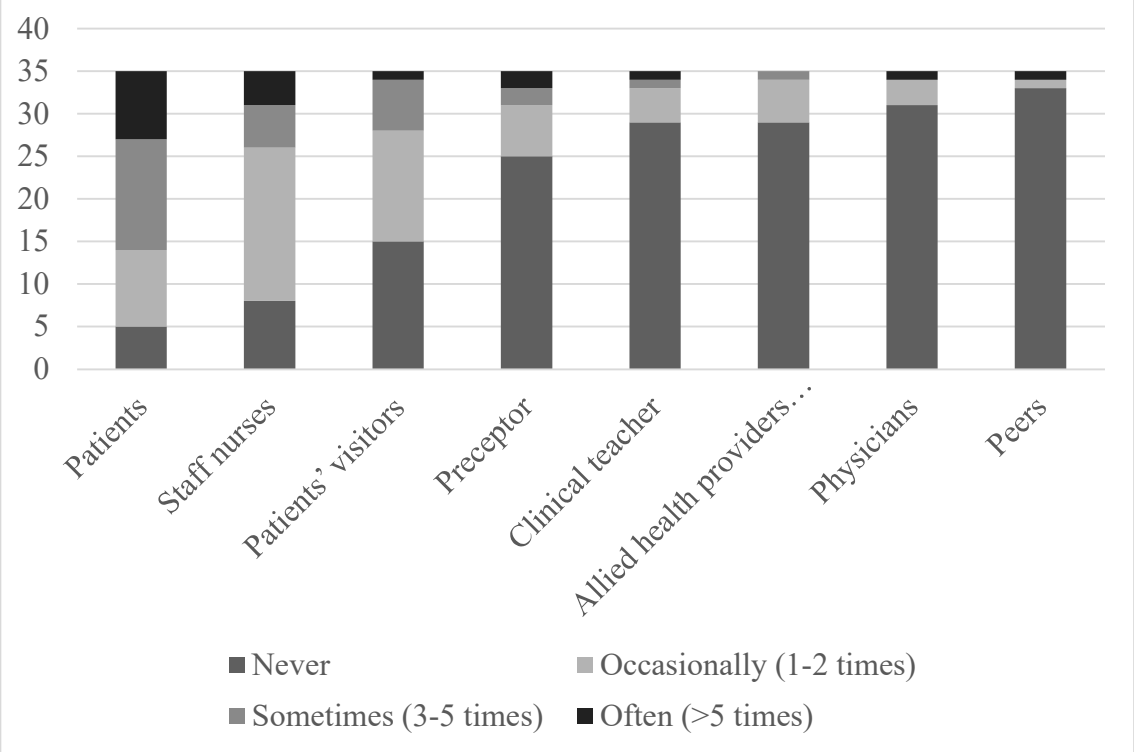


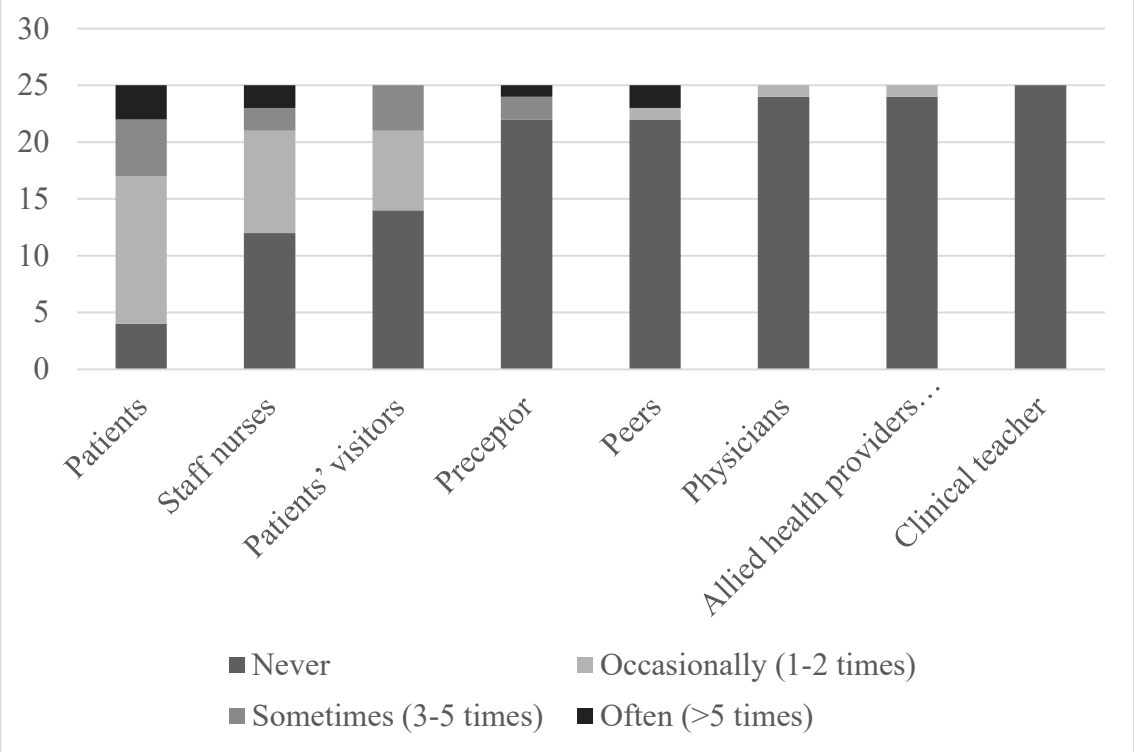
Table 5

Frequency of Racism Perpetrators

	Racism (*n*=25)				
In the past 12 months in my clinical placement, I have experienced racism from the following sources:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Patients	4	13	5	3	21 (84)
Staff nurses	12	9	2	2	13 (52)
Patients' visitors	14	7	4	---	11 (44)
Preceptor	22	---	2	1	3 (12)
Peers	22	1	---	2	3 (12)
Physicians	24	1	---	---	1 (4)
Allied health providers and staff	24	1	---	---	1 (4)
Clinical teacher	25	---	---	---	---

Figure 8

Frequency of Racism Perpetrators- Stacked Bar Graph



Negative Outcomes

Multiple negative outcomes were reported across all types of violence; however, anxiety was the most frequently reported among them. Other commonly reported outcomes included "anger" and "interrupted my learning." The least frequently reported negative outcome across all types of violence was "caused absenteeism." Appendix N presents comprehensive tables detailing the negative outcomes associated with each type of violence. Figure 9 presents a stacked bar graph illustrating the frequency of negative outcomes for verbal violence, while Figure 10 depicts the corresponding data for racism.

Figure 9

Frequency of Verbal Violence Negative Outcomes- Stacked Bar Graph

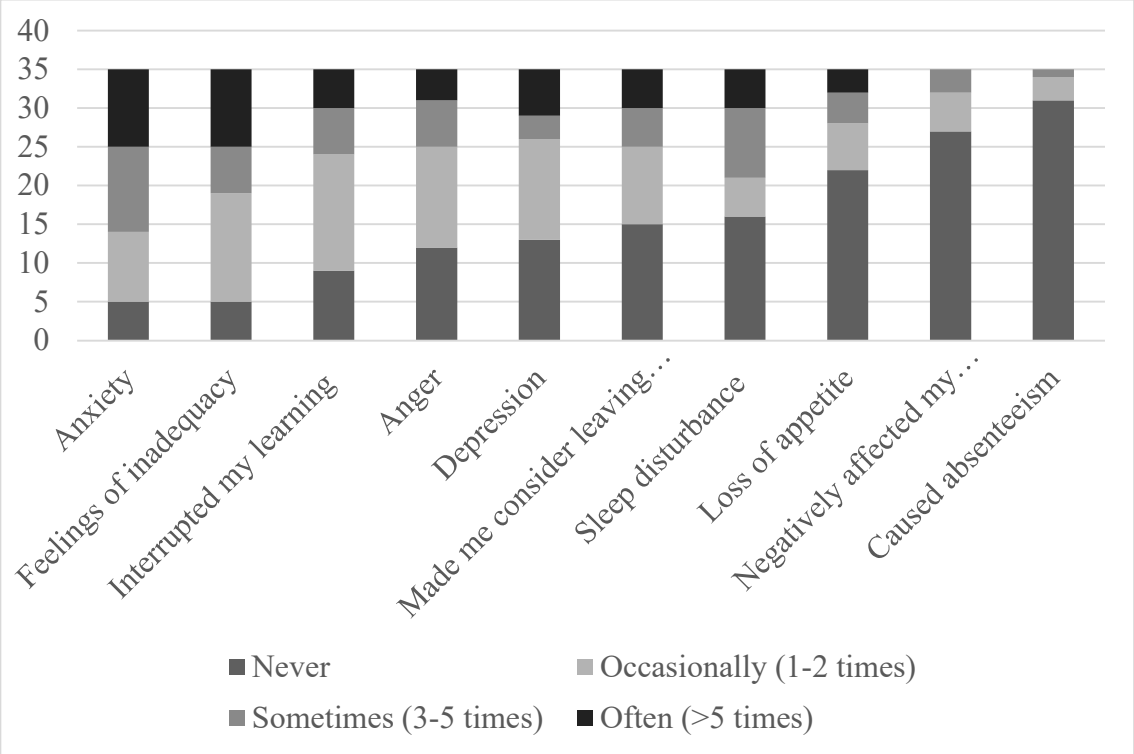
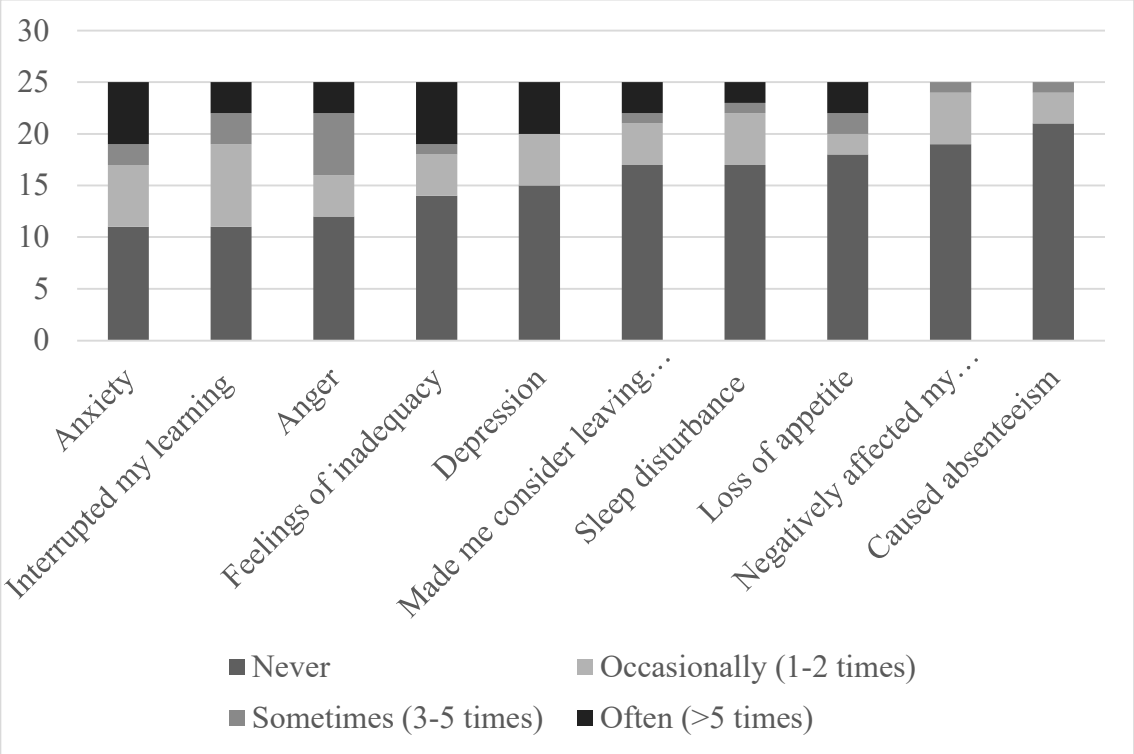


Figure 10

Frequency of Racism Negative Outcomes- Stacked Bar Graph



Responding Behaviours

Among participants that experienced verbal violence, physical violence, and racism, the most frequently reported responding behaviour was "took no action," whereas those who experienced sexual violence, the most common response was "avoided the perpetrator." 89% of participants who experienced verbal violence reported taking no action following the incident (31 of 35), followed by trying to pretend it never happened (83%; 29 of 35), avoiding the perpetrator (69%; 24 of 35), and telling the perpetrator to stop (31%; 11 of 35). Those that reported experiencing physical violence, 67% (10 of 15) took no action, followed by trying to pretend it never happened (53%; 8 of 15), telling the

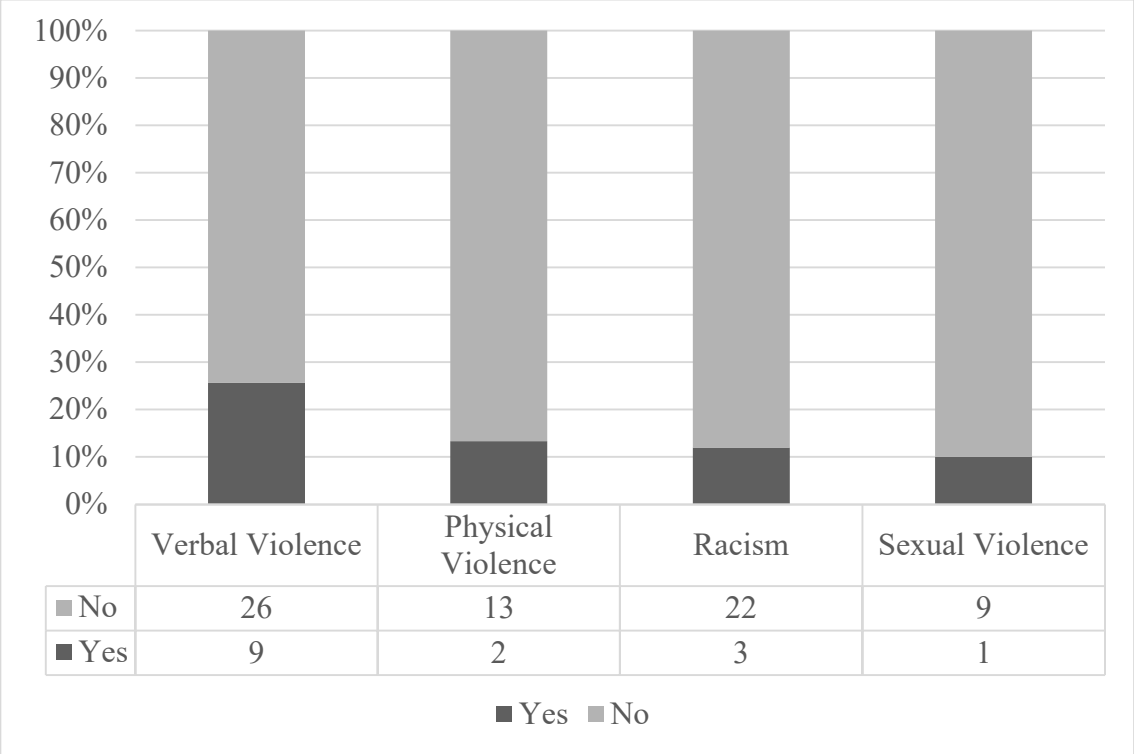
perpetrator to stop (47%; 7 of 15), and avoiding the perpetrator (40%; 6 of 15). Among the participants that experienced racism 96% (24 of 25) took no action, followed by trying to pretend it never happened (92%; 23 of 25), avoiding the perpetrator (52%; 13 of 25), and telling the perpetrator to stop (24%; 6 of 25). For those that experienced sexual violence, the most common responding behaviour was avoiding the perpetrator (80%; 8 of 10), followed by taking no action (70%; 7 of 10), trying to pretend it never happened (60%; 6 of 10), and telling the perpetrator to stop (60%; 6 of 10). Appendix O presents frequencies of reported responding behaviours.

Reporting Behaviours

Overall, the frequency of reporting violence was low, with verbal violence being the most frequently reported (26%; 9 of 35), followed by physical violence (13%; 2 of 15), racism (12%; 3 of 25), and sexual violence (10%; 1 of 10). Figure 11 presents a stacked bar graph illustrating the frequency and percentage of reporting associated with each type of violence.

Figure 11

Frequency of Reporting- Stacked Bar Graph



Among participants who reported incidents of verbal violence (*n*=9), disclosure to friends and family were reported by 100% of the participants (9 of 9), followed by disclosure to their clinical teacher or preceptor (78%; 7 of 9) and reporting it to their school (11%; 1 of 9). Those that reported physical violence (*n*=2) reported the incident to their friends or family (100%; 2 of 2), their clinical teacher or preceptor (100%; 2 of 2), filed a formal report (100%; 2 of 2), and reported it to their school (50%; 1 of 2). Participants that reported racism (*n*=3) chose to disclose incidents to friends or family (100%; 3 of 3), their clinical teacher or preceptor (100%; 3 of 3), and reported it to their school (33%; 1 of 3). The sole participant that reported sexual violence (*n*=1), disclosed

the incident only to their clinical teacher or preceptor (100%; 1 of 1). Refer to Appendix P for detailed frequencies of reporting behaviours.

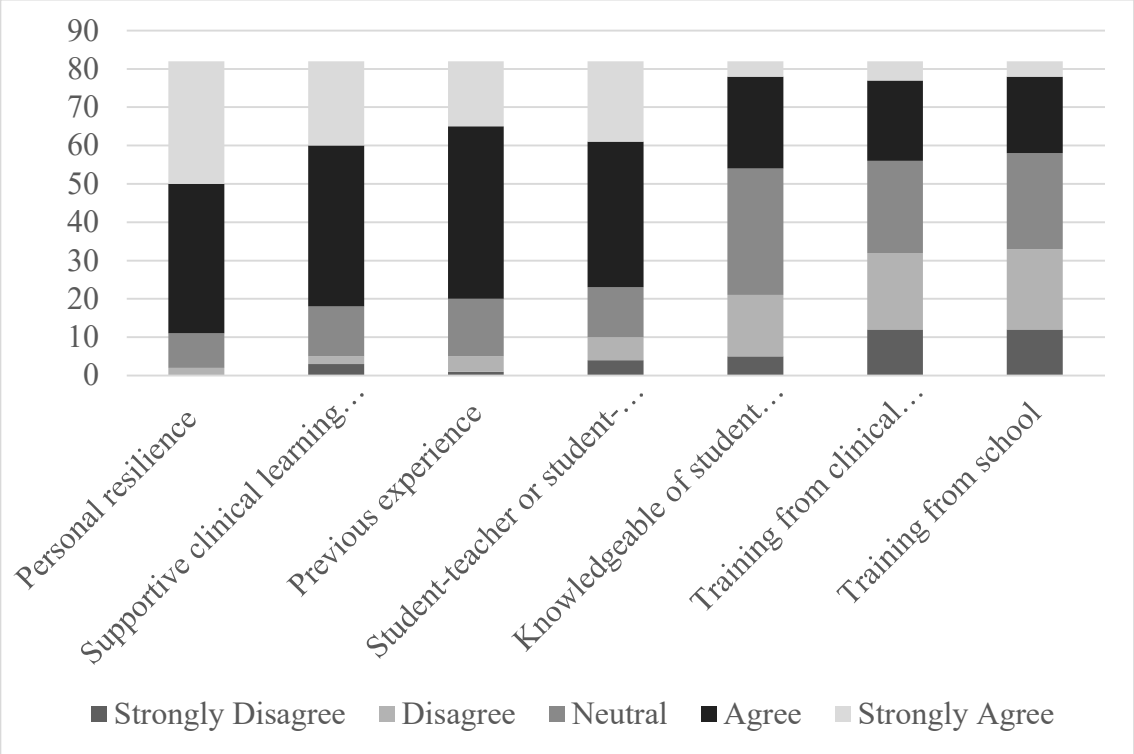
A substantial number of participants who chose not to report incidents of violence and racism attributed their decision to the belief that "nothing will be done about it." Other reasons cited for not reporting included "I do not know how to report it" and "it is not important enough for me." See Appendix Q for the frequencies of reasons participants agreed with for not reporting incidents of violence and racism.

Protective Factors

Regarding protective factors against negative outcomes, the items that participants agreed and strongly agreed with were "personal resilience" (*n*=71; 87%) and a "supportive clinical learning environment" (*n*=64; 78%), followed by "previous experience" (*n*=62; 76%) and the "student-teacher or student-preceptor relationship" (*n*=59; 72%). The three least-endorsed protective factors were "knowledgeable of student rights" (*n*=28; 34%), followed by "training from clinical placement" (*n*=26; 32%) and "training from school" (*n*=24; 29%). Refer to Appendix R for the frequencies of protective factors and Figure 12 for a visual representation of this data in the form of a stacked bar graph.

Figure 12

Frequency of Protective Factors- Stacked Bar Graph

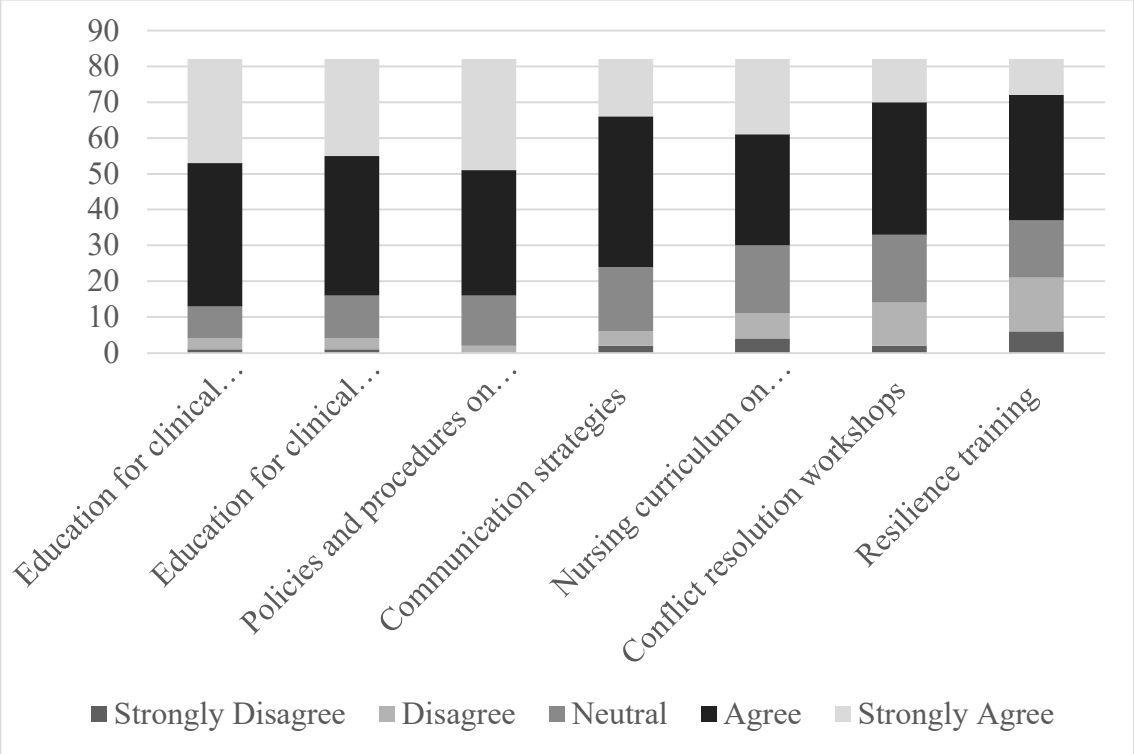


Recommendations

In terms of recommendations, participants agreed and strongly agreed with "education for clinical placement staff on managing violence and racism" (*n*=69; 84%) and "education for clinical teachers on management violence and racism" (*n*=66; 80%) as the two leading strategies for mitigating such incidents. The three least agreeable strategies were "nursing curriculum on violence and racism," (*n*=52; 63%) followed by *"*conflict resolution workshops," (*n*=49; 60%) and "resilience training" (*n*=45; 55%). This frequency data is presented in Appendix S, and Figure 13 illustrates it in a stacked bar graph format.

Figure 13

Frequency of Recommendations- Stacked Bar Graph



Chapter Summary

This chapter presented the findings of the research study, including sample demographics and the frequencies of the multiple variables such as types of violence, perpetrators, negative outcomes, responding and reporting behaviours, protective factors, as well as recommendations for mitigation. The mean age of participants was approximately 22 years (*SD*=±2.80), with the majority identifying as female (87%). The overall prevalence of violence was 61%. Verbal violence was the most prevalent type of violence, followed by racism. Patients were identified as the most common perpetrators across all types of violence. Anxiety was reported as the most prevalent negative outcome

across all type of violence, and most participants took no action in response to these incidents. Reporting rates were low, with the majority of participants sharing their experiences with friends and family. Among those who did not report, the primary reason cited was the perception that nothing will get done about it. Personal resilience was identified as the most prevalent protective factor against negative outcomes, while the most widely agreed upon recommendation was education for both clinical placement staff and clinical teachers on managing violence and racism. Chapter 6 will provide a critical analysis and in-depth discussion of these findings.

Chapter 6: Discussion

This chapter critically examines the research findings and discusses three overarching concepts that encompass key insights of the study. The first concept, *the complexity of the phenomenon*, examines the nuanced experiences of violence and racism within clinical placements, emphasizing the multifaceted nature of these incidents, their diverse forms, and the perpetrators involved. The second concept, *suffering in silence*, explores the internalized consequences of such experiences, underscoring inaction and social isolation. The final concept, *nurses keep their young*, offers insight into the strategies currently employed by students to navigate these challenges, contrasting them with the supportive measures they envision being implemented to mitigate harm.

The Complexity of the Phenomenon

This section addresses the first research question: What are the types and frequency of violence and racism experienced by nursing students, and who are the perpetrators? It outlines the prevalence and perpetrators of violence and racism experienced by nursing students and situates these findings within the context of existing literature. It further explores the multifaceted nature of these experiences, highlighting the complexity of the issue as it affects nursing students.

Prevalence and Perpetrators

The findings of frequency of types and perpetrators of violence and racism were grossly consistent with patterns reported in international research. The results in this study indicated that 61% of participants had experienced at least one form of violence, a prevalence slightly higher than the 45% pooled prevalence of workplace violence

reported in a meta-analysis by Lu et al. (2024). The most prevalent form of violence reported in this study was verbal violence (43%), followed by racism (30%), physical violence (18%), and sexual violence (12%). The prevalence rates for verbal and physical violence align with those reported in a meta-analysis conducted by Hallett et al. (2023), which found a prevalence of 56% for verbal violence and 17% for physical violence. The findings of this study indicate a lower prevalence for sexual violence compared to the meta-analysis (12% compared to 26%), whereas reported incidents of racism were higher (30% compared to 16%) (Hallett et al., 2023). The lower prevalence of sexual violence observed in this study may be attributed to contextual factors, such as the study setting being in a region with lower tolerance for sexual violence in contrast to other countries where gender-based power dynamics may be more pronounced leading to higher rates of sexual violence (E. Smith et al., 2023). The sexual violence reported in this study was experienced exclusively by participants who identified as female, a finding consistent with previous research (E. Smith et al., 2023). The higher prevalence of racism reported in this study may also be influenced by the contextual setting, as Canada's history of colonialism and systemic racism may contribute to heightened experiences of discrimination among racialized nursing students, particularly within the context of the "Whiteness of nursing" in the Western nursing profession (Montague et al., 2024). A local study in Ontario, Canada reported an alarmingly high prevalence of discrimination and racism (88%) among participants, all of whom identified as Black (Cooper Brathwaite, Versailles, Juüdi-Hope, Coppin, Jefferies, Bradley, Campbell, Garraway, Obewu, LaRonde-Ogilvie, Sinclair, Groom, & Grinspun, 2022). This study also found that when

analyzing rates of racism among participants who did not identify as *White (Caucasian)*, the prevalence increased from approximately 30% to 39%. Among participants who identified as Black/African American/African Canadian (*n*=4), the prevalence rose to 50%, while for those of East and Southeastern Asian origins (*n*=25), the prevalence was 44%. It is also important to note that inconsistencies in the definitions and classifications of violence across research studies hinder the ability to make accurate comparisons of findings.

With regard to perpetrators, the findings of this study largely aligned with previous research, identifying patients as the primary source of all forms of violence reported (Hallett et al., 2023; Lu et al., 2024; E. Smith et al., 2023). It is essential to acknowledge that this study did not distinguish between intentional and unintentional acts of violence by patients, including those resulting from factors beyond their control, such as medical conditions, mental illness, or substance misuse. Although the term perpetrator may carry a negative connotation and be misinterpreted as referring exclusively to intentional acts of violence, it aligns with the terminology commonly used in the relevant literature and is therefore employed in this study. Patients were the sole perpetrators of physical violence while both patients and visitors were identified as perpetrators of sexual violence. These findings differ slightly from those reported in the meta-analysis by Hallett et al. (2023), which identified nurses, in addition to patients and visitors, as perpetrators of physical violence, and both nurses and doctors, alongside patients, as perpetrators of sexual violence. These differences may be attributed to contextual factors, as previously discussed, including variations in cultural and societal norms or tolerance for violence

that may differ from the Canadian setting of this study. Participants in this study who experienced verbal violence or racism identified multiple perpetrators consistent with findings reported in previous studies, such as patients, patient visitors, staff nurses, preceptors, and clinical teachers (Dafny, Snaith, McCloud, et al., 2025; Hallett et al., 2023; Lu et al., 2024; Luhanga, Maposa, Puplampu, & Abudu, 2023; Luhanga, Maposa, Puplampu, Abudu, et al., 2023).

Multifaceted Nature of the Issue

This study found that while the majority of participants experienced only one form of violence (34%), more than a quarter of participants (27%) reported experiencing two or more forms. This finding is concerning, despite the small sample size, as previous research has shown that nurses who experience multiple forms of violence are more likely to leave their current positions and less likely to report excellent mental health (CFNU, 2024). Although the findings of this study show no differences in negative outcomes between those that experienced one versus multiple forms of violence, the cumulative impact may become more pronounced and severe over time, particularly as these experiences persist into professional practice following graduation. In addition to the multilayered nature of these experiences, participants reported a range of perpetrators involved in incidents of verbal violence and racism, including staff nurses and clinical teachers. In the qualitative systematic review by Dafny et al. (2023), nursing students reported a greater tolerance for violence when the perpetrators were patients compared to when members of the healthcare team were responsible. This was similarly reflected in the systematic review by Hallett et al. (2023), in which violence perpetrated by patients

was often attributed to cognitive impairment or illness leading nursing students to respond with greater sympathy and tolerance. Although not directly explored in this study, it is important to acknowledge that multiple perpetrators of verbal violence and racism beyond patients were reported, including staff nurses and preceptors, which may influence how students internalize and cope with these experiences over time. This is particularly significant given the persistent hierarchical culture within the nursing profession, where students often occupy the lowest position and the phrase "nurses eat their young" continues to reflect enduring power imbalances leading to intra-professional violence (Crawford et al., 2019; Johnston et al., 2024; Meissner, 1986; Xu et al., 2023). This issue is also concerning given that staff nurses, preceptors, and clinical teachers, who have been identified as perpetrators also hold evaluative authority over students during clinical placements. Previous research indicates that students are often reluctant to address instances of violence and racism due to fears of jeopardizing their academic progress, further highlighting the significant power imbalances inherent in these settings (Findley & Harris, 2020; Kurtgöz & Koç, 2025; Liao et al., 2025; E. Smith et al., 2023; Zhang et al., 2024). For participants who experienced racism, the reporting of multiple perpetrators highlights the intersecting identities that racialized nursing students must navigate. These students are subjected not only to intra-professional violence associated with their status as students but also subjected to discrimination due to their racial identity.

The multifaceted nature of violence and racism, encompassing diverse forms and multiple perpetrators aligns with Foli's Theory of Nurses' Psychological Trauma which emphasizes the uniqueness of each traumatic event to the individual (Foli, 2022; Foli &

Thompson, 2019). The complex and overlapping forms of violence and racism perpetuated by multiple individuals in clinical placements underscore the need for coordinated multi-level strategies to effectively address the issue.

Suffering in Silence

This section addresses the second and third research questions: How do nursing students respond to and report violence and racism? and What negative outcomes do students report after experiencing violence and racism? It highlights the internalized effects of violence and racism, the tendency of nursing students to respond with inaction, and the extent to which these findings align with previous research.

Internalizing Behaviour

The findings of this study indicate that nursing students experience a range of negative outcomes, both psychological and physiological, as a result of violence, with anxiety emerging as the most prevalent impact across all forms. Several studies have similarly cited anxiety as a common consequence of experiencing violence or racism (Clarke et al., 2012; Dafny et al., 2023; Dafny, Waheed, Cabilan, et al., 2024; Hallett et al., 2023; Hambridge et al., 2025; Kurtgöz & Koç, 2025; Liao et al., 2025; Montague et al., 2024; Tee & Valiee, 2020; Zhang et al., 2024). Participants in this study also reported additional outcomes including anger, feelings of inadequacy, impaired learning, depression, and doubt regarding their career choice, which are consistent with findings from previous research (Celebioglu et al., 2010; Clarke et al., 2012; Dafny et al., 2023; Fisher, 2002; Hallett et al., 2023; Hambridge et al., 2025; Liao et al., 2025; Qian et al., 2023; E. Smith et al., 2023; Tee & Valiee, 2020; S. P. Thomas & Burk, 2009). Sleep

disturbances, loss of appetite, and impaired patient care were also identified as negative outcomes of violence and racism, although they were less frequently reported. These findings have been documented in previous studies, albeit in only a limited number (Aliafsari Mamaghani et al., 2022; Qian et al., 2023; E. Smith et al., 2023; Zhang et al., 2024). Absenteeism was the least frequently reported negative outcome and was primarily observed among participants who experienced verbal violence or racism. This finding is also supported by previous research, with Liao et al. (2025), reporting absenteeism and job burnout among approximately 5% of their participants as a result of bullying.

In terms of their responses, participants in this study frequently reported taking no action when confronted with verbal or physical violence and racism, while avoidance of the perpetrator was a common response to incidents of sexual violence. This finding is consistent with the pooled prevalence reported by Lu et al. (2024), who found that 65% of nursing students in their meta-analysis took no action and remained silent when exposed to workplace violence. The responding behaviours to sexual violence observed in this study mirror findings from the integrative review by E. Smith et al. (2023), which documented passive responses such as avoiding the perpetrators and ignoring the behaviour. Although some participants in this study reported telling the perpetrator to stop, this was among the least frequently reported response behaviours. Previous research also reflects this finding, showing that while nursing students do sometimes respond assertively when faced with violence, such responses are less common than passive ones (Hallett et al., 2023; E. Smith et al., 2023).

The combination of less overt negative outcomes, such as anxiety, and passive responses, including inaction, illustrates how the impacts of violence and racism may persist beneath the surface, often remaining internalized and unrecognized unless explicitly communicated by the victim. This aligns with Foli's theory, which suggests that the experience and effects of traumatic events are inherently subjective, potentially resulting in a wide range of outcomes depending on the individual, including psychological and physiological impacts (Foli, 2022; Foli & Thompson, 2019). Although these impacts were consistently reported across all forms of violence and racism in this study, their severity and depth cannot be fully understood unless articulated by the individual.

Disempowerment

This study found that nursing students infrequently report their experiences of violence and racism. Only about 26% of participants who experienced verbal violence reported the incident, followed by 13% for physical violence, 12% for racism, and 10% for sexual violence. This pattern is consistent with findings from a meta-analysis by Lu et al. (2024), which revealed that 74% of nursing students did not report experiences of workplace violence. Among the participants in this study who did report their experiences, disclosures were primarily made to friends or family members, as well as to clinical teachers or preceptors. This was also reflected in previous studies in which nursing students reported their incidents of violence or racism to family and friends (Gungor & Tosunoz, 2024; Hambridge et al., 2025; Liao et al., 2025; Lyng et al., 2012). Participants who chose not to report their experiences attributed their decision to

perceptions that no action would be taken, that the incident was not significant enough to them, or that they lacked knowledge about how to report it. Notably, a concerning finding of this study was that some participants believed the violence and racism they experienced were inherent aspects of the job and feared potential victimization if they reported the incident. These findings are consistent with previous research that positions nursing students at the bottom of the contextual hierarchy, wherein they often feel powerless to challenge or change an environment that normalizes violence (Dafny et al., 2023). The qualitative systematic review by Dafny et al. (2023) found that nursing students often refrain from reporting experiences of workplace violence due to fear associated with their academic status, including concerns about being perceived as troublemakers or incompetent. The review also revealed a prevailing sense of helplessness among nursing students, as many believed that reporting would not lead to meaningful change and that workplace violence was an unavoidable aspect of the nursing profession and had to be endured (Dafny et al., 2023). With regard to racism, previous research indicates that Black nursing students often remain silent about their experiences due to fear of being perceived as overly sensitive or mischaracterized (Montague et al., 2024). The lack of knowledge regarding reporting procedures was also evident in previous studies where students refrained from reporting incidents of violence due to uncertainty about how to do so (Hambridge et al., 2025; Zhu et al., 2022).

These findings demonstrate that the true extent of violence and racism remains obscured due to widespread underreporting. Moreover, nursing students often do not feel empowered to take action against these experiences, perceiving that such efforts will not

lead to meaningful change, underscoring the deeply entrenched nature of violence and racism within the nursing profession. These findings also reveal that nursing students are caught between the discourse of taking action against the incident of violence and racism and the perceived necessity of enduring them in order to be seen as competent, particularly within the context of clinical evaluations. In relation to Foli's Theory of Nurses' Psychological Trauma, chronic exposure to violence without active resolution may contribute to allostatic load, potentially resulting in additional psychological or physiological consequences (Foli, 2022; Foli & Thompson, 2019). Failure to respond or report such experiences may exacerbate the negative outcomes associated with violence and racism. This lack of action among nursing students necessitates interventions not only at the individual level, but also at professional and organizational levels in response to the powerlessness students experience within the clinical hierarchy. Given the disempowerment experienced by nursing students, the responsibility for addressing violence and racism cannot rest solely with them. The perception that violence and racism are inherent aspects of the nursing profession also calls for a shift in discourse, particularly in light of Foli's theory which conceptualizes workplace violence as an avoidable form of trauma (Foli, 2022; Foli & Thompson, 2019). Shifting this perspective is essential to initiating the dismantling of violence and racism within the nursing profession, however until such change occurs, the internalization of these experiences and the absence of responsive action are likely to persist. Such change necessitates a top-down approach wherein professional and institutional structures actively challenge the notion that violence is inherently embedded within the nursing profession.

Nurses Keep Their Young

This section addresses the final two research questions: What protective factors do students report that mitigate the negative impacts of violence and racism? and What recommendations do students report that address violence and racism on the individual, professional, and organizational levels? The findings of this study, consistent with existing literature, indicate that while nursing students primarily rely on individual protective factors to cope with violence and racism, they emphasize the need for professional and organizational interventions to effectively address these issues within clinical placements.

The Status Quo

This study found that nursing students predominantly rely on personal resilience as a protective factor against negative impacts from violence and racism, followed by the presence of supportive clinical learning environments, previous experience, and student-teacher or student-preceptor relationships. The reliance on personal resilience has been documented in previous studies where nursing students employed internal coping strategies to mitigate the harm associated with experiences of violence and racism (Dafny et al., 2023; Hallett et al., 2023; Kim et al., 2022; Luhanga, Maposa, Puplampu, Abudu, et al., 2023; Qian et al., 2023; Tian et al., 2019). Previous research also identified supportive learning environments and interpersonal relationships as key factors in mitigating adverse experiences and promoting the success of nursing students (Aliafsari Mamaghani et al., 2018; Chachula et al., 2015; Dafny, Waheed, Snaith, et al., 2024; Johnston et al., 2024). This study found that participants did not perceive knowledge of their student rights or

training received from either their clinical placement or academic institutes as effective in mitigating the negative outcomes of violence and racism. This finding is consistent with several previous studies, including one in which approximately 66% of participants reported insufficient training from their academic institutes to prevent or manage workplace violence (Hambridge et al., 2025).

These findings align with Foli's Theory of Nurses' Psychological Trauma which acknowledges that while nursing students often rely on personal resilience to protect themselves against negative effects of violence and racism, there are also professional and organizational strategies that can play a critical role in mitigating these impacts (Foli, 2022; Foli & Thompson, 2019). The findings of this study in conjunction with previous research indicate that the current status quo of protective factors remain heavily reliant on individual strategies with insufficient emphasis on professional or organizational support. Given that nursing students identify the learning environment and interpersonal relationships as key protective factors, these elements can be strategically leveraged to complement and reinforce existing personal resilience, thereby enhancing efforts to mitigate harm. As outlined in Foli's theory, individuals process trauma differently based on a range of genetic, psychological, environmental, and other contextual factors, resulting in varying levels of personal resilience (Foli, 2022; Foli & Thompson, 2019). Consequently, an overreliance on personal resilience may perpetuate inequities, privileging those with greater inherent coping capacities while disadvantaging individuals whose processing mechanisms may be less robust. To ensure equitable opportunities for all students, it is imperative to broaden protective factors beyond individual resilience by

incorporating professional and organizational interventions, thereby reinforcing the necessity of multi-level strategies to effectively address violence and racism.

Hope for the Future

In contrast to earlier findings indicating that personal resilience is the primary protective factor currently employed by nursing students to cope with negative outcomes, participants in this study did not recommend resilience training as a strategy for mitigating violence and racism. Moreover, nursing students did not perceive other individual-level strategies, such as conflict resolution or communication training, as effective in mitigating incidents of violence and racism. The most frequently endorsed recommendations were at the professional level, including the provision of education for both clinical placement staff and clinical teachers on managing violence and racism. This was followed by the implementation of clear policies and procedures for reporting such incidents. These findings are consistent with prior research recommending enhanced reporting mechanisms and additional training, however, earlier studies tend to emphasize training for students rather than for staff and teachers (Aliafsari Mamaghani et al., 2018; Alsharari & Kerari, 2024; Celebioglu et al., 2010; Chang et al., 2023; Clarke et al., 2012; Dafny, Waheed, Snaith, et al., 2024; Del Prato, 2013; Ferns & Meerabeau, 2008; Findley & Harris, 2020; Hallett et al., 2023; Hambridge et al., 2025; Johnston et al., 2024; Johnston & Fox, 2020; Kurtgöz & Koç, 2025; Liao et al., 2025; Luhanga, Maposa, Puplampu, & Abudu, 2023; Magnavita & Heponiemi, 2011; Martinez, 2017; Meng et al., 2025; Minton & Birks, 2019; Qian et al., 2023; Solorzano Martinez & De Oliveira, 2021; Tee & Valiee, 2020; S. P. Thomas & Burk, 2009; Walker et al., 2024; L. Wang et al.,

2022; M. Wang et al., 2023; Warshawski, 2021; Xu et al., 2023; Younas et al., 2024; Zhang et al., 2024; Zhu et al., 2022). In their qualitative systemic review, Dafny et al. (2023) identified additional organizational-level recommendations, including preparing clinical settings to effectively integrate nursing students by clearly defining their academic role within the learning environment and enhancing peer support systems.

The findings of this study underscore the critical need for external support through professional and organizational strategies to effectively mitigate the harm associated with violence and racism experienced by nursing students. Participants in this study identified education for staff and teachers as essential to mitigating the negative impacts of violence and racism experienced by nursing students. This emphasizes the importance of fostering a culture of solidarity in response to such incidents, positioning staff and teachers as mitigators of harm rather than contributors to it. Rather than prioritizing individual-level interventions, nursing students identified the role of other nurses as central to mitigating the impacts of violence and racism. This finding aligns with Foli's Theory of Nurses' Psychological Trauma, which emphasizes that professional- and organizational-level strategies can enhance working conditions by serving as additional layers of support that complement individual coping mechanisms such as personal resilience (Foli, 2022; Foli & Thompson, 2019). As nursing students identify other nurses as critical to mitigating the effects of violence and racism, there is a pressing need to shift the prevailing rhetoric from "nurses eat their young" to *nurses keep their young*, a phrase that embodies a culture of support fostered through professional and organizational interventions.

Chapter Summary

This chapter presented the study's findings corresponding to the five research questions and integrated these insights within the broader scholarly literature. The findings largely corroborate previous studies conducted primarily in non-Canadian contexts regarding prevalence rates and also identify patients as frequent perpetrators across all forms of violence. Additionally, this study reinforces that nursing students experience both psychological and physiological harm resulting from violence and racism, while often failing to respond or report these incidents effectively. Although nursing students primarily rely on personal resilience as a protective factor against negative outcomes, they identified education for staff and teachers as key recommendations to mitigate these effects moving forward.

Chapter 7: Conclusion

This chapter concludes the thesis by outlining the study's strengths and limitations, and by discussing its implications for policy, education and practice, and future research.

Strengths

The study design is a notable strength, as descriptive cross-sectional studies are well-suited for generating preliminary data on the prevalence of specific phenomena (X. Wang & Cheng, 2020). Given the limited availability of quantitative data on violence and racism experienced by nursing students in clinical placements within a Canadian context, this design was appropriate. Another strength of this study lies in the diversity of the sample population, as the limited number of participants still represented a broad range of student backgrounds in terms of program level and race/ethnicity. The study was conducted online using an anonymous survey which mitigated concerns of reprisal, a factor identified in the literature as contributing to underreporting. Another strength of the study was its ability to recruit participants from a large sample frame within a relatively short period.

Limitations

Key limitations of this study included the low response rate, potential response biases, and the conflation of sex and gender, as well as race and ethnicity.

This study produced a 17% response rate which may be considered suboptimal however the insights gained from this preliminary study identify critical areas for further exploration and intervention within nursing education and clinical practice. Previous

studies have similarly reported low response rates; for example, Hunter et al. (2022) yielded a response rate of approximately 15% when examining the prevalence of violence experienced by nursing students in clinical placements in Scotland. Similarly, Hallett et al. (2021) found a response rate of approximately 8% in their study investigating the prevalence of aggression experienced by nursing student in the United Kingdom. In contrast, a Canadian study by Clarke et al. (2012) reported a higher response rate of 58% (n=674) while examining bullying experienced by undergraduate nursing students in clinical settings. Recruitment strategies employed in this study that could be applied in future research to improve response rates include offering multiple participation channels, such as in-person and online options, and allocating class time for survey completion.

Another limitation of this cross-sectional study are potential biases, including nonresponse bias and recall bias (X. Wang & Cheng, 2020). Given that this study employed a self-referral recruitment method and relied on retrospective self-reporting, it is possible that participants who chose to complete the survey differed in key characteristics from those who did not respond. Additionally, recall bias may have affected the accuracy of reported experiences. To mitigate these potential biases, participants were explicitly instructed to complete the survey regardless of whether they had experienced violence or racism. Additionally, the survey was distributed mid-semester while students were actively engaged in clinical placements, aiming to enhance the relevance and accuracy of responses.

This study conflated concepts of sex and gender, as well as race and ethnicity which limits conceptual clarity and could result in misclassification. Although nursing is

often referred to as a female-dominated profession, it is more accurately characterized as a gendered issue, as gender refers to socially constructed roles, whereas sex is biological (Johnson et al., 2009). Future research should align data collection with the gendered nature of violence in the nursing profession by using accurate terminology that reflects diverse expressions of identity including women, men, and gender diverse individuals (Johnson et al., 2009). Similarly, race and ethnicity are distinct concepts, with race generally determined on physical characteristics and ethnicity characterized by shared cultural, linguistic, or religious heritage (CIHI, 2022). Given the persistence of racism in nursing, it is essential to prioritize race-based data rather than conflating race and ethnicity. Future studies should systematically collect race-based data to accurately identify and address inequities that stem directly from racism (CIHI, 2022).

Implications

This section examines the implications of the study for policy, education and practice, and research, integrating insight from existing literature, Foli's Theory of Nurses' Psychological Trauma, and the current findings from this study.

Policy

Findings from this study, in conjunction with previous research, underscore the need for enhanced reporting policies and procedures to address violence and racism experienced by nursing students in clinical placements. Some studies recommended having a designated person as a resource for resolving such incidents as well (Walker et al., 2024). While existing literature advocates for a zero-tolerance policy toward violence and racism, there is a critical need to clearly define these phenomena. This includes

moving away from minimizing rhetoric such as terms like *bullying* and *burnout* and emphasizing precise terminology such as *violence* and *trauma* to accurately reflect the severity of the issues. Zero-tolerance policies within clinical learning environments should be clearly communicated to nursing students during orientation, including well-defined reporting mechanisms and structured management strategies. In addition to this, collaborative initiatives between educational institutions and clinical settings should be established to address violence and racism through the systemic collection of relevant data and the incorporation of nursing student feedback into policy and practice improvements. The prevailing rhetoric of "nurses eat their young" should be reframed as *nurses keep their young*, to help address the nursing crisis in Canada and to promote the success and retention of nursing students through the implementation of professional and organizational strategies. Clinical organizations must develop policies and procedures that articulate their commitment to ensuring a safe learning environment for students. These efforts should include strategies to reduce bureaucratic barriers associated with the classification of students as non-employees. By doing so, healthcare institutions, in collaboration with educational institutes, can extend workplace safety initiatives to include nursing students under their supervision and care.

Education and Practice

This study offers valuable insight into the experiences of violence and racism among nursing students, informing practical implications for both students and educators. Consistent with participant recommendations and supported by Foli's Theory of Nurses' Psychological Trauma, targeted education and training should be implemented for clinical

staff and teachers to effectively address and manage incidents of violence and racism. This training should be trauma-informed, and grounded in anti-oppression and anti-racist principles, equipping clinical staff and teachers with skills to recognize and respond to violence and racism in clinical learning environments. Furthermore, trauma-informed principles should be integrated into the evaluation practices of educators in clinical settings, recognizing that experiences of violence and racism are inherently individualized and can result in a range of impacts, including anxiety and diminished learning capacity. Clinical settings should be educated on the complex nature of learning that extends beyond a traditional apprenticeship model, with clearly defined student roles and responsibilities to help reduce intra-professional violence. Although education and training aimed at providing nursing students with coping strategies and de-escalation techniques are important, these interventions should not be the sole focus. Given their marginal status within the clinical hierarchy, nursing students may lack the authority and confidence to effectively advocate for themselves, even when adequately trained. Additionally, curricula addressing violence and racism within clinical settings should be introduced prior to nursing students beginning their clinical placements, to establish realistic expectations of the learning environment.

Research

This study provided preliminary quantitative data on the phenomenon within a Canadian context. To build upon these findings, future research should investigate the current strategies employed by nursing students and clinical teachers to address violence and racism in clinical placements. Such research would help identify gaps in prevention,

recognition, and response behaviours, as well as evaluate their effectiveness. This research will also examine the needs of nursing students and clinical teachers regarding effective strategies for managing violence and racism, as well as the types of support required to address these challenges. Further research is needed to explore the scope of psychological and physiological trauma experienced by nursing students, the impact of violence and racism on their learning, and the development of trauma-informed strategies to mitigate these effects. Most importantly, research is needed to precisely define violence and racism, and to conceptualize how nursing students experience these incidents in their experiential learning environments which also function as workplaces.

Conclusion

The aim of this study was to collect quantitative data on the prevalence, associated factors, and impacts of violence and racism experienced by nursing students within clinical placements in the Canadian context. The findings indicate that nursing students encounter various forms of violence at alarmingly high rates, perpetrated by multiple sources, including clinical staff and teachers. Furthermore, the study revealed that these incidents have significant psychological and physiological effects on nursing students, with some considering leaving the profession as a consequence. Despite these adverse outcomes, nursing students often refrain from responding to or reporting such incidents. The findings suggest that nursing students primarily rely on personal resilience to cope with the effects of violence and racism, while advocating for the implementation of professional and organizational strategies to mitigate these impacts.

This study utilized the Theory of Nurses' Psychological Trauma as a framework to recognize the complex nature of trauma and to situate violence and racism as avoidable forms of trauma requiring multi-layered interventions (Foli, 2022; Foli & Thompson, 2019). The findings of this study urge the nursing profession to liberate itself from the historically entrenched patterns of violence and racism by shifting the narrative from "nurses eat their young" to *nurses keep their young*, thereby fostering a culture in which nurses care for their own with the same compassion they extend to others. To retain the future nursing workforce and repair a healthcare system that is on the brink of collapse, attention must transition from individual-level approaches to broader professional and organizational trauma-informed strategies. This study provides a foundational basis for further research aimed at advancing efforts towards ultimately achieving this goal. As Paulo Freire's teachings suggest, liberation from oppression must emerge from within the oppressed group itself, through processes of critical introspection, transformative education, and profound enlightenment (Matheson & Bobay, 2007).

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Appendix A: Seach Strategies

Table A1 Ovid MEDLINE Results

#	Query	Results
11	limit 10 to English language	205
10	3 and 8 and 9 [nursing student and racism/violence and placement]	208
9	(placement or workplace or clinical placement or field placement).mp.	245415
8	4 or 7 [racism or violence]	106961
7	5 or 6 [violence]	92356
6	((workplace or exposure) adj3 (violence or abuse)).mp.	9543
5	(Violence or Workplace Violence or Exposure to Violence or Abuse, Workplace or Workplace Abuse).mp.	91541
4	(Racism or Systemic Racism).mp.	15626
3	1 or 2 [nursing student]	119876
2	(nurs* adj3 student*).mp.	47323
1	(School Nursing or Students, Nursing or Education, Nursing).mp.	110844

Table A2 CINAHL Results

#	Query	Results
S31	S1 AND S8 AND S15 AND S21 AND S29 (Limiters: English Language)	135
S30	S1 AND S8 AND S15 AND S21 AND S29	
S29	S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28	
S28	"bully*"	
S27	"assault"	
S26	"aggression"	
S25	"harassment"	
S24	"abuse"	
S23	"WPV"	
S22	"violence"	
S21	S16 OR S17 OR S18 OR S19 OR S20	
S20	"racial bias"	
S19	"race"	
S18	"prejudice"	
S17	"discrimination"	

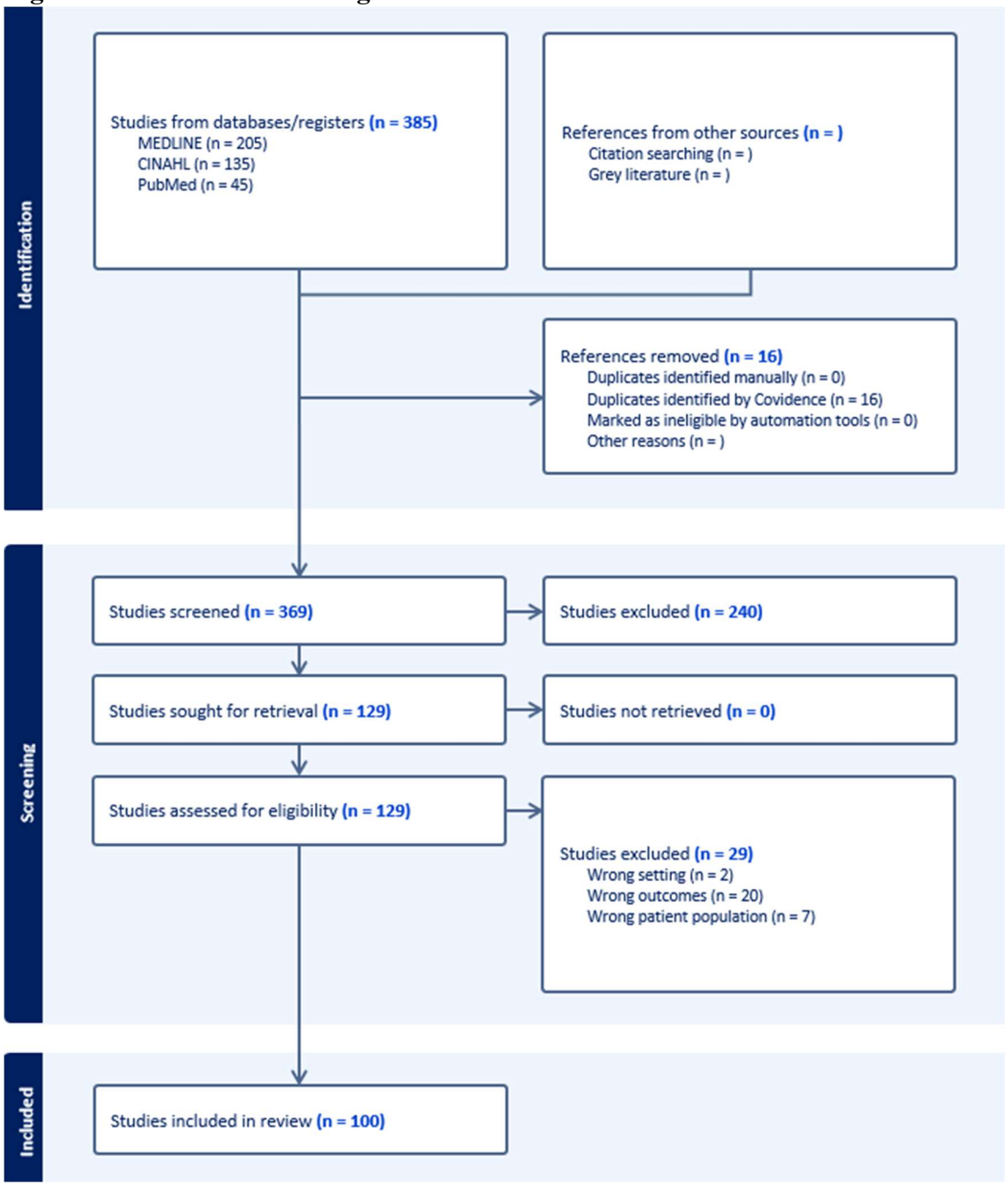
S16	"racism"
S15	S9 OR S10 OR S11 OR S12 OR S13 OR S14
S14	"practice"
S13	"placement"
S12	"practicum"
S11	"workplace"
S10	"clinical"
S9	"clinical placement"
S8	S2 OR S3 OR S4 OR S5 OR S6 OR S7
S7	"education"
S6	"nursing stud*"
S5	"baccalaureate"
S4	"bachelor of science in nursing"
S3	"undergraduate"
S2	"student"
S1	"nurs*"

Table A3 PubMed Results

#	Query	Results
6	Search: **((nursing student) AND (Canada)) AND ((racism) OR (workplace violence))** Filters: **in the last 5 years**	45
5	Search: **((nursing student) AND (Canada)) AND ((racism) OR (workplace violence))**	55
4	Search: **(racism) OR (workplace violence)**	20450
3	Search: **racism**	15767
2	Search: **(nursing student) AND (Canada)**	3442
1	Search: **nursing student**	78195

Appendix B: Flow Diagram

Figure B1 PRISMA Flow Diagram



Appendix C: Sample Size Calculation

At the time of the study's development, the population of the students enrolled in the basic and accelerated streams of the BScN program at a university in Southwestern Ontario who were currently participating in or had completed at least one clinical placement was estimated to be 515. Based on a 95% confidence level, an assumed prevalence rate of 40%, and a precision of 5%, the minimum required sample size was calculated to be 214.

$$n = \frac{\frac{z^2pq}{d^2}}{1 + \frac{z^2pq}{d^2N}} = \frac{\frac{(1.96)^2 \times 0.40 \times 0.60}{0.05^2}}{1 + \frac{(1.96)^2 \times 0.40 \times 0.60}{0.05^2 \times 515}} = \frac{\frac{0.921984}{0.0025}}{1 + \frac{0.921984}{1.2875}} = \frac{368.7936}{1.7161} = 214$$

Appendix D: Recruitment Email

Subject line: Invitation to participate in a survey

Email body: Hello,

You are being invited to participate in a research study conducted by Dr. Nancy Carter and Amrita Jessica Sondhi-Cooke (student investigator) about nursing students' experiences with violence and racism in clinical placements. The research study is titled: "Prevalence, associated factors, and impact of violence and racism experienced by nursing students in clinical placements."

You have been invited to participate because you are a [Southwestern Ontario university] site student in the basic or accelerated BScN program and have had a clinical placement. This research is being conducted as part of a Masters thesis at McMaster University in Hamilton, Ontario, which is being supervised by Dr. Nancy Carter, Associate Professor.

If you volunteer to participate in this study, you will be asked to fill out an anonymous online survey to the best of your ability and knowledge.
The survey is titled:
"Nursing Students' Experiences with Violence and Racism Survey"

The survey takes about 20 minutes to complete. All information provided will be kept completely private and confidential. Specific school information will not be reported. Your name or student number will not appear on the survey. The data will remain on secure, encrypted servers of McMaster University. All electronic files will be password protected.

By completing and submitting the survey online, you are providing your informed consent to voluntarily participate in this research study and you are giving us permission to use the information you have provided in the survey.
For more information and to participate in the study, please click on the link below.

Sincerely,
Amrita Jessica Sondhi-Cooke, RN, MSc Student

Nancy Carter, RN, PhD

Click here to do the survey:
https://surveys.mcmaster.ca/limesurvey/index.php/418651?lang=en

Appendix E: Recruitment Reminder Email

Subject line: Reminder: invitation to participate in a survey

Email body: Hello,

Recently we invited you to participate in a survey, about nursing students' experiences with violence and racism in clinical placements conducted by Dr. Nancy Carter and Amrita Jessica Sondhi-Cooke (student investigator). The research study is titled: "Prevalence, associated factors, and impact of violence and racism experienced by nursing students in clinical placements."

If you have completed the survey, thank you, and please disregard this reminder. If you have not completed the survey, we want to remind you that the survey is still available should you wish to take part.

Please consider participating even if you have not experienced violence and/or racism in your clinical placements.

You can access the survey through this link:
https://surveys.mcmaster.ca/limesurvey/index.php/418651?lang=en

You have been invited to participate because you are a [Southwestern Ontario university] site student in the basic or accelerated BScN program and have had a clinical placement. This research is being conducted as part of a Masters thesis at McMaster University in Hamilton, Ontario, which is being supervised by Dr. Nancy Carter, Associate Professor.

If you volunteer to participate in this study, you will be asked to fill out an anonymous online survey to the best of your ability and knowledge.

The survey is titled: "Nursing Students' Experiences with Violence and Racism Survey"

The survey takes about 20 minutes to complete. All information provided will be kept completely private and confidential. Specific school information will not be reported. Your name or student number will not appear on the survey. The data will remain on secure, encrypted servers of McMaster University. All electronic files will be password protected.

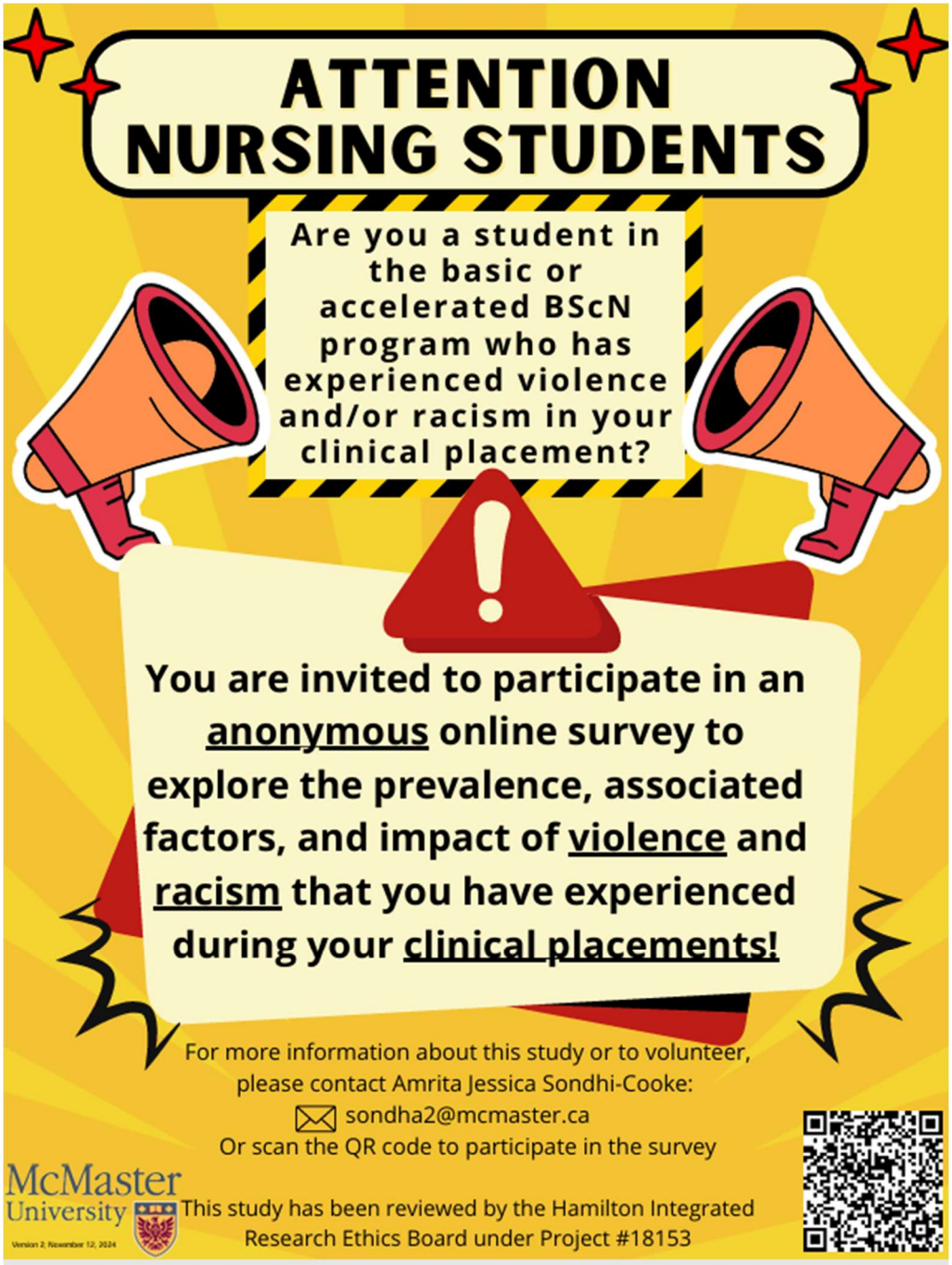
By completing and submitting the survey online, you are providing your informed consent to voluntarily participate in this research study and you are giving us permission to use the information you have provided in the survey. For more information and to participate in the study, please click on the link below.
Sincerely,
Amrita Jessica Sondhi-Cooke, RN, MSc Student

Nancy Carter, RN, PhD

Click here to do the survey:
https://surveys.mcmaster.ca/limesurvey/index.php/418651?lang=en

Appendix F: Study Poster

Figure F1 Study Poster



Appendix G: Additional Text with Ad

ATTENTION NURSING STUDENTS!

Are you a student in the basic or accelerated BScN program who has experienced violence and/or racism in your clinical placement?

You are invited to participate in an anonymous online survey to explore the prevalence, associated factors, and impact of violence and racism that you have experienced during your clinical placements!

The survey takes about 20 minutes to complete.

Your responses are very important, and they will assist in better understanding violence and racism that is experienced by nursing students in clinical placements.

Thank you so much for your consideration to participate in our study. Your responses are essential to its success.

For more information about this study or to volunteer, please contact Amrita Jessica Sondhi-Cooke: sondha2@mcmaster.ca

Appendix H: Survey Invitation and Consent Information

INVITATION

Research Study: Prevalence, associated factors, and impact of violence and racism experienced by nursing students in clinical placements.

You are being invited to participate in a research study conducted by Amrita Jessica Sondhi-Cooke (student investigator) and Dr. Nancy Carter about nursing students' experiences with violence and racism in clinical placements. You have been invited to participate because you are a student in a nursing program and have had a clinical placement. This research is being conducted as part of a Masters thesis at McMaster University in Hamilton, Ontario, which is being supervised by Dr. Nancy Carter, Associate Professor.

You are invited to complete the study survey if you meet the following criteria: (1) you are currently a [Southwestern Ontario university] site student in the basic or accelerated BScN program and (2) you have had at least one clinical placement.

To decide whether you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study. Once you understand the study, you will be asked to complete the survey if you wish to participate. Please take your time to make your decision.

There are no conflicts of interest that exist as it relates to any investigators of the study.

CONSENT FORM

WHY IS THIS RESEARCH BEING DONE?

This research is being done to help us understand the violence and racism that is experienced by nursing students in clinical placements to help develop strategies to support students. International studies have reported that nursing students experience violence and racism at unprecedented rates with negative impacts on emotional and physical well-being, clinical performance, with increased intentions to leave the profession. There is limited research done in a Canadian context that provides data on the experiences of nursing students with violence and racism in clinical placements, therefore this study is being done to address this gap.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this research is to investigate the prevalence, associated factors, and impacts of violence and racism experienced by nursing student in clinical placements. Clinical placements are a mandatory component of nursing education in Canada which provide a space where nursing students connect their theoretical knowledge with clinical judgement and build professional skills. A safe environment is required to optimize learning and build professional identity which

is compromised by negative experiences associated with violence and racism. Therefore, violence and racism in clinical placements need to be explored to support nursing student success and develop mitigation strategies.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you volunteer to participate in this study, you will be asked to fill out the anonymous online survey to the best of your ability and knowledge. The survey takes about 15 minutes to complete. The survey can be formally paused by entering an email address where a link can be sent in order to complete the survey at a later time. This email address will remain anonymous. Progress will be lost if you exit the survey without pausing. Foreseeable risks to you as a participant are low. Due to the nature of the study, there may be a risk of re-traumatization or feelings of discomfort from recalling past experiences. You may pause or stop the survey at any point and resume at a better time or choose to end your participation at any point during the data collection phase. Resources to the [Southwestern Ontario university] student wellness services can be accessed at [link]

HOW MANY PEOPLE WILL BE IN THIS STUDY?

We expect over 200 participants in this study.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

We cannot promise any personal benefits to you from your participation in this survey. However, possible benefits include understanding of violence and racism experienced by nursing students in clinical placements which can inform health care organizations where students have placements and Schools of Nursing regarding prevention strategies.

WHAT INFORMATION WILL BE KEPT PRIVATE?

All information provided will be kept completely anonymous and confidential. Any identifiers including your name or student number will not be collected or appear on the survey. The data will remain on secure, encrypted servers of McMaster University. All electronic files will be password protected. All research results will be disseminated and reported in aggregate format in a Masters' dissertation, as well in future publications, and no information that discloses your identity will be published or released without your specific consent or disclosure. If you would like to receive a copy of the results, please contact Amrita Jessica Sondhi-Cooke at sondha2@mcmaster.ca.

CAN PARTICIPATION IN THE STUDY END EARLY?

Participation in the survey is completely voluntary. You can choose to participate, not participate, or withdraw from the study without any explanation or consequences. You can withdraw from the study at any point while completing the survey, however, withdrawal will not be possible after submission of survey responses. Study participants can choose to not submit their survey; this will be

considered a withdrawal from the study since consent is implied when the survey is submitted. The research team does not need to be contacted if study participants decide to withdraw from the study by not submitting their responses.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

No, there is no form of compensation to participate in this study.

WILL THERE BE ANY COSTS?

There will be no costs or charges associated with the study.

IF I HAVE ANY QUESTIONS, WHOM CAN I CALL?

If you have any questions or concerns about this research study, please contact Amrita Jessica Sondhi-Cooke at sondha2@mcmaster.ca or Dr. Nancy Carter carternm@mcmaster.ca.

For the purposes of ensuring proper monitoring of the research study, it is possible that representatives of the Research Ethics Board, this institution, and affiliated sites may consult your original research data to check that the information collected for the study is correct and follows proper laws and guidelines. By participating in this study, you authorize such access.

By participating in this study you do not waive any rights to which you may be entitled under the law.

By completing the survey online, you are providing your informed consent to voluntarily participate in this research study and you are giving us permission to use the information you have provided in the survey.

☐ I confirm that I have read and understood the information in the consent form, have had any question answered, and agree to take part in this study.

Appendix I: Pilot Survey Response Sheet

Question	Criteria	Answer	
Q1	Questions are easy to understand	☐Yes	☐No
Q2	Correct spelling of words	☐Yes	☐No
Q3	Font size and space is appropriate	☐Yes	☐No
Q4	Adequate instructions for the survey are provided	☐Yes	☐No
Q5	Difficulty level of the survey is appropriate for the intended participants	☐Yes	☐No
Q6	Questions are reasonable in relation to the supposed study purpose	☐Yes	☐No
Q7	Able to pause the survey and continue it at a later time	☐Yes	☐No
Q8	Survey is easy to access on chosen device (desktop, laptop, or phone)	☐Yes	☐No
Q9	Sensitive nature of the survey is at an acceptable level (sexual violence)	☐Yes	☐No
Q10	Survey was easy to complete from start to finish	☐Yes	☐No

Q11	What device did you use to complete the survey:	
Q12	How long did the survey take to complete:	
Q13	Does the survey require any additional questions:	

Additional comments:

Filled by:	
Date:	

Appendix J: Nursing Students' Experiences with Violence and Racism Survey

DEMOGRAPHIC INFORMATION

How do you self-identify in terms of gender? *

Check all that apply
Please choose all that apply:

- [ ] Female
- [ ] Male
- [ ] Non-binary
- [ ] Prefer not to answer
- [ ] Other:

How do you identify your 'race'/ethnicity? *

Check all that apply
Please choose all that apply:

- [ ] First Nation or North American Indian
- [ ] Alaskan Native
- [ ] Inuit
- [ ] Métis
- [ ] Other Aboriginal or Indigenous
- [ ] White (Caucasian)
- [ ] Other European origins
- [ ] Black/African American/African Canadian
- [ ] Caribbean origins
- [ ] Latin, Central and South American origins
- [ ] African origins
- [ ] West Central Asian and Middle Eastern origins (e.g., Turkish, Iranian)
- [ ] South Asian origins (e.g., Indian, Sri Lankan)
- [ ] East and Southeast Asian origins (e.g., Chinese, Filipino)
- [ ] Other Asian origins
- [ ] Oceania origins (e.g., Hawaiian, Samoan)
- [ ] Prefer not to answer
- [ ] Other:

What is your age? *

Only numbers may be entered in this field.
Please write your answer here:

What is your program level? *

Please select one answer
Please choose all that apply:

- [ ] Level 2
- [ ] Level 3
- [ ] Level 4

VERBAL VIOLENCE

In this section, you will be asked about the frequency of the **verbal violence** that you have experienced, along with factors including perpetrators, negative outcomes, as well as responding and reporting behaviours.

In the past 12 months in my clinical placement I have experienced **verbal violence** *

Please choose **only one** of the following:

- ◯ Yes
- ◯ No

In the past 12 months in my clinical placement, I have experienced **verbal violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Non-verbally (e.g. rolling eyes)	○	○	○	○
Sworn, shouted, or yelled at	○	○	○	○
Harshly judged/criticized	○	○	○	○
Ignored or neglected	○	○	○	○
Ridiculed or humiliated	○	○	○	○
Been unfairly treated	○	○	○	○
Given unfair work allocation	○	○	○	○
Not received acknowledgment for good work	○	○	○	○
Denied learning opportunities	○	○	○	○
Not been treated as part of the multidisciplinary team	○	○	○	○

In the past 12 months in my clinical placement, I have experience **verbal violence** from the following sources: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Patients	○	○	○	○
Visitors	○	○	○	○
Clinical teacher	○	○	○	○
Preceptor	○	○	○	○
Staff nurses	○	○	○	○
Physicians	○	○	○	○
Peers	○	○	○	○
Allied health providers and staff (Occupational therapy, physiotherapy, housekeeping, unit clerks, etc.)	○	○	○	○

In the past 12 months in my clinical placement, I experienced negative outcomes from **verbal violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Anger	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Feelings of inadequacy	○	○	○	○
Made me consider leaving nursing	○	○	○	○
Caused absenteeism	○	○	○	○
Negatively affected my standard of patient care	○	○	○	○
Loss of appetite	○	○	○	○
Sleep disturbance	○	○	○	○
Interrupted my learning	○	○	○	○

In the past 12 months in my clinical placement, I have responded to **verbal violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Took no action	○	○	○	○
Tried to pretend it never happened	○	○	○	○
Told the perpetrator to stop	○	○	○	○
Avoided the perpetrator	○	○	○	○

In the past 12 months in my clinical placement, I reported the **verbal violence** *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence)

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I reported **verbal violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G03Q30]' (In the past 12 months in my clinical placement I have experienced verbal violence) and Answer was 'Yes' at question ' [G03Q34]' (In the past 12 months in my clinical placement, I reported the verbal violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Reported to my friends or family	○	○	○	○
Reported to my clinical teacher or preceptor	○	○	○	○
Reported to my school	○	○	○	○
Filed a formal report	○	○	○	○

In the past 12 months in my clinical placement, I did not report **verbal violence** because: *

Only answer this question if the following conditions are met:
Answer was 'No' at question ' [G03Q34]' (In the past 12 months in my clinical placement, I reported the verbal violence)

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It is part of the job	○	○	○	○	○
Nothing will get done about it	○	○	○	○	○
I will be victimized	○	○	○	○	○
It is not important enough to me	○	○	○	○	○
I do not know how to report it	○	○	○	○	○

PHYSICAL VIOLENCE

In this section, you will be asked about the frequency of the **physical violence** that you have experienced, along with factors including perpetrators, negative outcomes, as well as responding and reporting behaviours.

In the past 12 months in my clinical placement I have experienced **physical violence** *

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I have experienced **physical violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Pushed or shoved	○	○	○	○
Kicked	○	○	○	○
Slapped or punched	○	○	○	○
Hit with something	○	○	○	○
Had something thrown at me	○	○	○	○
Been threatened with physical violence	○	○	○	○
Had something of mine deliberately damaged	○	○	○	○

In the past 12 months in my clinical placement, I have experienced **physical violence** from the following sources: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Patients	○	○	○	○
Visitors	○	○	○	○
Clinical teacher	○	○	○	○
Preceptor	○	○	○	○
Staff nurses	○	○	○	○
Physicians	○	○	○	○
Peers	○	○	○	○
Allied health providers and staff (Occupational therapy, physiotherapy, housekeeping, unit clerks, etc.)	○	○	○	○

In the past 12 months in my clinical placement, I experienced negative outcomes from **physical violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Anger	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Feelings of inadequacy	○	○	○	○
Made me consider leaving nursing	○	○	○	○
Caused absenteeism	○	○	○	○
Negatively affected my standard of patient care	○	○	○	○
Loss of appetite	○	○	○	○
Sleep disturbance	○	○	○	○
Interrupted my learning	○	○	○	○

In the past 12 months in my clinical placement, I have responded to **physical violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Took no action	○	○	○	○
Tried to pretend it never happened	○	○	○	○
Told the perpetrator to stop	○	○	○	○
Avoided the perpetrator	○	○	○	○

In the past 12 months in my clinical placement, I reported the **physical violence** *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence)

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I reported **physical violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence) *and* Answer was 'Yes' at question ' [G04Q36]' (In the past 12 months in my clinical placement, I reported the physical violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Reported to my friends or family	○	○	○	○
Reported to my clinical teacher or preceptor	○	○	○	○
Reported to my school	○	○	○	○
Filed a formal report	○	○	○	○

In the past 12 months in my clinical placement, I did not report **physical violence** because: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G04Q31]' (In the past 12 months in my clinical placement I have experienced physical violence) *and* Answer was 'No' at question ' [G04Q36]' (In the past 12 months in my clinical placement, I reported the physical violence)

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It is part of the job	○	○	○	○	○
Nothing will get done about it	○	○	○	○	○
I will be victimized	○	○	○	○	○
It is not important enough to me	○	○	○	○	○
I do not know how to report it	○	○	○	○	○

SEXUAL VIOLENCE

In this section, you will be asked about the frequency of the **sexual violence** that you have experienced, along with factors including perpetrators, negative outcomes, as well as responding and reporting behaviours.

In the past 12 months in my clinical placement I have experienced **sexual violence** *

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I have experienced **sexual violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Been inappropriately touched	○	○	○	○
Been threatened with sexual violence	○	○	○	○
Had inappropriate sexual comments said to me	○	○	○	○
Had sexist remarks directed at me	○	○	○	○
Had suggestive sexual gestures directed at me	○	○	○	○
Had a request for intimate physical contact	○	○	○	○

In the past 12 months in my clinical placement, I have experienced **sexual violence** from the following sources: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Patients	○	○	○	○
Visitors	○	○	○	○
Clinical teacher	○	○	○	○
Preceptor	○	○	○	○
Staff nurses	○	○	○	○
Physicians	○	○	○	○
Peers	○	○	○	○
Allied health providers and staff (Occupational therapy, physiotherapy, housekeeping, unit clerks, etc.)	○	○	○	○

In the past 12 months in my clinical placement, I experienced negative outcomes from **sexual violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Anger	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Feelings of inadequacy	○	○	○	○
Made me consider leaving nursing	○	○	○	○
Caused absenteeism	○	○	○	○
Negatively affected my standard of patient care	○	○	○	○
Loss of appetite	○	○	○	○
Sleep disturbance	○	○	○	○
Interrupted my learning	○	○	○	○

In the past 12 months in my clinical placement, I have responded to **sexual violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Took no action	○	○	○	○
Tried to pretend it never happened	○	○	○	○
Told the perpetrator to stop	○	○	○	○
Avoided the perpetrator	○	○	○	○

In the past 12 months in my clinical placement, I reported the **sexual violence** *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence)

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I reported **sexual violence** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence) and Answer was 'Yes' at question ' [G05Q38]' (In the past 12 months in my clinical placement, I reported the sexual violence)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Reported to my friends or family	○	○	○	○
Reported to my clinical teacher or preceptor	○	○	○	○
Reported to my school	○	○	○	○
Filed a formal report	○	○	○	○

In the past 12 months in my clinical placement, I did not report the **sexual violence** because: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G05Q32]' (In the past 12 months in my clinical placement I have experienced sexual violence) and Answer was 'No' at question ' [G05Q38]' (In the past 12 months in my clinical placement, I reported the sexual violence)

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It is part of the job	○	○	○	○	○
Nothing will get done about it	○	○	○	○	○
I will be victimized	○	○	○	○	○
It is not important enough to me	○	○	○	○	○
I do not know how to report it	○	○	○	○	○

RACISM

In this section, you will be asked about the frequency of the **racism** that you have experienced, along with factors including perpetrators, negative outcomes, as well as responding and reporting behaviours.

In the past 12 months in my clinical placement I have experienced **racism** *

Please choose **only one** of the following:

○ Yes
○ No

In the past 12 months in my clinical placement, I have experienced **racism** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G06Q33]' (In the past 12 months in my clinical placement I have experienced racism)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Felt uncomfortable, excluded, or isolated because of my race	○	○	○	○
Had an inappropriate comment directed at me in relation to my race	○	○	○	○
Experienced oppression based on my race	○	○	○	○
Had a racist remark directed at me	○	○	○	○
Been discriminated against because of my race	○	○	○	○

In the past 12 months in my clinical placement, I have experienced **racism** from the following sources: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G06Q33]' (In the past 12 months in my clinical placement I have experienced racism)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Patients	○	○	○	○
Visitors	○	○	○	○
Clinical teacher	○	○	○	○
Preceptor	○	○	○	○
Staff nurses	○	○	○	○
Physicians	○	○	○	○
Peers	○	○	○	○
Allied health providers and staff (Occupational therapy, physiotherapy, housekeeping, unit clerks, etc.)	○	○	○	○

In the past 12 months in my clinical placement, I experienced negative outcomes from **racism** in the following ways: *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question ' [G06Q33]' (In the past 12 months in my clinical placement I have experienced racism)

Please choose the appropriate response for each item:

	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (more than 5 times)
Anger	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Feelings of inadequacy	○	○	○	○
Made me consider leaving nursing	○	○	○	○
Caused absenteeism	○	○	○	○
Negatively affected my standard of patient care	○	○	○	○
Loss of appetite	○	○	○	○
Sleep disturbance	○	○	○	○
Interrupted my learning	○	○	○	○

PROTECTIVE FACTORS

In this section you will be asked about **factors that protect you** against the negative outcomes resulting from violence and/or racism.

In the past 12 months in my clinical placement, **factors that protected** me from negative outcomes from violence and/or racism included: *

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Training from school	○	○	○	○	○
Training from clinical placement	○	○	○	○	○
Previous experience	○	○	○	○	○
Knowledgeable of student rights	○	○	○	○	○
Student-teacher or student-preceptor relationship	○	○	○	○	○
Supportive clinical learning environment	○	○	○	○	○
Personal resilience	○	○	○	○	○

RECOMMENDATIONS

In this section you will be asked about recommendations that you believe would help address the violence and/or racism that is being experienced by nursing students in the clinical setting on the **individual**, **professional**, and **organizational level.**

In the past 12 months in my clinical placement, I believe the following recommendations would have helped mitigate violence and/or racism on an **individual level**: *

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Resilience training	○	○	○	○	○
Conflict resolution workshops	○	○	○	○	○
Communication strategies	○	○	○	○	○

In the past 12 months in my clinical placement, I believe the following recommendations would have helped mitigate violence and/or racism on a **professional level**: *

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Nursing curriculum on violence and racism	○	○	○	○	○
Education for clinical teachers on managing violence and racism	○	○	○	○	○
Education for clinical placement staff on managing violence and racism	○	○	○	○	○

In the past 12 months in my clinical placement, I believe the following recommendations would have helped mitigate violence and racism on an **organizational level:** *

Please choose the appropriate response for each item:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Policies and procedures on reporting violence and racism experienced by students	○	○	○	○	○

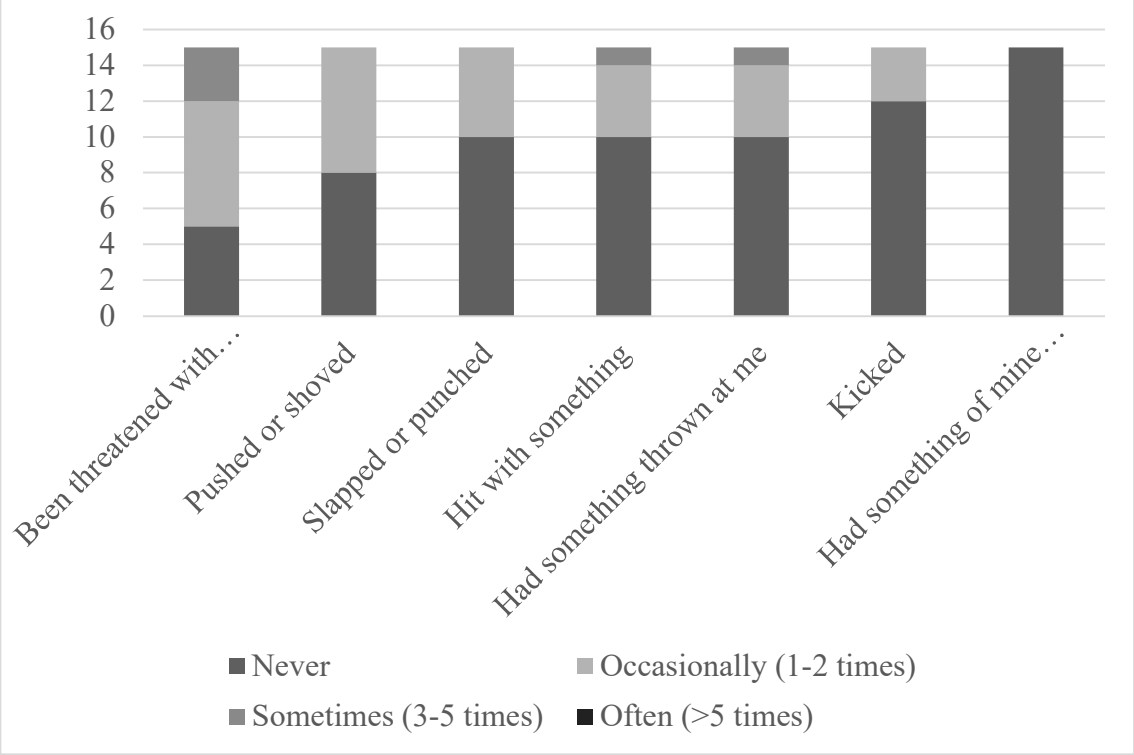
Thank you for participating in this study!

Appendix K: Frequency of Physical Violence

Table K1 Frequency of Physical Violence Examples

Physical Violence (*n*=15)					
In the past 12 months in my clinical placement, I have experienced physical violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Been threatened with physical violence	5	7	3	---	10 (66.67)
Pushed or shoved	8	7	---	---	7 (46.67)
Slapped or punched	10	5	---	---	5 (33.33)
Hit with something	10	4	1	---	5 (33.33)
Had something thrown at me	10	4	1	---	5 (33.33)
Kicked	12	3	---	---	3 (20)
Had something of mine deliberately damaged	15	---	---	---	---

Figure K1 Frequency of Physical Violence Examples- Stacked Bar Graph

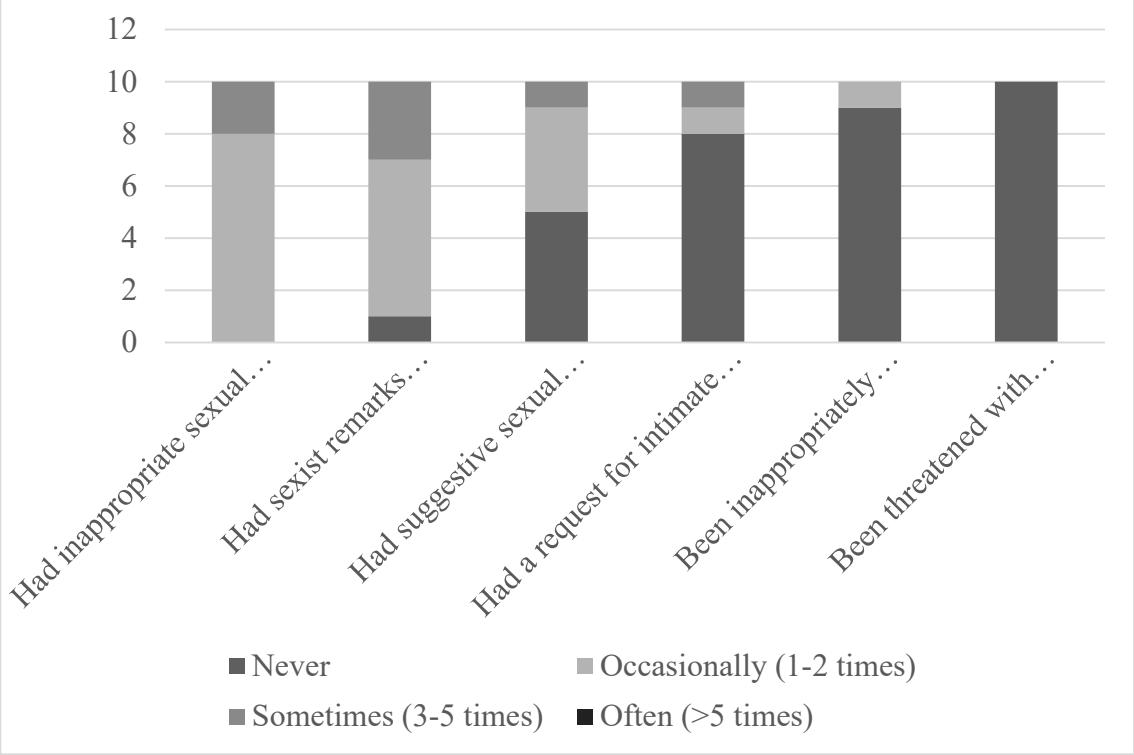


Appendix L: Frequency of Sexual Violence

Table L1 Frequency of Sexual Violence Examples

	Sexual Violence (*n*=10)				
In the past 12 months in my clinical placement, I have experienced sexual violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Had inappropriate sexual comments said to me	---	8	2		10 (100)
Had sexist remarks directed at me	1	6	3	---	9 (90)
Had suggestive sexual gestures directed at me	5	4	1	---	5 (50)
Had a request for intimate physical contact	8	1	1	---	2 (20)
Been inappropriately touched	9	1	---	---	1 (10)
Been threatened with sexual violence	10	---	---	---	---

Figure L1 Frequency of Sexual Violence Examples- Stacked Bar Graph



Appendix M: Frequency of Physical and Sexual Violence Perpetrators

Table M1 Frequency of Physical Violence Perpetrators

Physical Violence (*n*=15)					
In the past 12 months in my clinical placement, I have experienced physical violence from the following sources:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Patients	---	9	5	1	15 (100)
Patients' visitors	15	---	---	---	---
Clinical teacher	15	---	---	---	---
Preceptor	15	---	---	---	---
Staff nurses	15	---	---	---	---
Physicians	15	---	---	---	---
Peers	15	---	---	---	---
Allied health providers and staff	15	---	---	---	---

Table M2 Frequency of Sexual Violence Perpetrators

Sexual Violence (*n*=10)					
In the past 12 months in my clinical placement, I have experienced sexual violence from the following sources:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Patients	---	6	2	2	10 (100)
Patients' visitors	8	2	---	---	2 (20)
Clinical teacher	10	---	---	---	---
Preceptor	10	---	---	---	---
Staff nurses	10	---	---	---	---
Physicians	10	---	---	---	---
Peers	10	---	---	---	---
Allied health providers and staff	10	---	---	---	---

Appendix N: Frequency of Negative Outcomes

Table N1 Frequency of Verbal Violence Negative Outcomes

Verbal Violence (*n*=35)					
In the past 12 months in my clinical placement, I experienced negative outcomes from verbal violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Anxiety	5	9	11	10	30 (85.71)
Feelings of inadequacy	5	14	6	10	30 (85.71)
Interrupted my learning	9	15	6	5	26 (74.29)
Anger	12	13	6	4	23 (65.71)
Depression	13	13	3	6	22 (62.86)
Made me consider leaving nursing	15	10	5	5	20 (57.14)
Sleep disturbance	16	5	9	5	19 (54.28)
Loss of appetite	22	6	4	3	13 (37.14)
Negatively affected my standard of patient care	27	5	3	---	8 (22.86)
Caused absenteeism	31	3	1	---	4 (11.43)

Table N2 Frequency of Physical Violence Negative Outcomes

	Physical Violence (*n*=15)				
In the past 12 months in my clinical placement, I experienced negative outcomes from physical violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Anxiety	6	5	2	2	9 (60)
Interrupted my learning	7	6	2	---	8 (53.33)
Anger	9	6	---	---	6 (40)
Made me consider leaving nursing	9	5	1	---	6 (40)
Feelings of inadequacy	10	3	2	---	5 (33.33)
Sleep disturbance	10	4	1	---	5 (33.33)
Depression	11	3	1	---	4 (26.67)
Negatively affected my standard of patient care	11	3	1	---	4 (26.67)
Loss of appetite	12	3	---	---	3 (20)
Caused absenteeism	15	---	---	---	---

Table N3 Frequency of Sexual Violence Negative Outcomes

	Sexual Violence (*n*=10)				
In the past 12 months in my clinical placement, I experienced negative outcomes from sexual violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Anxiety	3	4	3	---	7 (70.00)
Anger	4	3	3	---	6 (60.00)
Negatively affected my standard of patient care	5	4	1	---	5 (50.00)
Made me consider leaving nursing	6	4	---	---	4 (40.00)
Interrupted my learning	6	4	---	---	4 (40.00)
Depression	9	1	---	---	1 (10.00)
Loss of appetite	9	1	---	---	1 (10.00)
Sleep disturbance	9	1	---	---	1 (10.00)
Feelings of inadequacy	10	---	---	---	---
Caused absenteeism	10	---	---	---	---

Table N4 Frequency of Racism Negative Outcomes

	Racism (*n*=25)				
In the past 12 months in my clinical placement, I experienced negative outcomes from racism in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Anxiety	11	6	2	6	14 (56.00)
Interrupted my learning	11	8	3	3	14 (56.00)
Anger	12	4	6	3	13 (52.00)
Feelings of inadequacy	14	4	1	6	11 (44.00)
Depression	15	5	---	5	10 (40.00)
Made me consider leaving nursing	17	4	1	3	8 (32.00)
Sleep disturbance	17	5	1	2	8 (32.00)
Loss of appetite	18	2	2	3	7 (28.00)
Negatively affected my standard of patient care	19	5	1	---	6 (24.00)
Caused absenteeism	21	3	1	---	4 (16.00)

Appendix O: Frequency of Responding Behaviours

Table O1 Frequency of Verbal Violence Responding Behaviours

Verbal Violence (*n*=35)					
In the past 12 months in my clinical placement, I have responded to verbal violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Took no action	4	11	5	15	31 (88.57)
Tried to pretend it never happened	6	10	4	15	29 (82.86)
Avoided the perpetrator	11	8	8	8	24 (68.57)
Told the perpetrator to stop	24	8	3	---	11 (31.43)

Table O2 Frequency of Physical Violence Responding Behaviours

Physical Violence (*n*=15)					
In the past 12 months in my clinical placement, I have responded to physical violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Took no action	5	2	2	6	10 (66.67)
Tried to pretend it never happened	7	2	1	5	8 (53.33)
Told the perpetrator to stop	8	3	3	1	7 (46.67)
Avoided the perpetrator	9	3	1	2	6 (40)

Table O3 Frequency of Sexual Violence Responding Behaviours

Sexual Violence (*n*=10)					
In the past 12 months in my clinical placement, I have responded to sexual violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Avoided the perpetrator	2	6	---	2	8 (80)
Took no action	3	3	1	3	7 (70)
Tried to pretend it never happened	4	2	1	3	6 (60)
Told the perpetrator to stop	4	3	3	---	6 (60)

Table O4 Frequency of Racism Violence Responding Behaviours

Racism (*n*=25)					
In the past 12 months in my clinical placement, I have responded to racism in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Took no action	1	7	6	11	24 (96.)
Tried to pretend it never happened	2	9	5	9	23 (92)
Avoided the perpetrator	12	5	3	5	13 (52)
Told the perpetrator to stop	19	3	2	1	6 (24)

Appendix P: Frequency of Reporting

Table P1 Frequency of Verbal Violence Reporting Behaviours

	Verbal Violence (*n*=35) Reported (*n*=9)				
In the past 12 months in my clinical placement, I reported verbal violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Reported to my friends or family	---	2	3	4	9 (100)
Reported to my clinical teacher or preceptor	2	2	4	1	7 (77.78)
Reported to my school	8	1	---	---	1 (11.11)
Filed a formal report	9	---	---	---	---

Table P2 Frequency of Physical Violence Reporting Behaviours

	Physical Violence (*n*=15) Reported (*n*=2)				
In the past 12 months in my clinical placement, I reported physical violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Reported to my friends or family	---	2	---	---	2 (100)
Reported to my clinical teacher or preceptor	---	2	---	---	2 (100)
Filed a formal report	---	2	---	---	2 (100)
Reported to my school	1	1	---	---	1 (50)

Table P3 Frequency of Sexual Violence Reporting Behaviours

	Sexual Violence (*n*=10) Reported (*n*=1)				
In the past 12 months in my clinical placement, I reported sexual violence in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Reported to my clinical teacher or preceptor	---	---	1	---	1 (100)
Reported to my friends or family	1	---	---	---	---
Reported to my school	1	---	---	---	---
Filed a formal report	1	---	---	---	---

Table P4 Frequency of Racism Reporting Behaviours

	Racism (*n*=25) Reported (*n*=3)				
In the past 12 months in my clinical placement, I reported racism in the following ways:	Never	Occasionally (1-2 times)	Sometimes (3-5 times)	Often (>5 times)	Total Frequency [Occasionally, Sometimes & Often] (%)
Reported to my friends or family	---	2	---	1	3 (100)
Reported to my clinical teacher or preceptor	---	2	1	---	3 (100)
Reported to my school	2	1	---	---	1 (33.33)
Filed a formal report	3	---	---	---	---

Appendix Q: Frequency of Not Reporting

Table Q1 Frequency of Not Reporting Verbal Violence

Verbal Violence (*n*=35) Did Not Report (*n*=26)						
In the past 12 months in my clinical placement, I did not report verbal violence because:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
Nothing will get done about it	---	4	3	12	7	19 (73.08)
I do not know how to report it	3	5	5	11	2	13 (50)
It is part of the job	6	5	3	10	2	12 (46.15)
I will be victimized	4	9	3	7	3	10 (38.46)
It is not important enough to me	2	9	6	9	---	9 (34.62)

Table Q2 Frequency of Not Reporting Physical Violence

Physical Violence (*n*=15) Did Not Report (*n*=13)						
In the past 12 months in my clinical placement, I did not report physical violence because:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
It is not important enough to me	1	1	2	8	1	9 (69.23)
Nothing will get done about it	1	3	1	8	---	8 (61.54)
I do not know how to report it	---	5	4	4	---	4 (30.77)
It is part of the job	3	5	2	3	---	3 (23.08)
I will be victimized	1	6	3	3	---	3 (23.08)

Table Q3 Frequency of Not Reporting Sexual Violence

Sexual Violence (*n*=10) Did Not Report (*n*=9)						
In the past 12 months in my clinical placement, I did not report sexual violence because:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
Nothing will get done about it	1	1	2	4	1	5 (55.56)
I do not know how to report it	1	2	1	4	1	5 (55.56)
It is not important enough to me	1	3	2	2	1	3 (33.33)
It is part of the job	6	---	1	2	---	2 (22.22)
I will be victimized	3	3	1	2	---	2 (22.22)

Table Q4 Frequency of Not Reporting Racism

Racism (*n*=25) Did Not Report (*n*=22)						
In the past 12 months in my clinical placement, I did not report racism because:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
Nothing will get done about it	---	1	3	11	7	18 (81.82)
It is not important enough to me	4	4	3	6	5	11 (50)
I will be victimized	2	7	3	4	6	10 (45.45)
I do not know how to report it	2	7	3	7	3	10 (45.45)
It is part of the job	8	2	5	7	---	7 (31.82)

Appendix R: Frequency of Protective Factors

Table R1 Frequency of Protective Factors

	Sample (*n*=82)					
In the past 12 months in my clinical placement, factors that protected me from negative outcomes from violence and racism included:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
Personal resilience	---	2	9	39	32	71 (86.59)
Supportive clinical learning environment	3	2	13	42	22	64 (78.05)
Previous experience	1	4	15	45	17	62 (75.61)
Student-teacher or student-preceptor relationship	4	6	13	38	21	59 (71.95)
Knowledgeable of student rights	5	16	33	24	4	28 (34.15)
Training from clinical placement	12	20	24	21	5	26 (31.71)
Training from school	12	21	25	20	4	24 (29.27)

Appendix S: Frequency of Recommendations

Table S1 Frequency of Recommendations

	Sample (*n*=82)					
In the past 12 months in my clinical placement, I believe the following recommendations would have helped mitigate violence and racism:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Frequency [Agree & Strongly Agree] (%)
Education for clinical placement staff on managing violence and racism	1	3	9	40	29	69 (84.15)
Education for clinical teachers on managing violence and racism	1	3	12	39	27	66 (80.49)
Policies and procedures on reporting violence and racism experienced by students	---	2	14	35	31	66 (80.49)
Communication strategies	2	4	18	42	16	58 (70.73)
Nursing curriculum on violence and racism	4	7	19	31	21	52 (63.41)
Conflict resolution workshops	2	12	19	37	12	49 (59.76)
Resilience training	6	15	16	35	10	45 (54.88)