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Teaching and Learning Courageous Followership: An Action Research Study

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TEACHING AND LEARNING COURAGEOUS FOLLOWERSHIP: AN ACTION RESEARCH STUDY

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Followership has been shown to be a developmental stage of leadership. Yet, there is a lack of followership theory in the health-care context. The purpose of this qualitative action research study was to explore how introducing Chaleff's dimensions of courageous followership influences the undergraduate nursing students' views of the follower role and informs their nursing practice. Secondary research questions asked how knowledge of these dimensions influences the nursing students' views while advocating, collaborating, and addressing lateral violence. Using purposeful sampling, 12 participants were recruited for this study. After attending a followership seminar, they completed online reflections and participated in individual and focus group interviews. Other data collection methods used were field notes and a researcher's reflective journal. Domain analysis, transcription, memo writing, axial coding, and thematic analysis were used to analyze the data. Brinkmann and Kvale's stages of validation guided interview validity. And Herr and Anderson's criteria for action research validity guided design validity.

In summary of this study's findings, learning followership was found to influence students' views by providing a new understanding of accountability, responsibility, and power to initiate action and engage in exemplary behaviors when advocating and collaborating. Willingness or unwillingness to follow was situational to contextual factors, and influenced

students' sense of engagement. Lived experiences were also seen to influence students' engagement and sense of power, and provided participants with a sense of certainty to move forward in their advocating and collaborating attempts. Finally, sight was identified as students' strength when advocating for others.

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Introducing Followership to Nursing

Context of Topic

The United States health-care system is undergoing significant changes related to the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), facing fiscally related restrictions on available resources in a time of growing demand for services. Yet, it must also continue to create knowledge and fold innovation into practice (Institute of Medicine [IOM], 2010). The passage of the ACA is seen as an opportunity to transform the nation's health-care system into a seamless, patient-centered, and evidenced-based system providing quality service (IOM, 2010). Part of this transformation involves transformation of the nursing profession.

Recognizing this, the Robert Wood Johnson Foundation and the IOM partnered in 2008 to establish a 2-year initiative on the future of nursing (IOM, 2010). In 2010, The IOM released its report *The Future of Nursing: Leading Change, Advancing Health*, which described in detail four key messages. First, nurses should practice to the full extent of their education and training. Second, an improved education system promoting seamless academic progression should allow nurses to achieve high levels of education and training. Third, nurses should be full partners with health professionals, including physicians, in redesigning national health care. And fourth, better data collection and improved information infrastructure is needed for effective workforce planning and policy-making to occur.

In their report, the IOM stated that a transformation in nursing leadership will be required to achieve transformation of the nation's health-care system, and a new leadership style that involves working with others as full partners, in a context of mutual respect and collaboration, is needed. This type of leadership, where mutual collaboration and respect is present, is supported within the nursing profession as it is associated with reduced workplace violence, improved patient outcomes, and reduced medical errors (Joint Commission, 2008).

Nursing is a practice profession, and leadership must take place within the context of practice (Ferguson-Paré, 2011). Clinical nurse leaders are more likely to be found at the patient bedside and not in a managerial role (Stanley, 2008). These leaders use their clinical experience and skills to assure patient needs and organizational goals are achieved, and they are vital for support of health-care policy (Stanley, 2012). Leadership skills are expected at all levels of nursing, and students should not wait for graduation to demonstrate these skills (IOM, 2010). Therefore, teaching leadership theory and how to apply leadership skills is considered an essential element of a sound baccalaureate program (American Association of Colleges of Nursing, 2008).

However, as nurses develop their leadership skills, the importance of being a good follower should not be ignored. The IOM (2010) explained in their report on the future of nursing that "effective leadership also requires recognition of situations in which it is more important to mediate, collaborate, or follow others who are acting in leadership roles" (p. 5). A good follower contributes to successful collaboration, provides information valuable to the team, seeks clarification, and gives constructive feedback (Tracy & Hanson, 2014). Yet, there is a lack of research of followership theory in the health-care context (Kean, Haycock-Stuart, Baggaley, & Carson, 2011). According to Latour and Rast (2004), the first step in leader development is to value followers and to understand that those who follow effectively will move into leadership positions over time. This is echoed by Dixon's (2009) view that the role of a follower can be considered a developmental state for leadership.

Followership

Despite followers outnumbering leaders in the workplace, little followership research has been developed independent of leadership (Dixon & Westbrook, 2003). Followership research is

distinct from follower-centric leadership research in that the former places the follower in a privileged role. A basic assumption of followership is leadership cannot be understood without considering how followership contributes to the leadership process (Uhl-Bien, Riggio, Lowe, & Carsten, 2014). However, most research is leadership focused and references followership as a variable influencing leadership effectiveness. Hoption, Christie, and Barling (2012) stated that this view neglects the power followers have on leader development.

Theoretical frameworks for the study of followership are described in the literature. One framework represents a role-based view. This view is concerned with the way leadership and followership is enacted in the context of hierarchical roles and what combination of traits and behaviors is needed to achieve organizational goals (Uhl-Bien et al., 2014). A second framework represents a constructionist view that presents leaders and followers interacting together to co construct followership and leadership (DeRue & Ashford, 2010; Uhl-Bien et al., 2014). In this framework, interactions do not necessarily follow a hierarchical role; instead, interactions are studied in a social and relational context (Uhl-Bien et al., 2014).

Followership theories remain in their formative stages, though strides have been made in building the followership body of knowledge. Kelley (1992) contributed to the literature with his description of followership types and behaviors. Kellerman (2008) also described five follower types but refrained from developing a list of followership attributes. Experts in this field continue to explore descriptors such as, but not limited to, traits, types, and roles.

Chaleff's dimensions of a courageous follower is a model to be used as a social contract between employers and employees (Dixon & Westbrook, 2003). Those in the follower role are challenged to stand up to their leaders and for their leaders by demonstrating courage to assume responsibility, to serve, to challenge, to participate in transformation, and to take moral action.

Chaleff (2009) later added the courage to speak to the hierarchy as another dimension of a courageous follower. This model of courageous followership has been the basis for other studies. For instance, Dixon, Mercado, and Knowles (2013) studied generational differences among followers based on Chaleff's model. It has also been used in disciplines outside of organizational leadership. Schell and Kuntz's (2013) study participants included nurses and engineers. The authors wrote that nurses were faced with ample opportunities to display courageous followership behaviors, and when nurses displayed strong levels of courage to participate and courage to take moral action, the health-care organization benefitted.

How Followership Relates to Nursing

The American Association of Colleges of Nursing (AACN, 2008) issued *The Essentials of Baccalaureate Education for Professional Nursing Practice*. These essentials provide clear descriptions of expected nursing educational outcomes in shaping professional behaviors. They also provide curricular elements and frameworks for developing a baccalaureate nursing curriculum. Of all the essentials listed, nine detail the expected outcomes of graduates of baccalaureate nursing programs, and three mirror Chaleff's (2009) courageous followership dimensions. These three essentials are the following:

- Essential II: Basic Organizational and System Leadership for Quality Care and Patient Safety
- Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes
- Essential VIII: Professionalism and Professional Values

Essentials II and VI. The rationale for Essential II, in part, is that leadership skills emphasizing ethical and critical decision-making are essential. Teaching mutually respectful

interprofessional communication and collaboration skills, including conflict resolution strategies, is needed. These skills are what allow nurses to "recognize, interrupt, evaluate, and correct healthcare errors" (AACN, 2008, p. 13).

Essential VI is considered imperative to nursing in that teamwork between health-care professionals is associated with safe, high quality health-care delivery. Effective interprofessional and intraprofessional collaboration, as described in this essential, is dependent upon a definition of shared goals, clear role expectations between members, a flexible decision-making process, and open communication patterns. It is an expectation that all health-care professionals educate future clinicians to provide patient care as part of an interprofessional team (AACN, 2008).

This emphasis on interprofessional collaboration is seen throughout health-care literature (Lancaster, Kolakowsky-Hayner, Kovacich, & Greer-Williams, 2015; Tracy & Hanson, 2014). However, nurse researchers have also brought to light barriers preventing nurses from engaging in effective collaboration practice. Some of the barriers stem from a paternalistic medical culture in which nurses are stereotyped as females dominated by male physicians (Ten Hoeve, Jansen, & Roodbol, 2014). Others cite the lack of educational opportunities for students from various health-care disciplines (viz., medicine, nursing, and pharmacology) to interact and practice collaboration skills (Hall, 2005). Finally, barriers to collaboration exist within the nursing profession itself. Lateral violence, or bullying, is described as overt behaviors manifested as infighting, sabotage, scapegoating, withholding information, and criticism (Griffin, 2004). This nurse on nurse violence is embedded in nursing culture (Bradbury-Jones, Sambrook, & Irvine, 2007).

Courageous followership does provide practical strategies for nurses working to overcome barriers created by professional cultures, lateral violence, and lack of experience. Chaleff (2009) said the courage to challenge happens when the follower appropriately initiates confrontation to examine not only the leader's actions but also the group's actions (Dixon & Westbrook, 2003). Behaviors violating personal and professional values or jeopardizing outcomes, which in the health-care field is safe patient care, are to be challenged. Challenging the use of diminishing language or derogatory terms is also part of the courage to challenge. Strategies to engage in courageous followership include overcoming groupthink, avoiding knee-jerk rejections, giving input, giving feedback, and understanding effective leadership (Chaleff, 2009).

Essential VIII. Essential VIII directs baccalaureate education to develop professional values and behaviors. Educating future nurses of possible dilemmas they will face and making decisions in an ethical manner is essential. Altruism, autonomy, respect for human dignity, integrity, and social justice are professional values guiding the nurses' ethical behavior. According to the AACN (2008), "Ethics is an integral part of nursing practice and has always involved respect and advocacy for the rights and needs of patients regardless of setting" (p. 27).

Advocacy for the rights and needs of patients regardless of setting has become a fundamental value in professional nursing (Hanks, 2007). The behaviors most often cited as evidence of nursing advocacy in practice include acting as the patient's voice, protecting the patient, relationship building, and improving communication (Hanks, 2008). Nurses are directed to use their power to advocate for patients and influence the direction of change in health care (Fackler, Chambers, & Bourbonniere, 2015). Nursing literature has demonstrated that nurses and

nursing students feel powerful when engaging in patient advocacy knowing their voices were heard, and their expertise was recognized (Bradbury-Jones et al., 2007; Fackler et al., 2015).

Barriers to advocacy do exist. These barriers are similar to those described as barriers to collaboration. MacDonald (2007) suggested that the context in which a nurse works, such as the nature of relationships with other health-care team members, may contribute to advocacy barriers. Bradbury-Jones et al. (2007) wrote of nursing student experiences in which having a voice was empowering. However, such disempowering experiences as disrespect, lack of understanding, and lack of encouragement resulted in a lack of voice. A particularly disturbing finding was when students described an inability to speak up, despite witnessing poor practices, because of their disempowering experiences.

Acting as a patient advocate is not without risk to the nurse. Consequences of advocacy can range from simple feelings of frustration to more significant events, such as demotions or disruption of workplace relationships. Advocacy is seen as a form of risk-taking and can be a professional dilemma for nurses (Hanks, 2008). Zerwekh observed that despite having a sense of duty to advocate, some participants remain silent due to fear of reprisal (as cited in Bradbury-Jones, 2007, p. 348). Chaleff (2009) described this fear when explaining another courageous followership dimension, the courage to take moral action: “Moral action is taken with the intention of bringing the actions of the leadership and organization into line with fundamental values that govern decent organizational behavior while preserving the capacity of the organization to fulfill its purpose” (p. 149).

Assuming the follower has already exercised the courage to challenge, the courage to take moral action revolves around decision-making processes to either leave the organization, appeal to higher levels of authority, or evaluate how to conduct oneself when facing potential

consequences. Chaleff (2009) also discussed the duty to disobey. Followers have a duty to disobey an order if it is morally unacceptable or when the welfare of others is in jeopardy, even if the group agrees with the leader. Courage is needed to voice one's decision to disobey.

Similarly to Chaleff's discussion of one's duty to disobey, Carsten and Uhl-Bien (2012) defined constructive resistance as a form of objection where the follower directly challenges an order from a superior or leader. They also described constructive resistance as being a part of upward communication. Another part of upward communication is prosocial voice. Prosocial voice is a term used to describe when followers take actions not required by the job but that lead to the advancement of organizational goals. Here is where followership theories depart from nursing. In followership, voice is considered an extra-role behavior (i.e., an action taken that is not required). In nursing, exercising voice to advocate for positive patient outcomes is a professional duty (Hanks, 2007).

Identifying the Leader

Any misunderstanding between the label of follower and the behaviors of courageous followership may prove provocative to those unfamiliar with followership theory. As the distinctions between these terms are made, it seems appropriate to discuss who nurses identify as their leader(s). Nursing leadership literature focuses largely on leadership concepts and applying these concepts in practice. Studies asking nurses directly who they identify as leaders are few.

Cleary, Horsfall, Jackson, Muthulakshmi, and Hunt (2013) studied viewpoints of recent nursing graduates about multiple issues in nursing. These graduates could not identify constructive leaders in the clinical environment but did identify senior nurses, preceptors, and nurse educators as having some relevant leadership qualities. Kean et al. (2011) studied how leadership is perceived and experienced by community nurses, and following emerged as an

analytical category. The participants described their following as supporting others, being diplomatic, and resisting requests. They also argued that they would only follow a leader who shared their values and beliefs. The authors concluded that the nurses held socially coconstructed views of leaders, but they did not discuss who the nurses identified as their leader(s).

Stanley (2006), on the other hand, specifically asked nurses to identify their clinical leaders, and they did not always identify senior nurses or nurse managers. As a matter of fact, nurses filling significant managerial roles were not seen as clinical leaders at all. Rather, nurses acknowledged those who had clinical expertise, who empowered and supported them, who were approachable, and who demonstrated attributes of caring as their leader or role model. A match between these attributes and one's own values and beliefs was key to how nurses identified their leaders, and often, these leaders were coworkers (Stanley, 2012).

Problem Statement

Advocacy for the rights and needs of patients is a fundamental nursing duty. Nurses, including nursing students, are expected to act as the patient's voice. However, literature has shown that disempowering experiences related to lateral violence and collaboration barriers diminish nurses' sense of voice. Nursing students are often in a following role and may feel this role is powerless. Nurse educators must recognize there are circumstances where students may not feel powerful. In addition, they must find a way to teach students to act as the patient's voice no matter what contextual factors are present and to recognize their power whether in a leading, following, or collaborating role.

Purpose of the Study

The purpose of this qualitative action research study was to explore how introducing the dimensions of courageous followership influences the undergraduate nursing students' views of the follower role and informs their nursing practice.

Research Questions

The primary research question was, How does knowledge of the dimensions of courageous followership influence the nursing students' views and practices? Secondary questions for this study were the following:

- How does knowledge of courageous followership strategies influence the nursing students' views of their advocacy role?
- How does knowledge of courageous followership strategies influence the nursing students' views about inter- and intraprofessional collaboration?
- How does knowledge of courageous followership strategies influence the nursing students' views related to lateral violence?

Context of the Study

Participants of this study were traditional undergraduate nursing students attending a public university in South Texas. Traditional students are those who are pursuing their first baccalaureate. The nursing program at this university gives students from each semester the opportunity to apply the knowledge and skills learned in the classroom to real-life medical situations in a hospital setting. These days are clinical days. During clinical days, students are paired with an experienced registered nurse (RN). This pairing off changes each clinical day. It is unplanned and rare that a student is paired with the same nurse more than once. The RNs are accustomed to precepting nursing students because many students from other universities rotate

through the hospitals 7 days a week. On clinical days, professors make continual rounds assessing the students' clinical knowledge and skills, and they consult with the precepting nurse regarding the students' performance. At the end of each day, the students and professor gather for a postconference. During this time, discussion and activities are at the professor's discretion. Though each professor has their own routine and style, all are guided by the same course objectives. Therefore, the students experience a similar structure during their clinical days.

Introduction of Researcher

As a PhD candidate in organizational leadership studies, I have become aware and interested in followership theory. I am also an advance practice registered nurse in the state of Texas, practicing full time as a nurse practitioner (NP). In the state of Texas, there are regulations in place limiting my scope of practice. Not all states have these scope of practice laws that limit NP practice. These regulations trigger my sensitivities of the paternalistic nature of medicine. Though health care is becoming more patient centered and encourages interprofessional collaboration, these old state regulations keep paternalistic practices a reality for me.

Though I am a leader in my own profession, I often feel constrained by rules put into place by another profession, which limit my autonomy. This may be why followership theory appeals to me. It does not see one role (leader) overshadowing and commanding over another role (follower). It views both roles working together toward a common goal. Both have the equal duty to hold the other accountable when the goal is not being met.

Significance of the Study

According to the IOM (2010), "There are many times when nurses, for the sake of delivering exceptional patient and family care, must step into an advocate role with a singular

voice" (p. 5). Collaboration is a worthy activity. However, as literature has shown, it often fails. This leaves the nurse with few alternatives when speaking to hierarchy. Yet, an ability to speak to hierarchy is necessary when advocating for a patient's well-being. Introducing courageous followership into nursing provides practical solutions to lateral violence and disempowering actions, which are proven barriers to patient advocacy and collaboration.

Contributions to Literature

This action research study provides an in-depth understanding of how nursing students perceive and use followership theory. Followership theories are not well known in the nursing field, and many misconceptions may exist due to the negative connotations associated with the term follower. Furthermore, there are a limited number of studies asking nurses or nursing students to identify their leaders. This study provided nursing students the opportunity to identify their leaders. Its findings will contribute to nursing, higher education, followership, and leadership studies. And hopefully, the value of teaching followership theory as an adjunct to current leadership and collaboration studies in nursing is demonstrated.

Literature Review

Followership has appeared in organizational literature since the 1950s. Yet, the dynamic between leaders and followers has not been fully studied (Cox, Plagens, & Sylla, 2010; Popper, 2011; Uhl-Bien et al., 2014). Uhl-Bien et al. (2014) posited that this gap in literature reflects a misunderstanding of followership constructs and how these constructs relate to leadership.

This review of literature begins by reviewing the constructs of followership and addressing common misunderstandings. This is followed by a review of followership history, which outlines how these constructs evolved through the years. Having this historical review of followership clarifies how the view of followers as passive subordinates is evolving to a view in which followers are active participants. As active participants, followers are engaged with their leaders in a socially constructed relationship. Therefore, how social identity, group benefits, and social context impact the follower-leader relationship is also reviewed. Furthermore, literature that specifically addresses followership in nursing is discussed as well as the major factors that influence the social context of nursing: the historical perspective of the nursing profession, the expectations to engage in collaboration, and the duty to serve as a patient advocate. Finally, followership studies that potentially benefit the nursing profession are identified and reviewed.

Identifying Literature

Literature was searched in the following databases: EBSCO, Medline, ERIC, CINAHL Plus, CINAHL Complete, PsycINFO, Healthsource: Nursing/Academic Edition, TOPICsearch, and Professional Development Collection. Several websites were accessed for policy information, formal reports, and statistical data. Reference lists were used to locate further sources, and peer reviewed journal articles, reports, and books were reviewed. Keywords used were leadership, followership, nursing, collaboration, advocacy, power, voice, nursing education,

higher education, and teams. Keywords were also combined to search followership and nursing, nursing and leadership, nursing and advocacy, nursing and collaboration, nursing and higher education, nursing and power, and nursing, engagement, and voice.

The studies that were found using these search methods generally fell into followership, leadership, and nursing categories. Only studies that were follower-centric or studied followership constructs, however, were reviewed. These followership studies consistently described the same historical path of followership theory. Early researchers focused on how the role of followers influenced leaders, while later researchers studied the follower-leader relationship as a socially constructed process. Multiple studies identified social contextual factors as an area where further research is needed. Social contextual factors suggested for future study included leader-follower fit, work climate, and organizational structure.

Only a handful of studies were available in which nursing and followership were studied together. One study explored how leadership was perceived by nurses, and followership was therefore studied indirectly. Another study examined dimensions of courageous followership with nurses and engineers as participants. Both studies took a role-based perspective of followership and not a socially constructed perspective. Both study authors concluded more research was needed on social contextual factors influencing follower behaviors.

There was an abundance of studies that discussed nursing leadership. Topics included the role of leadership, teaching leadership, importance of leadership, and behaviors of leadership. However, few researchers asked nurses directly who they identified as their leaders. Thus, there is a clear gap in literature.

Nursing literature was reviewed for social contextual factors that may influence the follower-leader relationship in the leadership process or the follower role in nursing. It was

found that issues influencing the nursing profession are many. These issues range from nursing education, work environment, and health-care regulations. However, the contextual factors that were found repeatedly during this review concerned a nurse's duty to serve as a patient advocate, to collaborate with health-care professionals in disciplines other than nursing, and how the history of nursing still influences the profession.

Followership Theory

In followership theory, leadership is about the relationship between leaders and followers within a social group (Reicher, Haslam, & Hopkins, 2005). Followership theory has also been defined by Uhl-Bien et al. (2014) as the study of the nature and impact of followers in the leadership process. It is not the study of leadership from the followers' perspective; instead, it is about how followers view and behave in relation to leaders.

Followers have been characterized as sheep, obedient, bystanders, isolates, and passive (Baker, 2007; Kellerman, 2008; Kelley, 1992). These negative connotations associated with the follower label have become entrenched, and followers are often viewed as what leaders are not (Hoption et al., 2012). However, followership theorists make a distinction between followership and following. In followership theory, an individual assumes the role of an active participant who by choice has consented to follow a leader. This consent may be withdrawn at any time, and rank or authority has little to no role in this choice (Cox et al., 2010). The follower is not a subordinate lacking power because in followership theory, power is never abdicated.

Just as the leader is committed to organizational goals, so is the follower. Achievement of organizational goals is a common purpose shared by leaders and followers (Chaleff, 2009). In followership theory, leaders and followers are accountable to one another (Baker, 2007). Chaleff (2009) viewed courageous followers as stewards of the group who share the responsibility for its

success. Therefore, if the leader's actions are not consistent with organizational goals, it is the follower's duty to stand up to their leader.

The idea that followers have a duty to stand up to and for leaders (Chaleff, 2009) is important because it challenges the notion of followers as having no power. It also holds followers accountable to enact their power when leaders' actions are not in line with organizational goals and values. Followers are also expected to enact their power when the actions of their fellow followers are out of line with organizational goals or values. This follower accountability directly chips away at the negative connotation of followers as submissive and passive.

Kellerman (2008) explained that such words as *collaboration*, *team building*, *empowerment*, and *distributed leadership* were becoming popular in corporate America, which made it easy to believe a level playing field between leaders and followers existed. She believed this was a false notion. Kellerman (2008) further argued that most organizations still have hierarchical structures, and "the fear of following has precluded us from exploring followership in full" (p. 7).

It is important to explore followership in full because the concepts of followership provide a path for followers to take when leadership and collaboration fail and when a level playing field is not level. Followership research is small compared to the body of leadership research. However, followership researchers have embraced the idea of followership instead of fearing it, and they have slowly been building its body of research.

Followership Theory's Historical perspective

Early views of followers. Followership literature is small compared to traditional leadership literature (Baker, 2007; Bligh, Kohles, Pearce, Justin, & Stovall, 2007; Dixon, 2009).

Despite references to followers as far back as the 1930s, the development of followership theory distinct from leadership theory did not begin to flourish until the past 30 years (Cox et al., 2010; Dixon, 2009). This lag has been attributed to a social contagion, first described by Meindl, Ehrlich, and Dukerich (1985), which drove a romantic view of leaders as charismatic heroes (Bligh et al., 2007). Leaders were viewed as Great Men with inborn natural abilities, while those born without had no chance of acquiring such talents. Therefore, followers were typically posited as the dependent variable in early traditional leadership studies (Dvir & Shamir, 2003). There was no need to question the follower's role in organizations until organizations began to change.

Followers' role reframed. In the 1980s and 1990s, advancing technology, changing workforce, global markets, and reduced resources caused a flattening of the organizational structures, which had traditionally been vertical (Baker, 2007). This change led to more delegation of power and responsibility. During this time, Kelley published his article "In Praise of Followers," which reframed the follower in a positive light and as a powerful contributor to the organization (as cited in Dixon, 2009, p. 35). Furthermore, he posited that there was not just one type of follower. Kelley described a typology using dependent-independent and passive-active quadrants. Based on these quadrants, followers are either alienated, exemplary, conformist, or passive (Kelley, 1992). Kelley argued that all followers should be exemplary followers because they tend to be highly participative, critical thinkers who are able to courageously dissent yet also be committed to the organization (Latour & Rast, 2004; Uhl-Bien, 2014).

In 1995, Chaleff published his book *The Courageous Follower* which, along with Kelley's publication, gained widespread popular acceptance (Baker, 2007). Chaleff also viewed the follower in an active role. He described four dimensions in which a courageous follower acts

within a group. These are the courage to assume responsibility, the courage to serve, the courage to challenge, and the courage to participate. The last dimension can occur within or outside the group, depending on the leader's response to the follower's courage to take moral action (Chaleff, 2009). These are the dimensions most described in followership studies. However, the courage to speak to the hierarchy was added by Chaleff in 2009. Chaleff's premise was that leaders seldom use their power wisely over long periods of time unless they are kept accountable by effective followers who courageously stand up to and for their leaders (Chaleff, 2009; Uhl-Bien et al., 2014).

In 2003, Dixon and Westbrook added to followership literature by demonstrating a positive correlation between organizational levels and measures of Chaleff's follower behaviors. The organizational levels described were (a) Level 1, operations; (b) Level 2, supervisors; (c) Level 3, middle management; and (d) Level 4, executives. As the organizational level increased, so did courageous followership behaviors. Lower levels of followership behavior were seen in lower organizational levels (Dixon & Westbrook, 2003). Dixon (2009) also believed that followership is a development stage of leadership and that it should be included as part of the leadership development process in organizations.

Followership socially constructed. In 2007, Baker noted that few articles had been written about followership in the 21st century. Since that time, there has been an uptick of new studies focused on followership theory. Carsten, Uhl-Bien, West, Patera, and McGregor (2010) investigated followers' socially constructed views of followership. Three views were presented. In the first view, described as passive construction, participants provided traditional descriptions of passive followers. They felt that it was important to defer to leaders and described the follower as having a lack of responsibility. In the second view, described as active construction,

participants stated followers should express their opinion and offer input only when asked. Leaders were seen as having more experience and knowledge to make decisions. In the third view, described as proactive construction, participants felt that followers should take initiative to challenge leaders' assumptions, offer advice, and provide feedback to their leaders before being asked. Whether followers acted in accordance to their self-identified view depended on social context. When their views of the follower role did not match the social context, stress and dissatisfaction was reported. This was not the only study where social context seemed to influence the leader-follower relationship.

The Role of Social Context in Followership Theory

The role of social context is well recognized as the third element in the leader-follower dynamic (Carsten et al., 2010; Lapierre, Bremner, & McMullan, 2012; Popper, 2011). For leadership to happen, a shared social identity must exist. According to Reicher et al. (2005), "Where people do form such a group, then one can expect leadership to emerge. Where they fail to form such a group, then it will be impossible for anyone to exercise leadership" (p. 553). Without the group, the leader has no one to lead. Belonging to a group benefits not only the leader by meeting this need but also the follower by providing individual and group benefits. Kellerman (2008) declared that followers follow other followers and leaders for stability, for order and meaning, and for a community to which they belong. Walter (2008) pointed out that most people cannot keep track of complex societal issues or be expected to have the knowledge to do so. Thus, a benefit of belonging to a community is sharing the collective workload (Kellerman, 2008). Butler added that another goal of group collusion is self-protection (as cited in Napier & Gershenfeld, 2004, p. 135). The possibility of losing group benefits is a contextual factor that can moderate the leader-follower dynamic.

Followership in Nursing

Most followership studies have been confined to leadership and organizational disciplines. Currently, few studies about followership can be found in the field of nursing. Yet in 2011, Pilkington, a contributing editor for the *Nursing Science Quarterly*, gave a nod to followership when she introduced a new column titled "Leading-Following Perspectives." As part of her introduction, she suggested leadership is not a stand-alone topic but depends upon the notion of followership.

Schell and Kuntz (2013) studied how clinical nurse leaders and engineers each demonstrated courageous followership behaviors while implementing an organizational change. All but one of successful change initiatives within the primary data set saw nurses who displayed courageous followership behaviors of taking responsibility and serving. In addition, all initiatives where nurses displayed courage to participate and take moral action were successful. However, nurses did not display the later stages of courageous followership. It was hypothesized these behaviors were perceived as too risky. The authors recommended further study to test this hypothesis.

Kean et al. (2011) conducted a qualitative study exploring how leadership is perceived and experienced by community nurses. In their findings, leaders were sometimes followers, and followers were at times leaders. Furthermore, followers did not always fit into a single typology described by followership literature. Study participants moved in and out of these typologies, depending on their value systems and the situational context of the work environment. The authors wrote of a lack of followership in the health-care context and advocated for a greater understanding of leadership and followership in this context.

Social Context of Nursing

Multiple followership studies have recommended exploring the role of social context in the leader-follower relationship (Carsten et al., 2010; Junker & van Dick, 2014; Padilla, Hogan, & Kaiser, 2007). Understanding how followership theory may benefit the nursing profession first requires a better understanding of the contextual factors influencing how professional nurses function as a social group. Per this review of literature, the social contextual factors influencing the leader-follower relationship in nursing include the profession's historical perspective, the expectations to engage in collaboration, and the duty to serve as a patient advocate.

Historical perspective. In the preindustrial era, most health care was provided by women. During the industrial revolution, the wealthy male-dominated medical profession established itself as the only legitimate source of competent health care. Care provided by untrained physicians was discredited (Hall, 2005). As women entered into the workforce during the late 19th century, they were encouraged to go into nursing as it was deemed women's work. Often, these women were from the middle class. Nurses were seen as the doctor's helper. At the time, health care was physician centered. By the late 20th century, the focus of health care shifted and became patient centered.

Once health care refocused on patient needs and not on physician needs, nursing began a professional transformation. This transformation has been closely tied to its education, innovation, theory, and protocol development (Ten Hoeve et al., 2014). Nurses have become more autonomous in practice, which may be seen as an open challenge to past notions of authority and boundaries held by medical discipline (McCallin, 2001). Studies have shown that nurses are acutely aware of their previous subordination to the medical profession and the lingering public image of oppression by dominating physicians (Ten Hoeve et al., 2014). Today,

when conflict surfaces between the two professions, gender and social class issues are sometimes triggered (Hall, 2005).

Collaboration. Collaboration is thought to facilitate the development of a common language and a common conceptual framework between team members based on values that transcend their specific profession's values (Hall, 2005). Aston, Shi, Bullot, Galway, and Crisp described how improved communication and collaboration are linked to improved patient outcomes (as cited in Lancaster et al., 2015, p. 276). Because of this link, a collaborative approach is favored and encouraged by health-care administrators (Hall, 2005). It is an expectation that nurses will participate in collaboration with other disciplines (AACN, 2008; IOM, 2010; Joint Commission, 2008). Nurses have also expressed that building positive relationships with other nurses and physicians is important in building and maintaining their sense of power (Fackler et al., 2015).

However, barriers to effective interprofessional collaboration do exist. Though the focus of health-care delivery has become patient focused, many hospitals still have a hierarchal structure. In this structure, physicians continue to view themselves as in charge (Lancaster et al., 2015). For instance, when Hall (2005) surveyed medical students about their views on interprofessional collaboration, the majority felt that the physician had the final word on the team plan.

Relational barriers to collaboration do not lie between physician-nurse relations alone. Nursing literature has reported lateral violence in the profession for several decades, and new graduates are particularly vulnerable to this type of violence (Griffin, 2004; Roberts, 2015). Lateral violence is perpetrated by nurses on nurses. Examples of such acts include demeaning comments, scapegoating, gossiping, breaking confidence, and passive aggressive communication

(Griffin, 2004). The issue even prompted the U.S. Joint Commission on Accreditations of Hospitals to issue a requirement that all hospitals develop policies to prohibit such behavior (Joint Commission, 2008).

Roberts (2015) reported Freire's oppressed group behavior theory as the most cited explanation for lateral violence in the nursing profession. In this theory, powerlessness and fear is the basis for aggression and anger being directed inward toward one's own group. Empowerment of nurses is considered essential for decreasing lateral violence (Roberts, 2015). This is particularly true for new graduates and nursing students who are often targets (Griffin, 2004; James & Chapman, 2009). Bradbury-Jones et al. (2007) studied the meaning of empowerment for nursing students. Though their findings supported the notion that lateral violence is embedded in the nursing culture, the authors felt that the most significant implication was that nursing students are so disempowered by this violence that their voice to advocate for patients is lost.

Advocacy. Patient advocacy is a hallmark of the professional nursing role (AACN, 2008). It is considered a fundamental value of professional nursing and part of all ethical codes for nursing (Hanks, 2007). Foley, Minick, and Kee (2002) found that nurses define advocacy as acting as a patient's voice. When their voices are heard, nurses report feeling more powerful and willing to take on additional roles of leader, mentor, or role model (Fackler et al., 2015). Furthermore, nursing students view advocacy as an empowering experience having a positive effect on their sense of confidence and self-esteem (Bradbury-Jones et al., 2007).

Just as barriers to collaboration exist, barriers to advocacy are reported in the literature. Work environment factors, such as institutional constraints, lack of power, and relationships with other health-care members, are frequently cited (Fackler et al., 2015; Hanks, 2008; MacDonald,

2007). Fear of reprisal is also another barrier to advocacy (Bradbury-Jones et al., 2007; Hanks, 2007). This fear may have merit in that nursing research does speak of advocacy as a form of risk-taking where nurses may experience feelings of frustration and acts of retribution, such as negative labeling and organizational demotion (Hanks, 2008).

There is a consensus among researchers to include advocacy as part of nursing education (Bradbury-Jones et al., 2007; Fackler et al., 2015; Hanks, 2008; MacDonald, 2007). Hanks (2008) recommended that nurse educators provide students with a realistic perspective of advocacy experiences as possibly being a positive or negative experience. Collaboration skills are seen as especially relevant for nurses attempting to advocate, and nursing education should include learning experiences that will help nurses navigate the many interprofessional relationships they will encounter (MacDonald, 2007).

Where Followership Theory Contributes to Nursing

Followership theory does not speak of advocacy or collaboration per se, but followership researchers have studied upward communication. This form of communication mirrors the behaviors also used in advocacy and collaboration. Studies in followership theory have investigated what influences a person's ability and tendency to engage in upward communication.

Carsten and Uhl-Bien (2012) examined the association of followers' beliefs in the coproduction of leadership with upward communication and the moderating role of context. Contextual moderators were leader consideration, leader-follower relationship quality, and autonomous work climate. Coproduction beliefs were defined as "the extent to which individuals believe the follower role involves partnering with leaders to advance the mission and achieve optimal levels of productivity" (Carsten & Uhl-Bien, 2012, p. 211). The authors also found,

through previous research, that individuals with strong coproduction beliefs did not view followers as passive or submissive. These individuals believed followers significantly strengthened the outcomes of the leadership process (Carsten & Uhl-Bien, 2012).

In their study, Carsten and Uhl-Bien (2012) aimed to quantitatively show a relationship between coproduction beliefs and upward communication. It was suggested those with higher coproduction beliefs would see upward communication as a part of their contribution to the leadership process. Upward communication consists of voice and constructive resistance. Voice is considered a positive form of expression. It is self-initiated and intends to improve outcomes. Constructive resistance involves dissent that involves challenging a leader's request for action and working with the leader to develop an alternative solution (Carsten & Uhl-Bien, 2012).

Carsten and Uhl-Bien (2012) did find a positive relationship between coproduction beliefs and upward communication. Equally important, they found that context did moderate the use of voice but not constructive resistance. Participants with stronger coproduction beliefs showed a stable voice regardless of moderators. Participants with weak coproduction beliefs varied their voice behavior. Their voice behavior increased if the leader's style was considerate, if the relationship quality was high, and if there was an autonomous work climate. The lack of moderating effects on constructive resistance was thought to be secondary to the risky nature of this behavior.

Carsten and Uhl-Bien (2013) later investigated whether followers' beliefs in the coproduction of leadership predicted their intention to object to or comply with an unethical request by a leader. The study results did show followers with weak coproduction beliefs were more likely to comply with unethical leader requests. Followers with stronger coproduction beliefs were less likely to do so. Individuals with weaker coproduction beliefs displaced

responsibility onto their leaders. The authors suggested that the sense of personal responsibility is not sufficient to constructively resist. Followers must also believe the context will allow them to act on their beliefs. It was suggested future research should examine contextual factors associated with followers' belief in their ability to successfully resist unethical requests. Contextual factors suggested for study were organizational values and work group climate.

Study Design

Overall Approach and Rationale

Advocacy for the rights and needs of patients is a fundamental nursing duty. Nurses, including nursing students, are expected to act as the patient's voice. However, literature has shown that disempowering experiences related to lateral violence and collaboration barriers diminish nurses' sense of voice. Even when witnessing poor patient care practices, a sense of duty did not override the risk of engaging in advocacy. Nursing students are often in a following role and may feel this role is powerless. The purpose of this qualitative action research study was to explore how introducing the dimensions of courageous followership influences the undergraduate nursing students' views of the follower role and informs their nursing practice.

The purpose of action research is to change practices during the research process to bridge the theory-practice gap (Munn-Giddings, 2012). Cochran-Smith and Donnell (2006) discussed the problems and issues occurring from practice, and gaps between what is intended and what occurs are the focus of this type of research. Munn-Giddings (2012) contended that action research is based in practice, not separated from it. At its core, action research is context bound and addresses real-life issues. For these reasons and the purpose of this study, an action research approach was appropriate.

Herr and Anderson (2015) described how this design places a double burden on the researcher. One burden is to improve practice, while the other burden is to create knowledge. The action research dissertation brings an additional burden in that dissertations are intended to make knowledge claims that are transferable to similar situations. However, action research is most often intended to create local knowledge, and it address needs of those in a specific setting.

Therefore, in an action research dissertation, the researcher must consider how generated knowledge can be used by those in the setting and be transferred outside of the research setting.

Herr and Anderson (2015) further described their preference to remain eclectic in defining action research but advised researchers to make clear which definition they choose in their dissertation, since the definition influences the researcher's epistemological decisions. To resolve the burdens created by an action research dissertation, this study was influenced by two traditions. First, qualitative action research in education, as described by Mills (2014), involves using "narrative, descriptive approaches to data collection to understand the way things are and what the research means from the perspectives of the participants in the study" (p. 20). By using narrative, descriptive approaches to collect data, the burden to improve practice is addressed. Second, action science addresses the larger burden to create and share local knowledge. In action science, prevailing theories are explored in a self-reflective way to understand how these theories may be perpetuating the very problems identified for study, and it is centrally concerned with the organization's ability to learn (Herr & Anderson, 2015).

The remainder of this chapter addresses my dual role as teacher and researcher. Ethical considerations are also outlined. This is followed by a description of the population of interest, including sampling and inclusion criteria. Data collection methods are then detailed within a timeline. Validity criteria for this study concludes the chapter.

Researcher's Role

In this study, my dual role was that of teacher and researcher. There is little distance between teacher researchers and participants in action research (Mills, 2014). Cochran-Smith and Donnell (2006) explained that this can potentially lead to professional dilemmas, yet the boundaries between practice and inquiry must be blurred for the practitioner to have the

opportunity to interrogate their own assumptions, create their own questions, gather multiple types of data, and develop a course of action that is valid in local contexts. Herr and Anderson (2015) said the worst action research is done by researchers who do not acknowledge their positionality and its implications. In this section, I outline my teaching tasks and the steps I took as a researcher to protect the students, and I address positionality.

Teacher. During the semester, I oversaw my own students' clinical skills acquisition and professional development. Specific clinical skills included medication administration, physical assessment, identifying nursing diagnosis, and proper nursing documentation. Specific professional skills involved developing effective collaboration and communication and assuring patient safety. I was also responsible for the students' safety. Though the study participants were not my assigned students, I did feel an obligation during any interaction with a student to foster their professional development, offer guidance, and assure their actions did not jeopardize patient safety or confidence.

Researcher. As a researcher, I have negotiated the blurred boundaries between teacher and researcher. Issues of accuracy and validity must be addressed, and they are addressed later in this chapter. However, Mills (2014) declared that the most complex issue in action research is protecting the rights and freedoms of students. As the researcher, protecting these rights and freedoms was my responsibility. This was accomplished in two ways: by obtaining institutional review board (IRB) approval and participant consent. I also heeded the advice of Herr and Anderson (2015) to make the decision-making process explicit within the dissertation body and provide a narrative style, which allows a researcher to reflect on the research process and findings.

Positionality. Action research is participatory and undertaken by insiders (Charles & Ward, 2007). I am a practicing nurse practitioner and a clinical professor. Cochran-Smith and Donnell (2006) stated that the practitioner researcher "can know through systematic inquiry into the situations in which they practice is worth knowing" (p. 508). I have been a nursing student. I am a preceptor. I have been a charge nurse. I have advocated. I have collaborated. I am a leader. I am a follower. I am an "insider," and action research is led by "insiders" (Munn-Giddings, 2012).

As an insider, it was necessary for me to always be aware of my position as a professor. I engaged in a study with students who were the participants. Though the recruiting process assured I would not be their direct supervisor, participants may still have placed power in my professor role. Therefore, I was required to navigate the blurred lines of researcher and teacher by supporting the participants as they were learning yet still create a safe place for open and honest dialogue during interviews and reflections.

Ethical Considerations

IRB approval from both the university where I was enrolled and from the students' university was obtained. By doing this, accountability was placed not only with me as the researcher but also with the committee chair and within a university context (Mills, 2014). Before beginning data collection, written consent from students to participate in this study was requested (see Appendix A). This included consent to audiotape interviews, videotape focus group discussions, and include their reflection journals as part of study data. Students were given the choice not to participate and the option to withdraw their consent at any time during the study. If choosing not to participate, student(s) were still allowed access to information being discussed and were welcomed to participate in the discussion. Students were told there would be

no reprisal for withdrawing from the study. In return for their consent, participant anonymity and confidentiality were assured. Using pseudonyms to conceal student identities, name of the hospital, and name of the university were methods used to do this. I also agreed not to engage in any deception, such as including comments made off the record or secretly record conversations. Access to study data was denied to anyone not directly related to the study.

Other Ethical Issues

There was no additional concern for protecting patient identity because nursing students and I are bound by the Health Insurance Portability and Accountability Act (HIPPA) to protect patients' privacy and medical information. Students were also instructed not to use nurses' names in their journals. There was no additional concern for protecting participant identity because study participants were students, and I am already bound by the Family Educational Rights and Privacy Act (FERPA) to protect students' educational records.

Population of Interest

Creswell (2014) explained that purposeful sampling in qualitative research will best help the researcher answer their research questions. Purposeful sampling allows persons or activities to be deliberately selected to provide relevant information to the researcher's questions, since selecting participants in qualitative research is neither probability nor convenience sampling (Maxwell, 2013). For this study, undergraduate nursing students were purposefully selected. Inclusion criteria required participants to be actively enrolled in the study site's traditional undergraduate nursing program. Because students enrolled in the accelerated program generally have shorter clinical rotations and would likely graduate before the study's conclusion, they were excluded from eligibility. Eligible participants were also required to be in good academic standing (to avoid attrition), be at least 18 years of age (for ease of consent), and be willing to

participate in interviews, write online reflections, and attend a seminar (to maximize participation). Finally, eligible participants could not be currently enrolled in any courses taught by me. Site approval was contingent on this. However, it is possible I may be their clinical professor in future semesters.

Timeline

Lewin's iterative spiral of planning, acting, observing, and reflecting has been widely used in action research (Charles & Ward, 2007). The outline of this section reflects each stage of this spiral. Though these stages are ordered, Kemmis and McTaggart (2000) emphasized that these stages overlap, and initial plans can "quickly become obsolete in the light of learning from experience" (p. 277). The authors further stated that the criterion of success is not how accurately steps were followed but whether there is an evolution in the participants practice, in the understanding of practice, and in the situations in which they practice.

Plan. Once IRB approval was given for this study, recruiting efforts began. Professors were asked to allow time during their classes for the study to be introduced to students. Other school leaders agreed to set aside time during various meetings to introduce the study. Once access was obtained to potential participants, those interested were asked to meet outside the class or meeting room for the study details, screening questions, and obtaining consent. It was communicated that no student was required to participate and that no monetary compensation for those who did was available. It was clearly communicated to students no grade or credit would be given for participation in the study. It was also clearly communicated that their identity would be protected.

Those who chose to participate were interviewed in a location outside of the hospital. The most common location was my on-campus office. Each interview lasted 45 to 60 min. The

purpose of the interviews was to gain an understanding of the students' current views of followers, leaders, the relationship between leaders and followers, the relationship between followers and followers, advocacy, collaboration, and past experiences with any of these topics. The interviews were audio recorded. Due to IRB time constraints, these interviews were completed at the end of the semester when the hospital clinical days were complete. This did allow students to discuss insights about their beliefs surrounding the topics listed. In addition to individual interviews, focus groups were conducted (see Appendix B). Each group consisted of four to seven students. These focus group discussions were completed before the individual interviews and were videotaped. Permission to do so was part of the consent process.

Action.

The action in this research began by raising the participants' awareness of leadership, followership, and collaboration theories. Leadership and collaboration discussion was limited, since the focus of this study was followership theory. However, some discussion of leadership and collaboration was needed to understand the differences between the three. These topics were introduced during a 1-hr followership seminar outlining the basic tenets of followership and the dimensions of courageous followership. PowerPoint slides and videos were also part of the seminar. The seminar was limited to 60 min due to participant time constraints.

After completion of the focus group interviews and introductory seminars, dimensions of courageous followership were further discussed through online reflections. The reflections were designed to provoke deeper thinker of previously held beliefs and their origin. They were also designed to consider how past incidences could have come to a different conclusion if followership principles were applied (see Appendix C).

An online reflection was sent to participants once a week for 3 weeks. This allowed each reflection to address one or two dimensions of courageous followership per week. On the third week, the third and fourth reflections were sent together with a deadline approximately two weeks away. Twelve participants were sent four reflections each. Forty-eight were sent out; 41 were returned.

Observe and reflect. Because there is an overlap between action, observation, and reflection, reflections began in the action phase of this study but extended into the observation and reflective stage as well. Participants were encouraged through the reflective questions to observe and reflect how the dimensions of courageous followership were relevant in their daily experiences or influenced past experiences, particularly in the clinical setting. Each week of journaling represented an additional week of observing and reflecting on followership principles and how these principles worked in their life experiences. These experiences could be current or past experiences. During this time, I was also journaling observations and reflections on the research process, the teaching process, and thoughts and actions of the participants.

The first individual interview was scheduled 2 weeks after the last reflection was received. Even though conducting interviews is an action, the interviews were also an opportunity for participants to express their observations and reflections regarding courageous followership dimensions. It was also the first time since the introductory seminar that I was able to listen to the participants' in-depth personal observations, perceptions, and beliefs regarding the research topic.

Natural conclusion of a research cycle. Action research involves a spiral of planning, acting, observing, and reflecting (Charles & Ward, 2007; Kemmis & McTaggart, 2000). This process was ongoing and occurred several times during the course of this study. Once an action

was taken, observations and reflections determined what additions or changes to the original research plan would occur. This dissertation provides an accounting of the study's first action research cycle. There was a natural conclusion to this first cycle as outside realities partially drove this conclusion. For instance, participants became less able to provide time toward the study, and engaging in collaborative activities beyond what was approved by the IRB would have been an ethical violation. Additionally, sufficient data were obtained to answer the current research questions and provide a "deepened understanding of the questions" (Herr & Anderson, 2015, p. 107), which is an element of validity criteria.

Data Collection

Two points made by Maxwell (2013) were used to guide the decision-making process for selecting this study's data collecting methods. First, the researcher is the main research instrument and must use his or her eyes and ears to make sense of situations. Second, the methods selected depend on the actual research situation and what works most effectively to gather the needed information. Herr and Anderson (2015) also advised the researcher to convey the fluid and emergent nature of the action research process when outlining methodology because the research itself will continue to evolve and be shaped by the context of the study.

Individual and group interviews. Interviews provide the researcher with an understanding of the interviewees' points of view, meaning of their experiences, and uncovers their lived world (Brinkmann & Kvale, 2015). This information is part of what was being sought through this study's research questions. Both individual interviews and focus groups, which are a form of group interviews, were conducted in this study. Though individual interviews and focus groups are separate data collection methods, their combination can be beneficial to researchers

by providing complementary views and a more comprehensive understanding of phenomena (Lambert & Loiselle, 2008).

Molzahn, Starzomski, McDonald, and O'Loughlin contended that individual interviews allow the researcher to explore personal experiences, while focus groups examine opinions and beliefs about the phenomena being studied (as cited in Lambert & Loiselle, 2008, p. 230). Furthermore, Morgan explained that focus groups should be seen as a research technique that collects data through group interactions on a topic the researcher has selected (as cited in King & Horrocks, 2010, p. 65). Focus groups are also useful in the initial stages of a research project when the researcher is unfamiliar to the social context (King & Horrocks, 2010), and findings can help determine the most relevant questions to further explore during individual interviews (Lambert & Loiselle, 2008). Based on this information, it was decided to hold focus group interviews before individual interviews. Morgan also suggested that the optimal size for a focus group should be no less than six participants or conversation may be difficult to sustain (as cited in King & Horrocks, 2010, p. 67). Therefore, it was also decided to keep the focus group size at six.

Reflective journals. Collecting data through online journals made sense for this study in several ways. First, reflection is a step in Lewin's iterative spiral, which is a core element of this study. Second, numerous studies have demonstrated journaling as a powerful reflective strategy (Epp, 2008). Third, journal entries reflect data to which participants have given attention (Creswell, 2014), and journaling encourages reflection and expression of feelings (Ruiz-López et al., 2015). Journaling also allows access to how the participants are feeling and thinking about the research topic and process.

Participant journals were not the only type of journaling in this study. Data were also collected from my own reflected journal. The researcher is part of the social world that is being studied and will influence it and be influenced by it (Maxwell, 2013). Keeping a research journal allowed me to reflect on how my own background, culture, and experiences may have shaped my decisions and interpretations. The journal also added trustworthiness to this study as decisions, interpretations, and biases were made transparent to others.

Field notes. According to Creswell (2014), field notes are observational notes taken by the researcher about the behavior and activities of individuals at the research site. For this study, the individuals observed were the participants. Observation field notes were written at various times during the study. Field notes were written as individual interviews and focus groups occurred. A template was used when taking these notes. Template elements were (a) date, time, and location of the observation; (b) key ideas; (c) repeated comments; and (d) body language and vocal tones.

Audio- and videotaping. All individual interviews were audiotaped. All focus groups were videotaped. Videotaping allows both verbal and nonverbal behavior to be captured, and it can also be easily analyzed from a qualitative perspective (DeCuir-Gunby, Marshall, & McCulloch, 2012). Doody, Slevin, and Taggart (2013) said the weaknesses of focus group analysis are related to its complex process and warned researchers that group consensus may be misinterpreted when people give similar answers or withhold views. A videotape captures the group interactions in a way that allows repeated review of the data during analysis. It also captures elements of the group discussion the researcher may miss while facilitating the interview.

Data Analysis

Herr and Anderson (2015) stated that ongoing data analysis is imperative for the action research process. There should be a commitment to documenting this ongoing process because it will ultimately result in a description of the research and decision-making process. The authors further stated that during this process, action researchers will often use data analysis procedures common to qualitative inquiry. These may include such procedures as coding, using data analysis software, memoing, or journaling.

Leech and Onwuegbuzie (2007) outlined seven of 21 identified qualitative data analysis techniques. One technique outlined by the authors was domain analysis as conceptualized by Spradley (1979). According to the authors, this method of data analysis is appropriate for interview data, observational data, and personal journals. These were types of data collected in this study. The authors also said domain analysis is appropriate for data collected through action research as is this study. Additionally, domain analysis is useful when researchers are interested in understanding relationships among concepts. This study's research questions focused on understanding the nature of the relationships among courageous followership, advocacy, collaboration, and lateral violence. Finally, the authors described domain analysis as helpful in creating future questions for study participants. It was thought this would prove beneficial when moving from group interviews to individual interviews. For these reasons, domain analysis was selected to analyze data collected.

In addition to domain analysis, data analysis software was also used in this study. Dedoose (Version 7.5.9) was selected to help sort and organize excerpts identified from individual and focus group interviews. However, it was important to first assure that the interview transcriptions produced were trustworthy.

Preliminary analysis was completed while transcribing audio and video recordings. Skukauskaite (2014) stated, "Transcribing *is* analysis; it constitutes a logic the researcher creates as she listens to the recording, entextualizes the speech, and makes decisions about what to transcribe, in what ways, for what purposes, and with what outcomes." (p. 4). It is therefore important transcribing decisions are made transparent. Doing so can provide grounded warrants for claims made about observations and interactions (Skukauskaite, 2012).

According to Hammersley (2010), decisions about transcription include how much of the recording should be transcribed, who will transcribe the recording, how will speech be represented, how to label speakers, and whether to include nonword elements. Through transcribing a researcher can learn about interviewees, interviewing skills, and processes of meaning construction (Skukauskaite, 2014). For these reasons, this study's recordings were manually transcribed from beginning to end. Pauses, pitch, intonation, overlaps, pace of talk, and nonword elements were included. Recordings were listened to more than once. Memos were written while listening to recordings and reading transcriptions.

Hammersley (2010) mentioned that any label given to speakers conveys information about them. With this in mind, the initial decision to assign numbers to this study's participants was quickly changed to giving them gender specific pseudonyms. A name seemed to give each participant more humanity than a number would. Excluding gender would assume it was not important. It was unknown if gender would be an important factor to this study, so this information was included. It was important that those reading the transcripts could easily identify what parts of the recordings were from the participants and what segments were from me. Therefore, I assigned myself the label of primary investigator.

Maxwell (2013) described memo writing as a part of qualitative data analysis. Memos are different from field notes in that field notes are taken during data collection, and memos are written after the fact. Memo writing can represent preliminary analysis of the field notes. For this study, memos were regularly written during transcription of interviews and while coding interview excerpts. The memos demonstrate and make transparent analytic thinking during data collection. Memos were also written as each category was analyzed and as themes were identified.

Braun and Clarke (2006) described thematic analysis as a qualitative data analysis method for searching across a data set to find repeated patterns of meaning. In this study, Braun and Clarke's step-by-step thematic analysis guide was used to identify themes across the entire data set. The steps can be summarized as the following: (1) familiarizing self with data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. According to the authors, themes are describing something important that has been identified in the data. The importance of what is identified should also relate to the research question. A theme should also represent patterned responses and meaning within a data set (i.e., interviews and reflections).

Researcher judgment is necessary because a theme is not determined solely by prevalence within a data item or across a data set. It is determined by what the researcher decides is crucial. This is, in part, why Braun and Clarke (2006) disagreed with the idea that themes emerge from the data because it conveys a passive account of the analytical process and does not acknowledge the researcher's active role in selecting patterns of interest. For this study, the word *emerging* is retained with the acknowledgement that the process of identifying the emerging themes was an

active process involving the researcher's judgment of what counts as crucial and what elements of data would or would not be included in the dissertation's account.

Before beginning the step-by-step guide, Braun and Clarke (2006) suggested that a few decisions must be made beforehand and kept in mind during analysis. These decisions address how the data themes are identified. For instance, does the researcher use a realist versus constructionist view, look at specific aspects of the data set or the entire set, use an inductive versus theoretical thematic approach, or identify themes on a semantic or latent level. The authors emphasized that these decisions can be combined in any way as long as the end product describes what was done and why.

In this study, epistemology falls between essentialism and constructionism by taking a view described by Braun and Clarke (2006) as "critical realism which acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of reality" (p. 81). A rich thematic description of the entire data set was provided, which the authors believed is useful when participants' views on a topic are unknown. Themes identified were strongly linked to the data themselves, which can be considered an inductive approach. In addition, part of an inductive approach involves reading and rereading data for themes. For this study, data items and the data set was read multiple times with limited consideration being given to previous research on the topic. Another aspect of the inductive nature of this study was questions that evolved during analysis. For instance, lateral violence was initially seen as an issue in the clinical setting. After preliminary analysis, questions were expanded to explore experiences in the school setting. Themes were also identified at a semantic level. Semantic level analysis is a progression from a basic description of data patterns to theorizing the significance of what these patterns mean.

“Validity” or Credibility

Herr and Anderson (2015) explained that criteria for good research is commonly described by positivists as validity, while naturalist researchers use the term trustworthiness. However, the authors did not believe either term was adequate for action research because neither acknowledges its action-oriented outcomes. Furthermore, they argued that action research should not be judged by the same validity criteria used to validate positivistic or naturalistic research. Herr and Anderson (2015) believed a new definition of rigor, which does not marginalize action researchers, is required. Though their notions of action research validity are a departure from those used for quantitative and qualitative research, the authors did elect to use the term validity. The authors used the term for strategic reasons as it is often part of the language commonly introduced to doctoral students and provides an authoritative voice for students to appropriate while defending their dissertation proposal.

There is no one set of validity criteria to judge the goodness of action research (Herr & Anderson, 2015). For this study, validity was examined on a micro and macro level. On the micro level, goodness of data collection was examined using Brinkmann and Kvale’s (2015) interview validity criteria. Herr and Anderson (2015) wrote that focusing on the process, not the findings, is often a common critique of action research dissertations. Despite this critique, it seemed intuitive to examine, on a macro level, the validity of the research approach and not just the methods. Therefore, this study used criteria described by Herr and Anderson (2015) to assess action research validity.

Interview validity. Brinkmann and Kvale (2015) emphasized that validity does not belong to a separate stage of an investigation but should be threaded throughout the entire research process. Maxwell (2013) explained that two broad types of threats to validity are

researcher bias and reactivity. Researcher bias cannot be removed, so it must be explained what they are and how they will be dealt. Reactivity, being the influence of the researcher on study participants, cannot be eliminated. Therefore, this influence should be understood and used productively.

This is especially true for interviews, which was the bulk of this study's data collection, because the researcher is a powerful influence who always influences the informant and the interview situation (Maxwell, 2013). Brinkmann and Kvale (2015) also described seven stages of interview validation. As each of the following stages is reviewed, strategies used to address threats to validity are discussed. This is done to demonstrate the thought put into ruling out plausible alternatives and threats to interpretation.

Thematizing. This refers to the study's validity resting on the soundness of the study's theoretical presuppositions and logic from theoretical derivations to the study's research questions.

Designing. This stage involves two aspects of validity. First, validity of knowledge is related to the soundness of the study's design and methods used. Second, validity is also found when the knowledge produced is beneficial to the human situation and minimizes harmful consequences.

Interviewing. Validity, in this stage, refers to the trustworthiness of the participants' reports and the quality of the interviewing process. Trustworthiness of participants' responses during interviews, focus group discussions, and reflections cannot be guaranteed. Though I always felt that this study's participants were truthful, an answer that is not truthful is not always without meaning. Brinkmann and Kvale (2015) said validity in this situation "differs with different questions posed to the interview texts" (p. 287).

Transcribing. Validity from oral to written language is dependent upon the linguistic style of the transcript.

Analyzing. This stage is concerned with whether questions are valid and if interpretations made are sound.

Validating. In this stage, validity involves reflective judgment of the forms of validation to be used in a specific study, the application of validity strategies, and deciding on which community is best for a dialogue on validity. For this study, a more pragmatic form of validation was followed. In pragmatic validation, knowledge is action instead of observations alone. This aligned well with this study's design. Additionally, validation rests not only on observations but also on interpretations but with the intent to act on these interpretations. This pragmatic validation can take many forms. It involves those who will be using the knowledge produced. Deciding who will use the knowledge, how change will be directed, and what is considered desired results is part of pragmatic validation. Patton believed this makes the researcher's credibility an important criterion when judging validity of results (as cited in Brinkmann & Kvale, 2015, p. 293).

Reporting. In this stage, the questions are whether a report gives a valid account of study findings and about the role of the readers of the report in validating results. By providing rich descriptions of data, making research decisions transparent through journaling and note-taking, and incorporating strategies to assure validity throughout the research process, a valid accounting of study findings is provided in this dissertation. As for readers of this study, Taylor stated that "validity of social theories can thus be tested by examining the quality of the practices they inform and encourage" (as cited in Brinkmann & Kvale, 2015, p. 292).

Action research validity. Herr and Anderson (2015) argued that just as naturalistic researchers insist on their own validity criteria separate from quantitative assumptions, action research validity should not be judged using the same criteria as positivistic or naturalistic research. The authors further clarified that action research validity should be no less rigorous but requires a new definition that does not marginalize action researchers. The authors proposed the following set of five validity criteria to the goals of action research.

Process validity (a sound and appropriate research methodology). Some criteria may be borrowed from naturalistic research, and multiple perspectives help prevent viewing events in a self-serving way. Process validity asks how the problems are framed and solved in a way that allows ongoing learning of the individual or system.

Democratic validity (results that are relevant to the local setting). This refers to the extent to which research is done in collaboration will all parties and stakeholders. Cunningham referred to this also as local validity (as cited in Herr & Anderson, 2015, p. 69). Local validity is when a problem emerges from a specific context, and solutions are appropriate for that specific context.

Catalytic validity (the education of researcher and participants). This refers to the degree to which the research process reorients participants' view of reality, and it leads to a deeper understanding of the social reality being studied. Both researcher and participant must be open to this new view of reality but also understand their role in it. By doing so, participants become focused and energized, moving them to take some action. When the researcher describes the changes in his or her own understanding and the changes in the participants' understanding, the action research becomes more powerful.

Outcome validity (achievement of action-oriented outcomes). This refers to the extent to which action occurs leading to the resolution of the problem that prompted the study in the first place. Furthermore, rigorous action research not only solves a problem but also "forces the researcher to reframe the problem in a more complex way" (Herr & Anderson, 2015, p. 68). Herr and Anderson (2015) felt that this form of criterion was important because many action research studies stop after the problem is diagnosed or after implementing a single solution. In both instances, the original problem is not resolved.

Dialogic validity (the generation of new knowledge). This refers to the trustworthiness of the research and its monitoring. It focuses, during and after the study, on validation of methods, evidence, and findings. All of which should resonate with a community of practice. Monitoring can be done through critical and reflective dialogue with other action researchers.

Findings

The purpose of this qualitative action research study was to explore how introducing the dimensions of courageous followership influences the undergraduate nursing students' views of the follower role and informs their nursing practice. The primary research question was, How does knowledge of the dimensions of courageous followership influence the nursing students' views and practices? Secondary questions asked more specifically how knowledge of courageous followership strategies influences the nursing students' views of their advocacy role, their views about inter- and intracollaboration, and their views related to lateral violence.

The remainder of this chapter continues with an overview of participants and study activities. This is followed by a review of the primary and secondary research questions and the presentation of category findings relevant to each question. Themes identified from the category findings are then provided. This is followed by a review criteria used to assure the study's validity. The chapter is then concluded with a summary.

Participant Overview and Summary of Activities

For this study, 13 participants signed consent forms to participate: 11 participated in the focus group interviews, 12 completed the followership seminar, and 10 completed online reflections. Of a possible 48 reflections, 41 were received back. Individual interviews were completed by 10 participants: five of them allowed time for member checking. Of these five participants, four attended a member checking session to review transcripts and preliminary findings and offer suggestions for future followership educational activities. The fifth participant, who had since graduated, reviewed preliminary findings and offered suggestions for future followership teaching via email.

Of the original 12 participants, three were male and nine were female. Their ages ranged from early 20s to early 50s. Several participants were military veterans. Most had previously worked in the health-care field but not in nursing. The majority of participants were in their first and second semester of nursing school (junior year), whereas one participant was finishing her fourth semester (senior year). There were no third semester students who participated in this study.

The participants for this study had been in a clinical setting engaged in their role of student nurse and actively practicing their clinical skills. The students met with their clinical professors in a hospital setting 2 to 3 times a week for clinical days. There were many hospital sites, and they were all in South Texas. Students were on the hospital premises for 8 to 9 hrs including a 1-hr pre- or postconference. This time was structured by the clinical professor.

Clinical professors were present to teach, coach, and advise their students. However, each student was assigned for the day to a registered nurse. These nurses agreed to serve as preceptors, though staffing constraints did not always allow the nurse to opt out of this precepting role. Before nurse-student assignments were made, some professors consulted with the nursing staff about student learning needs. The charge nurse had the final decision as to which nurse was paired with a student.

During their clinical time, students were expected to work toward positive patient outcomes through advocacy and collaboration. Though students are always expected to demonstrate knowledge of leadership concepts and application of these concepts, students often occupy the role of follower. Thus, participants for this study had the opportunity to apply the concepts of courageous followership in current clinical situations and reflect on past clinical situations.

Category Findings: Followership

Process. Discussions about followership began in the focus group interviews. Participants were asked to describe a follower and what followers did. Immediately following each focus group interview, participants attended a 1-hr followership seminar. During this seminar, basic followership principles and dimensions of courageous followership were introduced. A brief history of followership theory and a 5-min video showcasing cases of failed followership were also part of the seminar. From this point forward, any subsequent data about the participants' views of followership came after their participation in the 1-hr seminar and during their reflections or individual interviews. The online reflections began 1 week after completion of the focus group interviews and followership seminar. The reflections were completed over a course of 4 weeks. Individual interviews began 2 weeks from the completion of the online reflections and took place over a 4-week period.

Online reflections. Reflections were analyzed through domain analysis (Spradley, 1979). Their analysis began as they were returned from week to week. All reflections were read multiple times and line by line to identify cover terms and semantic relationships. One purpose for completing the analysis of the reflections before conducting the interviews was to use the data to then formulate structured interview questions. Though a list of interview questions was prepared for each individual interview, these questions were also supplemented with structured questions from the domain analysis of the reflections. This provided a more individualized approach to each interviewee and an opportunity to follow up on comments made in their reflections. This also allowed participants to name cover terms that were not initially obvious. According to Spradley (1979), using the participants' own words to identify a cover term is preferred.

Focus group and individual interviews. Analysis of each interview began during transcription. Each interview was transcribed, and each verbal exchange was listened to multiple times for accuracy. Transcription notes were taken during this process. From the transcripts, interview excerpts were then identified, coded, and organized through Dedoose (Version 7.5.9). During this process, parent codes were created. Some of these codes were a priori, while others were emergent. Child codes were also created as subsets of a parent code. Excerpts were reviewed multiple times and at different times to guard against drifting. In addition, responses were considered in the context of whether it was made before or after the followership seminar. A memo was written on each parent code and its associated child code while rereading through it. For this process, each code was examined individually for patterns, connections, and relationships to other codes. Outliers and unexpected findings were also identified. Some parent codes were blended in as child codes while new parent codes were identified. Interview and transcription notes were also reviewed during the memo making process. Additionally, since interview analysis was taking place while the interviewing process was ongoing, it was possible to use emerging data to supplement the interview questions for clarification or probing during subsequent interviews.

Initial participant definition of follower. Before the basic principles of followership were introduced to participants, they were asked to describe a follower. During their online reflections, they were also asked to reflect further on how they viewed followers, and how they came to hold these views. Participants provided several descriptors of what they had previously thought a follower to be. These descriptors are considered to be participants' initial definition of a follower, or traditional definition.

Reflections. The descriptors from the online reflections were identified belonging to a semantic relationship where participants used traditional definitions and previously held views of followers to describe what it meant to be a follower. Participants used terms such as drones, subordinates, lackeys, and lemurs. Participants also characterized followers as individuals who could not make decisions on their own, take accountability for their own actions, and question their leader. For instance, Caesar wrote, "followers do what they are told without regard for consequences to themselves or others." A cause-and-effect semantic relationship was identified where participants described followers as having a dead-end profession, a lifestyle with a ceiling, and the inability to make a conscious choice.

Interviews. During focus group interviews, participants were also asked to describe a follower. They made no distinction between a good or bad follower. During these interviews, participants shared similar views expressed in their reflections. Lizette felt that followers "can be weak because they do not know what they are doing." Serena felt that it was "a bad connotation" and was "more uncomfortable to be a follower." Michael "saw a follower as someone who doesn't stand apart. Someone who waits for instruction and carries through." Angel said, "usually there's someone taking the lead and initiating the things we have to do, and someone else is watching, so I consider them followers." Robin felt that a follower might be "a student that's not as comfortable, then they'll just kind of be the observer."

Two participants recognized the negative connotation associated with followers but expressed an opposing view. During the second focus group interview, Michael said, "I always viewed the people that followed were kind of that basic foundation that the leader really needed." During the study's first individual interview, Shannon expressed her view that being a follower

"didn't mean that you were dumb, you know . . . unimaginative, or you didn't have motivation, but it was more of a passive role."

Reframed participant definition of follower. During the followership seminar, participants were introduced to basic followership theory and Chaleff's (2009) five dimensions of courageous followership. The online reflections that followed provided further reflection on these dimensions.

Reflections. After participants completed their reflections, they were asked about the follower's role. They said being a follower could be positive and fulfilling; it was an opportunity to help leadership and organization, to have a job and a purpose, and to have a real effect on the team. When discussing how their perspective of following was different as a result of reframing its definition, Shannon wrote, "I no longer look at it as a lack of leadership but rather the opportunity to help leadership and the organization move towards a better path." Angel realized, "I cannot make the actual decisions but I can make choices." Lizette wrote in her reflection, "In the past, these views kept me from learning as much as I could have from others." She continued with, "being a follower is by far more positive and fulfilling than it is a bad thing" and "I know to become an expert in certain areas, I must be a follower first to learn and grow." Shannon went on to write in her reflection, "a follower could try to transform a situation . . . have a responsibility and have the right to change a situation." Carol explained, "I learned more about how to be a good leader through being a follower" and "I can serve my leader and patients better." Robin wrote, "it is my responsibility to use my knowledge and skills . . . even though I was not confident in my abilities."

Participants also realized that the traditional view of followership had influenced their past experiences. Lizette shared her insights after attending the followership seminar. She wrote,

"[it] kept me from learning as much as I could have from others & allowing them to be in charge of what they did best." Angel wrote, "I never let any of my peers have any leadership over me." She went on to say, "[this] led to clashes I have experienced with other leaders." During one group project, Angel discussed a clash with a team member: "I could never follow what she said so the group tore in half." Eli said, because of the emphasis on leadership, "there was definitely a time of adjustment that I had to get through when asked to be a member of a team." He admitted he still "feels the negative connotation the word follower usually brings." Sheila recalled the following memory:

> I can remember being taught growing up that both being a leader and team player were equally important. However, I remember my friends always wanting to be the one in charge, and not being happy in other roles. Their displeasure when not in the leader role caused me to not want to be part of their group.

Interviews. Interview excerpts mirrored the perspectives shared during the reflections. During the second focus group interview, Shannon said she believed "followership is active" and "followers are actually really powerful. They're what gave the leader their power. They are not someone who is not the leader." Caesar felt that being a follower is "a step to becoming a leader." He compared this to being the "same as a child, and then you get skills. You learn how to pick up, build blocks . . . things like that. Eventually, you're an adult. You go to engineering school. You learn how to build a skyscraper." However, he also expressed some hesitation in accepting the idea of followership when he said, "I'm wondering if somebody came up with followership as a means to keep people at a lower level" and "is this just a way to justify being a follower? Just trying to make . . . are we just trying to make ourselves feel better for being a follower?"

A few participants also shared how the traditional view of followership had interfered in previous experiences. Angel realized her previous ideas of followers had "led to clashes" she had

"experienced with other leaders." Robin described how difficult it was to assume the role of follower before understanding followership:

> This past semester we had a big group paper for research, but I did not want to be the leader. I wanted somebody else to be the leader. It was really hard for me to sit back and let this person kind of learn as [we], as far as being a leader . . . it was hard for me to follow.

Reframing the follower role. After participants attended the followership seminar and completed their online reflections, they were again asked about the follower role. Their descriptors and views of a follower, and the follower role, were coded in a way that reflected their new insights. These insights were seen to be a reframing of previously held definitions and views of the follower role.

Reflections. Some new insights participants shared pertained to the follower's role. Angel wrote in her reflection:

> Although I was told to be a leader, I was also told to listen to those who were authority figures such as teachers, parents, elders, and people in charge. This was a form of being a first follower or even just a good follower. I was taught how to take initiative steps.

Eli wrote, "as a courageous follower I plan to stay true to my values, advocate for my patients, and support my fellow followers and leaders." Sheila had experienced a bullying incident and noted, "the principles of courageous followership could have been helpful in that specific situation because I could have gone to the instructor." Carol noted, "I learned more about how to be a good leader through being a follower."

Interviews. Repeatedly, participants spoke of followers holding leaders accountable or speaking up and questioning them when they were out of line. When asked during their individual interviews why we have followers, responses varied. Lizette felt that "if we didn't have followers, we really wouldn't have a leader." Eli added, "because not everyone can be a leader at the same time." Angel shared her opinion: "what I've learned, we have followers to

basically support the leader." Michael felt that followers were "there to do the work." His sentiments were echoed by others. For instance, Sheila said, "they're the ones who actually make change" and "you can have a dozen leaders but if they're all trying to lead, and no one is willing to follow . . . you're not going to get anything accomplished." Robin believed followers were needed because "that's how things get done"; she said, "I think they're the worker bees." Michael elaborated more on his thoughts about followers, he explained that followers "do some of the hardest things that are required within that organization or group. That's kind of why we have them because we can't just have one person do everything. We need followers. They're essential."

Reframing the purpose. Another important element of followership and courageous followership is focusing on the common purpose and not the leader. For their online reflections, participants were asked to describe what they thought was the common purpose in the health-care setting. They were also asked to explain how shifting their focus off the leader and onto the common purpose influences their view of the follower's role. This topic was not discussed during interviews.

Participants wrote extensively about this shift of focus in their reflections. When shifting her focus, Sheila said she now feels "more comfortable advocating for patients" and "feels more autonomous." Lizette also felt that "you can make more of your own decisions . . . there is more autonomy and therefore you can accept more responsibility for your actions and decisions." Shannon wrote, "focusing on this purpose allowed me to not only do my job without being asked to but also do it without angst." Similarly, Caesar felt that focusing on the common goal provided him "free reign to implement solutions that are more efficient." Michael found that "believing in a common purpose is easier than a person" and he felt "responsible for seeing that

mission through." Eli wrote that shifting his focus to the common purpose was important to him because it allowed him "to focus on the task at hand rather than being hypercritical of decisions and actions." Michael shared similar feelings about an unpopular policy that proved to be effective. He wrote that by focusing on the common purpose, he "can be more accepting of a difficult policy if it takes even an ounce of weight off someone else's shoulder." Robin shared her new insight: "I must own and be responsible for my role in achieving this goal" and "it means I am responsible for the actions of others if I knowingly allow them to hinder or violate the common goal."

Type of follower. Before the followership seminar and during their focus group interviews, it was noted that participant descriptions of followers did not distinguish between good or bad. Therefore, they were first asked to distinguish between a good and bad follower during their individual interviews. Online reflections did not require participants to do this. Any reference to a good versus bad follower during online reflections was usually a description provided while answering another question. Hence, the analysis of the interviews was more helpful in identifying how participants defined a good versus bad follower. Whether the role was managed in a good or bad way was differentiated by the follower's behaviors, intentions, and attributes. These factors were described in relation to the leader, the group, the follower's level of engagement, and the follower's critical thinking (see Table 1).

Reflections. There was little description of a bad versus good follower in the reflections. Eli felt that "leading by example" was a followership quality by "showing peers the professional way to act." Carol indicated that as a follower her goal has been to make her "leader happy by working hard, being efficient, having initiative, [and] requiring minimal supervision." Shannon shared her concern: "[I do not] want my leaders to think that I am in any way undermining their

authority but [I] still do not follow blindly." Lizette wrote, "If I do not agree with what it is they are asking of me or suggesting, I am not afraid to stand up and express to them." Serena, on the other hand, felt that "when you do things only so that your boss or your leader or your charge nurse can look at what you're doing, you're missing the point."

Interviews. During the interviews, participants were asked directly to describe a good versus bad follower. Rebecca indicated that a good follower "would be the one to listen, want to take other's ideas and compare them against their own." Carol felt that a good follower would take a task "and do it to the best of their ability with a positive demeanor." Eli echoed Carol by saying, "a good follower does it to the best of their ability without a whole bunch of complaining." Eli also felt that being a good follower meant being a good teammate: "if you're not pulling your own weight, then you're not a good teammate . . . you're not a good follower." This is similar to Michael's view that a good follower "advocates for everyone they're working with." Sheila thought a good follower would communicate well with the leader and even be "challenging when maybe [it] doesn't seem like the leader you're following doesn't have people's best interest in mind." Laura stated, "I think a good follower is supportive of the other followers" and "listens." Angel said followers "would try to resolve their own issues before making it such a big problem that has to involve everyone. They're like a leader under the leader." Lizette also said being a good follower meant "taking responsibility for what you're doing and coming forward and saying what you did was wrong, and you're willing to accept the consequences."

Behaviors of bad followers were described as well. Shannon stated, "it's easy for followers to just gang up and attack the leader but really that's not helping." Laura described her

frustration during a group project when a group member would not do his part: “we’d have a group meeting and he would come in and try to lead the group.” Robin had similar feelings about

Table 1

Differentiating Between Good and Bad Followers

Role management	Bad follower	Good follower
Toward the leader	Has bad intentions Insubordinate	Willing to learn from the leader Does not overstep the leader Keeps the leader focused on the goal
Within the group	Does not do his/her own part Tries to lead the group Hurts fellow followers Not a team player Destructive to the team	Reminds the team what the team is about Advocates for fellow followers Rallies the troops in times of change Pulls his/her own weight Communicates effectively
Engagement	Self-serving Does not do his/her own part Does not listen Stagnate	Willing to listen Does tasks to the best of his/her ability Advocates for patients Gives feedback Has a positive demeanor Takes responsibility for his/her actions Does not need permission to take initiative
Critical thinking	Does not anticipate Does not prepare Follows blindly Does not make conscious choices when following	Stays levelheaded and professional Resolves issues before they affect the group Focuses on the goal

a bad follower: “someone that’s trying to be a leader and I would say maybe plots to move the leader out, kind of coming from a malicious place.” She felt that the follower’s intentions were

then “self-serving.” Eli also felt that a bad follower would “probably just act selfishly” and “not have the patient’s best interest at heart.” Michael agreed:

> A bad follower ignores what the leader says. He doesn’t have anyone’s back. He’s not supportive of the unit. He’s usually there just to show up, get a job done and isn’t involved in the emotions of the environment. He’s just there and stagnate.

Shannon mentioned as well that a bad follower is “someone who’s not engaged.” Angel explained that a follower was bad when not doing their part: “the rest of the group starts questioning . . . it creates altercations between the group members that are doing what they are supposed to do and the group member not doing what they are supposed to do.” Lizette also said a bad follower “kind of did not do their part.” And Caesar felt that bad followers “are not making a conscious choice.” He further stated that if someone was “not going beyond what your baseline tasks are, maybe you’re a follower, just not a highly efficient follower.”

Reframing their follower roles. Different roles in followership were discussed during the followership seminar and reflection questions. The role of first follower was introduced. This is the first person in a group to show support of a leader, idea, policy or decision. Another role distinction made was that of the fellow follower. These are work or school peers.

Reflections. In one online reflection, participants were directed to reflect on a past disorienting experience. They were then asked, as a courageous follower, what responsibility they had in the experience. Though participants were not asked specifically about the role of a first follower, during domain analysis a semantic relationship was identified. Participants often described new insights and intentions that were a result of understanding the role of a first follower. Looking through these experiences with a follower’s lens, Angel shared her thoughts:

> I cannot make the actual decisions but I can make choices that prepare me to be the best help without being asked to do so. I learned from this experience that courageous followers do not need to be directed and that we also have responsibilities. I felt like a

> leader and that is because first followers are leaders. I never thought I was a follower until we actually had our first meeting.

Angel also wrote that a part of being a first follower is "standing up against disrupters, class clowns, and troublemakers." Carol said, as a follower, "[I am] consistently looking for what I can learn through difficult experiences" and "learned more about how to be a good leader." As a first follower, Eli said, "[I can] advocate for my patients" and "support fellow followers and leaders."

As fellow followers, participants felt that a large part of the fellow follower's role is dealing with lateral violence. This is discussed in further detail later in this chapter. Participants wrote that fellow followers should advocate for one another, speak to the victim, offer support and encouragement, and confront the perpetrator. Sheila confided in her reflection: "as a courageous follower, I believe it is my responsibility to stand up to bullying regardless of who the perpetrator and victim are."

Interviews. During their interviews, participants often spoke of the fellow follower's role. Robin felt that a good fellow follower meant "having a well working unit . . . trusting each other and each other's work." A good fellow follower also contributed to successful collaboration and mentored others. Eli described this when sharing his story of transitioning from the military to the private health-care sector. He spoke of how "a great team of followers and leaders . . . they were able to help and provide guidance." Eli went on to say, "you could call it mentorship. You could call it being a good, being a good fellow follower." Being a bad fellow follower resulted in, as Eli described, a "loss or respect" among peers and "all kinds of things could happen. They could be getting the wrong therapy. They could be . . . they could have the wrong side operated on." Caesar spoke of being present for a fellow follower: "It's a safe place. I'm not going to go

tell your business. If you just have that for people, you know . . . it really makes you a good leader and a good follower."

As in the reflections, a part of the fellow follower's role is dealing with lateral violence. When confronting a bully, like other participants, Angel felt that "it is the follower's role." As a fellow follower in this situation, Carol said, "I would probably then be their supporter and encourage them to go talk to the next level up." These excerpts allude to advocacy, which is further described later in this chapter.

Reasons to follow. During the analysis of the interviews, factors that the participants cited as eliciting a willingness to follow emerged. Reflecting on the participants' statements, it was noted that the decision to follow also reflected the participants' sense of engagement. These reasons are summarized in Table 2 and are detailed in the following section. Included in this summary are reasons participants gave to not follow, which are outlined later in this chapter.

Personal reasons. Oftentimes, participants' choice to follow was due to a personal reason. One of these reasons included the participant's own values. Eli felt that he was a good follower due to his "strong work ethic." Caesar stated, "my value is to be a good worker. And if my job says you will train subordinates, and they will be good workers too then to be a good worker, I have to do that." Others expressed loyalty toward the leader as a value influencing when they would follow. Shannon recalled when she was told to do something a certain way by a leader: "I didn't question her because I respected her and thought she was really in it for the good of patients." Personality aspects such as having a positive outlook and attitude, being extroverted versus introverted, having initiative, or needing reassurance were also personal reasons. Carol said, "I'm an extrovert most of the time, but other times I'll be more introverted and keep my mouth shut." The participant's belief in the leader or the goal was another reason to follow.

Sheila said, “when I believe in the message or the task or the goal, then I will give everything I possibly can.” The follower’s emotions and type of follower were also personal reasons to follow. Lastly, wanting to learn from a mentor or needing help to reach a goal were reasons for following.

Situational. A second factor cited as a reason to follow was the situation the participant was experiencing. The reason to follow most often mentioned was urgency of the situation. Angel explained, “And there’s emergency situations that we need somebody that’s telling everybody what to do” because the leader “in that emergency situation knows how to react and respond when the team, when the team is kind of freaking out.” Carol agreed that in such situations “you don’t have time to do the collaborative process.”

Another situation where participants were willing to follow was when they experienced uncertainty. The uncertainty was related to their obligation to authority, to role boundaries as a student, and of their own skills. Life situations were also seen as a reason to follow. Shannon said, “if you have other things going on in your life, it’s okay if I’m not the leader right now.” Lastly, believing change could happen was another situation in which participants were willing to be a follower. Carol shared how she felt after being promised a change that did not happen, especially after working hard to achieve that change: “I probably became more . . . reserved. It was just, it was hard to get your heart wrapped in to do the best you could.” She went on to say, “it made it really hard to have that positive attitude. It kind of makes you . . . kind of just down.”

Group. Another factor influencing a willingness to follow was the group the participant was a part of. Their role in the group, the type of fellow followers in the group, and fair distribution of work all played a part in how engaged as a follower they might be.

Type of leader. Participants’ willingness to follow was influenced by the leadership they

Table 2

Contextual Factors Influencing Whether to Follow or Not to Follow

Reason to follow or engage	Reason to resist following or disengage
Personal reasons:	Personal reasons:
Values	Emotions
Emotions	loss of faith in the leader
Personality	loss of faith in the group
having a positive outlook	Belief there is a better solution
being an extrovert versus introvert	Being a good follower
having initiative	Not comfortable in his/her role
needing reassurance	Other priorities in life
Belief	
in the leader	
in the goal	
Goals	
wanting to learn from a mentor	
needing help in reaching a goal	
Type of follower	
Situational:	Need to advocate:
Urgency	Unethical requests
crisis	Professional concerns
Uncertainty	
of authority	
of ethics, laws, and rules	
of boundaries	
of own skill level	
Belief change can happen	
Group:	Group:
Role expectations	Break down in collaboration
Type of fellow follower	trying to lead
Fair distribution of work	not sticking to the role
	Members with bad intentions
	Lateral violence
Type of leader:	Type of leader:
Good leader	Bad leader
good intentions	bad intentions
trustworthy and fair	broken or lack of trust
accepts input and listens	does not listen
gives feedback	lack of faith
similar work experience as followers	shows favoritism

encountered. Trust in the leader was cited more than any other factor as a reason to follow. Additional reasons expressed frequently by the participants were if the leader accepted input, gave feedback, listened, had good intentions and a good personality, and was fair. A leader with past experiences doing the same work as what the follower was currently doing was important and mentioned often. Shannon's comments were a good representation of this when she said, "they're going to believe in you and want to follow you because they know you've been in the trenches with them."

Reasons not to follow. As with factors eliciting a willingness to follow, factors resulting in a reason not to follow also emerged during the data analysis of the interviews. These factors were previously summarized in Table 2. It was also noted that when participants were less willing to follow, their sense of engagement with the leader or group diminished.

Personal reasons. Factors for resisting to follow or contributing to a lower level of engagement were not all simply the opposite of the reasons to follow. Similar to the reasons for following, personal reasons were also why participants resisted following. Their emotions and discomfort in the role were described. For instance, Serena shared how she felt after her preceptor made a negative comment: "I think that as a student it is really uncomfortable sometimes . . . and I don't want to spend 8 hrs with them." Participants also believed there was a better way to accomplish a goal. Eli agreed that he may not follow the leader if he saw "a more efficient way of doing it." Lastly, having other priorities in life was also seen as a reason not to follow.

Need to advocate. Participants felt that an unethical request or a professional obligation to advocate was a reason to resist following. In the face of such a situation, being a good follower was the reason for resisting the pressure to follow. Lizette spoke to this when she said,

"if a bad leader were to cross that line, then as a follower, to be a good follower, you have to recognize that's what's happening and put a stop to it." In such a situation, Carol described her attitude as the following: "I can't do this and if you don't like it . . . You know what? Come on let's take it down to the boss, and see what's gonna happen. I'm here for the patient. Period."

Group. A loss of faith in the group was also cited by participants as a reason to resist following or decrease their sense of engagement. Robin shared an example of this:

> At that moment that's when I realized I didn't want to associate myself with them anymore. They were not doing anything and that's not my style. I mean even if someone comes to me and I, I don't feel it's that big of an issue . . . as a student leader I'm trusted to be their voice whether I agree with them or not.

Followership was not solely directed toward the leader, it was also directed toward the group. Participants felt that other followers trying to be the boss or not sticking to their role was a problem. Fellow followers in the group with bad intentions were also an issue. Lastly, lateral violence between members of the group was a reason not to follow the group, and this led to low levels of engagement. Shannon shared her frustration after being a target of group lateral violence: "they weren't helping me complete the goal and, if anything, they are making me feel bad about doing it, you know . . . which would only discourage me from continuing."

Type of leader. Not surprisingly, participants felt that a bad leader was a reason to resist following. During her interview, Lizette shared her thoughts:

> If there was a bad leader that wouldn't listen whenever I had a problem, then my attitude probably changed like, Why do I have to do everything that you ask me to do and hear you out, but whenever I have something to say, you can't listen to anything I say? Then I wouldn't want to give them that respect.

Attributes of a bad leader were identified during domain analysis of the reflections and are discussed elsewhere in this study. However, when relating these attributes to reasons for not following, participants felt that a leader who did not listen, showed favoritism, had bad

intentions, or who broke trust should not be followed. A lack of faith in their leader was another factor in resisting following and low engagement.

Category Findings: Leadership

Process. During focus group and individual interviews, participants were asked specific questions regarding leadership. Therefore, a parent code called *leadership* was created as a place to group data relating to this topic. Participants were asked to describe a good and bad leader. Hence, it was a natural step to then create a child code called *leaders* and subdivide these relevant excerpts under *good* or *bad* leader. Participants were also asked to identify their leaders. Excerpts of their answers were coded as *identified leaders*. However, two codes emerged organically while reading and rereading excerpts. Participants shared stories or examples that reflected a way they learned leadership. The code *learning leadership* was then created. Likewise, participants also described situations where different types of leadership styles might be appropriate. A code *situational leadership* was created for these excerpts.

Blended into data analysis were the semantic relationships identified while analyzing the participants' online reflections. A long list of words describing the characteristics of a leader was compiled. These were considered attributes of a leader. Participants described rationales for being a leader as well. These were coded as reasons for being in a leadership role. In addition, transcription notes from the interviews were reviewed for additional insights.

This process provided the findings outlined in the following section. First, a definition of a leader was created. A description of a good versus bad leader is then provided. The participants also described those they identified as leaders. This is followed by participants sharing how they learned or are learning leadership. Concluding this section are descriptions of participants' preferred leadership style.

Defining a leader. During focus group interviews and reflections, participants were asked to describe a leader—not to differentiate between good or bad leaders—and they used positive descriptors to describe them. Negative descriptors were rarely used unless participants were specifically asked to describe a bad leader. Though it was observed that they tended to describe leaders in a positive light, the participants did not seem aware of this. Therefore, they were asked to differentiate between a bad and a good leader during their interviews.

Good leader. Data regarding good leaders came mostly from the interviews. However, one semantic relationship from the domain analysis of the reflections was relevant to this section. Participants listed attributes of leaders. A good leader was thought to be someone special. For instance, Eli wrote, "a leader was someone special or someone who lead great victories during war, civil rights movements and great feats of science." Carol wrote that a leader is "concurrently a follower."

In the interviews, good leaders were described as having had what Rebecca called "experience of being in the grunt position." As Eli explained, "a good leader never asks you to do something they wouldn't do." Several participants felt, as Robin did, that a "good leader leads by example." This meant a good leader was not above doing the same work as followers. Eli believed they were able to "show you they would do it along with you." Leaders were also described as mentors. They were seen as approachable by being supportive and as a safe place to seek support. Their concern was for the team, advocating for the group, supporting its members by challenging members to grow, and delegating to strengths. Participants thought a good leader was also a good follower who was open to input and accountable. Part of being open to input meant listening to others. A good leader, Angel said, "listens to the whole team." Lastly, a good leader, according to Lizette, would "step up to the plate." Likewise, Michael thought a leader

was the "first to take action" because this type of leader "doesn't wait for anyone to do something."

***Bad leader*.** Data regarding bad leaders came solely through the analysis of the interviews. A bad leader was described as a dictator who was controlling, bossy, felt above the rules, and wanted everything their way. A bad leader did not provide feedback or guidance and was not open to input. This type of leader did not listen. Not listening was often cited as a quality of a bad leader. An example of such sentiments was Laura's comments. She said, "they do more talking than listening. A bad leader only listens to people above them." A self-serving leader was also frequently cited as a bad leader. Someone who pursued their own agenda or did not take care of their followers was seen as self-serving. Lastly, a leader who expected others to do work they were not willing to do or was too lazy to do it was seen as a bad leader. Sheila explained, "it can give off the impression that those people think that they are above certain things while other people . . . it's their role to fill those tasks. It can be very condescending."

Identified leaders. Participants were also asked during interviews to identify their leaders in the school and clinical setting. Leaders were usually associated with a role and rarely linked to authority. For instance, when speaking of authority figures, Shannon said, "you never hear from them." Robin followed up Shannon's statement by saying, "they're not as engaged." Sheila was an exception; she stated, "I see leaders as more of as like power positions." However, when asked if someone could be a leader without legitimate power, she said, "Absolutely. I think those are kind of the unacknowledged leaders." Discussion of identified authority figures took place mostly in participant reflections and is discussed later in this chapter.

According to Caesar, leaders are not always "the top dog." Charge nurses, floor nurses, and unit educators were identified as clinical leaders during the interviews. Michael said, "a lot

of the leadership that I see actually comes from the nurses themselves." Lizette had similar feelings: "a charge nurse, it's in the name already. That's how I look at them. They're in charge. They're in lead for today. I could go to them if I need anything." Caesar also said, "[at the hospital] my leader was the person I'm precepting with." Only two participants, Eli and Carol, mentioned doctors as leaders, yet they both went on to describe other nurses as leaders too. Clinical professors were repeatedly cited as the participants' main leader. Michael declared, "I see a lot more access to my clinical instructors and even some of my classroom professors just as the ideal leadership." Shannon echoed Michael's thought:

> I was going to say that for me the leaders are more my clinical professors, not that my lecture professors couldn't be, but there's just too many of us. But since clinical is [a] smaller group, you get to know them better, and they can really, I don't know, teach you and help form you and guide you, so for me those are my leaders.

Other students were also identified as leaders in the school setting. Shannon spoke of some other students: "they were really good people to ask for advice, and they would teach you." The value of these identified leaders to participants was repeatedly described as their ability to teach, their experience, and their approachability. When Sheila was asked specifically what made her view someone as a leader, she replied, "Their ability to teach. I'm trying to think of the word to use. Encourage me! Support me so in times when I felt really unsure or very uncomfortable having that person say you can do this."

Learning leadership. Though not specifically asked to do so, participants shared their stories about the ways they had learned leadership. Experiences had clarified to them how they wanted to lead. Carol felt that "being a follower first" allowed her time for modeling how a leader should behave. Participants described their past mistakes, feedback from leaders, and failed advocating and collaborating experiences as ways they learned how to lead. Sometimes these experiences were more of a prompt to adjust their leadership style. As a result of these

experiences, participants described themselves as being more flexible, more collaborative, and less controlling when in a leadership role. Angel explained, "I would say in the past I dictated too much. And now I'm just kind of exploring when is it a necessary approach to be a dictator or free leader or letting someone else lead the group." Robin acknowledged her past mistakes with followers: "I should have been more accountable to them and making sure they were okay with getting their work done or if they needed help." While the majority of participants agreed that leadership is learned, some participants believed there were aspects to leadership that could not be learned. Carol stated, "You can't just make a leader. There's certain innate abilities that God gives you and that's how it is, but there's pieces of leadership, I think, you can work on."

Leadership style. In general, participants spoke of a collaborative style of leadership as good leadership. Sheila indicated that "a bad leader is definitely the dictator" and "it doesn't provide a collaborative environment." Yet, participants understood situations may dictate other leadership styles. Urgency of the situation was cited most as a valid reason for an authoritative approach. In this situation, Angel explained, "there are situations where leaders need to act more . . . where they delegate specifically in emergency situations so that needs to be a little more controlled." She felt that, in this case, it was "best if one person was making the decision." Carol described how "the criticality of the mission" directed leadership style. She went on to explain, "If it's very critical and it's not only the time thing, but it also depends on the lives on [the] line. We don't have time. Go!" The participants' own lack of knowledge was also a reason for a less collaborative approach because they felt that they did not have the knowledge or experience needed to lead. Shelia admitted, "[I am] just not at that point yet where I know enough to collaborate with different professions." Caesar shared his opinion: "you're just entry level so you really, I don't think you should have a say."

Category Findings: Exemplary Behaviors

Process. During the data analysis of the interviews, it was observed that the participants were often describing behaviors they considered desirable. These behaviors were desired in a person whether they were in the role of follower, fellow follower, or leader. These behaviors were coded as *exemplary behaviors*. Examples of participant critical thinking became a child code of exemplary behaviors because the outcome of their critical thinking was observed to be an exemplary behavior. This is the same reason the parent code titled *engagement* was changed to a child code of exemplary behaviors: The outcome of engagement was an exemplary behavior. However, the behaviors described by participants as demonstrating engagement were similar to exemplary behaviors. This made it difficult to differentiate the two at times. During memo writing, findings from the domain analysis of the online reflections were also considered, since several semantic relationships described desired behaviors.

Ideal behaviors. Participants considered certain behaviors as ideal or desirable. These behaviors have been termed exemplary behaviors. A person with ideal behaviors, as described by participants, is professional, a team player, an effective communicator, and a critical thinker. These behaviors are not passive and require some level of engagement. The exemplary behaviors summarized in Table 3 reflect engagement in a professional, collaborative (team player), communicative, and cognitive (critical thinking) sense. The following section outlines the participants' descriptions in more detail.

Professional. In their reflections, participants described desired behaviors that demonstrated professionalism when building a relationship with patients. Treating others as they would like to be treated was one way to do this. Michael described how he valued "trying to understand other's concerns" and "placing myself in their shoes." Treating patients with respect

Table 3

Exemplary Behaviors

Professional	Team player	Communication	Critical thinking
Strong work ethic	Collaborates	Listens to others	Organized
Good at what they do	Helps fellow followers	Accepts input	Prepared
Gives their best	Picks up slack	Gives feedback	Problem solver
Good attitude	Works with the team		Anticipates needs
Takes responsibility and ownership	Teaches others		Takes initiative
Timeliness			Drives good care

was often mentioned as a desired behavior. Caesar spoke of "respecting all patients and their wishes." Shannon said she valued "respecting and caring for all." In addition, Robin wrote that she also valued "respecting all patients and their wishes." Taking responsibility was another desired behavior. For instance, Sheila wrote of feeling "a responsibility to use my knowledge and skills." There was also a responsibility to respect patient values. Lizette explained, "I cannot inflict my beliefs on them" and "must be aware topic is sensitive to them." Angel realized she must "be aware and sensitive to their beliefs and values." And Caesar said it was important to "maintain boundaries" and to "separate my values from professional values to give them autonomy."

During interviews, these behaviors were also described when referring to good leaders and good followers. Shannon described a good leader as someone who "really knows everyone's role and knows what it's like." A good leader took responsibility. Lizette said, "they have to step up to the plate" and "make sure what needs to be done is done. They are held accountable." Yet, similar sentiments were shared about good followers. Like her previous description of a good leader, Lizette thought a good follower meant "taking responsibility for what you're doing." Yet,

Sheila felt that it was a good follower's "responsibility to step in" when an issue with the leader arose.

Team player. Being a team player was a desired behavior described mostly during interviews. However, Robin wrote in her reflection, "Delivering patient care is a team effort." During his interview, Michael described how "People get hurt. Not everything that should have been done gets done, and things get overlooked" when health-care workers are not collaborating. Carol believed the "bottom line is patient care" and when a team does not work together, it is patient care that "is going to be impacted negatively."

Being a team player was a behavior both good followers and good leaders were said to demonstrate. Laura believed "a good follower was supportive of the other followers." Angel said a good follower "reminds the team what the team is about" and "they're kind of like a leader essentially under the leader." Eli felt that "if you're not pulling your own weight, then you're not a good teammate . . . you're not a good follower." When speaking about leaders, a good leader took the group into consideration. Sheila said good leaders "work together toward the goal." Carol described a good leader as someone willing to "step out of the leader role, go down, and say, 'I'm going to show you how to do this.'"

Communication. Effective communication was a desired behavior, and its importance to participants emerged during the interviews. Carol stated, "communication is very critical, and it pulls in all the different things we've been taught." Sheila said, "communication is really important to me, so I don't blindly follow." Robin shared how keeping an open communication loop is "essential in maintaining a positive constructive work environment." When participants described good leaders and good followers, both were said to be able to listen to others, provide feedback, and accept input. When Sheila described a good leader, she spoke of receiving "tons of

feedback," and she said, "that was really validating to me." She further stated, "[the leader] listened to our ideas and our input, and I gave everything I could." Likewise, when Laura described a good follower, she said, "they're the ones actually willing to listen to others, their ideas, their input, and then give feedback and actually make a change."

Critical thinking. In their reflections, participants described ways they tried to demonstrate critical thinking. Most of these ways, but not all, meant anticipating, being prepared, and organizing or improving timeliness. These were considered desirable behaviors. For instance, Lizette wrote of anticipating needs in her reflection. She was committed to being "fully prepared," and she said, "[I would] have to practice scenarios in my head and think through what my actions would be." To assure timeliness, Lizette realized she would have to "delegate tasks," "cluster work," and "find short cuts, while still being neat and thorough." Angel declared, "[I wanted to] ensure that anyone that needed my help would have my immediate response." And she explained that her way to anticipate needs was to "ensure to get familiar with at least one room." Others wrote of thinking through their actions, being proactive in assessing patients, and engaging in proactive communications.

These same behaviors were seen in descriptions of good leaders and good followers during participant interviews. Caesar felt that a good follower would be able to "project what the need is before they want it." Michael stated that good followers were "able to see efficient or better opportunities within the system that they've been working in." Likewise, a good leader, according to Angel, was able to "bring helpful tips, organize." Caesar also saw a good leader as having "the ability to make the most efficient way for the group," while Shannon said a good leader "increased productivity."

Engagement. During analysis, participants described actions that represented a sense of engagement. Therefore, a code was created to capture these descriptions. By rereading and reflecting on each excerpt in this code, a more detailed picture of engagement emerged.

The most often cited example of a desired behavior showing engagement was someone taking initiative. Participants felt that taking initiative meant not waiting to act, being the first one to act, and going the extra mile. In his online reflection, Michael shared a story about a fellow follower's actions, which he recounted during his interview: "she was first off, making life simpler for the nurses. Just kind of doing things that need to get done without ever being asked." Caesar spoke of "preparing for the next step, and part of that is kind of leadership but it is kind of like I've empowered myself."

Other ways to show engagement was by anticipating, active listening, bringing helpful tips, being self-directed, learning, accepting work, empowering self, thinking critically, taking the role seriously, and taking responsibility. In the nursing context, behaviors demonstrating engagement were providing patient education, caring, minimizing sickness, impacting care, advocating, providing safe care, keeping things moving, prep rooms, and representing the profession.

Driving factors of engagement.

Personal factors. Driving factors of engagement were identified by participants as one's personality, attitude, moral compass and values, sense of conviction to meet the common purpose, and upbringing. In their reflections, Carol described being brought up with a "strong work ethic, and that you should give your best in all you do." Angel revealed, "I have always been the one to stand apart in a crowd" and "standing up for what is right." During her interview, Robin explained that she understood that because of personality some "A student that's not as

comfortable, then they'll just kind of be the observer." And Shannon explained why she took initiative in completing tasks: "I saw that as helping the common purpose when we did have down time, you know, helping things roll along, helping them turn beds, helping prep for when we did get a rush."

Contextual factors. A participant's level of engagement was also influenced by contextual factors. A bad leader, lack of feedback, and refusal to accept input discouraged engagement. The opposite of these factors—being a good leader, providing feedback, and accepting input—fostered engagement. For instance, Shannon explained why a group was willing to follow a health-care provider she observed leading hospital rounds: "His personality was very genuine and kind. He just wanted to get . . . make sure all bases were covered." In addition, past disorienting experiences and fair work distribution fostered engagement. Sheila said, "having a really good leader that I trusted that I thought listened to our ideas and our input, and I gave everything I could and picked up other people's slack."

Disorienting experiences. As part of the online reflections and learning about followership, participants were asked if they had been through a disorienting experience in the clinical setting. They were also asked to describe how this experience made them feel and if it resulted in a personal transformation. If so, they were then asked to describe this transformation. Additionally, participants were asked to reflect on and describe what responsibility they had as a courageous follower in the experience. Through domain analysis, three important semantic relationships came out of this reflection activity: (1) the cause of the disorienting experience, (2) the result of the disorienting experience, and (3) the result from the transformation.

Causes. Causes of disorienting experiences for participants were often related to being overwhelmed by demands on their time and emotions. For instance, participants wrote in their

reflections of being stretched too thin, of constantly running back and forth, of having so many things thrown at them, of being given more and more patients while still being responsible for all duties, and of being asked to do more than they could handle. Their lack of experience sometimes led to a disorienting experience. Angel described a situation where she "had no prior preparation" and "did not know how to be a follower in this situation." Lizette said, "[I felt] emotional stress because I knew that many of these things could be life-threatening" and "didn't get to experience while in training." Robin remembered not being "use to situation [*sic*] and didn't know how to handle." Similarly, Michael wrote of an experience in which he had "never been in this position before." Issues with collaboration were also a problem. Participants shared situations, as Shannon did, where the "patient was obviously in distress, but no one was trying to help her," and one incident where Angel said, the "doctor is shouting at me." Lastly, being in their new role triggered disorienting experiences as well. Michael shared how he "had no idea how to interact with the patient" and had to remind himself he was a nurse: "I was in an actual nursing role." For Eli, his role as a nursing student was the first time he had to "interact with a medically fragile patient who was not a military-aged man." In addition, particularly distressing and common disorienting experiences for participants were incidents where they failed or witnessed a failure to advocate for a patient. These incidents are described in more detail later in this chapter.

Result of disorienting experiences. The disorienting experiences triggered emotional reactions. Participants spoke of feeling confused, disoriented, shocked, frustrated, flustered, and helpless. Sheila described being "appalled." Robin wrote of "breaking down in tears more than once" and being "extremely uncomfortable." One participant, Carol, went "through physical stress," while Lizette described being in "emotional distress." She also "didn't know how to act"

and “felt unready.” Michael “could not express comfort or knowledge towards patient.” Shannon also “felt confused” and “didn’t know what to do.”

Result of transformation. Each participant shared how going through this experience had transformed their outlook. Table 4 summarizes participants’ descriptions of their transformation after a disorienting experience. Their transformation shaped their views of accountability, how they collaborated, and how they communicated. Their descriptions are outlined in more detail in the following section.

Accountability. Shannon reflected on her disoriented experience and said, “[what] I saw was how a follower could try to transform a situation. Followers have a responsibility and a right to change the situation.” Robin stated, “[I feel] more confident in myself when it comes to overcoming situations” and “[I plan to] remind myself of my responsibility and ability to learn skills.” Lizette said, “I have to take responsibility for my actions” and “recognize things were going to happen, and I couldn’t let them stress me out every time.” Michael wrote that he became “more proactive in being in patient rooms and assessing them.”

Collaboration. Carol realized from her disorienting experience that it was necessary to transform to a more collaborative leadership style. She realized that “being a follower can be very fulfilling” and that “being a follower is much more difficult than barking out orders.” Angel wrote that she “became a first follower within the hospital.” And Eli felt that “with a great team of followers and leaders,” he could make the necessary transition from “hardened line medic” to a “compassionate hospital medic.”

Communication. From his experience, Michael learned the importance of communication: “[I] began communicating more with my clinical patients on the level a nurse should” and “having proactive communication.” Angel explained, “sometimes standing against

the leader is needed, but this specific experience taught me that I could do this without causing a commotion and drama."

Table 4

Transformation as a Result of Disorienting Experiences

Accountability	Collaboration	Communication
Became more proactive	Became a first follower	Learned to listen
Recognized I had an important role	Learned that being a follower is very fulfilling	Reanalyzed how to approach a situation
Ensured that anyone that needed my help would have my immediate response	Became a collaborative leader and follower	Began communicating more with patients
Became a confident worker	Learned that being a follower is more difficult than barking out orders	
Had to take responsibility for my actions		
Became the worker I knew I could be		
Had to be realistic with myself		
Learned that followers have a responsibility and a right to change a situation		

Category Findings: Advocacy

Process. The first of three secondary research questions for this study was, How does knowledge of courageous followership strategies influence the nursing students' views of their advocacy role? As part of the online reflections, participants were asked to reflect on the followership principles they had learned—specifically, the dimensions of courageous followership—and how they might use these principles when dealing with failures to advocate. Through domain analysis, semantic relationships were identified.

Advocacy was discussed during group and individual interviews. Several codes were created during analysis similar to the line of questioning found in the interviews. However, some codes emerged naturally. For instance, when describing their advocate role as students,

participants shared things that interfered with their advocacy efforts. They also shared why they advocated, even though they were rarely asked this question directly. At times, the reasons why they advocated were communicated indirectly through stories. In addition, participants communicated their experiences of failed advocacy and learning advocacy through their stories and explanations. Both semantic relationships and created codes were considered during analysis.

Participants' description of advocacy.

Reflections. Participants were not asked to define advocacy in their reflections. However, they were asked to describe how they would address issues of failed advocacy as a courageous follower. Lizette wrote, "I want to be an advocate for every single one of my patients and make sure they are getting the care they deserve" and "I can stand up for their rights and dignity if anyone tried to give them less than they deserve." Robin said, "[If I saw] a patient being put at risk because of inaction, I'm comfortable addressing the situation and escalating the issue if necessary." Caesar was insightful with his thoughts: "presence is also powerful to keep people from escalating into a violent mood. Simply walking with someone that needs an advocate to confront an aggressor can assist the parties to have a civil dialogue."

Interviews. Participants were asked specifically to define advocacy during their interviews. Shannon described advocacy as "taking time with the patient to really understand what they want." Sheila felt that it could mean "speaking up for people who don't have a voice." Angel agreed when she said, "you have to speak up for your patient, and I mean, and advocate to the other professions what your patient is thinking." Michael thought advocacy meant "making sure the patient is safe and comfortable." Robin felt that advocacy meant "sometimes putting yourself out there just to do what's right." She further stated, "I don't know how else to explain

it, but it's always the right thing. It's having integrity." Caesar also expressed advocating "can be that you're doing something in their interest when maybe they don't think it's in their best interest." Shannon agreed, "going against your patients' wishes sometimes is also advocacy because you know that it's better for them."

Advocacy was also described as having nuances in how it is carried out. Eli suggested:

> How we advocate is also important so in, in that situation you could be extremely respectful and, you know, tell the doctor exactly what you think or depending on the situation, might be able to pull him aside later on or talk to your boss.

Angel described how she might advocate: "I want to be able to be strong for that patient and tell other team members respectfully, They can't handle things that you're doing to them . . . can we do something else? I . . . just . . . just fighting for their rights." Sheila suggested, "you can build a relationship with your patient and then that relationship will help you advocate for them."

Participants' view of advocacy's purpose. Throughout the discussions about advocacy, whether in interviews or reflections, the patient's safety was the underlying reason to advocate. All participants, without exception, felt that advocacy's purpose was for the well-being of the patient. Serena wrote in her reflection that advocacy was "for the patient's good, health, and well-being." Sheila said during her interview, "I do believe a huge part of it is safety." Eli felt that advocacy is needed because the "patient population isn't well-versed in medical care and how everything goes."

Focus of advocacy efforts. Patients were most often the recipient of the participants' advocacy. The examples the participants gave were similar to Shannon's response, "It's all about the patient." As Laura explained, "I'm supposed to advocate for my patients. It's hammered into me to advocate for my patient." However, participants did not feel that acts of advocacy were limited to patients. Shannon mentioned that professors "need to advocate for themselves a little

bit on behalf of their students," while another participant shared how she had seen professors advocate for students. Also needed was an advocate for the group. Leaders were also seen as needing an advocate. Laura shared her reason: "[I need] to advocate for my charge nurse who has to make a decision based on staffing that nobody likes, and sometimes I have to advocate for my nurse and the decision she makes." Lastly, the need to advocate for oneself was expressed by several participants.

Driving factors of advocacy.

External factors. Participants indicated that there were external factors that drove advocacy, such as rules, regulations from the Board of Nursing, scope of practice, prison time, fines, HIPPA, federal laws, state laws, policies of the organization you are working for, and standards of care. Sometimes wanting something drove advocacy. As Shannon explained, "If you want better hours, you're gonna have to advocate for yourself."

Internal factors. Internal factors driving advocacy were values, ethics, upbringing, morals, and culture. Sheila believed "it's the right thing to do," which brings "a sense of "justice." Sheila explained:

> I am not the kind of person who can stand by and do nothing. It is just . . . it is just not the way I was raised. It is not what I believe in. It comes back to fairness and justice.

Robin felt that "if you see something that you know is wrong . . . you need to say something. You can't just be a bystander because then you become part of the problem." Laura shared her thoughts:

> But whether you believe in God or the universe or karma or whatever it is . . . eventually you have to come to the end of the line and then just hand it over. And I can't . . . I did everything that I could. If there is something else that I could have done . . . please show me. Please, you know, universe, God . . . whatever . . . Jesus . . . please help me. Could I have done anything better?

Sense of duty. A sense of professional duty was also a driving factor. Two excerpts, one from Michael and one from Caesar, exampled this sentiment. Michael stated, "I'm there to become a nurse, and I take the responsibilities as if I was a full-fledged nurse." And Caesar affirmed, "that's who we are as a profession." During a focus group interview, participants were purposefully asked the following closed-ended question: Are you a nurse if you are not advocating? Participants responded in the negative. Robin said, "Not a good one." Angel replied, "not a professional one." During an individual interview, Caesar was asked to describe what advocacy meant to him. He responded by saying, "standing up for some values that really aren't yours . . . they don't have to be yours." He was then asked, "if they weren't your values what would make you want to stand up for them?" He quickly responded, "because it's your job!" Sheila was also challenged during her interview when she was told, "but there are other people who advocate for their patient." She responded by saying, "Absolutely! And I hope they do as well, but I think it is . . . it is part of our role." She also explained, "I think part of it is a level of understanding that we will have that maybe others don't." Lizette explained:

> You get paid to go in and give medicine and whatever . . . do basic care for a patient, but you also really have the role of being an advocate. And if you just completely ignore that and didn't do it . . . that patient, all your patients, are the ones that really get let down.

Carol, who has a military background, mentioned a flap jacket while describing her sense of duty to advocate for patients: "I am your flap jacket. You're my patient. You're my kid. I am your flap jacket. And the day I can't do that then I need to step out of that role."

Barriers to student advocacy. Sharing stories during interviews brought to light the barriers that nursing students faced as they made their first attempts to advocate. These barriers included participants' uncertainty related to the boundaries innate to their student role and their

level of knowledge and experience. Other barriers included issues surrounding hierarchy and power. Failures in communication was also seen a barrier.

Uncertainty of boundaries. One common barrier to student advocacy was their uncertainty of boundaries, since they were a guest in the clinical setting and did not view themselves as part of the system. As explained by Shannon, these barriers meant that the student's "voice didn't have much weight." Robin agreed, "Students don't have the voice that they should have." Laura admitted, "you need to watch what you are saying because we would like to be able to come back." Serena fretted over not pointing out that a nurse had broken a sterile field: "I was standing over the patient. I could have told her, Could we just get another sterile kit because you broke sterile field? and . . . I should have said that. That would not have cost our clinical site rotation." She did later report the incident to her professor and charge nurse. But she felt that if she had said something sooner, this "would have meant going out of my lane," she said, "and it would have been like *fine*. . . no more students are going to come."

Uncertainty of knowledge and experience. There was also uncertainty related to lack of knowledge and experience. Eli shared how advocating was difficult during these instances: "instances in which I lack knowledge and so whenever I run into that, I definitely don't feel prepared." He further explained, "[I] look it up when I have a free minute, there or later on. And try to get back and follow up on everything." Shannon could see "why nurses are the way they are toward students." She went on to explain, "nurses have kind of been around the block, so they know what is a real issue and kind of isn't."

Uncertainty of hierarchy and power. Other barriers preventing students from advocating were in part related to hierarchy and power differential. Laura spoke of the student's position as a barrier: "the position is when someone is coming down on us and being prepared for somebody

to go, Well you're just a student." Laura added that she worried someone would say to her, "I know this little student is not trying to tell me how to do my job." A sense of intimidation from those in power also limited participants' willingness to advocate for others. Caesar admitted he considered his options when he watched a professor bully a student: "just the intimidation like . . . I might not advocate for my fellow student because I need to pass this class." He also discussed intimidation in the clinical setting:

> I can see some intimidation. You know, with people who already have degrees, and they kind of see students as less than subordinates to them. It's like you're not here. You're here, but you're really not working, you know? You're not really part of the system.

After seeing her assigned nurse break a hospital policy, Carol questioned what she could have done differently:

> maybe I should have just gone ahead and just taken the heat and let her yell at me, you know . . . and create a big ruckus in the room. I don't know what was right. I just knew that was wrong.

This was similar to how Shannon felt it would be if she ever had a conflict with a precepting nurse: "if what I thought was the patient's wishes were conflicting with what their nurse understood . . . then I mean she obviously . . . that's her patient. That's her job. She's gonna trump me."

Failure to communicate. Failing to communicate also was a barrier to advocating. Angel declared, "I've seen some people don't even attempt to see what the patient needs or wants or their beliefs." The breakdown in communication could occur one-on-one with the patient, as Robin shared when she spoke of her hospitalized father:

> He's not in pain now. He's probably gonna be in pain tomorrow. But he still had the right to know what he was about to get and to be asked, Are you in pain? Do you want your pain pill?

Other failures to communicate happened during failed collaboration between health-care members. Shannon described a breakdown in communication between a nurse and a physician. The physician was not acknowledging what the nurse was saying to him. Shannon explained the situation: "even if he didn't believe the nurse . . . I mean that's his patient too. He should be a patient advocate as well and just gone and seen for himself what the patient was going through." She continued:

> I felt like it was a bit of bullying, you know, the nurse's job is to be the watch dog, the physician can't be there all the time, and patients' conditions change, you know . . . that's not a weird occurrence. So for him to straight up basically say she was lying and that her assessments were inaccurate was a bit of bullying.

Laura shared an experience where she had information about her patient, but the physician "didn't know anything about his care. They didn't know he was on arm restraints. They didn't know that he couldn't swallow yet." She explained, "It was all in my hands . . . the information they needed . . . that was missing."

Consequences experienced after failing to advocate. For these findings, data analysis of the interviews was supplemented with domain analysis of the reflections. Several of the disorienting experiences described in the online reflections were due to a failure to advocate. During interviews and in reflections, participants shared times when they failed to advocate. These perceived failures were usually a result of witnessing a licensed health-care professional fail to do what was best for, or failing to protect, the patient. When participants did not report it or stand up for the patient after witnessing an incident, they viewed this as their own failure to advocate.

Participant emotional distress. In their online reflections participants shared how these failures also made them feel. Carol described feeling "between a rock and hard place," and she said, "I feel I have failed the patient." Even though Shannon tried to find a way to advocate for

her patient, she still felt "disoriented and confused" when she witnessed a failure to advocate. Whether it was a result of their inaction or the action of others, failing to advocate for patients elicited emotional responses among the participants. Sheila shared her outrage during a clinical rotation. A child she worked with, on one particular clinical day, was deaf and communicated through sign language. She knew sign language and communicated with the child throughout the day. But when she left the hospital at the end of her clinical day, the child did not have anyone to communicate with. Sheila described how upset she was by this: "I was still really ticked that he didn't have an interpreter." She further explained:

> They had an interpreter during the actual day but only for like four or five hours during the day. Um . . . because how else is he supposed to freaking communicate? You're in [a] psych hospital where you are seeing kids that have behavioral issues but you're not providing him [with] what he needs to *not* have behavioral issues. It was *so* counterintuitive to me. And . . . I, I just . . . my mind is still blown.

Similar emotions were expressed during the interviews. Serena commented, "I couldn't protect the patient, so I feel in a way that I failed." During her individual interview, Carol spoke of "lost sleep" over an incident and how it still bothered her. She first described the incident during a focus group interview. She shared how she had "just watched a Foley put in a guy" and was "horrified" because she knew the sterile field had been broken, and she did not speak up. Sitting next to her, Serena said, "I just went through the exact same thing. It was horrible." Carol also shared a story where she forgot to write down a patient's heart rate while taking vital signs. Later she apologized for the oversight. When she was unable to recall the actual heart rate, the nurse responded inappropriately; Carol said, "[the nurse wanted] excuse my language . . . a BS number. And it infuriated me." After witnessing a failure to advocate, Laura described being "almost in tears because it was just so sad. The last person they cared about during the discussion was patients."

Loss. Participants described in their interviews other consequences of failing to advocate other than their emotional reactions. Failing to advocate also colored their feelings about others. Carol said, "I now have zero trust for . . . for all of them, for that particular nurse, for the clinical faculty, that I was over. I don't have . . . not only is it trust . . . it's respect!" Caesar believed patients could also "lose confidence in the system." Michael felt that failing to advocate could also cause "people to get hurt or things to fall to the way side and leads [*sic*] to problems down the road." And worst case scenario for patients, according to Caesar, was "they die." Eli believed that "if there is a way in which they can be advocated for and they're not, and they get worse, then it's a little bit more your fault for not doing your job," which could ultimately lead to a nurse losing not only their job but also their livelihood.

***Learning through negative experiences*.** Not all consequences of failed advocacy were negative. Examples of learning emerged during analysis of the interviews. Each failed advocacy story and description of the emotional fall out that resulted were also followed by a reflection or intention not to let it happen again. For the participants, a consequence of failing to advocate was learning how to better advocate in the future. For example, Serena who previously shared her distress for not speaking up to the nurse said, "I've been thinking about that . . . like for . . . ever since it happened." During a focus group interview, she explained, "I could have told her, Could we just get another sterile kit because you broke sterile field? and . . . I should have said that." Carol, who had also remained quiet when observing a nurse break sterile field, said:

> I did what I was supposed to do and now in hindsight, you know . . . I don't *care* anymore. I'm gonna find that charge nurse and say, You know what? This is it! You don't like me . . . fine. I don't really care. I'm here to be an advocate for that patient.

At the time of the incident, she felt the need to protect the school's relationship with the hospital. Through this disorienting experience, she now intends to speak out instead of staying silent.

Angel shared an experience in her reflection, which she later discussed during her interview. At the time of the incident, she was "really frightened." During a delivery, a physician was asking her to do things and get things. Being a student, she did not know where to find what was needed. She felt unprepared: "[I] wanted to cry at that point because I was like I don't know what to do." After this incident, she was determined to be better prepared for the patient. During her individual interview, she explained further:

> we had weekly reflections that we wrote about every week for clinical. And I told my instructor, I was like, "You know everybody can do this," but I was like, "not everybody is going to until they experience something like this."

She went on to say, "if you aren't prepared in that situation and you stop . . . you're wasting moments of that patient's life."

Even in the story shared earlier describing a disagreement between the nurse and the physician, with the physician refusing to believe the nurse's patient assessment, Shannon eventually recognized her role as an advocate during the incident. During the interview, as an experienced nurse, I recognized Shannon was advocating for the patient, yet Shannon did not seem to recognize this:

> Primary investigator: "You said that, let me see, that you went back to the patient [reading reflection] 'I went back to the patient and stayed with her.' What was the purpose of you going back and staying with her?"
> Shannon: "Um well, I couldn't help the doctor-nurse fighting situation . . . there's not much I could do for the patient except be calming. I mean she was like still with it. She was still talking, but she just had this great fear that something bad was going to happen. Her color was bad. Her eyes were rolling like it . . . she was really scared so I thought, What can I do to help this situation? Well . . . not deal with those children over there, but I'm just gonna go be with my patient, so I just kind of stood by her, rubbed her back, said, 'You're going to be okay.'"
> Primary investigator: "and by doing that . . ."
> Shannon: "Just kind of waited . . ."
> Primary investigator: "and by doing that you were demonstrating what?"
> Shannon: "ewww . . . I don't know . . . um . . . I guess . . . advocacy in a way?"

Though the participant felt that this incident was a good demonstration of failure to collaborate and bullying, it inadvertently became a good example of advocacy. By reflecting on the situation during her interview, she realized she had been advocating for the patient. It was an aha moment for the participant.

Learning through positive clinical experiences. Learning advocacy was not always a result of a negative clinical experience. Caesar shared how he learned to challenge someone's actions by tactfully presenting it as a question. For instance, he once noticed a nurse had written two numbers inversely. Instead of saying directly she had done something wrong, he asked her where she found those numbers. This brought her attention to the error, which she corrected. I asked Caesar about this approach. He reasoned, "whoever you're talking to. You don't want them to feel belittled or you don't want them to feel inferior." When I asked why he would bother to bring the error to the nurse's attention, his voiced raised as he said, "because you're advocating for the patient." His actions were validated when the nurse noticed and "was grateful."

Angel had a positive learning experience because of another's failure to advocate. The hospital staff did not take the time to address a patient's dietary restrictions. This left him without a meal when a tray of food arrived that he could not eat. A replacement meal was ordered, but no one was available to go to the cafeteria to pick it up. She decided to take the initiative to go get the meal. From this experience, she realized that "that could have been avoided entirely" and "if you could just avoid stress in any way, then you should try to because you could do that . . . then you could, would probably do it on something bigger too." Her actions were validated when "the nurses seemed happy because they didn't have to do it." And

Angel said, I didn't have to waste time looking for an aid and then the patient got his food as soon as possible."

Another example of learning advocacy through a positive outcome was described by Michael, who worked at the triage window of an emergency room. He was accustomed to monitoring patients waiting in the waiting room. However, one patient caught his attention, and he spoke up to the nurse. The patient then was brought back to the triage area for closer monitoring. Despite labs and vital signs appearing in safe range, the participant and coworkers continued to insist something was not well with the patient. This prompted the patient to be taken to a room and placed on the monitor. It was quickly realized he was having a heart attack. The participant revealed, "from that moment, I kind of realized what I can do for these patients."

Learning through life experiences. During analysis, participants were seen learning how to advocate through life experiences by witnessing or experiencing a failure to advocate when not in the health-care provider role. Sheila has a special needs child and has learned through the years to navigate the school system to assure all available resources are provided. When she sits down with the child's teachers, she says, "these are the things she needs to be successful." Robin and her family were in a vehicle hit by a drunk driver. Her sister was seriously injured but so was the drunk driver. Once at the hospital, Robin's sister received the doctor's attention while the injured drunk driver waited. She described her thoughts during this time:

> I kind of felt bad for him because he was a mess. And I, you could . . . he was still sitting there. It impacted me, even though I was so angry that he had hurt my family and probably killed his best friend. I was 14, I think at the time, but it stuck with me that I still didn't feel it was right for him to just be sitting there.

She went on to explain how this experience allows her to advocate for all patients regardless of their background. She explained, "I have personal experience with that, so I know if I'm able to

feel that from a personal experience, that I will overcome those feelings if I'm ever put into that type of setting."

A student's value as an advocate. Being students in health care, participants previously spoke of reasons why their voice was not valued. However, during analysis, it was observed that participants often spoke of their value as advocates because of the "sight" they offered. When Eli was asked why a student has power to advocate, he answered:

> Maybe not power but it gives . . . we have a little bit more [long pause] . . . *sight*, if that makes any sense. So a nurse on the floor, they're there for 10-, 12-hr shift. They've got three patients. And you know, they're intently focused on those three patients. What had to get done and what doesn't . . . hopefully. And so they're, you know, you can kind of get blinders on with that. As a student, you don't . . . you don't have all that responsibility. I mean, you do, but it's not as intense. And so you just have a little broader range of view, if that makes any sense.

Lizette shared a similar sentiment:

> We're kind of just still learning, so I think we're like an extra set of eyes, and then we see when things are kind of not right or when something shouldn't be done with the patient, and then we would let an RN know or let our teachers know. Then they just kind of make a difference in that. It's a huge . . . if we're, if we're able to see that . . . because we don't have as much to do . . . then it's a really big role because at the end of the day we can make a big difference.

During his interview, Michael described being able to *see* when he explained that part of advocating was "stating concerns towards the nurse things that you've seen that maybe they might not catch and sometimes you can." He further explained, "I'm seeing with the experience and knowledge of a student, but it shouldn't be any less than them [nurses] or the doctors." During his discussions about followership and reframing the definition of a follower, Michael also felt that "if you see something that you know is wrong or something that needs to be addressed . . . that's where you just have to stand up and at that point you're a leader-follower . . . you're getting something done for the patient." Laura described an opportunity to sit in on a patient care conference with the social worker while she advocated for community resources for

the patient. Laura appreciated that she "got to see some of it. Just didn't get to really participate." It was Caesar who previously described how he "saw" a nurse transpose numbers and used tact to bring the error to light.

Participants' view of the follower's advocacy role. After completing the followership seminar, participants were asked to discuss the follower's advocacy role in their online reflections and during their individual interviews.

Reflections. In their reflections, participants were asked how the principles they learned from Chaleff's courage to challenge could be used in the face of lateral violence. Though there was no overt mention of advocacy, the majority of participants wrote of advocating when applying these followership principles. Lizette wrote, "as a good leader and follower of leaders, I probably should have advocated for the other nurse." Shannon wrote of her experience of standing up to nurses making fun of how another nurse smelled. Robin wrote of her comfort in "addressing the situation" if "seeing a colleague being bullied" or "a patient being put at risk." Michael shared his experience: "the majority of our group who witnessed this all took action against the nurse. Not only were his actions morally wrong but they were unsafe towards the patient." The relationship between followership and lateral violence is further detailed later in this chapter.

Interviews. Several participants felt that those in the role of follower should advocate for the staff and for the patients' safety. Others felt that there was an additional need to also advocate for one's self. As Michael summarized, "a good follower advocates . . . for their leader and advocates for everyone that they're working with while at the same time advocating for their client . . . their patient." As a follower, Robin felt that it was important "if you're seeing things being done that aren't right . . . making sure that the right person hears about it, and then just

holding the leader accountable to their role." She also suggested, "if you feel strongly enough, you go to the next person and continue that advocate role." Angel also felt that "followers do need to point out to the person in charge like, This isn't what the patient wants. We need to find a better solution." As Sheila indicated, "everybody has power. I think it's a matter of how you use it. Even as a follower . . . you hold the power so if you don't follow . . . nothing happens. So, it's still using your voice."

Some participants compared the follower's role as an advocate to the leader's role as an advocate. For instance, Robin stated: "I would say the followers have a bigger role because they're, they're kind of out there in the field. They're seeing everything. They're hearing more things." A similar thought was expressed by Shannon who felt that followers were "in the front lines with that patient knowing their best wishes." She went on to say, "the leaders are going to be in charge of way more patients than the follower is so . . . there's no way they can really advocate as well." Angel felt that when advocating, "they're not all going to be leaders," and advocates would be "aids and nurses and other health team among the floor."

It was also pointed out by Michael, roles are dynamic and "changing constantly and within the nursing role" so when advocating, it "doesn't matter which role, you can just go in if you see something that you know is wrong or something that needs to be addressed." Laura shared a story where the roles of leader and follower seamlessly changed while she rendered first aid. While spending the day at a river, she came upon a couple. The young woman was semiconscious, and her boyfriend did not know what was wrong. The participant began to take action. After some time, an EMT arrived to help. Being a student, she deferred to his expertise. Laura recalled:

> While I was giving him report . . . and it was nice because I advocated for her . . . that she needed help. And so by advocating for her, it turned into . . . I was still advocating but

> then it turned into . . . by following an EMT, someone who had more experience . . . who knew more than I did . . . following him became advocating for her.

Category Findings: Collaboration

Process. Question 2 of the secondary questions was, How does knowledge of courageous followership strategies influence the nursing students' views about inter- and intraprofessional collaboration? As part of the online reflections, participants were asked to reflect on the followership principles they had learned—specifically, the dimensions of courageous followership—and how they might use these principles when dealing with failures to collaborate. Through domain analysis, semantic relationships were identified. For instance, in one semantic relationship participants described ways to collaborate. In another, they wrote of reasons for collaboration.

Interview questions were specifically directed toward this topic. Participants were asked to describe the meaning of collaboration, how they visualized collaboration happening, what it is they do when collaborating, its purpose, what makes it fail, and what happens when it fails. They were also asked to describe the follower's role in collaboration, their roles as students, and if they felt prepared to collaborate. Resulting codes were created following this line of questioning. However, other codes emerged during data analysis. For instance, participants described how roles influenced collaboration. Roles other than the follower or student role were described, such as the fellow follower's role and the leader's role. They also spoke of student collaboration among one another. Sometimes participants described how collaboration could be encouraged or promoted.

Participants' vision of collaboration.

Reflections. Direct references to collaboration were found mostly in the interviews. In their online reflections, participants often made indirect references to collaboration in

conjunction with another matter. For instance, Michael wrote of serving the common purpose through collaboration:

> I put the common purpose above the organization because it needs to be there. We have a mission statement and it does not change. Our policies change. Our leaders change. Our followers change but that mission statement does not change. The entire staff and myself are responsible for seeing that mission through.

Angel echoed Michael's sentiments in her own reflection:

> The focus should always be on the common purpose rather than the leader. I would hope this is how it already is in healthcare settings. This is why collaboration exists. Nurses are assigned several patients to care for. Doctors make rounds to all their patients. Receptionists keep messages and vital patient information. Techs provide basic tasks that other healthcare professionals cannot attend to. The point is to work as a team to meet the specific needs of the individual patient.

When Carol described her personal transformation after a disorienting experience, she wrote: "[I] needed to transform to be a more collaborative leader/coworker" and "I had to learn to share power and allow others the opportunity to learn. I had to learn how to listen."

Interviews. During the second focus group interview, participants were asked if being in a group, going from patient room to patient room, and one person doing the talking and making the decisions was collaboration. Shannon, Angel, and Robin immediately rejected this description. Shannon specifically said, "that's not collaboration." She went on to share her experience:

> When I did my critical care rotation at the ICU, that was the first time I had seen like walking rounds where you have any physician on the case, the primary nurse, the pharmacist, the respiratory therapist, and you're in the patient's room and family members are there, and you're talking about rounds, and you're discussing the plan of care, that to me was the first time I really saw good collaboration.

Though most of the participants described collaboration as happening in a group, others described it differently. According to Caesar, "collaboration isn't always seen. You can see it in

evidence in the charting, in how the patient is doing and getting better. Obviously, something is going on." Robin agreed, "I kind of see collaborating as the bigger picture."

Lizette felt that the reason for collaboration was to "get the best solution we can." Sheila believed "the purpose is to work together to build something. It's to accomplish a task, to accomplish a goal." She also described collaborating as "each person laying bricks to build the whole structure." Angel provided another purpose for collaboration by explaining, "there's going to be a big work load at the beginning of the day" and "it's [collaboration] just making sure that the day flows smoothly and that there is the least amount of altercations." She went on to explain:

> Sometimes you give up some things you don't want to do and take on some tasks other nurses aren't gonna be able to get to at the moment. You get benefits from the collaboration. It's just a bunch of compromises honestly. And it's supposed to be in the health-care setting. It's gonna be the best thing for the patient and the team.

Eli said, "the majority of collaboration is advocating for that patient because there's no other reason to be talking to the rest of the team except for the patient."

Carol stated, "if it's [collaboration] done well, it's done openly with respect and trust." Serena described collaboration in her clinical setting: "it's really neat because there's no hierarchy in the room. You don't feel anybody's more valued than the other." Sheila agreed:

> When we're working together, I do believe you are equal and that is how you truly collaborate with someone. You might have different credentials. You might have different duties outside of that collaboration, but during that time you're working together on the same level.

Shannon added to this by saying, "the point of collaboration is not one person's perspective is in charge. You know everyone's perspective is equal."

Ways to promote collaboration.

Communication. When describing ways to promote collaboration during their interviews, participants identified effective communication as important. Carol stated, "communication is very critical, and it pulls in all the different things we have been taught." Robin spoke of "listening." She said, "It's coming to the table with your set of opinions and ideas, and really listen and actually be able to hear what other people bring to the table too." Eli agreed, "you can't get anything done without communication." Robin added, "it is being able to listen to input, provide constructive feedback. And work as a team."

Experience. Experience was also identified most often by participants as a way to promote collaboration. When Eli was asked if he felt prepared to collaborate, he said, "Yes, I mean once again, as long as I don't have a knowledge deficit going into it. The first couple of times of anything is always shaky, but you work through it." Shannon shared the value of participating in an interprofessional collaborative learning exercise:

> At first, we were nervous to work with them. They're graduated. They're doctors. They know more than us, but it was really eye-opening, and it was nice to know they're in the same boat. They have no idea what's going on, and they're so grateful for the practice. They were making mistakes like we were, so it was really good. It kind of made me wish we had done more throughout the whole time in school.

Angel had similar feelings after her interprofessional collaborative experience: "there were certain things they need to practice just like we need to practice. It is eye-opening. One profession isn't better than the other." Angel also spoke of a class assignment that provided a collaborative learning experience: "we were forced to collaborate. I know we put up a really good fight. We really didn't like it in the beginning, but it ended up working out somehow in the end."

Role management.

Follower. Participants expressed ways followers should manage their role while collaborating. As Carol said, "a good follower will receive the task and do it to their ability." Eli added, "if you're not pulling your own weight, then you're not a good teammate . . . you're not a good follower." Being a good teammate was mentioned often as an important part of collaborating as a follower. Laura felt that "a good follower is supportive of other followers." Angel believed part of the follower's role was "reminding the team what the team is about." Shannon also described followers as having a role in stressful situations: "trying to rally the troops, you know, when things change. No one likes change so just helping in times you know are going to be stressful on the leader or stressful on the group." Part of a follower's role was also how they managed their relation to the leader. Robin described followers as "giving the leader information to provide structure that is needed for the whole group." Sheila also felt that followers should "continue whatever role they have in whatever is happening but still voicing concerns. Speaking up, maybe, if something doesn't seem right." Besides speaking up to the leader, Michael declared that followers needed to be supportive: "[followers] need to be able to support them because you're their ground . . . you're their tool."

Leader. Participants felt as Lizette did when she said, "I think even leaders need to collaborate too because I just think it gives the best results no matter what it is you're doing." Sheila agreed: "A good leader definitely does delegate and collaborate. And sees people's strengths and the area where maybe aren't strong. And gives them the tools they need to be successful." To do this, the leader needs to understand the group and goal. Caesar explained:

> They have to be able to understand the goal, how the group needs to get to the goal, and then the actual physical way of getting the group to achieve the goal. They have to give them the tools, any resources, any education. They're the mass provider for the group.

When collaborating as a leader, participants felt that communication was important. Angel stated, “a good leader listens to the team” and “they would be able to listen to all sides.” Carol said ideal communication is “telling people upfront this is what we need to do and letting them kind of see more of the big picture, then it gives buy in to the process.” Michael said, “a good leader hears the people that they’re working with, that’s the simplest way I could put that!”

According to Sheila, a leader “lead by example by doing it themselves.” Carol elaborated on this by saying a good leader was “able to step out of the leader role, go down and say, You know what? Here, I’m going to show you how to do this.” Robin said:

> When it comes to collaborating, I think the leader is also kind of in a follower position too. They equally have to get things done. They’ll have a piece they need to contribute. I just think even if it’s in an informal way is just putting the pieces together.

Like followers who rally the troops, in Shannon’s view, leaders had a role in “motivating” and “inspiring the team.” Lastly, Angel also felt that the leader should “advocate for the group.”

Fellow follower. Fellow followers also were described as having tasks specific to their collaborating role. Fellow followers were thought to be supportive of one another. Laura said, “a good follower is supportive to the other followers” and “we stick together.” Robin felt that fellow followers “trust each other” and “they trust the work that each other does” when collaborating. Lizette remarked that fellow followers united to “make a situation better” and, she said, “our voices can be heard.” Eli also thought advocating for one another was “just being a good teammate.” In his interview, he also spoke of how fellow followers provided guidance and help. When asked to clarify, Eli said, “you could call it mentorship. You could call it being a good fellow follower.”

Ways collaboration fails.

Personal. When asked what makes collaboration fail, participants described a variety of barriers. Personalities could sometimes be a barrier. Sheila explained this was due to "personality differences. People's ideas and beliefs how about thing should be done." Carol agreed, "personalities definitely have a play on it. If there's some people that are very dominating, domineering type of personalities. Hard headed. It's gonna make it harder to have a cohesive team." Laura indicated that collaboration failed "when people get too big for their britches." Robin agreed that "egos" did get in the way. As Lizette said, "they think they can do it themselves" and "they kind of want to ride solo, so they don't cooperate." Eli shared his reasons for why he thought collaboration failed: "acting selfishly" by "not having the patient's best interest at heart. Not having the team's best interest at heart or the institution's, as a whole, interest at heart. Only thinking about yourself."

Failing to manage role. Laura shared a sentiment most every participant agreed with: "if everybody just did their part, then everything would be fine. You don't necessarily have to agree with somebody to be able to do your part." Trying to do someone else's part was mentioned most often by participants as a reason for failed collaboration. Laura remembered someone in particular:

> We did have somebody that came in who never did his part. He didn't contribute. All he had was notes for everyone else's part, and he wasn't doing his part. I remember saying, "He is trying to lead this group, and he's not the group leader!"

Sheila agreed that "too many people trying to lead" interfered with collaboration. This was a problem to Laura because people were "not respecting other people's space even if it's, especially, if it's intellectual space." In addition, "they're not doing what they should," according to Michael. This aligned with Eli's feelings that "not being a team player, not being a follower"

and “bad leadership, bad advocacy, bad followers” contributed to failed collaboration. Angel also agreed, “a bad follower creates altercations that can split the group.” Robin explained that a bad follower might “plot to move the leader out” and “their intent is not for the best interest of the group. It’s probably self-serving.”

Ineffective communication. In the collaborative process, according to Carol, “A lot of the problems are because of communication breakdowns.” Caesar agreed, “A bad collaboration, I don’t know the percentage, but a vast majority of things always comes down to communication.” Eli added, “You can have the best communication but if you’re communicating with somebody who doesn’t have the time of day for you, then it’s not collaboration.” One cause of ineffective communication was lateral violence. Robin spoke of observing nurses in separate cliques not interacting with one another, “even though they’re expected to in order to care for their patients and communicate with physicians.” Michael explained a consequence of lateral violence was “people not being able to speak up for someone whether it be a patient, themselves, or a coworker.” Another example of ineffective communication was poor communication between hospital policymakers and implementers of the policies. Laura expressed her frustration about a new policy implemented without input from staff: “yes, I understand you want me to do hourly rounding. Yes, I see it is helping patient outcomes, and we’re getting educated on it, but it’s not collaborative.” Sheila was frustrated with decisions made by administrators when certain resources were not available to her patient who was hearing impaired.

Barriers to students’ collaborating efforts.

Uncertainty of boundaries. Participants spoke of barriers specific to them as students. For one, participants often worried about going out of their lane. For instance, Laura and Serena discussed, during their focus group interview, how Laura could have advocated after witnessing

both failed collaboration and failed advocacy. Laura concluded, "[to say anything] would have meant me going out of my lane." Lizette said, "[I would collaborate] so long as it was something I'm comfortable with." Otherwise, she would "just maybe ask a question." When Shannon described her role as a student, she said, "my role is to just listen and observe. I mean a few times I would try to say something, but it's not like anything major."

Lack of voice. Participants were also aware that they were not final decision makers and could only give feedback. Even though they felt that clinical professors listened to them, they knew professors were not final decision makers either. For example, Shannon commented, "professors are receptive to hearing us, and I know that sometimes they are busy or rules don't allow them to change the things we don't like, so sometimes it feels like they are listening just to appease us." Caesar stated, "a student can collaborate, but it's not real collaboration. You don't really have a voice in the treatment of the patient."

Lack of collaborating experiences. Angel shared a story from clinical where she had been frightened when a doctor asked her things she did not know about. He reassured her there was no need to be scared to talk to him. This prompted Angel to be asked if she felt comfortable talking to those in other disciplines, such as a pharmacist or radiologist. She said, "no." She only felt comfortable speaking to another nurse or nurse aide. Angel explained: "because I have experience doing that. I have peers. They're going to be nurses" and "going to clinical, I see nurses the majority of the time." She explained further: "We don't practice. I'm scared to confront a doctor. It makes me feel dumb. I don't know how to talk to a doctor." Sheila also shared her lack of collaborative experiences: "I haven't in clinic had much of that experience yet to really collaborate. Ask questions? Absolutely. To observe? Definitely but just not at that place yet where I know enough to collaborate with different professions."

Consequences of failed collaboration. Causing the patient harm was the most frequently cited consequence of failed collaboration. This was said to happen because, as Lizette explained, "if you don't collaborate, or if you refuse to, then you're missing out on a better solution you could have gotten because you're just one person and someone else might have really good ideas." Shannon also felt that when "collaboration doesn't happen, problems don't get solved or things get missed or swept under the rug." Additionally, Michael said, "not everything that should be done gets done, and things get overlooked." According to Carol, "patient care is going to be impacted negatively. Taking longer to get things done for the patient."

Failure to collaborate could result in a "poor reflection on the team, [and] hospital," according to Angel. Lizette agreed, "it makes everybody look bad." It also had a negative effect on the team. Shannon felt that it was "destructive to the team" and "discouraging." Eli said, "in the broader view fellow followers, teammates lose respect for you because you're not being a good follower." Michael agreed that failing to collaborate with a fellow follower "would affect their patient and that would probably affect them. Probably affect the unit and team as a whole."

Category Findings: Lateral Violence

Process. The last secondary question for this study was, How does knowledge of courageous followership strategies influence the nursing students' views related to lateral violence? During online reflections and individual interviews, participants were asked questions specific to lateral violence. They were asked to explain what happens when lateral violence takes place and how a follower might deal with lateral violence. In both reflections and interviews, participants described behaviors considered to be lateral violence, or bullying. Participants also described different roles they occupied when the bullying took place. These different roles included lateral violence between students, between students and nurses, and between nurses.

Online reflections were analyzed using domain analysis. This allowed several semantic relationships to be identified. For instance, participants described things that were a result of lateral violence, attributes of lateral violence, and ways to deal with lateral violence. From the analysis of the interviews, codes were generally created following the interview's line of questioning. For instance, codes for the consequences of lateral violence and the follower's role in dealing with lateral violence came from the interview questions.

In addition to direct questioning, participants often shared stories of lateral violence during their reflections and interviews. Many times, these stories were told while discussing other such topics as collaboration or advocacy. A code for lived lateral violence experiences was then created based on the participants' descriptions. Participants also shared stories of lateral violence happening between students in the school setting. Because it was unknown if this behavior was unique to nursing students, participants who had received degrees in other fields were asked to share any experiences with lateral violence in both their degree programs. These stories and questions led to the creation of codes for lateral violence in the school setting and reasons for student-on-student lateral violence.

Participants' description of lateral violence.

Reflections. In general, lateral violence was described as abhorrent and absolutely intolerable. Sheila wrote of witnessing "shaming over grades or inability to perform tasks in skills lab" between students. Lateral violence initiated by nurses against participants was often related to the nurse not wanting to precept a student. Michael wrote of an incident involving a member of his clinical group. The student's precepting nurse "displayed much disgust for the student's skill and ability." Eventually, the nurse "went off on her for even daring to ask him to clean the patient. By the end of the day the student was broken down crying to the rest of the

group." Shannon described being told by nurses, "don't touch anything" and "don't slow me down," and being asked, "Are you smart and confident or am I going to be a babysitter today?" She also wrote of nurses' use of body language, such as "rolling eyes" and "grunting while asking if they had to have a student." Lizette noticed similar body language: "nurses make mean faces or roll their eyes at another nurse." She also described how nurses "talked about each other behind their back" and "criticized the action of another nurse." Laura wrote of a similar observation: "There is so much backstabbing."

Interviews. Participants also described lateral violence during their interviews. Robin described the actions of a fellow student. She felt that his actions were also sexual harassment: "He demeans women. He has no absolute respect for women." She went on to say, "he knows we can hear when he's talking and he . . . it doesn't change." Sheila described how other students "get in their little cliques, and they talk about other people." As for bullying between students, Sheila said, "it's more passive aggressive than direct bullying. I have overheard derogatory comments made, inappropriate sexual comments. It definitely exists." Angel said, "you hear people come back to you and say they were saying this about you." She added, "I can't say I'm perfect either but usually when somebody hits me with words, I hit back with words too."

Laura described how a nurse responded to a question she asked during report. When Laura asked why a patient needed vital signs every 4 hrs instead of the usual 8 hrs, she recalled the nurse yelling, "because I said so!" And, "all of the other nurses looked at me," said Laura. Carol also described incidences of lateral violence in the clinical setting: "you just know when it's happening and it's like . . . golly, I can't do anything right. You're just a piece of . . ." She also described how others engaged in lateral violence: "they can do it just isolating you or just

ignoring you." According to Angel, "the nurses don't stand up for you either," which is a part of lateral violence.

Causes of lateral violence between students. During the interview process, several participants described incidences of lateral violence between students. Instead of focusing only on lateral violence between nurses, interview questions were adjusted to explore participants' experiences with lateral violence between students. Participants agreed they had seen and/or experienced lateral violence in the school setting. When asked about reasons for lateral violence in the school setting, some attributed this behavior to a mostly female population. Several participants disagreed with this explanation. Based on their experiences at other colleges, these participants felt that the student-on-student bullying was a result of other factors. For instance, Sheila pointed out: "we're very much perfectionists. And we work really hard. And I think for some people the need to be the best overshadows being a kind human being." She also said, "competitiveness is a part of it." Angel commented that in other universities, she did not see lateral violence. Her reasoning was the following: "we're not as involved with each other in those universities" and "the group projects they assign are nothing compared to what they assign us here . . . we don't have to collaborate on an everyday basis or even hang out with each other."

Consequences of lateral violence. Participants described multiple consequences of lateral violence in their reflections and interviews. Lateral violence provoked negative emotional reactions and led to different types of loss. Ultimately, lateral violence resulted in harm to the patient.

Negative emotional impact. Participants wrote in their reflections how negative emotional reactions were provoked by lateral violence. Angel how she felt as if she "wasn't part of the team and wasn't important." When being a target of lateral violence prevented Carol from

advocating for her patient, she wrote of how she "lost sleep over it." Lizette wrote, "it causes tension and a feeling of being uncomfortable for the person they are gossiping about." She described how students felt: "we still feel guilty just for knowing and reporting it or standing up for that person." Michael spoke of his classmate who was "broken down and crying" after being the target of lateral violence by a nurse. Laura felt "sad and frustrated." When witnessing lateral violence, Shannon wrote of feeling "very disoriented and confused." Sheila felt "horrible for not intervening fast enough" for her classmate.

During their interviews, Carol and Lizette described the negative emotional impact of lateral violence. Carol worried about a coworker who was constantly at target of lateral violence: "[this person] was just gonna roll over and give up at that point." She went on to explain further: "it's gonna affect me as a person emotionally to where it makes it like I really hate coming to work. I really hate working with this person because it's so negative." Lizette explained:

> It's putting people in a bad mood, either they're sad or they're angry. They're not in a good mood to be there to help others and uplift other people if you're bullying. I think it makes someone feel less than what they really are.

Loss. During their interviews, participants described various potential losses resulting from lateral violence. Angel remarked, "you could lose important staff." Caesar worried students "leaving school" was a potential loss. Eli felt that it could result in a "higher turnover rate in that department because nobody wants to work there." Michael expressed similar worries about the consequences: "you end up losing people. You end up losing work efficiency. You end up losing trust in that unit or group. Everything just kind of begins to crumble because of maybe one or two people's actions." Carol explained, "they're undercutting you, undermining you, so trust is going down. I'm losing respect for that individual." There was also concern for a loss of collaboration. Caesar stated, "when you separate people, that's not working for a common

purpose." Robin felt that "it creates an atmosphere of hostility and an environment that becomes toxic and it just spreads."

Harm to patients. Sheila believed lateral violence "could result in a patient dying." She went on to explain: "we become a bit more careless and clumsy. If the people that you are thinking you can count on because they are your coworker, and they're the cause of that extreme stress, it's more than one ball getting dropped." Lizette said, "It's taking away from the patient. It's taking away from the tasks that we need to be doing." Robin expressed, "if I'm arguing with someone over or talking about someone behind their back, that's not doing anything to contribute to your job and to your patient care." Robin also worried about the consequences of lateral violence in the school setting. She explained, "the way these people are now with people they know and have to see every day is going to translate to how they practice in their nursing."

How participants deal with lateral violence. During their reflections and interviews, participants spoke of ways they had dealt with lateral violence. They also shared how they thought lateral violence should be dealt with in a general sense.

Reflections. Laura felt that the best way to deal with lateral violence was "to not participate in the bashing sessions that occur." Carol revealed, "what I ended up doing was working harder to show them that I could do a great job but more importantly I would praise them for their work." Michael, who's classmate had been a target of lateral violence, explained how he felt about the incident: "the majority of our group who witnessed this all took action against the nurse. Not only were his actions morally wrong but they were unsafe towards the patient." He went on to say, "We as students were baffled by this nurse, especially a charge nurse. Part of being a follower is to hold our leaders accountable, and we had to that day." Caesar also wrote of advocating on behalf of someone else: "simply walking with someone that

needs an advocate to confront an aggressor can assist the parties to have a civil dialogue." Sheila, who described feeling horrible for not intervening for her classmate, wrote: "[I] decided to speak with the student who had been bullying after class. I needed him to know that his behavior was inappropriate and offensive." Angel wrote that she would "address lateral violence by trying to confront it subtly." She felt that confronting it directly "would cause more tension or lateral violence in the unit." Her solution was "bringing it up to the charge nurse." Lizette disagreed and wrote, "a very good rule of thumb is to just always address any issues you may have with the coworker directly and if that doesn't work then take it to the charge nurse."

Interviews. When dealing with lateral violence, Laura explained, "I've had to learn how to talk to them and kind of dumb myself down, not make myself dumber but present myself in a way that is not intellectually threatening." Carol preferred to "sit down and . . . communicate." She said, "Don't just ignore." Eli agreed, "I think communication is probably the best way to handle that as a student." He felt that this meant "talking to somebody that you trust and getting advice." Michael's suggestion was the following: "you confront it and bring it up to the chosen leader" because "they are in that higher position, they have that authority. Their word, I'd say, in a perfect world is final." Lizette said, "if I was at least a little bit comfortable with that person, I would probably try and tell them. Try to put a stop to it. If I couldn't, I'd probably tell the charge nurse." Eli indicated how he would deal with lateral violence: "[it] depends on the severity . . . if it's so intense that I feel like I should say something at that point I would." Caesar declared, "I can always advocate for anyone. It's like bullying, you know, you always have the ability to step in and stop the bully." For those who have been a target of lateral violence, Carol also said, "I would probably then be their supporter and encourage them to go talk to the next level up. To talk to that individual and say hey, What's up."

Category Findings: Authority and Power

Process. Power and authority were examined as two distinct codes. These terms were purposefully distinguished as separate when speaking to participants. This was done to be consistent with the participants' followership teaching where authority, or legitimate power, is seen as only one source of power. Though participants at times would use these terms interchangeably, they generally did discuss and describe power and authority as separate and distinct from one another.

Authority. Though some data regarding authority came from the interviews, the majority came from the online reflections. More than likely, this was because one of the reflection activities specifically asked participants to (a) reflect on their relationship with authority as a child, (b) explain how this influences their reaction to authority in present day, and (c) describe other choices they have now as an adult to effectively relate to authority. Domain analysis identified several semantic relationships relating to authority.

Childhood views of authority figures. Participants described authority figures while growing up as parents, coaches, teachers, neighbors, other parents, and elders. These authority figures were described as knowing best, having more experience, and being in charge. As Lizette wrote, "I never felt as if I should be in charge or have more authority than those who took care of me." Caesar explained, "I respected the authority and made her priorities my priorities." Repeatedly, participants described being taught as children to respect authority figures. For instance, Sheila wrote in her reflections, "I was taught to respect my elders and authority figures." Shannon shared the following:

> My parents were very big on teaching me not to accept whatever you heard first, but rather question and look for reasons why we are asked to do things. My friends were always surprised when I would speak frankly with my parents or ask them why instead of obeying. My teachers had similar reactions. My questioning was often taken as defiance.

Michael wrote, “I was raised in a military family. As such my relationship with authority was very submissive. I was in a sense trained to obey those who had authority over me.” Robin shared how she was raised: “that respect should always be mutual regardless of the position I am in or the position of others.”

Present day view of authority figures. When speaking of how they currently interact with authority, participants spoke more of their willingness to question authority but doing so, as Eli wrote, “with tact and respect.” Michael explained how his view of authority has changed with age. He wrote, “I respect their position but I’m going to question them.” And Sheila stated, “respect is mutual and not automatically given.” Carol wrote of learning to “adjust to different styles of authority.” Robin has learned what she can do through previous interactions with authority figures: “I can tailor my response to a situation more objectively.” Angel said, “I know when it’s appropriate to debate, correct, and question and when [it’s] not appropriate.”

Reasons to resist authority. Participants did describe reasons for resisting authority. Robin wrote that she would resist an authority figure that was “disrespectful” to her or others. Before following through with a request, Lizette said, “[it] must comply with my beliefs.” Eli shared similar sentiments: “I generally have a good relationship with those who were in a power of authority unless I just fundamentally disagreed with their use of authority or decisions made.” Michael felt that it was acceptable to resist authority if “there is a better process” and “to increase communication, find other options, and understand one another.” Participants most often described resisting authority as questioning the authority figure. For instance, Shannon wrote, “I have learned there are some leaders you trust, and might obey without question, but I often still search for the why behind the request before carrying it out.” When dealing with authority, Lizette explained, “I am not the same little girl I was before, and I have a choice to

avoid or resist authority." When describing other ways to resist, Angel spoke of "overstepping boundaries." And Michael wrote, "I can object and go against my leader."

Resisting authority as a child and current day fears. As a child, the consequences of resisting authority included loss of privileges, spanking, dismissal, and being sent to their room. When participants explained their present-day relationship with authority, their stance against the fear of authority was often cited. Carol wrote, "I have a high regard for authority, as I do not want to receive the wrath of non-compliance." Lizette explained, "I am not afraid to stand up." Michael wrote, "I am not afraid to question or discuss their view." Shannon stated, "[I am] aware of my tone, body language, and vocabulary. I don't want my leaders to think that I am in any way undermining their authority." Serena wrote, "I consider my Mom to be one of my best friends, and this relationship has made me view people of authority with less fear."

Power. References to power were most often made during the interviews. This was in part due to the interview questions. For example, participants were asked in one interview question how a follower has power to advocate or collaborate when not in an authority role. Participants generally agreed authority was not needed to have power or to be a leader. Sheila said in her interview, "everyone has power. I think it's a matter of how you use it." Shannon said, "followers are actually really powerful. They're what gave the leader their power." Sheila said, "I see leaders more as power positions." However, she also felt that "even as a follower you hold the power because if you don't follow, nothing happens so it's using your voice."

Exercising power to confront. Participant also felt that being a follower was not an excuse for not exercising their power, particularly when experiencing conflict with authority. Sheila remarked, "If there is an issue with the leader, then I do think it is the follower's responsibility to step in." Angel agreed, "they should confront the leader when they step out of

line." Lizette said, "if a bad leader were to cross that line, then as a follower, to be a good follower, you have to recognize that's what's happening and put a stop to it." Exercising their power to confront as a follower was most often seen as necessary when advocating. Angel wrote, "Followers do need to point out to the person in charge like, This isn't what the patient wants. We need to find a better solution." Robin stated, "if you're seeing things being done that aren't right," it is important to make "sure that the right person hears about it" and to "hold the leader accountable to their role." Shannon said, "if you're considered a follower because you don't have the leader title . . . I guess it would still be, voice your opinion. Don't be afraid. Advocate for your patient."

Power as a barrier. When collaborating and advocating, participants also felt that power could be a barrier. Power in the hands of others was seen as a barrier. Laura believed collaboration should mean "being able to say, I don't necessarily agree with you, but I'm interested about your viewpoint, but power gets in the way." Caesar explained, "I could see for brand new students who have never dealt with medicine before or with medical professionals before . . . there's a hierarchy there, within hierarchy, hierarchies within hierarchies." Lack of power was seen as a barrier as well. Robin declared, "the students don't have the voice that they should. Even though we have student leaders that do voice, I think sometimes it's not taken seriously." Shannon commented, "if what I thought was right for the patient or if what I thought was the patient's wishes were conflicting with what their nurse understood . . . she's gonna trump me." Shannon also agreed with Sheila in saying, "as a student nurse, you know that your voice doesn't really have that much weight."

Power in taking initiative. Emerging from analysis was the participants' descriptions of how power provided a willingness to take the initiative to act. After reframing the definition of a

follower and learning to focus on the common purpose, participants communicated this same willingness. They also shared how exemplary behaviors meant exercising power to take initiative. In her reflection, Shannon wrote of the common purpose, "This purpose makes me feel very independent as a nurse because I know that I do not need to check with a supervisor about every decision." Caesar said, "[it] gives me free reign to implement solutions that are more efficient." Lizette wrote:

> By shifting the focus off the leader and onto the common purpose you are not just serving and benefiting one person, but serving an entire population and organization. You can make more of your own decisions and not follow all commands and suggestions from just one person. By doing this, there is more autonomy and therefore you can accept more responsibility for your actions and decisions.

Sheila felt that "each team member would feel more autonomous." Angel wrote, "I do not need someone to tell me to do every little task. I will pull my weight and go above and beyond." Michael said:

> It doesn't matter which role, you can just go in if you see something that you know is wrong or something that needs to be addressed. That's where you just have to stand up and at that point you're a leader-follower. You're getting something done for the patient.

Shannon explained her actions in the hospital setting: "I saw that as helping the common purpose by when we did have down time . . . helping things roll along, helping turn beds, helping prep for when we did get a rush, that way patients weren't left in the waiting room." When discussing followership, Angel shared her observations of a nurse: "she didn't go ask people what she should do. She took initiative and did a lot of patient education. She didn't have to ask for help for that, and she went beyond the extra mile." Carol spoke of watching others demonstrating exemplary behaviors during collaboration: "they took responsibility of the patient and in decisions they were making for the patient."

Demonstrating their power to take initiative was also seen as a demonstration of leadership. Lizette said, “I’m gonna take this chance, or I’m gonna take this risk. I’m gonna step up if I know that this is right, and a doctor told me to say something else . . . that’s a leader.” Caesar said:

> I look at what the leader might want me to do next, then I get started on preparing for the next step, and part of that is kind of leadership but it is kind of like I’ve empowered myself to take the initiative.

When speaking of good followers, Angel stated “[they] would try to resolve their own issues before making it such a big problem that has to involve everyone. I mean they’re kind of like a leader essentially under the leader.” Sheila felt that “it’s a natural progression where someone has to step forward and begin a task or a movement or an event . . . maybe there’s a power element to it that some people would like to have.” There was one reflection sharing these sentiments. Lizette wrote, “I learned from this experience that courageous followers do not need to be directed, and that we have responsibilities. I felt like a leader, and this is because first followers are leaders.”

Themes

Process of identifying themes. Braun and Clarke (2006) provided a step-by-step thematic analysis guide “doing” (p. 86) thematic analysis. Six phases were described by the authors: (1) familiarizing self with data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. This process is not linear but rather recursive as movement is back and forth.

For this study, Phase 1 began by reading and rereading the online reflections in an active way. This provided familiarization. Transcribing all the interviews provided the time to read and reread, and it facilitated immersion in the data. Phase 2 began when online reflections were

analyzed for semantic relationships by reading line by line multiple times for cover terms and included terms. Interview transcripts were read beginning to end before rereading while creating excerpts and assigning initial codes. Codes were grouped into parent codes, or categories, with child codes within the parent codes, or subcategories. For example, followership was a parent code. Reasons to follow, good follower, bad follower, and reframed definition of followers are examples of child codes assigned under the parent code of followership. The search for themes in Phase 3 began by refocusing on codes and consolidating them. Excerpts were reread to verify that their original coding did not drift. Some parent codes became child codes. For instance, learning followership was changed from a parent code to a child code of followership. The initial categories used to group subcategories remained consistent, with the exception of new categories of power, authority, engagement, and exemplary behaviors. Once analysis of all data items was complete, the extensive memos for each existing category were written. To write these memos, each subcategory was analyzed for patterns of repeated responses across the entire data set. Mind maps were used to help clarify relationships between the categories. Based on this memo writing, Phase 4 began by reviewing potential themes and realizing that several categories should be blended into another. For instance, power and authority were paired, whereas engagement became part of exemplary behaviors. Again, extensive memos were written based on the remaining categories. Mind maps were again used to help clarify how these categories related to one another. Having a rich description of each category allowed themes to be defined from the entire data set. The writing process for this chapter is accurately described by the activities described in Phases 5 and 6. Themes were refined and redefined to be concise. An effort was made to provide sufficient evidence, or prevalence, of the themes from the data set. Part of this

effort involved going beyond description but also making an argument in relation to the research questions. However, this argument is found in the next chapter.

For this study, the major categories began with followership, leadership, advocacy, collaboration, and lateral violence. Through data analysis, four new categories were identified. These new categories were exemplary behaviors, engagement, power, and authority. Though Braun and Clark (2006) referred to themes and subthemes, I refer to categories and subcategories. Connections and relationships between categories and repeated patterns of responses were identified through their six-phase process. Connections were noted where study findings overlapped. Relationships between categories were seen when categories informed one another. Four themes were identified across the data set: (1) the effects of learning followership, (2) factors that influence followers' level of engagement and willingness to follow, (3) the influence of lived clinical experiences, and (4) sight as an advocating strength.

The effects of learning followership. The first theme that was identified for this study was the effects of learning followership. Learning followership provided participants with a new understanding of their accountability, responsibility, and power as followers to initiate action and engage in exemplary behaviors. Participants initially defined followers using negative connotations. There was no distinction between a good or bad follower. Descriptors included lackeys, lemurs, and drones. Lizette described followers as "weak." Participants felt that followers did not make their own decisions or take accountability for their actions. For instance, Caesar said, "followers do what they are told without regard for consequences." Michael agreed that a follower is "someone who waits for instruction." Though some of these views were shared during the online reflections, most were discussed during the focus group interviews, which were held before the action piece of this study was implemented.

After the followership seminar and reflections, participants were asked again for their thoughts about followers. Now participants described not only bad attributes and behaviors of a follower but also good attributes and behaviors. Shannon stated, “I no longer look at it as a lack of leadership but an opportunity to help leadership” and “a follower can transform a situation.” Robin declared, “it is my responsibility to use my knowledge and skills.” They also realized how their previous view of followers had influenced their past experiences. Lizette said, “it kept me from learning as much as I could from others.” Angel admitted, “I could never follow what she said so the group tore in half.”

Understanding followership, participants could describe the role of follower when advocating, collaborating, or dealing with lateral violence. When advocating, Michael felt that “a good follower advocates . . . for their leader and advocates for everyone that they’re working with while at the same time advocating for their client.” Angel suggested, “followers do need to point out to the person in charge like, This isn’t what the patient wants. We need to find a better solution.” Participants also shared examples of how they had advocated from a follower role. Shannon explained how she directed a complement to a nurse in front of the other nurses who were making fun of the same nurse. Laura described how she assumed the follower role once someone with more experience arrived to render first aid to the victim she had been aiding. Part of advocating as a fellow follower meant helping another follower deal with lateral violence. In addition, participants shared stories of how they advocated for fellow classmates. For instance, Michael described how his clinical group stood up to an abusive nurse. Carol said, “I would probably then be their supporter and encourage them to go talk to the next level up.”

When collaborating, participants also described the role of follower. Eli felt that “if you’re not pulling your own weight, then you’re not a good teammate . . . you’re not a good

follower." Laura believed "a good follower is supportive of other followers." Followers' role in the group meant supporting the team and helping the group adjust to change A follower was also seen as needing to provide the leader with information, speaking up to the leader, and supporting the leader.

Participants also acknowledged their power as a follower. Sheila said, "everyone has power. I think it's a matter of how you use it. Even as a follower." Shannon felt that "followers are actually really powerful." A follower was expected to use this power to resist bad leadership and advocate. Sheila said, "If there is an issue with the leader, then I do think it is the follower's responsibility to step in." Shannon said, "voice your opinion. Don't be afraid. Advocate for your patient."

Learning to focus on the common purpose allowed participants to see their power as a follower and take the initiative to act. Examples of this includes when Caesar wrote, "[it] gives me free reign to implement solutions that are more efficient." Lizette wrote:

> By shifting the focus off the leader and onto the common purpose you are not just serving and benefiting one person, but serving an entire population and organization. You can make more of your own decisions and not follow all commands and suggestions from just one person. By doing this, there is more autonomy and therefore you can accept more responsibility for your actions and decisions.

Angel felt much like Caesar and Lizette; she said, "I do not need someone to tell me to do every little task."

During data analysis, it was observed that participants frequently described desired behaviors. Initially, these types of behaviors were used to describe a leader. Participants also described ideal ways an individual should advocate and collaborate. For this study, these behaviors were coded as *exemplary behaviors*. After the followership seminar and online reflections, participants began to hold followers accountable for the same behaviors. Examples of

exemplary behaviors were being professional, a team player, an effective communicator, and a critical thinker.

Just as a leader is expected to act professionally so is the follower. For instance, participants felt that taking responsibility was an exemplary behavior. Lizette said of leaders, "they have to step up to the plate" and of followers, "taking responsibility for what you're doing." As a team player, both leaders and followers had roles. Angel said a good follower "reminds the team what the team is about," whereas Sheila said good leaders "work together toward the goal." This same pattern continued as participants described effective communication and critical thinking. Good leaders and followers listened to others, provided input, and gave feedback. Good leaders and followers were expected to think through their actions, be proactive in patient care and communication, and think ahead by being prepared and anticipating patient needs. For example, Michael said good followers were "able to see efficient or better opportunities within the system," whereas Caesar saw a good leader as having "the ability to make the most efficient way for the group."

Part of doing these behaviors the desired way meant doing them in an engaged way. For instance, Eli described "being able to prioritize stuff and think critically about the situation." When advocating, Serena added, "you can be proactive." Being engaged also meant listening actively, suggesting helpful tips, and being self-directed. When looking at analysis charts on Dedoose, the code co-occurrence for exemplary behaviors was highest with engagement. Additionally, the most often cited behavior seen as demonstrating engagement was taking initiative. To participants, taking initiative meant not waiting to act, being the first to act, or going the extra mile. Michael shared how he takes initiative:

> I'll run into those rooms, and I know there is literally only one thing I can do in that room and that's CPR, and I'm gonna do it. If I can show up for a meeting, it's a lot better of a meeting when there's two people as opposed to just one person there.

Caesar said, "I get started on preparing for the next step, and part of that is kind of leadership but it is kind of like I've empowered myself to take the initiative."

Factors that influence followers' level of engagement and willingness to follow. The second theme identified in this study was that a follower's level of engagement and willingness to follow was situational to contextual factors. When discussing each of the main categories, participants often mentioned why they would or would not follow. When they were unwilling to follow, there was usually a reason for resisting their role as a follower. When there was a reason to follow, there was usually a motive to act. This willingness to act was seen as engagement. During the analysis process, it was observed that participants' sense of engagement was embedded into their willingness to follow. When they resisted following, these expressions seemed to reflect disengagement or less engagement.

Whether participants chose to follow was situational to contextual factors. As Eli said, "I think that the situation definitely does have an impact on how I interact with the rest of the team and the leader." Reasons given to follow were personal, situational, group related, and leader related. Personal reasons included values such as a strong work ethic, being a good worker, or being loyal. Personal beliefs such as believing in the leader or a goal, or needing help to reach a goal or learn a skill were reasons given to follow. Urgency in a situation was a reason to follow. Angel said, "There's emergency situations that we need somebody that's telling everybody what to do." Uncertain situations were also a reason to follow. When participants were unsure of their role boundaries or the role of authority, they were willing to follow. Carol remarked, "It's kind of like where's my line? I don't quite know where it is. I mean I don't want to get fired, but you

also need to do the right thing." Shannon felt that if someone had "other things going on" in their life, this situation could influence that person's willingness to follow. Robin described why someone would be willing to follow certain leaders. She explained, "I think part is trust. They know that this decision the person is gonna make are going to be good ones, so they can trust those decisions."

Reasons to resist following were similar but not the same as reasons to follow. Reasons given were also personal, group and leader related but differed in the need to advocate. This was also seen as a reason to resist following. Participants described personal reasons to resist following, such as believing there was a better way to solve a problem, losing faith in the leader or the group, or having other priorities. Not understanding the purpose made it difficult to follow. Eli explained, "It might be between myself and another teammate, and you know, why are we doing this? I don't really understand." Participants felt that bad leadership was a reason not to follow. As Lizette said, "In my eyes I didn't think they were being a very good one so that would be a different situation where I wouldn't be a good follower."

Lateral violence among members was also a reason not to follow. Participants shared stories of lateral violence they had experienced or witnessed in the clinical setting. Lateral violence was also experienced and witnessed in the school setting. The acts could be peer-on-peer incidences. For instance, Robin described a particular incident: "He demeans women. He has no absolute respect for women, which is odd considering this field that he is going into." Sheila said, "People are really good at hiding it. I think they get in their little cliques and talk about other people." She went on to describe lateral violence in school as "more passive aggressive than direct bullying." Angel admitted, "I can't say I'm perfect either but usually when somebody hits me with words, I hit back with words too." Participants described faculty

engaging in what they considered lateral violence as well. In his reflection, Eli wrote, "a professor who did not agree with the attitude the students had during a clinical lesson, . . . let them know her feelings rather unprofessionally." Caesar shared a story of witnessing a professor intimidating fellow students. He said, "she was wrong, and she wouldn't admit that she was wrong . . . that can be a barrier." When asking what was the barrier, Caesar elaborated by saying, "a barrier to advocacy. Just the intimidation like . . . I might not advocate for my fellow student because I need to pass this class."

How a participant chose to follow also depended on the situation. An example of how a willingness to follow couples with higher engagement can be found in Sheila's statement: "when I believe in the message or the task or the goal, then I will give everything I possibly can." Carol shared how she worked harder after being promised a change. Lizette said:

> If someone were to really listen to whatever I had to say if I did have a problem in the setting, wherever I was working, then I would be . . . they're so good to me. I need to continue to be good to them.

Eli stated, "I'd be a lot more apt to try and please or go above and beyond what's asked of me if everything is on an even field."

Reasons to resist following seemed to also relay a diminished level of engagement. For instance, Angel explained, "when there's favoritism and someone's participating in altercations . . . I say that I don't want to work my best anymore." Sheila admitted that when the workload was distributed unevenly, she resisted by saying, "I don't have time to do all of that. Someone else is going to have to help." She also said, "I'm not gonna put in this much effort when I truly and really don't have the time to do it if I'm not going to get genuine feedback."

The exception to this pattern of decreased engagement coupled with resisting to follow is when there is a need to advocate. Instead, the intention to act or engage is clearly present with an

intention to resist following. For instance, Carol said, "I don't *care* anymore. I'm gonna find that charge nurse and say, You know what? This is it! You don't like me . . . fine. I don't really care. I'm here to be an advocate for that patient." Robin explained that the driving force for entering nursing school came when she was no longer willing to work for a medical company: "They weren't listening to me, even though I was advocating for patient safety because I didn't have credentials."

The influence of lived clinical experiences. The third theme that was identified in this study was the influence that lived clinical experiences had on participants' engagement, certainty, and sense of power. Throughout the data analysis process, it was observed that participants often related their interview answers to past experiences. They told stories of life, work, and family experiences. However, most of their stories were about clinical and school experiences. The presence or absence of lived experiences were seen as influencing the participants' level of engagement and sense of power.

Experiences were most often represented in participants' discussion of advocacy. A particular cluster of stories was a result of an online reflection. Participants were asked if they had experienced a disorienting experience in the clinical setting. If so, they were asked to describe how they felt and if it resulted in a personal transformation. If so, they were then asked to describe their transformation. Lastly, they were asked what responsibility they had as a courageous follower in the situation. These disorienting experiences led to participants transforming the way they held themselves accountable and the way they collaborated and communicated with others. During analysis, it was observed that the behaviors resulting from their transformation also reflected exemplary behaviors and an increase in their level of engagement. Therefore, a disorienting experience was considered a driving factor of

engagement. For example, Robin said, "[I plan to] remind myself of my responsibility and ability to learn skills." Michael wrote that he became "more proactive in being in patient rooms and assessing them." Lizette also explained, "I have to take responsibility for my actions."

While discussing advocacy, participants told stories of clinical experiences where they were part of a failure to advocate or had witnessed a failure. For participants, these negative experiences triggered emotional distress. During data analysis, it was observed that participants were learning how to be better advocates as a result of these negative experiences. They described doing this with exemplary behaviors and were now more willing to act. For instance, Angel intended to be better prepared for patients. Carol suggested, "you're just going to now have to step up to the plate." Serena realized from her experience she should have also spoken up: "I could have told her, Could we just get another sterile kit because you broke sterile field? and . . . I should have said that. That would not have cost our clinical site rotation." Shannon had witnessed a failure to advocate, which resulted from a nurse and a physician failing to collaborate. She reflected on the situation and realized that there were other proactive actions the nurse could have taken. She believed the nurse could have been more direct in her communication or even gone to her manager. In the end, Shannon realized the nurse took matters into her own hands: "she just said, Screw that doctor, and called her own code."

Participants also described positive experiences when advocating. During analysis, it was noted that each participants' story described how advocacy began when they chose to take initiative and how they later realized the importance of continuing to take initiative. For instance, Angel took the initiative to go and get a replacement for a patient. She said, "I was like, I'll do it. I went ahead and got the meal and went down to the cafeteria, which none of the nurses wanted to do." After doing this, she thought that the nurses were happy, and the patient got the food as

soon as possible. She also thought, "if you could just avoid stress in any way, then you should try to because you could do . . . then you could, would probably do it on something bigger too." Michael described an incident while working in the emergency room. He was assigned to the triage window where he could observe patients in the waiting room. A patient who had been sent back to the waiting room caught his attention and concern. He spoke up and continued to speak up regarding his concerns. This facilitated the patient being put in a room and placed on a cardiac monitor where it was discovered he was having a heart attack. Michael said, "from that moment, I kind of realized what I can do for these patients."

In contrast, participants spoke of situations where experience was lacking. When experience was lacking, participants' level of engagement and sense of power were also influenced. Barriers to participants' collaborating effects were previously identified as uncertainty of boundaries, lack of voice, and lack of collaborating experience. This lack of experience made it difficult to engage fully in collaboration. Caesar stated, "a student can collaborate, but it's not real collaboration. You don't really have a voice in the treatment of the patient." Shannon said, as a student, "my role is to just listen and observe." Lizette shared her thoughts:

> If I knew what I was talking about and I knew why I was saying it, then I would without a doubt. But if it was something I wasn't too sure on and I knew that they knew more than I did, I probably wouldn't. I might just maybe ask a question and see if what I am thinking is right.

Angel admitted she was not comfortable speaking to professionals in other disciplines. When asked why, she said, "We don't practice. I'm scared to confront a doctor." However, she was comfortable speaking to those in the nursing discipline. Angel explained: "because I have experience doing that. I have peers. They're going to be nurses." Sheila said, "I haven't in clinic had much of that experience yet to really collaborate." Shannon shared her experience: "the only

time we ever worked with another profession there was also physicians there. There was no respiratory therapist. There was no one who would normally be at a code." When Eli was asked if he felt comfortable collaborating, he said, "as long as I don't have a knowledge deficit going into it. The first couple of times of anything is always shaky, but you work through it."

Sight as an advocating strength. The fourth theme that was identified in this study was sight as an advocating strength. During the analysis process, it was observed that participants were using a group of words that conveyed similar meanings. The words *sight*, *see*, *seeing*, *saw*, *hindsight*, and other similar words were often used while describing advocacy. Phrases representing the same concept were also used. For instance, Lizette said, "we're like an extra set of eyes." And Carol stated, "I just watched." Eli spoke of students having "a little bit broader range of view." These observations would at times be voiced as Michael described: "Stating concerns towards the nurse things that you've seen that maybe they might not catch and sometimes you can." Caesar did voice a concern after he observed an error in transcription. When asked why he would even bring up the error, he exclaimed, "because you're advocating for the patient!" Lizette described an instance where she offered help as a way to advocate for patients in her clinical setting. She said, "I don't have to do this, but I've been in a couple of these rooms, and I've seen that's what they need, and I'd like to help." Different from most descriptions, Angel did speak of hearing as part of advocating. She said, "you're hearing their views, their cultural views, their opinions, so you have to speak up for your patient."

Validity

Process. For this study, the word *validity* was chosen to describe credibility of findings. Though it is a term more commonly used for more positivist forms of research, it was used in this study as suggested by Herr and Anderson (2015). Despite having different views of action

research validity, compared to quantitative or qualitative researchers, the authors chose to use the term for strategic reasons. They felt that using a language relatable to dissertation committees was needed by doctoral students writing action research dissertations and seeking approval of their proposals. For this study, these issues were less of a concern. But in the interest of maintaining consistency with the framework the authors provided, the word *validity* was retained for this study. Also, in this study, validity was considered on a microlevel using Brinkmann and Kvale's (2015) seven criteria for interviews. In the next chapter, validity was considered again on a macrolevel using Herr and Anderson's (2015) five criteria for action research validity.

Interviews.

Thematizing. For this stage, a critical stance was taken during data analysis by playing devil's advocate toward the study findings. It was questioned whether the investigation was actually investigating what was intended to be investigated. Research questions were frequently reviewed to assure research methods were logical choices for answering the questions. Multiple explanations of the data were theorized, not just the interpretation biased toward the researcher's explanations (Brinkmann & Kvale, 2015). For instance, when considering driving factors of engagement, an explanation other than followership was considered. In addition to checking, questioning, and theorizing, I relied on the outside perspective, expertise, and experience of the dissertation committee.

Designing. The intention of this study was to address issues of lateral violence, failures in collaboration, and failures in patient advocacy. Advancing knowledge of what does not help and what does help address these issues will benefit the human situation of those working in the nursing profession. Assuring the soundness of the design starts with outside evaluation by the dissertation committee but continues throughout the research process. As the iterative spiral was

happening, it was necessary to continually go back to stage one to check, question, and theorize the analysis. Thought processes were made transparent in my log and reflexive journal.

Interviewing. Safe space for open dialogue was created during the interviewing process. Each focus group interview began by outlining ground rules. These rules provided an expectation of respectful dialogue and turn-taking. Also, confidentiality regarding all discussion between members was agreed upon. During individual interviews, the participants selected the interview location. Participants were reassured that they were not expected to agree with my views of followership and that the purpose of the study was to understand their views. A condition of using this study site was to not have a direct supervisory position with participants. Therefore, participants were free to express their views without a self-perceived threat of retribution. In addition, catching the use of leading questions was a great concern. Reflective journaling and analysis of this journal provided a transparent self-critiquing of interviewing skills as they evolved from the first to the last interview. As Brinkmann and Kvale (2015) explained, the decisive issue is not whether a leading question was used but where did it lead, and did it lead to worthwhile knowledge.

When specific excerpts were being coded during analysis, answers in context to the whole question and conversation were considered. Brinkmann and Kvale (2015) also warned of "expertification" (p. 246) of meaning. This is where the researcher interprets the meaning of participants' lived worlds through his or her own reality. This is a threat to validity. To prevent such expertification, several participants were asked to go through a member check analysis of their individual and focus group interviews and student reflections.

Transcribing. For this stage, transparency about the methods was key. To strengthen transcriber reliability and validity, all interviews were manually transcribed using a verbatim

rendering. The researcher was consistent in how frequent repetitions such as “like” and sounds were included. The flow of speech, pauses in conversation, rise in pitch, or the end of a phrase were noted. These phrases were not always complete sentences or grammatically correct. Also, each spoken phrase was listened to multiple times for accuracy. Lastly, during the member checking meeting, several of the participants reviewed the transcript of their interview. Each agreed it was an honest rendering of the conversation.

Analyzing. For this stage, respondent validation, or member checking, of interpretations was obtained. During this process, previously coded excerpts and their meaning were reviewed often to prevent any drift in their definitions (Creswell, 2014). Transcripts were reread multiple times. Surprise findings or outliers were followed up. Rival explanations were considered.

Validation. Here is where reflexive journaling, maintaining a research log, and rich memo-taking were vital in demonstrating researcher credibility.

Reporting. The first step in informing practice will start with the dissemination of results. This will begin with a public defense, providing a bounded copy of this dissertation to the affiliated university, future conference presentations, and publications.

Chapter Summary

The purpose of this qualitative action research study was to explore how introducing the dimensions of courageous followership influences the undergraduate nursing students’ views of the follower role and informs their nursing practice. Secondary questions asked how knowledge of courageous followership strategies influences the nursing students’ views of their advocacy role, their views about inter- and intracollaboration, and their views related to lateral violence. Participants were undergraduate nursing students attending a public university in Texas. A total

of 12 participants attended a followership seminar; 11 participated in a focus group interview; 10 completed 4 weeks of online reflections and an individual interview.

The bulk of this chapter outlined the seven main categories resulting from data analysis. The main categories were followership, leadership, advocacy, collaboration, and lateral violence. Exemplary behaviors and power and authority were two categories that emerged during analysis. Category findings were presented in relation to the research questions posed. From these category findings, four themes were identified. Finally, the chapter concluded with the presentation of validity criteria.

Discussion and Recommendations

Though nursing students are always expected to demonstrate knowledge of leadership concepts and apply these concepts, students often occupy a follower role. A student role is by its nature a follower role. Individuals assume the follower role to achieve a personal goal. According to Kelley (1992), "They understand the need to learn the ropes, and pay their dues. By proving themselves in the follower's role, they hope to win the confidence of peers and superiors" (p. 53). Followership theory is not routinely taught to nursing students. There is often classroom preparation and expectation to perform as an exemplary leader. However, their role as a follower is neglected. There is no classroom preparation or expectation to perform as an exemplary follower. Their role as a follower is managed and controlled through policy. It is not developed.

Nursing students are also expected to advocate and collaborate on behalf of their patient. However, literature has shown there is a gap between the theories of collaboration and advocacy and the actual practice of both (Hanks, 2008; Lancaster et al., 2015). Additionally, disempowering experiences related to lateral violence and ineffective collaboration, diminish students' sense of power. Knowing this, nurse educators must find a way to teach students how to advocate for their patient, no matter what contextual factors are present, and to recognize their power whether in a leading, following, or collaborating role. The focus of this study has been on nursing students' role as followers.

The purpose of this qualitative action research study was to explore how introducing the dimensions of courageous followership influences the undergraduate nursing students' views of the follower role and informs their practice. The primary research question was, How does knowledge of the dimensions of courageous followership influence the nursing students' views

and practices? Secondary questions asked more specifically how knowledge of courageous followership strategies influences the nursing students' views of their advocacy role, their views about inter- and intracollaboration, and their views related to lateral violence.

Part of asking participants how followership influenced their views of the follower's role while advocating, collaborating, and addressing lateral violence meant first hearing their views on each subject. In addition, understanding how they related to leaders while in the follower role meant exploring their views concerning leadership. During data analysis, each of these topics became a category, and two additional categories emerged from these topics. These two new categories were exemplary behaviors and power and authority. Knowing participants' views about each category, in a general sense, provides a more robust understanding during the discussion of the themes occurring later in the chapter. Additionally, understanding how these views are consistent or differing from literature is informative to those studying advocacy, collaboration, lateral violence, leadership, and/or followership.

Connections and relationships seen between the categories allowed four themes to be identified. The first theme's discussion describes how learning followership provided a new understanding of one's accountability, responsibility, and power as a follower to initiate action and engage in exemplary behaviors. The second theme's discussion explains how a follower's level of engagement and willingness to follow was situational to contextual factors. The third theme, how lived clinical experiences influence engagement, certainty, and sense of power is discussed. The final theme's discussion describes how students viewed their sight as an advocating strength.

To summarize, each of the major categories identified during data analysis and outlined in the previous chapter are discussed here in further detail. These categories are leadership,

followership, exemplary behaviors, advocacy, collaboration, lateral violence, and power and authority. This discussion is followed by a summary of the themes that emerged from the major categories and across the data set. Current literature is related to both the category findings and the emergent themes. At the end of this discussion, reflections of the action research process and study validity are shared. Study recommendations follow a conclusion of study findings.

Discussion

Leadership. Kelley (1992) made the following observation of other studies: "When people did study followers, they simply asked for their view about leadership. The prevailing assumption was that followers had nothing of interest to say about themselves" (p. 12). In this study, similar to previous studies, participants were asked for their view of leadership. However, participants were asked with the assumption that they, as followers, did have something of interest to say.

Identifying leaders. Nursing literature abounds with studies addressing leadership concepts and how to apply these concepts. However, few studies specifically ask nurses to identify their leaders. When participants were asked what a leader does or to describe a leader, they used adjectives similar to those used to describe a good leader. Descriptors were all positive. This is consistent with literature where leaders have been socially constructed to an elevated status and significance in society (Bligh et al., 2007; Cox et al., 2010; Kelley, 1992; Meindl et al., 1985). For this study's participants, it was important that their leader had prior experience doing the same work they were currently learning. They wanted leaders who understood the work. Repeatedly, identified leaders were teaching the participants. These leaders were approachable and willing to do the same work. Because participants valued those who could teach them, most of the leaders they modeled were experienced nurses or other students.

This also included their clinical professors. A person in a position of legitimate power was not identified as a leader unless the previously mentioned attributes could also be associated with them. These findings were consistent with literature where nurses held socially coconstructed views of leaders (Kean et al., 2011), and leaders were described as those who demonstrated clinical expertise and were approachable and supportive (Stanley, 2006). A match between these attributes and their own beliefs was also a factor in how participants identified their leaders who were oftentimes other nurses (Stanley, 2012). Shamir also wrote of close leaders as leaders having direct contact with followers, and they were attributed with behaviors such as coaching, giving feedback, and setting personal examples (as cited in Popper, 2011, p. 32).

Administrators as distant leaders. Participants understood the hierarchical nature of hospital organizations and saw those in administrative roles as authority figures and distant leaders. These administrators were not part of the participants' day-to-day work or learning process. Their presence was known only from the lens of setting policy or addressing a problem. Failure of administrators to communicate rationales for certain policies was a source of frustration to participants, especially if the new policies were perceived to make their work harder. Such policies seemed to demonstrate to the participants that administrators did not understand the realities of their work. For this study, participants were generally indifferent to these distant leaders. Their indifference to distant leaders is not consistent with Popper's (2011) discussion of distant leaders. Popper explained that distant leaders are often seen as visionaries. Followers tend to relate to distant leaders based on traits versus behaviors, and these leaders are at times subject to narratives accompanied by a social contagion that results in a description of the leader based on projections. Hutchinson and Jackson (2013) contended that distant leaders are often positioned as transformational leaders influencing their followers.

For the participants is this study, an explanation for their indifference may be found by understanding who they identify as leaders. As explained previously, participants identified experienced nurses, students, or professors as leaders. Popper (2011) stated that the closer a leader is to their followers, the more likely the follower will relate to the behaviors. Stanley (2012) differentiated between clinical leadership and positions of legitimate power. Clinical leaders are less likely to be in a controlling position and more likely to be working at the bedside. He explained that a clinical leader is an expert nurse who motivates and inspires their followers. A clinical leader is also approachable, an effective communicator, and an empowered individual. Their practice is visible to others. Distant leaders are often credited as being the transformational force in nursing leadership (Hutchinson & Jackson, 2013). However, participants in this study were inspired and influenced more by their close leaders.

Leadership style. Participants were found to favor a collaborative leadership style. This finding is not surprising as collaboration is considered an essential component of undergraduate baccalaureate education and key to delivering safe patient care (AACN, 2008). A finding not readily seen in literature was the participants' openness to accept a change in leadership style if a valid situation presented itself. Participants were willing to accept an authoritative style during an urgent situation or a situation where the participants themselves were lacking adequate knowledge. However, once these situations changed, a collaborative approach was expected to resume. This willingness to accept a change in leadership style is consistent with Popper's (2011) discussion regarding threatening situations and crises. She wrote that these situations result in the need for security and a protective caregiver and that the leader serves as a substitute providing the follower with a sense of security. Being students and still learning, participants

understood they did not always know what to do next. In these situations, they were willing to defer to the leader.

Learning leadership. Participants shared through stories ways they had learned leadership. Though leadership is part of most undergraduate nursing school's curriculum, participants never referenced their didactic experience when describing their leadership learning. Instead, participants referenced experiences as the way they learned leadership. This was done by learning from past mistakes, feedback from leaders, failed advocating experiences, and failed collaborating experiences. These experiences allowed participants to become more flexible, accountable to followers, more collaborative, and less controlling. Participants also learned by observing leaders in the clinical setting and by modeling the behaviors they found desirable. Their learning through observations of others in a social setting seems to indicate a social cognitive orientation. However, participants did invest time in making meaning of their experiences, which is a constructivist orientation (Merriam, Caffarella, & Baumgartner, 2007). Siding with a particular orientation is not as important as noting that the participants' learning process was rooted in interactions and experiences.

Followership. Chaleff (2009) encourages those learning about followership to move beyond the negative images associated with the follower role. The sooner the idea of a powerful follower is embraced, the sooner a synergistic relationship can be fully developed between the leader and follower. A balanced leader-follower relationship then promotes the wholesome use of power which then makes it possible to improve the lives of those being served.

Learning followership.

A change in perspective. Followership theory speaks of leadership as a cocreated process between the leader and follower (Uhl-Bien et al., 2014). During this process, leaders and

followers should not focus on one another but on a common purpose (Chaleff, 2009). Shifting the focus onto the goal and off the leader resonated with study participants. They immediately understood its implications. They understood it was not just the leader's responsibility to achieve the goal. They also realized they hold equal responsibility and accountability in achieving the goal. This change of perspective had an empowering influence. It sparked their intention to take initiative and action. It strengthened their determination to advocate for their patient because, to the participants, the welfare of the patient is the common purpose in health care.

Differentiating good from bad. Understanding the idea of leadership as a cocreated process and focusing on the common purpose reframed the ideals and expectations of the follower role. By doing this, participants experienced another change in perspective. Participants, who initially described followers with a negative connotation, were now able to distinguish between a good and bad follower. When asked to describe a good versus bad follower, they communicated their vision of how these types of followers behave. A good follower fit the prototype of an exemplary follower as described by Kelley (1992). This type of follower also resembles what Chaleff (2009) identified as an effective follower. A bad follower's behaviors were similar to behaviors of other follower types described by Kelley (e.g., pragmatist, conformist, and alienated). The behaviors of both can also be compared to Carsten et al.'s (2010) follower schemas of passive versus proactive, respectively. The importance of this perspective shift relates to the impact accepting the follower label has on individuals. Hoption et al. (2012) found in their study that the follower label was associated with lower positive affect. This resulted in fewer intended extra-role behaviors, which is indicative of a follower's willingness to take initiative. The authors believed mitigating the negative connotation associated with the follower role was a promising way to encourage a follower's contribution to the leadership

process. By learning followership principles, participants realized a negative connotation should be placed on how the follower behaves in the role, not the label.

Contextual factors in following. An ongoing question in followership studies is how contextual factors inform the follower role. For instance, Carsten and Uhl-Bien (2013) suggested a closer examination of the contextual factors associated with a follower's belief of their ability to resist an unethical request from a leader. In a different study, Carsten and Uhl-Bien (2012) questioned how a follower's interaction with leaders and work culture may influence the follower's coproduction beliefs. Baker (2007) also recommended an examination of the relational nature between leaders and followers. In addition, Hoption et al. (2012) recommended a closer look at the role organizational context on followers' view of their role. Kean et al. (2011) felt that the lack of research in the health-care context was notable, and further research of followership in this context was recommended. Though not a research question, participants in this study did contribute to the discussion of how contextual factors inform the follower role.

Reasons to follow. In this study, participants oftentimes described factors that made them more willing to follow or more likely to resist following. Reasons to follow were summarized as personal, situational, group, and type of leader. Personal reasons included the participant's personal values, emotions, personality, belief in the leader and/or organizational goal, own goals (one requiring mentoring or assistance), and their follower type. They also expressed a willingness to accept a different leadership style in certain situations. Much like situational leadership, followership was at times situational. In times of urgency or in times of uncertainty, participants were willing to assume a less collaborative role with their leader. For instance, a crisis was seen as an urgent situation and a valid reason to defer to the leader. Other reasons to take a less collaborative role included (a) uncertainty of the ethics, laws, and rules imposed by

authority; (b) the explicit or implicit boundaries of their student role; and (c) the uncertainty of their own skill level. Contextual factors of the group also influenced the follower's willingness to follow. If the participant accepted their role and assignment in the group, they were more willing to follow. The follower type of other group followers made participants more willing to participate. They preferred group members who were considered good followers (i.e., exemplary or effective followers). It was also important the work distribution was fair within the group. The final contextual factor participants spoke of was the leader. Participants were more willing to follow a leader that had good leadership behaviors, a good personality, and similar experiences as the followers.

Reasons to resist following. Participants also described reasons making them less likely to follow. These contextual factors included personal reasons, a need to advocate, group issues, and the type of leader. A loss of faith in the leader or group was a personal reason described. In addition, a belief in a better solution, other priorities in life, or not being comfortable in their role or assignment were other personal reasons provided. Interestingly, participants said sometimes to be a good follower, one must resist following. This is consistent with their assertion that a need to advocate is also a reason to resist following. Unethical requests and professional concerns were described as provoking a need to advocate. During their focus group interviews and before attending the followership seminar, participants described followers as lemurs blindly following the leader without making a conscious choice. Knowing that they now understand a follower can be a good follower and be good by not following is encouraging. This seems to indicate that their focus is on the common purpose, which is the patient's welfare, and not solely on the leader.

Most followership studies focus on the leader-follower relationship (Uhl-Bien et al., 2014). However, Wong et al. found social group identification as having the largest effect on

nurse work engagement (as cited in Bargagliotti, 2012, p. 1423). In this study, participants spoke of choosing to follow not only the leader but also the group. This occurred organically and mostly during their discussion about collaboration. Poor collaboration contributed to participants being less willing to follow. Examples of poor collaboration were group members not adhering to their role within the group or a fellow follower trying to take over the lead. Fellow followers with bad intentions or engaging in lateral violence also made participants less willing to follow. These concerns ultimately resulted in a loss of faith in the group causing the participant to turn away or disengage.

In this study, the final and most common reason for resisting to follow was a bad leader. A bad leader was said to have bad intentions, not listen, show favoritism, and break trust with the follower leading to a lack of faith in their ability. Just as with the group, these issues led to a loss of faith in the leader, which also caused participants to disengage. The participants' reaction to their loss of faith in a leader or the group may be explained by Bargagliotti (2012), who reported that trust is an antecedent to nurses' work engagement.

Exemplary behaviors.

The ideal way of being or doing. Exemplary behaviors as a category emerged when participants were observed frequently explaining ways they thought people should behave when demonstrating an ideal. This could be an ideal leader, follower, collaborator, or advocate. For participants, a good leader, a good follower, and a good fellow follower were identified by their exemplary behavior. For instance, participants felt that an ideal leader or ideal follower takes initiative. This was a behavior valued by participants. Therefore, in this study, it was considered an exemplary behavior. Engagement was another concept that also emerged as it was difficult to separate engagement from an exemplary behavior. The ideal to participants also meant that these

activities would be carried out, as Kahn described when defining work engagement, "as fully physically, cognitively, and emotionally connected with their work roles" (as cited in Bakker, 2011, p. 265). Participants described engagement as an antecedent to exemplary behaviors. This means that when someone demonstrates the exemplary behaviors of professionalism, being a team player, communicating effectively, and thinking critically, they are demonstrated by someone who is also engaged in their work.

Engagement as an antecedent. The specific behavior most often cited by participants as showing engagement was taking initiative. To participants, taking initiative meant taking the first step, which is an act often associated with leadership. This explains why participants, despite being in a follower role, often referred to their own acts of initiative as acts of leadership. By saying they had led from below or were acting as a leader in the follower role, the credit of being an exemplary follower is given to the leader role. Taking initiative is not an act exclusive to leadership. It is also an attribute of an exemplary follower and a courageous follower (Chaleff, 2009; Kelley, 1992). It describes an ideal regardless of role.

Factors influencing engagement. Participants perceived level of engagement as being closely aligned with their willingness to follow. If willing to follow, participants described attitudes and behaviors consistent with engagement. If resisting to follow, participants described attitudes and behaviors consistent with disengagement. However, it is not possible to say someone who resists following is not engaged. For example, participants suggested that being a good follower meant not following at times if doing so would harm the patient. Refusing to follow, in this situation, was a way to advocate. Hanks (2008) explained that advocating requires a sense of conviction to act on behalf of the patient. It is difficult to claim that a health-care provider who is actively advocating, by not following, is not engaged.

Participants also described other factors that influenced their level of engagement. Personal factors such as their personality, sense of conviction, values, and attitudes had an influence. Leader type and quality of communication were also factors discussed. The type of leader was the contextual factor most often cited as influencing one's level of engagement. All of these factors were consistent with known contextual factors (Bargagliotti, 2012; García-Sierra, Fernández-Castro, & Martínez-Zaragoza, 2016; Kean et al., 2011). However, participants' most dramatic examples of a shift in engagement toward exemplary behaviors came through their stories of disorienting experiences. This study's finding provides a new perspective on nursing work engagement.

Disorienting experiences were often caused by participants feeling overwhelmed by their work demands, lacking clinical experience, experiencing poor collaboration, and adjusting to their new role. Commonly described, and particularly distressing, were disorienting experiences involving incidents where participants failed or witnessed a failure to advocate for a patient. These experiences triggered emotional reactions that eventually transformed into a proactive approach in assuming accountability in their role while collaborating and when communicating. James and Chapman (2009) explained that undergraduate nursing students' preconceived expectations of the nursing profession can conflict with the reality of their clinical placement resulting in dissonance. This sense of dissonance is an opportunity to construct new frames of reference allowing students to become critical thinkers and decision makers (King & Baxter Magolda, 2011).

Advocacy.

Defining or describing. When participants were asked to describe advocacy, their responses were initially seen as definitions of advocacy. However, their descriptions were

actions, so it was a struggle to understand if participants were defining advocacy or describing the way it is done. The struggle to differentiate between its definition and the way it is done cannot be easily resolved because advocating is often defined by taking action. MacDonald (2007) supported this in her discussion paper where advocacy is summarized as an action taken by an advocate to represent the needs of another. In his concept analysis of barriers to nursing advocacy, Hanks (2007) also summarized definitions by describing advocacy as an act or process of advocating. In this study, participants felt that it was not one particular act that defined advocacy but a collection of actions. Like exemplary behaviors, engagement was again an antecedent. MacDonald (2007) explained that in her study of relational ethics, the theme of engagement stresses the emotional connections between the patient and nurse. It is this connection that allows the nurse to then understand the patient's experience.

Focus of advocating efforts. Participants most often felt that patients were the focus of their advocacy. Indeed, patient advocacy is often the focus of nursing advocacy articles (Hanks, 2007; Hanks 2008, MacDonald, 2007). Yet, in this study, participants also spoke of advocating for peers, leaders, the group, and themselves. When advocating on behalf of the patient, their role was often to act as a buffer between the patient and other people. These other people may be other health-care providers or even the patient's family. When advocating for their peers, their role was often to assist in dealing with incidences of lateral violence. When advocating for themselves, the purpose was most often to assure desirable work conditions by standing up to hierarchical organizational demands. Advocating for the leader meant supporting the leader.

Driving factors of advocacy. Participants were motivated to advocate by external factors such as health policy, law, or threat of punitive action. However, internal factors were described more so as the reason for taking action. Most participants spoke of long-held values and a sense

of ethical duty to speak up for those in need. These values and a sense of ethical duty preceded their entrance into nursing school. This is consistent with Hanks's (2008) summary of research in which he found that an effective advocate must have a sense of caring, respect, and conviction for the patient's well-being. In this study, the most often described internal factor for advocating was a sense of professional duty to protect the patient.

Advocating when values compete. Of interest, participants felt that it was acceptable to go against a patient's wishes or request if they saw it as protecting the patient. For instance, Shannon used the example of telling a diabetic there were no more sodas, even though this was not true. Here she is overriding the patient's autonomy to make choices and decisions regarding their health care. The patient's right to autonomy is a professional value in nursing. The AACN (2008) described autonomy as the right to self-determination, and professional practice of this value is demonstrated when nurses respect patients' right to make decisions about their health care. However, to Shannon, the primary goal of advocacy is to keep the patient safe. By not telling the truth about the soda inventory, she was protecting the patient. This brings up the question as to how nurses resolve competing professional values. For this study, one online reflection did ask participants to consider how they would resolve a conflict between a personal and professional value. However, this did not include how they would choose between competing professional values. In most circumstances though, participants felt that it was important to set aside their own personal values as part of advocating.

***Barriers faced when advocating*.** Participants described barriers they faced specifically as students trying to advocate for their patients. A common barrier described was an uncertainty of their boundaries. Often, they were worried that speaking out would jeopardize their school's relationship with the hospital. It was clear they were considered guests. They also felt a sense of

intimidation from those in power or the hierarchical nature of most hospital organizations. This sense of intimidation was in the clinical and school setting. Students did not always speak up in the clinical setting or to their professors for fear of retribution. Another barrier was their lack of knowledge or experience, which prevented students from speaking up at times. The end effect of all these described barriers is how they inhibit the students' voice. These barriers were consistent with Bradbury-Jones et al.'s (2007) study, which examined the meaning of empowerment for nursing students. In their study, learning in practice, power, and team membership were identified categories that could empower or disempower students. Hanks (2007) also summarized barriers to nursing advocacy. Lack of power, lack of education, threats of punishment, and institutional constraints were identified barriers. Though not seen as a barrier specific to the student role, participants also described failing to communicate with patients or other health-care providers as a barrier. However, the barriers identified as unique to their student role did have an end result of failing to communicate. If students have no voice or a weakened voice their observations are not being communicated effectively.

Uncertainty in using an advocating voice. Literature speaks of using voice to advocate for patients or acting as the patient's voice (Hanks, 2008). Yet, as literature shows, having a voice does not necessarily mean someone will advocate. Bradbury-Jones et al. (2007) wrote of participants witnessing poor practice but feeling unable to challenge the practice. In this study, participants did not feel that their voice was relevant or carried power. This may explain why participants rarely used the word *voice* when describing advocacy. Voice was only one way to take action, and in their eyes, it was not always an effective way. Participants spoke more of their ability to see things. Sight was their advocating strength. Though the words *see*, *seen*, *seeing*,

saw, *sight*, and *extra set of eyes* were used by participants what was being described is their skill of observation.

The follower's role as an advocate. When participants were asked to describe the follower's role while advocating, much like a student, they also described incidences where the follower can see things that others might miss. Followers were thought to have a bigger role than leaders in advocating for the patient, since followers were more aware of the patient's needs. Though followers may not have authority, they were said to have power and were expected to advocate for their patient. Followers were seen as the liaison between patient and others. Others could be family, the organization, or authority. It was also the follower's responsibility to steer the leader, if necessary, in a way that abided the patient's values. During collaboration, followers became the patient's biggest advocate by taking the lead and speaking up. According to MacDonald (2007), a collaborative relationship built on trust provided a workplace better able to support the nurse's ability to advocate. This description is consistent with the views expressed by participants in this study concerning the consequences of failed collaboration and barriers of collaboration. When collaboration failed, in their eyes, advocacy also failed.

Broadening the view of advocacy through followership. Advocacy is often studied in literature as an individual activity focused on the patient (Hanks, 2007; Hanks, 2008; MacDonald, 2007). However, participants in this study often described it as happening in a team setting. These descriptions were often heard as participants discussed followership. Learning followership seemed to broaden their view of advocacy. For instance, a good follower was said to advocate for everyone. Followers were responsible for advocating for themselves by speaking up if not competent to complete an assigned task, asked to do something unethical, or asked to break any personal values. Fellow followers' biggest advocacy role was for each other in the face

of lateral violence. These views reflect elements of Chaleff's dimensions of courageous followership taught in this study. Chaleff (2009) described courageous followers as being alert to the needs of each member, supporting a peer who takes a courageous stand, and not leaving a fellow follower without support.

Learning advocacy through experience.

Positive experiences. Positive advocacy learning experiences in the clinical setting were described by several participants. In each incidence, the participant shared something they had done for a patient. In each story, there was a positive outcome for the patient and/or health care was provided. In each story, the participant's actions were different but all started when the participant took initiative to help the patient. In Bradbury-Jones et al.'s (2007) study, the participants felt empowered and validated by their actions. Likewise, in this study, participants learned the impact they could have on a patient through these experiences. Their reactions were similar to the participants' reactions in James and Chapman's (2009) study. James and Chapman explained that providing comfort to patients allowed their participants to feel worthy, valued, and that they made a difference to the patient.

Negative experiences. Negative advocacy learning experiences were often described by participants in this study as well. Many advocacy stories, from the clinical setting, described an incident where participants witnessed a licensed health-care professional fail to advocate for a patient. In witnessing this, participants felt that they too had failed to advocate. It was their belief they had an obligation to speak up but did not. Participants also told stories of previous life experiences, outside of their nursing student role, where they had witnessed a failure to advocate. These experiences all had a deep, emotional impact on the students. When asked during their online reflections to describe a disorienting experience, most of the stories surrounded some sort

of incident where they had witnessed a failure to advocate. In their stories, they went on to describe an internal reflective process where critical thinking took place. This allowed them to think through and plan how they would react if a similar incident occurred again. Participants learned how they preferred to handle a similar situation in the future. Changes they intended to make included increasing their level of engagement and their willingness to resist authority. In a sense, an unexpected consequence of failing to advocate was sometimes learning how to be a better advocate. This is consistent with MacDonald's (2007) contention that due to a sense of emotional connection with the patient, a perceived violation of patients' rights or dignity served as a powerful trigger driving nurses to advocate.

As a student in the clinical setting. Hanks's (2008) study of lived experiences of nursing advocacy, similar to participants' experiences in this study, found that nursing advocacy experiences can be both negative and positive events. He also contended that advocacy is primarily learned on the job after graduation. This study's findings differ. Participants' learning was seen at times to begin with previous life experiences outside of nursing then continue while in school. However, the learning that happened in school took place through experiences in the clinical setting, not in the classroom. This may in part due to Foley et al.'s (2002) finding that nurses learned advocacy by observing other nurses advocating. This type of observation is not possible in a classroom. This finding also relates to a previous finding in this study. Previously, students' sight, or rather, their ability to observe was described as their strength when advocating. This held more power than their voice. It stands to reason, if a student is actively observing as a way to learn advocacy, they are likely to see things easily missed by others focused on other aspects of health care.

Collaboration. In nursing, collaboration is a professional expectation. The AACN (2008) stated that inter- and intraprofessional communication and collaborative skills are essential for delivery of evidenced-based and patient-centered care. However, just as romancing leadership causes the value of followers to be overlooked, the value of the group is often overshadowed as well. When discussing ways to achieve goals, the merits of leadership are many times the sole focus. Even in followership theory, the merits of the individual follower can at times become the sole focus of discussion. Overlooked in this discussion is the importance of the group. Chaleff (2009) was mindful that the dynamics of the leader-follower role is more complex than two individuals. He indicated that there is usually more than one follower interacting with the leader, and these followers also interact with one another. Furthermore, the roles of leader and follower are dynamic. People may move in and out of these roles at any given time.

A vision of collaboration. Participants' vision of collaboration can be summarized as a group of people coming together as a team to achieve a common goal. Participants felt that the purpose of collaboration was foremost to achieve the best patient outcome. However, another important purpose of collaboration was to assure smooth and safe daily operations. Every person brings their own skills and knowledge respective to their discipline as a contribution toward the goal, does their part, and attends to their part. This mirrors the description of collaboration provided by Hall (2005) where team members assume roles specific to their profession but analyze problems and identify goals while assuming mutual responsibility to reach a goal.

Lancaster et al. (2015) described collaboration as making rounds with team members and informing each other of changes to the patient's plan of care. Similarly, for participants in this study, collaboration was most often visualized in the form of interdisciplinary rounds. However, it was acknowledged that people do not have to be in the same room for it to be done. It can

happen through reporting and charting. One participant felt that sometimes collaboration was invisible. Participants also expected communication to be done calmly with respect for each other's intellectual space and skills and saw compromise between team members as an important part of the decision-making process. Participants viewed the role of leader and follower during the collaborative process as dynamic and changing back and forth between members of the team. A leader will make the final decision but only after receiving input from others. Similarly, Fackler et al. (2015) reported that nurses believed collaboration required active and continuous input by all health-care members in the patient's plan of care.

Role management while collaborating. Participants did not view the collaborative process as devoid of roles. In fact, a large part of their discussion regarding effective collaboration was the role of roles. Though each person brought specific knowledge and skills to the group, each person also had a role to fulfill. Roles could be that of leader, follower, or fellow follower. Participants also described specific behaviors expected of each role. These behaviors mirrored those used to previously describe good followers, good leaders, and exemplary behaviors. Not fulfilling the expectations of their role or trying to assume someone else's role often led to a failure in collaboration. Specifically, participants felt that the act of someone in the group stepping out of their role and trying to lead them was frowned upon. This was seen as different from a group member taking initiative. If initiative was well-intentioned and meant to meet the common purpose, the action was considered exemplary behavior of a good follower. Chaleff (2009) spoke of followers respecting each other's boundaries and only crossing them with mutual consent to avoid turf wars. He also spoke of appreciating each other's differences as these differences provide different paths to reach the common purpose.

Management of power while collaborating. Along with role management, participants expected for authority and power to be equalized between roles during collaboration. There was also an expectation for there to be effective communication during collaboration. This is consistent with Fackler et al.'s (2015) discussion regarding collaboration. When mutual trust and respect existed between nurses and physicians, nurses felt powerful and did not perceive themselves on a different level of authority than the physicians. Hall (2005) wrote that in order to maintain status-equal between team members and to interact meaningfully, each team member must be aware of the other's expertise. In this study, participants felt that each person was expected to focus on the common purpose. Interestingly, Fackler et al. (2015) also reported that participants' sense of power was built in collaborative relationships when everyone was focused on good patient outcome.

Reasons collaboration fails. In this study, participants believed a reason collaboration failed was ineffective communication. Participants stated that a lack of explanation from administration for new policies or why a resource was not available was a source of frustration and an example of ineffective communication. In addition, personal factors such as domineering personalities, egos, selfishness, and refusing to cooperate were described as reasons collaboration fails. However, lateral violence was the most often cited cause of ineffective communication by participants. Lateral violence was said to result in health-care workers not speaking up for themselves, patients, or coworkers. It also prevented the sharing of important information. These views are consistent with multiple studies attributing lateral violence to the erosion of collaborative relationships and compromised patient safety (Laws, 2016; Roberts, 2015).

Challenges students face when advocating.

Inconsistent learning experiences. Participants said the primary consequence of failing to collaborate was harming the patient. Therefore, it was important to them to collaborate and to do it well. They expressed a level of comfort in collaborating within their own profession. Participants explained that spending hours at the beside with nurses, completing collaborative projects with other nursing students, spending time with other nursing students in the school and clinical setting, and interacting often with nursing professors had resulted in this comfort. These opportunities to collaborate with one another had allowed first-hand experience with intraprofessional collaboration. However, their primary way of learning interprofessional collaboration was limited to didactic discussions in the classroom. Learning in the clinical setting was often by chance. In listening to the participants' stories, it was observed that their learning experiences of interprofessional collaboration were often unintentional, sporadic, and left to chance. One student may have several positive experiences, whereas another student may have had only negative or no experiences. This study's participants acknowledged that experience was what they needed to improve their collaboration skills. Hall (2005) acknowledged that schools have been remiss in helping faculty develop experiences needed to promote interprofessional collaboration education. MacDonald (2007) recommended that nursing education consider learning experiences that assist nurses to meet the challenge of navigating the various interrelationships they will encounter in the workforce.

Barriers to collaborating. Participants expressed a willingness to collaborate but felt limited by their student status, lack of knowledge, uncertain boundaries, and underdeveloped communication skills, all of which limited their voice in the collaborative process. These barriers mirrored those previously outlined in the discussion concerning advocacy. This is not surprising when oftentimes collaboration is needed to make advocacy happen. Collaboration skills are

particularly important when nurses attempt to advocate with other professionals who hold different professional values and perspectives (Hall, 2005; MacDonald, 2007). Fackler et al. (2015) wrote that nurses felt powerful when their voices were heard and their expertise was acknowledged. Feeling powerful also meant using one's voice to speak up on behalf of another.

Lateral violence. In this study, participants were asked to describe their experiences of lateral violence. The acts of lateral violence experienced or witnessed by participants of this study were similar to those described in the literature. Examples of lateral violence, listed by Griffin (2004), include gossiping, making snide remarks, making faces, and withholding pertinent information. Each participant had a story to share involving lateral violence. This is not surprising as literature suggests that lateral violence is embedded in nursing culture (Bradbury-Jones et al., 2007; Laws, 2016; Roberts, 2015). Additionally, participants did witness conflict between disciplines. However, these incidences are not considered lateral violence. Lateral violence refers to bullying within the same discipline. The fact that Griffin's (2004) participants believed there was interpersonal conflict between physicians, nurses, and ancillary staff should be addressed. However, it should be addressed as a collaboration issue.

Origins identified in the school setting. While listening to participants share their lateral violence experiences, incidences of lateral violence in the school setting were recognized. This led to participants being asked specifically of experiences occurring in the school setting. Once realizing this behavior was happening well before nursing students arrived into the workforce, participants were asked for their explanation as to why lateral violence was happening in the school setting. Participants who entered nursing after obtaining degrees in other fields, felt that the lateral violence they witnessed or experienced was unique to the nursing discipline. They speculated it was due to excessive group work and competitive and perfectionist personalities

with a need to be the best, and these factors overshadowed being kind. Their explanation is a new insight as current literature focuses on causes but not origins of the behavior. Literature speculates reasons as to why lateral violence occurs in nursing (Laws, 2016; Roberts, 2015), but explanations offered are varied. Marginalization and oppressed group behavior as a cause has been suggested (Roberts, 2015). The Joint Commission (2008) contended that lateral violence may be due to systemic factors related to authority, empowerment, roles, values, and embedded hierarchies. Roberts (2015) concluded that lateral violence is a learned behavior and is related to power dynamics. Her study's findings reflect previous research. For this study, it is suggested that this learned behavior begins in the school setting and is then carried forward into the workplace.

Loss as a consequence of lateral violence.

Trust. Having been a target of lateral violence, participants described feeling negative emotions and loss. They were also concerned of the potential harm to the patient. Their negative emotions, such as loss of sleep and feelings of guilt, confusion, and hating to come to work, were consistent with lateral violence literature where the same reactions are described (Bradbury-Jones et al., 2007; Griffin, 2004; Roberts, 2015). Participants in this study also reported a loss of trust and loss of voice after experiencing lateral violence. Trust was an attribute participants believed a good leader, a good follower, and the group should have. Trust was a reason to follow. Loss of trust was a reason not to follow. When lateral violence eroded trust, participants were less willing to collaborate or assume a follower role. The relationship between lateral violence and a nurse's intention to leave a job is often referenced in studies (Griffin, 2004; Laws, 2016; Roberts, 2015). This reflects the loss of engagement and unwillingness to follow described in earlier findings when followers lose their trust in a leader or group.

Voice. Voice was previously defined in this study as when what someone says is validated and acknowledged (Fackler et al., 2015). Voice is described as a primary way nurses advocate (Hanks, 2008; Rainer, 2015). When lateral violence is happening, participants described feeling a loss of voice. Their ability to communicate is disrupted, and this failure to communicate has been described by participants as a reason for ineffective collaboration. They also identified a failure to collaborate as a reason for failing to advocate. Lateral violence's role in closing off effective communication, disrupting collaboration, and resulting in failed advocacy, as described by participants, is well cited in nursing literature (Laws, 2016).

Ways to address lateral violence. Though participants said an important consequence of lateral violence was the failure to advocate and collaborate, their discussions focused more on the direct harm it caused to the victim and the team. In dealing with lateral violence, there were ways participants had taken action and ways participants believed action should be taken. In the past, participants had tried to dumb themselves down, turn their cheek, or lead by example as a way to deal with lateral violence. Moving forward, participants were in agreement as to how the victim and those witnessing lateral violence should handle the situation. Most agreed that the perpetrator should be confronted. If this did not work, only then should an authority figure be notified. In this situation, authority was seen as a resource. Griffin (2004) also suggested that leadership is essential for decreasing disruptive behaviors; when leadership is done in a strong, consistent, and supportive way, it deters the disruptive behaviors.

However, the resource most often identified was a fellow follower. Fellow followers were described as having a central role when dealing with lateral violence. When participants were asked what the follower's role was in dealing with lateral violence, they said it was their responsibility to stand up for and support their fellow followers. These responses were similar to

those in the discussion concerning followership. Attributes used by participants to describe a good fellow follower included advocating for one another, offering support and encouragement, and confronting the perpetrator of lateral violence. MacDonald (2007) found that nurses' ability to advocate for patients was significantly influenced by their relationships with other health-care workers. Bradbury-Jones et al. (2007) found that their nursing student participants felt empowered when they felt as though they belonged to the team or as though someone was looking out for them.

Power and authority.

Difficulty finding voice. Fackler et al. (2015) defined power as knowledge, experience, self-confidence, and voice. The authors also explained that voice is empowering if it is validated and acknowledged. Participants agreed they would feel more confident in speaking up if they had more knowledge and experience. Similarly, Bradbury-Jones et al. (2007) found that the opportunity to learn in practice was empowering to their nursing student participants. As nursing students, participants in this study were in the process of building their knowledge and experience. They recognized the need to use their voice to advocate for patients, fellow followers, and themselves. However, power could at times act as a barrier. Power in the hands of others and lack of a meaningful voice were thought to have a limiting effect on their collaborating and advocating abilities as students. Bradbury-Jones et al. (2007) also found that despite feeling empowered when advocating, students still had difficulty finding their voice to advocate.

Participants came to the study with a mature view of authority. At some point, before this study, participants' view of authority had evolved from where it was as a child to where it stood at the time of this study. They expressed respect for authority but also an understanding that it

was necessary to speak up to authority in certain situations. The reasons for resisting authority were similar to those provided when describing reasons to resist following: being disrespectful to others, believing there is a better solution, ineffective communication, or conflicting values. Participants did not see their lack of authority as an excuse for not exercising their power because they felt that everybody has power. However, due to uncertainty of the consequences, there was still hesitation in exercising their power. According to Carsten and Uhl-Bien (2013), a sense of personal responsibility may not be enough for followers to constructively resist unethical requests if they do not believe the context will allow them to act on this sense of responsibility. The nature of the health-care context may increase the difficulty participants in this study have in finding their voice. Lancaster et al. (2015) wrote, "inadequate communication and a dictatorial, authoritative arrangement among healthcare providers foster hostility, frustration, and distrust which hinder collaboration and jeopardize quality patient care." (p. 282).

Finding power as a follower. In this study, participants described how power provided a willingness to take the initiative to act when advocating or collaborating. After reframing the traditional view of a follower and shifting their focus onto the common purpose, participants described having this willingness. Part of demonstrating exemplary behaviors as a good follower meant exercising power to initiate (Chaleff, 2009; Kelley, 1992). As followers, they did not feel authority was needed to exercise power. Being a follower was not an excuse for not exercising their power. Exercising their power to confront those in authority was often mentioned by participants, especially if there was an issue with the leader or a need to advocate. Carsten and Uhl-Bien (2012) found that followers with strong coproduction beliefs will engage in voice despite moderating behaviors such as leader type. Their views were also consistent with the

dimension Chaleff (2009) referred to as the courage to challenge, which participants learned during this study.

In this study, participants suggested a willingness to engage in voice after feeling empowered to act. How they felt empowered might be explained by Carsten and Uhl-Bien's (2012) study of follower's belief in the coproduction of leadership. The authors described upward communication as consisting of voice and constructive resistance. Voice in their study is an extra-role behavior, whereas constructive resistance is a form of objection. In their study, a positive relationship was found between coproduction beliefs and both forms of upward communication. Those who believed leadership was coproduced were more likely to engage in upward communication. In this study, participants' role as followers was reframed as part of the coproduction of leadership. Participants were taught to not focus on the leader but instead on the common purpose. They were also taught the five dimensions of courageous followership, which also emphasizes the coproductive roles of leaders and followers around a common purpose.

Themes

The effects of learning followership. Fagan, Parker, and Jackson (2016) acknowledged that student nurses are in a subservient position due to their role as a learner and visitor to a clinical organization. This position influences their confidence in speaking up and how their contribution is valued. Hoption et al. (2012) found that being assigned the label of follower was associated with lower positive affect and fewer intended extra-role behaviors. Withholding extra-role behaviors only reinforced the view of followers as having no initiative. The authors suggested that effective followership studies may mitigate this negative connotation by encouraging follower's contributions to leadership.

In this study, teaching participants a reframed definition of a follower, clarifying the different types of follower roles, and shifting the focus off the leader and onto the common purpose, facilitated a new understanding of their responsibility and accountability as a follower in reaching a common goal. This had an empowering influence on participants when advocating, collaborating, or caring for patients by sparking their intentions to take initiative and engage in exemplary behaviors. This reaction is consistent with Carsten and Uhl-Bien's (2012) findings that followers with stronger coproduction beliefs were more likely to voice concerns and ideas and were less likely to see their role as insignificant. In addition, Fackler et al. (2015) found that when nurses felt powerful, there was willingness to take on additional roles, such as mentors, committee members, or role models.

Participants were taught that effective followers and courageous followers have an important role and do contribute to the organization (Chaleff, 2009; Kelley, 1992). After learning Chaleff's (2009) dimensions of courageous followership, participants often spoke of speaking up to a leader if this was needed to maintain focus on the common goal. They understood their role as a follower was not to obey the leader but focus on the common purpose of the health-care team. Understanding the power inherent to their follower role, participants also spoke of their responsibility to act as a courageous follower when speaking up to a leader or taking action for the benefit of the patient. This is also consistent with Carsten and Uhl-Bien's (2013) findings that individuals with strong coproduction beliefs, who do not romanticize leaders, are less likely to displace responsibility and less likely to obey a leader's unethical requests.

Participants also spent much time thinking critically about their follower role. Each identified themselves as a good follower. Being a good follower also meant being professional, a team player, an effective communicator, and a critical thinker. It was important not to blindly

follow and to be alert when the need to question or challenge a leader was necessary. Participants were concerned with the leader's motives and being clear about why they were following the leader. They also spent time considering when to maintain or overstep boundaries and when to ask for rationales and clarification, especially when these things were necessary to properly advocate for their patients. Similarly, Kelley (1992) described exemplary followers as viewing teams with a critical eye to assure themselves that the task and team are appropriate before moving forward as a member. Likewise, with leaders, followers will internally question and evaluate the leader's decisions.

The participants' description of a good follower conveys a sense of engagement and the expectation of exemplary behaviors. Bakker (2011) described engaged employees as physically, cognitively, and emotionally connected to their work roles. They are immersed in their work and dedicated to reaching work-related goals. Bargagliotti (2012) defined work engagement in nursing as the following: it is "the dedicated, absorbing, vigorous nursing practice that emerges from settings of autonomy and trust" (p. 1424). Engagement and critical thinking are the two constructs used by Kelley (1992) to identify different types of followers. Highly engaged and critical thinking followers are exemplary followers. These types of followers exercise independent thinking and take initiative. They support the team and the leader yet are willing to stand up to the leader. Kellerman (2008) also described different types of followers along an axis of engagement. In order from least to most engaged, these types are referred to as isolates, bystanders, participants, activists, and diehards. Their actions range from doing nothing to showing passion and deep involvement.

An area where participants were not sure if they were being a leader or follower was when they took initiative. Chaleff (2009) declared that initiative is needed for the courage to

assume responsibility. This is one of the five dimensions taught to participants. A distinguishing characteristic of a courageous follower is having the willingness to initiate action without being told to do so. This exemplary behavior also demonstrates engagement (Kelley, 1992) However, participants associated it more with leaders. This was understandable when literature often refers to desired behaviors using a leadership lens. For example, controlling one's own behavior to achieve goals is called self-leadership (Steinbauer, Renn, Taylor, & Njoroge, 2014).

Part of the participants' online reflections and followership seminar was studying Chaleff's dimension of courageous followership, the courage to assume responsibility. Here it was clarified that taking initiative was a follower's responsibility. It was not solely a leader behavior. Participants began to see how exemplary behaviors belonged to followers as well as leaders. In addition, taking initiative can be viewed as an autonomous act. Taken in the role of a follower, these independent acts may be learning experiences toward leadership. As previously discussed, in this study it was noted that participants' leadership learning came through experience. Latour and Rast (2004) suggested that followers who follow effectively will generally transition to formal positions of leadership. Dixon (2009) concluded in his study, based on a consistent correlation of visionary leadership behaviors and follower behaviors, that it is reasonable to consider the role of follower as a developmental stage for leadership.

Factors that influence follower's level of engagement and willingness to follow. García-Sierra et al. (2016) explained that nursing work engagement is not related to a personality trait or disposition alone. It is related to the interactions of multiple factors such as learning through experience, leadership style, and positive work climate, all of which influences the nurse's performance. Likewise, Baker (2007) believed followers must be studied in context of their relationships. Contextual issues of power, control, motivational intentions, personal

characteristics, climate, behavioral intentions, and desire outcomes of followers should be examined (Uhl-Bien et al., 2104). Carsten and Uhl-Bien (2013) suggested that contextual factors associated with a follower's belief in resisting an unethical request would also be associated with their sense of power to act. In this study, participants' engagement aligned closely with their willingness to follow. This, in turn, was influenced by contextual factors. Factors identified by García-Sierra et al. (2016) as influencing engagement were similar to those the participants spoke of as influencing their willingness to follow; these factors were personal reasons, situational factors, work group characteristics, and leader characteristics.

Personal factors contributing to participants' willingness to follow surrounded their personality. For example, having a positive outlook was a described personality quality. This is also an individual antecedent to engagement identified in García-Sierra et al.'s (2016) literature review. Participants felt that a person's follower type also influenced one's willingness to follow. Whether a person is introverted versus extroverted, needing reassurance, or having initiative were personality traits identified by participants. These are also traits of various followership types that are rooted in level of engagement (Kellerman, 2008; Kelley, 1992). Other personal factors described their motive for following. Needing help in reaching a goal, seeking a mentor, or believing in a goal were also reasons participants were willing to follow. Kelley (1992) wrote of seven paths to followership where a person has made a conscious decision to assume the follower role for specific reasons. These reasons, like those described by participants in this study, can include a need to learn the ropes from someone with more experience or following out of loyalty to the leader. Sometimes following is simply chosen because it allows the person to do the work that is part of their dream.

In this study, situational factors contributing to participants' willingness to follow were related to urgency and uncertainty. The kind of urgency was the urgency experienced during a crisis or emergency. Popper's (2011) discussion of threatening situations and crises triggering a need for security and the search for someone to provide it may explain why this willingness occurs. Uncertainty was related to the uncertainty of their own or another's authority and the boundaries placed on their autonomy. Autonomy was described by Bargagliotti (2012) as an intrinsic motivator to nurses and was found to be an antecedent to work engagement. Yet, Hall (2005) explained that the health-care professions continue to establish and redefine boundaries between the various disciplines. As nurses become more responsible for their own acts, this can be interrupted as challenging boundaries of other disciplines. Conflicts and strains arise. Participants expressed the tension between being autonomous in their work and crossing a boundary. Another uncertainty was participant's level of skill and knowledge. When uncertain of their abilities, participants were more willing to follow. James and Chapman (2009) described similar findings when their participants would at times stand back and not ask questions when they lacked confidence. Participants who were confident actively looked for learning opportunities and used initiative to work within the scope of their student role.

Work group characteristics were also identified by participants in this study as influencing their willingness to follow. They spoke of fair distribution of work, the follower type of fellow followers in the group, and incidences of lateral violence as influencing factors. In addition, members in the group were expected to manage their role by doing their assigned work and not try to take over someone else's role, especially the leader's role. Participants also wanted their work trusted by others. As previously discussed, a good follower was a team player, a supportive team member, and professional. Having good fellow followers on the team gave the

participants a willingness to follow. When trust had been established, participants were willing to follow not only their fellow followers but also their leaders. A broken or lack of trust was given as a reason for not following. García-Sierra et al. (2016) found predictive organizational variables for engagement. These variables occurred on the institutional level and on the ward level. On the ward level, fair work distribution, work climate, feeling part of the community, and leadership style of managers were variables predictive of engagement. Bargagliotti (2012) also identified trust as an antecedent of nursing work engagement, and expected on the organizational level, between colleagues and of leaders. She explained: "Trust is an antecedent of work engagement for nurses as it frees intellectual capital to be directed towards work, rather than towards protecting self from the effects of poor decisions by others" (p. 1423). James and Chapman (2009) found that when shown trust by their clinical preceptors, their nursing students began to establish a sense of value and independence.

In this study, lateral violence within the group decreased participants' willingness to follow and their level of engagement. Participants' accounts suggest that lateral violence may have origins in the school setting. This finding may give understanding to Roberts' (2015) literature review where lateral violence is suggested to be a learned behavior. Findings in this study suggesting that the competitive nature among students and tendency toward perfectionism are causes for lateral violence in school finds support in literature. London, Downey, and Mace (2007) referred to situational factors affecting engagement. The authors explained that a culture of competition, rather than collaboration, highlights differences and validation of one's own intellect rather than learning and growth. This dynamic undermines engagement, motivation, and confidence of students.

Leader characteristics and leadership style influenced participants' willingness to follow.

Participants were willing to follow good leaders who shared the same work values. Their identified leaders were rarely linked to authority but more to a role, such as other nurses or clinical professors. This aligns with the participants' description of a good leader as someone who did the same work the participants were learning, did not feel above doing the same work as followers, and was willing to follow. A good leader was a mentor, approachable, a good listener, and a person who took initiative. These views support Stanley's (2006) definition of a clinical leader: Clinical leaders are experts in their field who, because they are approachable, effective communicators, and empowered, are able to act as role models and motivate others by matching their clinical practice to their beliefs and values about nursing. Similarly, Kean et al. (2011) found that their participants described a good leader as being approachable, good listeners, and available to staff. The nurses in their study argued that they would not follow a leader that did not share their same values and beliefs.

This study's participants, as in other studies (Hutchinson & Jackson, 2013; Stanley, 2006; Stanley, 2012) provide descriptions of desired leadership consistent with value-based, authentic or servant leadership (Nahavandi, 2009). Kean et al. (2011) also found that nurse participants in their study were influenced by beliefs, values, and the situational context. Therefore, they did not fit into one category but might move categories based on the situation. Likewise, in this study, participants were most often willing to follow a collaborative leadership style yet would be willing to follow an authoritative style during times of urgency or uncertainty. Hutchinson and Jackson (2013) ascertained that transformational leadership has dominated and influenced nursing leadership to such a degree that a false assumption has been created suggesting a consensus on the nature of leadership has been reached. The authors explained that this leaves little motivation to empirically investigate alternative understandings of nursing leadership, and

they questioned whether nurse leaders are as transformational as reported in literature. In their view, it was imperative for nurse-researchers to embrace new ways of thinking about leadership.

Discussion regarding contextual factors has generally shown that a willingness to follow aligns with a highly engaged follower. However, an exception to this pattern was noted as participants discussed advocacy. In their view, a good follower could only be a good follower by not following if asked to do something that would harm the patient. In these situations, as unwilling followers, they became highly engaged. MacDonald (2007) reported that emotional responses to perceived violations of a patient's dignity or right were powerful triggers for advocacy. Participants in this study described external factors, such as laws, policies, and professional standards, driving their advocacy. However, most factors were internal. As found in other studies (Foley et al., 2002; Hanks, 2007), participants' drive to advocate was based on their upbringing, values, beliefs, and culture. Their sense of duty was the dominant driving factor to advocate, and advocacy was seen as inherent to nursing. They also felt that a good follower advocated for patients and fellow followers. Brown et al. (2011) explained that people have a strong motivation for self-consistency. Violations to self-consistency are disturbing as these violations contradict their moral values. Participants learned in this study that a good follower does speak up to a leader or other fellow followers. All participants identified themselves as good followers. Therefore, as an advocate, self-consistency is not violated by refusing to follow. Further motivation to engage is present, since not advocating would indeed result in a violation of consistency.

The influence of lived clinical experiences. Whether perceived as positive or negative, experiences influenced participants' level of engagement and resulted in new knowledge used later as a source of power when advocating, collaborating, or dealing with lateral violence.

Fackler et al. (2015) studied hospital nurses' lived experiences of power. The authors found that nurses felt powerful when participating in interprofessional rounds, speaking up on behalf of patients, and acting as change agents. Power was defined as knowledge, experience, voice, and self-confidence. Bradbury-Jones et al. (2007) also found advocating experiences to be empowering and having a positive effect on students' self-confidence. A lack of voice was disempowering to their students.

In this study, participants described their clinical and school experiences. Some of the experiences, particularly those involving a failure to advocate by speaking up, were disorienting and caused moral distress. However, the value of the disorienting experience was the experience itself. Through critical thinking and reflection, participants were then able to resolve their feelings of dissonance. Some of the experiences described were positive. Participants expressed self-confidence in their ability and saw their value as an advocate. Similarly, Bradbury-Jones et al. (2007) were able to show how learning in practice, being part of the team, and having the opportunity to exercise their power contributed to students' sense of empowerment. The authors also found that self-efficacy levels increased and engagement in further learning occurred when students felt empowered.

Advocacy stories overshadowed collaboration stories in this study. This may be attributed to the nature of nursing. Learning nursing is learning advocacy. Collaboration, on the other hand, is only part of advocating, and there is an array of different ways to advocate. Yet, participants valued collaboration. James and Chapman (2009) learned that students wanted to actively participate with the health-care team. Participants in this study believed effective collaboration was essential to advocacy. These views are supported by MacDonald (2007), who stated that collaboration skills are extremely relevant when nurses are attempting to advocate in an

environment with competing professional values. Participants described barriers to their collaborating efforts related to uncertainty concerning their boundaries, a perceived lack of voice, and lack of experience. Following Fackler et al.'s (2015) definition of power as knowledge, experience, voice, and self-confidence, participants' views reflect minimal collaborative power. This is a concerning finding as MacDonald (2007) explained that collaborative relationships are what supports a nurse's ability to advocate.

Multiple studies urge the inclusion of collaborative and advocating experiences as part of the nursing students' education (Fackler, 2007; Hall, 2005; Hanks, 2007; Hanks, 2008; James & Chapman, 2009; MacDonald, 2007). Hanks (2008) asserted that nurses learn to advocate after graduation. In this study, participants are seen learning to advocate in their student role. Doucette et al. (2014) also found clinical experiences to be a profound resource for learning and reflecting on these experiences further added to students' learning. Foley et al. (2002) suggested that faculty can help identify situations in which students engaged in advocacy. These encounters can then be discussed while describing critical thinking processes used in advocacy. In this study, several times participants did not recognize they had advocated for a patient. When students did advocate, whether the experience had been positive or negative, it was a learning experience. This is relevant as Hanks (2008) found that experience allowed nurses to gain confidence as an advocate. Hall (2005) felt that experiential learning is also needed for building collaboration skills. She explained that time spent learning and working together in a meaningful way is necessary to move past differences in professional values and culture.

Sight as an advocating strength. Speaking up is a key factor in advocating for patient safety (Rainer, 2015). Though voice is seen as a source of power, it has no power if not used. Understanding why nursing students do not use their voice is an ongoing question (Bradbury-

Jones et al., 2007). In this study, when participants described a positive advocacy learning experience, they had chosen to speak up. In the stories where students described a negative advocacy learning experience, they had remained silent. Rainer (2015) related this to moral distress resulting from inaction. Other times, participants spoke up but still had a negative experience because they did not feel their voice was heard. Hanks (2008) warned that taking action sometimes will still result in frustration, which should be stressed to students as it allows a realistic perspective.

While describing their role in advocacy, participants' use of voice was not utilized nor was it described with the same confidence as when discussing their ability to observe. Their confidence as advocates was rooted in their ability to observe. Participants' assertion that their ability to observe is what they do well may have credibility. Foley et al. (2002) found that nurses learned to advocate by watching other nurses and by gaining confidence from working with mentors who provided a safe environment. This observational learning aligns with the social cognitive orientation theory, which posits that learning is possible by observing others in a social setting (Merriam et al., 2007). It is plausible that participants are in a better position to observe as they are actively learning through observation and engaged in the activity.

Research Process

Process reflection. An action research dissertation creates a dual challenge for the doctoral student. Herr and Anderson (2015) explained that action research is meant to inform local practice, not contribute to a larger knowledge base. However, the goal of a dissertation is specifically to generate new knowledge. In addition, the ongoing nature of action research can create a problem for the doctoral student for who must at some point create an accounting of what has happened thus far for the purposes of the dissertation. Herr and Anderson (2015)

explained that “it may not be possible to write up the whole undertaking, but rather just a piece of the understanding” (p. 106). The authors further explained that simply choosing a stopping point for the accounting of events does not necessarily mean the research cycle will stop. The authors said the doctoral student may need to place a bound on their research for dissertation purposes. The research is ongoing but the dissertation accounts for what has occurred thus far. For my study, the natural next step would be to begin a new phase in the action research cycle based on observations and reflections from the first cycle described in this chapter. However, a full research cycle has concluded. This is the point where I have chosen an accounting of what has occurred will begin.

Herr and Anderson (2015) wrote that action researchers are often not prepared for the politics of action research and the resistance it creates against their efforts. Action researchers build these issues into their research and are trained to deal with them. I had to adjust my data collection methods due to micropolitics in order to gain participant access and time. These adjustments to time and access did limit collaborative options. Despite a low level of collaboration, validity is not lost. Roberts and Dick (2003) wrote of a tension that arises between the complementary roles of action and research, which is not often recognized. The authors explained that the resolution of this tension is resolved when a balance between the two is relevant to the context. In situations where there is little understanding of what action is appropriate for the situation, emphasis on the research role is suggested. This starting emphasis does not dictate the continuing emphasis. For this study, it was appropriate to place emphasis on the research role in action research because there is little understanding of how followership fits into the nursing discipline. Because there is now a better understanding of followership in the

nursing context, the next iterative cycle should emphasize and assure a higher level of collaboration.

Action research validity.

Process validity. This study borrowed heavily from naturalist research. My intention for this study was to explore meaning and interpretation of followership to participants. Therefore, interviews and reflections were appropriate data collection methods. However, the participants had to first learn the principles of followership and how these principles may apply to their nursing practice. The introduction of followership principles was not meant to be an experiment, and it was not to be correlated with other concepts. The introduction was meant to "enhance the lives of students and teachers through positive educational change" (Mills, 2014, p. 172). Furthermore, I was also interested in learning about the appropriateness of the teaching methodologies I used for teaching followership principles. Therefore, an educational action research design was appropriate to choose.

Democratic validity. Participants did offer ideas for further action during their member checking session. Though the seminar and online reflections were actions, much of the research was done on participants rather than with participants. This is in part due to the nature of the research questions. The study had two aims: to explore meaning and to introduce followership principles into a new context. The dual aims were challenging to address. However, choosing one aim over the other would have resulted in a less robust study. The participants did not know followership theory. Any conversation about the meaning of followership and how it applies to collaboration, advocacy, and lateral violence would have been short. Therefore, an action was needed. The introduction of followership principles was the action of this study. This was done through online reflections and by conducting a followership seminar. The action taken was

appropriate to answer the research questions. However, the collaboration aspect of the action with participants and other stakeholders was minimal.

Catalytic validity. For this study, the aim of introducing followership principles was to reorient participants' view of reality away from past descriptions of followers and toward a new understanding of followership principles and the role of followers. This new and deeper understanding would then drive the participants to advocate and collaborate in a more focused and energized manner. In essence, the first action research cycle of this study was to reorient participants to a new reality.

Often in my reflections, concerns were expressed because the action in this study seemed too simple and understated compared to the highly activist examples I read about in multiple action research handbooks. It was not until data analysis was complete that a claim could be made to have met catalytic validity. During the analysis process, it was possible to now see how a simple shift of thought had a profound effect on the participants' intent to take action, especially when advocating for patients, fellow followers, and themselves. Based on this study's findings, catalytic validity was achieved.

Outcome validity. For this study, the outcome validity has strengths and weaknesses. This study did move beyond diagnosis of the problem. From a micro viewpoint, introducing followership principles did produce change in the participants' views, and perhaps this will begin to close some of the theory-practice gap found in advocacy and collaboration. Yet, another research cycle would best demonstrate how participants carry this knowledge forward in their practice. Additionally, the problem is not completely resolved on a macro level. This is due in part because the action taken has not been moved beyond the boundaries of the study and its participants, and only a single solution strategy was implemented.

Another important aspect of outcome validity is how it forces the researcher to reframe the problem in a more complex way, which often leads to a new set of questions. For this study, this aspect of outcome validity was achieved. As analysis of the data progressed, a shift began in my understanding of followership and its potential role in nursing education. Of all the research questions, followership had the biggest role in advocacy. In addition, its role in collaboration is simple but effective. Knowing this about followership will now help direct the focus of new research questions when moving into a new research cycle. Furthermore, the concept of engagement came to the forefront and was a force in all studied categories. As a researcher, I will now consider other ways engagement can be fostered by using the contextual factors identified in the study as a guide.

Dialogic validity. For this study, transparency was maintained throughout the research process by keeping a reflective journal and research log. I remained conscientious of how decisions would impact the ethical integrity and validity of the study. In the end, dialogic validity will be determined by others through the defense of this dissertation and reporting findings to a larger community.

Conclusion

Much time is spent teaching leadership concepts to undergraduate students. Followership concepts are absent from instruction. Yet, much of a student's time is spent in a follower role. Negative connotations of followers go uninterrupted by not acknowledging or teaching the expectations and power of this role. As shown by participants in this study, resisting the label of follower led to break downs in collaboration due to an unwillingness to be led. However, there are legitimate reasons, learning a profession being one, for choosing to assume the follower role. This does not mean giving up power or critical thinking. Once participants understood this, they

were able to see outside of themselves and focus on the common purpose. Introducing followership principles to undergraduate nursing students did provide a new understanding of their follower role. This new understanding allowed participants to see their accountability, responsibility, and power to initiate action and engage in exemplary behaviors while in their follower role.

Though followership is shown in this study to shift participants' level of engagement and sense of empowerment toward exemplary behaviors as they advocate and collaborate, a larger concept came to the forefront during this study. The concept of engagement was seen as influential in answering the primary and secondary research questions. It was a major force in leadership, followership, advocacy, collaboration, and lateral violence. It was also difficult to separate from exemplary behaviors because an element of an exemplary behavior was engagement. As this study has shown, exemplary behaviors are not exclusive to leaders. Good followers also engage in these behaviors. Understanding this also allowed participants to move past the negative connotation of the follower role. They understood that the negative connotation belongs to how a person engages in their role, not the role itself.

This study also demonstrates how participants' level of engagement is closely aligned with their willingness to follow and how lived experiences also influence their engagement. Whether positive or negative, participants learned from their experiences and expressed a more proactive, engaged approach when advocating, collaborating, or dealing with lateral violence. For educators, there should be an emphasis on experiential learning in the areas of advocacy and collaboration. Reflective practice should also have a role in this learning allowing students to find value in any experience whether negative or positive.

This study also provided a deeper understanding of leadership, advocacy, collaboration, lateral violence, exemplary behaviors, power and authority, and followership as separate categories. These concepts each required to be explored before understanding how learning followership might influence them. Exploring participants' views on each concept provided rich data. Data for each category can stand on its own. Even if not concerned with followership, a researcher interested in advocacy, collaboration, lateral violence, nursing leadership, or exemplary behaviors will find that this study enhances knowledge of these concepts. For instance, advocacy is not solely directed toward patients but also toward others in their social group. Additionally, lateral violence may be a learned behavior beginning in the school setting. The social group, or fellow followers, is seen as having the biggest role when addressing the behavior. Also, advocacy and collaboration are best learned through lived experiences, and the ability to do both is influenced by contextual factors that modify engagement.

Recommendations

For this study, a recommendation is to allow more time for each phase of the action research cycle. This consideration to time should be worked into the second iterative cycle. The second cycle might also include a larger number of participants. Suggestions for action, including those made from this study's participants, are implementing followership principles in the clinical setting, conducting followership workshops, participating in collaboration exercises using followership principles, or providing a broader introduction of followership principles as an adjunct to leadership studies. The second cycle should include other stakeholders, such as faculty and interested administrators, as well. It is also recommended that quantitative data collection techniques be woven into further action research cycles (Mills, 2014). Studies correlating the individual categories outlined in this study may further demonstrate how each

relates to the other. For instance, questions might ask if followership behaviors positively correlate to advocacy behaviors or which contextual factors correlate the strongest to level of engagement as a variable.

Whether a part of action research or not, investigating individual categories as separate or overlapping concepts is recommended. This study's findings generated new questions and concerns. For instance, many advocacy studies are oriented toward patient advocacy only. However, participants in this study spoke of advocating for one another and themselves. This perspective should be explored as it may provide a better understanding of group dynamics and collaboration. Interested researchers might also consider exploring the school setting as the origin of lateral violence in nursing. Current studies suggest that lateral violence is a learned behavior. Future researchers may question if lateral violence is a learned behavior originating in the school setting and from whom or how are students learning these behaviors. A better understanding of this may prevent the unwanted behavior from moving into the workplace where it disrupts both collaboration and advocacy.

Participants communicated meaningful learning experiences related to advocacy. However, meaningful learning experiences related to interprofessional collaboration were lacking. Another recommendation would be to incorporate more experiences into the clinical setting. Yet, this has been the same recommendation made by multiple studies spanning several years indicating this suggestion produces no effect. Instead, collaboration may be better served by researchers seeking to understand if it is valued more in theory than practice or if it is happening in a way different from current definitions. For instance, participants in this study described collaboration as a group activity done together. However, one participant felt that it also happened invisibly and physically separate from one another.

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Appendices

Appendix A

Consent Form

Teaching and Learning Courageous Followership: An Action Research Study
Consent to Participate in a Research Study
University of the Incarnate Word

You are being asked to participate in a research study conducted by Karen Walker Schwab, PhD student at the University of the Incarnate Word, under the supervision of Dr. Audra Skukauskaite. The purpose of this study is to explore how introducing the dimensions of courageous followership through an action research process influences the undergraduate nursing students' views of the follower role.

Procedures:
If you agree to take part in this research, you will be invited to participate in one 45-60 minute audiotaped individual interview, and one 60-120 minute videotaped focus group interview. You will also be invited to attend a 1-2 hour seminar about followership. Finally, you will be invited to contribute the work you produced through reflective journals kept weekly for 4-6 weeks following the seminar.

Risks and Benefits of Being in the Study:
The risks for participation are minimal. Student identities and contributions will be protected throughout the study by assignment of pseudonyms, and this protection will be maintained in any publication that follows. Access to data (reflection journals, audiotapes, videotapes) will be limited to the researcher and researcher supervisor, both of whom have completed ethics and record-protection training (CITI).

There is a risk of local participant recognition if students are identified as being part of the researcher's study group. However, the exact semester in which data collection takes place will be confidential, and identities of those participating in the researcher's study will not be made public to other students' as a measure to limit identification risk.

There is also a risk for feelings of stress during the interviews if sensitive topics such as lateral violence (bullying) is brought up for discussion. These feeling could also reoccur while writing weekly reflections.

Audio and videotapes will be destroyed at the conclusion of this study. Videotapes will not be used for any public purpose and will be viewed only by the researcher and research supervisor for analysis purposes.

The possible benefit of this research is adding to participant knowledge of courageous followership dimensions and understanding practical strategies when facing barriers to collaboration or advocacy. As well, participants may benefit by participating in the action research process which expands their knowledge and experiences surrounding the research process.

Duration of the Study:
Data collection for this study will be conducted for five months. While data collection is continuing, any participant may return to the researcher to request in writing that their data be excluded from the data set.

Participation:
Participation is voluntary and you have the right to refuse participation without penalty of any kind. You have the right to stop participating at any time, including leaving during individual interviews, focus group interviews, and seminar without penalty of any kind.

You will not be graded on your participation in this study or knowledge of courageous followership. A decision not to participate in this study or to withdraw from the study will not affect your grades or current or future status at [redacted]. You have the right, at the end of the study, to be informed of the findings of this study.

Contacts and Questions:
To contact the University of the Incarnate Word committee that reviews and approves research with human subjects, the Institutional Review Board (IRB), and ask any questions about your rights as a research participant, call: UIW IRB, Office of Research Development [redacted]. For questions about the research study and your participation you may contact Karen Walker Schwab at [redacted].

Statement of Consent:
If you completely understand the expectations and rights of participants in this study, all of your questions have been answered to your satisfaction, and you are willing to participate in this study please sign and date this consent form in the space provided. To sign this consent form, you must be 18-years-old or older by today's date.

Your signature indicates that you (1) consent to take part in this research study (2) that you have read and understand the information given above, and (3) that the information above was explained to you.

_____	_____
Participant name	Date Signed
_____	_____
Participant Signature	Date Signed
_____	_____
Principal investigator signature	Date signed

Appendix B

Interview Questions

Focus Group Interviews

1) **Leadership Questions:**
   - What do leaders do?
   - What makes a good leader?
   - In the hospital setting, describe how leadership is organized?
   - In the school setting, describe how leadership is organized?
   - Explain who the leaders are and who are the followers.

2) **Followership Questions:**
   - Describe a follower.
   - What do followers do?

3) **Collaboration Questions:**
   - Describe collaboration.
   - What are your views regarding collaboration in healthcare?

4) **Advocacy Questions:**
   - Describe advocacy.
   - What are your views regarding advocacy?
   - Who is responsible for assuring advocacy is happening, leaders or followers? Explain

Is there anything you would like to add?

Individual Interviews

1) **Leadership Questions**
   - What do leaders do?
   - What makes a good leader?
   - What makes a bad leader?
   - How do you lead?
   - Who do you view to be leaders in the clinical setting?
   - Who do you view to be leaders in the school setting?

2) **Followership Questions**
   - Describe a follower.
   - What do followers do?
   - What makes a good follower?
   - What makes a bad follower?
   - How do you follow?

3) Advocacy Questions:

Describe what advocacy means to you?
Describe how you advocate?
Who is responsible for assuring advocacy is happening leaders or followers? Explain
What helps you advocate?
What hinders you?
Do you feel you have power to advocate as a student? Explain this to me.
Feeling this way… describe how this works when you are in the clinical setting?

4) Collaboration Questions:

Describe what collaboration means to you?
How do you collaborate?
Who have you collaborated with and how did that go?
What helps you collaborate?
What hinders you?
Do you feel you have power to collaborate as a student? Explain this to me.
Feeling this way… describe how this works when you are in the clinical setting?

Is there anything you would like to add?

Appendix C

Sample Online Reflection

Weekly Reflection

Teaching and Learning Courageous Followership: An Action Research Study

The Courage to Assume Responsibility

This dimension is more valued than the other dimensions combined. Chaleff (2009) describes courageous followers as assuming responsibility for themselves and the organization. They find ways to fulfill their potential and maximize their value to the organization. They initiate actions to improve the organization. "Authority" to initiate comes from the follower's ownership and understanding of the common purpose and from the needs of those the organization serves.

<u>Part One:</u> Assuming responsibility for our own personal development.

This begins with self-examination. Courageous followers do not wait for performance evaluations. They assess their own performance. Followers must examine their relationship with leaders. This starts with understanding our relationship with authority. The way we deal with those in authority is deeply ingrained from our childhood "authority" relationships (parents and teachers). We learned to survive by complying, avoiding, or resisting authority. Work environments can reinforce your childhood relationship to authority.

Reflection Activity: Please share the type of relationship with authority you experienced as a child. How did you react to those in authority? As an adult, how does your childhood relationship with authority influence your reaction to those in authority today? Discuss what other choices you have, now as an adult, to relate effectively to authority.

<u>Part Two:</u> Assuming responsibility for the organization.

Having passion for your work; acting without being told; influencing work culture; supporting and questioning rules; not waiting for someone to fix a problem; testing new ideas; and breaking old mindsets are ways courageous followers assume responsibility for the organization. Assuming responsibility benefits the organization and those it serves.

As courageous followers, our focus is on the organizational purpose. When this "common" purpose is shared with leaders, control shifts from the leader to the purpose itself. Therefore, we are full participants able to act… to take initiative.

Reflection Activity: What do you think is the "common purpose" in most healthcare settings? Explain how shifting your focus off the leader and onto the "common purpose" influences your ability to assume responsibility for the organization (and those it serves). Please provide examples if possible.