

Students' perceptions of bullying behaviours by nursing faculty

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This study describes the types, sources, and frequency of bullying behaviours encountered by nursing students in their final year of nursing education. Six hundred thirty-six respondents reported encountering at least one bullying behaviour from School of Nursing (SON) Faculty during one year of classroom or clinical course work. The results of the study also indicated SON Faculty as the most frequent source of three of twelve bullying behaviours. These behaviours were (a) assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes, (b) bad grade given as punishment, and (c) unmanageable workloads or unrealistic deadlines. Responses were based upon student perceptions and thus it is unknown whether the behaviours actually occurred or whether grades and workloads which were fairly given were perceived by students as being punitive. Either way, student perceptions that faculty are a source of bullying behaviour is of concern given the potential negative impact on student health and academic performance. The most common student responses to bullying behaviour included passivity, confrontation and reporting the behaviour, demonstrating uncivil behaviour and increased use of unhealthy coping behaviour. Recommendations to address bullying in nursing education include modifying curricula to include education on identifying and responding appropriately to bullying behaviour, establishment of a code of behaviour and disciplinary action for code violations, and open forums for faculty and student discussions.

Introduction

According to Hutchinson (2009), the concern over the presence of work-related violence and its impact on the wellbeing and retention of nurses continues to be a major concern in the nursing profession. Bullying is one of the frequently encountered forms of work-related violence. Previous studies have described the presence of bullying, both in the nursing workplace and in the nursing academic setting, and the negative impact of bullying on nurses and nursing students (Jackson, Clare, & Mannix, 2002; Kolanko, Clark, Heinrich, Olive, Serembus, & Sifford, 2006; Lewis, 2002; McKenna, Smith, Poole, & Coverdale, 2003; Ozturk, Sokemen, Yilmaz & Cilingir, 2008; Quine, 2001; Randle, 2003). Lacking from the literature, however, are studies focusing on the frequency, sources, or the experience of bullying among senior year nursing students.

This article emanates from a larger study conducted to describe the phenomenon of bullying in nursing education. A previous published article focused on the perceptions of bullying behaviours perpetrated by school of nursing classmates (Cooper, Walker, Winters, Williams, Askew, & Robinson, 2009). A third article, in development, will address bullying behaviours by hospital and clinic nurses.

This article focuses on the issue of bullying by faculty and addresses three research questions:

1. What are the types and frequency of bullying behaviours in nursing education reported by nursing students?
2. Who are the sources of bullying behaviours in nursing education and what is the frequency of bullying from these sources as reported by nursing students?
3. What behaviours do nursing students report using to cope with bullying in nursing education?

Because there is limited research on the phenomenon of bullying in the senior year of nursing education in the United States, this study will add to the profession's understanding of the nursing student experience at this time point. This is of special interest because of the potential to improve the educational experience prior to students entering a workforce in which bullying has been well documented.

Literature review

Bullying

The phenomenon of bullying has been a frequent topic of research within the field of nursing and education (Cassell, 2010; Cooper, et al, 2009; Clark & Springer, 2010; Hutchinson, 2009; Ozturk, Sokmen, Yilmaz, & Cilingir, 2008) since The Joint Commission (2008) issued regulations requiring hospitals to implement policies addressing uncivil behaviour in the workplace. The Joint Commission's action was based upon concerns about the relationship between uncivil behaviour and negative patient outcomes.

For the purpose of this study, bullying was defined as long-term aggressive or negative acts or behaviours, carried out repeatedly over time, and directed at someone who finds it difficult to defend him / herself because of a relationship with the bully that is characterised by an imbalance of power. A person simply behaving badly or in a rude manner or isolated one-time incidents of negative acts or behaviours are not included in this operational definition of bullying (Einarsen, 1999; Gillen, Sinclair, & Kernohan, 2004; Oleweus, 2003).

Negative workplace behaviours in nursing and nursing education

Bullying in education may have devastating outcomes. Two examples are illustrated in the following cases. In one case, a professor murdered other professors at Concordia University (Rogers & Kelloway, 1997) and in another, a student murdered faculty at the University of Arizona, School of Nursing. While these are the extreme examples, these are familiar stories connecting workplace violence and educational experiences.

Bullying is one of the many ways workplace violence and negative workplace behaviours manifest themselves. Violence, best described on a continuum (Anderson, 2001; Hazler & Carney, 2000; Mayhew & Chappell, 2001), includes acts ranging from

teasing (e.g. sending offensive messages) to terrorism. The impact of workplace violence is negative on people, environments, organisations, and professions (Center for Disease Control and Prevention [CDC], 2002).

When it comes to the future of nursing care, Wieck (2003) cited, “Who is going to take care of me?” (p. 151) as the question of the decade. It is well established that recruitment and retention of quality nursing staff is a growing problem facing most health care agencies across the country, with the registered nurse positions reflecting the highest vacancy rates (American Nurses Association [ANA], 2001). This shortage has been blamed on (a) a general decrease in the workforce as the result of the aging “baby boom” generation, (b) a decrease in the attractiveness of health care careers, and (c) the increasing dissatisfaction of the current health care workforce (ANA).

Developing strategies to combat the dissatisfaction and make health care careers more enticing, a health, safe, and satisfying work environment is imperative (American Hospital Association [AHA], 2002; Cropanzano & Wright, 2001). Jackson, Clare, and Mannix (2002) reflected on the problem of workplace violence (bullying, physical violence and assault, and sexual harassment) when they asked, “Who would want to be a nurse?” (p. 13). Bullying in nursing has been identified as a work-based stressor that affects not only the nurse, but also the patient care the nurse provides.

Lewis (2002) noted the history of nursing in its hierarchical structure and formality of rules could contribute to the opportunity for bullying. Crawford (1999) maintained that rigid hierarchical structures, especially when power is used in a controlling rather than motivating manner, support a culture of bullying. Philpin (1999) singled out hospitals as powerful institutions that immerse staff in a culture of rigorous rules and regulations that must be learned and followed.

Anderson (2001) reported many nurses consider themselves powerless to report negative incidents, especially when the incidents appear to be relatively minor. Responses to their reports of bullying, such as “he’s just a hot tempered boss . . . you’re the problem, you’re too sensitive, it’s all in your head” (p. 670) also led nurses to feel partly responsible for the bullying. One contributor to this feeling of being partially responsible may be explained by the second-class, subordinate nature of nursing that causes nurses to feel oppressed and powerless against bullying (Duffy, 1995).

In schools of nursing, a hierarchy exists that reflects the dynamics of other workplace environments. The classroom embodies the structure of workplace units. Instructors and faculty represent supervisory positions. Students embody the status of subservient workers. If teacher-learner relationships are not positive, the student’s needs for support and respect can go unmet, disempowering the student.

Meissner (1986) proposed that because of practiced authoritarianism, nurse educators became drill sergeant-like instructors where obedience was demanded. These approaches often led to lack of nurturance, assistance, and support that student nurses needed to succeed in the profession. Almost 20 years later, Thomas (2003), referencing

bullying in educational experiences, supported Meissner's suggestion that nurses do 'eat their young'.

The question, "Who would want to be a nurse?" (Jackson, Clare, & Mannix, 2002, p. 13) calls our attention to behaviours that have a negative impact on professional values, commitment, and attitudes. Two authors have suggested that bullying originates in schools of nursing (Baltimore, 2006; Hutchinson, 2009). Whether this is true or not, nurse leaders are obligated to explore, eliminate, and prevent these behaviours from occurring in the learning environment.

Bullying behaviour is not exclusively a United States (U.S.) phenomenon. In a three-year study conducted in the United Kingdom on nursing students' self-esteem, Randle (2003) identified bullying as a common complaint among students and a routine experience in the process of becoming a nurse. Randle concluded the way a student nurse was treated during training shaped the student's process of becoming a nurse. If the student is socialised into a nursing culture that accepts bullying as a routine practice, the results can be deleterious.

In 2004, Celik and Bayraktar looked at the types of abuse experienced by nursing students in Turkey. Verbal abuse was the most frequently reported type of abuse. All participants identified their classmates as a source of verbal abuse, indicating that the problem is widespread. Verbal abuse from faculty was reported by 41.3%, while 83% had experienced academic abuse. Participants also reported instances of sexual and physical abuse while in nursing school, although not necessarily from faculty members.

In another study (Ozturk, et al, 2008) in Turkey, one-fifth of the academic nurses (including educators and health professionals) in the sample reported the presence of bullying in the workplace. Of those respondents reporting bullying, 61% reported taking no action to end the abuse. Seventy percent noted that the source of bullying were managers while 46 % reported colleagues as the source.

In the U.S., Magnussen and Amundson (2003) noted students report that some nursing instructors actually impede their educational experiences, undervalue nursing students, or treat students in uncaring ways. The authors suggested that nurse educators have a responsibility to help students recognise and embrace nursing as a profession and a moral obligation to address student bullying and ensure that students' educational experiences are positive.

While faculty may not intentionally behave in ways to demean or embarrass students, their negative behaviours contribute to a hostile learning environment that has negative consequences. In their study of uncivil faculty behaviours, Kolanko and colleagues (2006) described some of those consequences as student anger, frustration, and a sense of powerlessness. The authors noted students often felt disrespected and caught in a power struggle that faculty were sure to win. Because of the power imbalance, they believed there was too much to lose if they stood up for themselves or tried to confront faculty.

Conceptual framework

Historically, nursing's hierarchical structure and rules have contributed to opportunities for bullying that have led to a culture of bullying (Lewis, 2002). According to Cassell (2010), 72% of bullying incidents in higher education are attributed to an imbalance of power due to the hierarchical structures of higher education. Within universities, schools of nursing reflect the same hierarchical structures. For example, instructors and faculty represent supervisory positions and students are often seen as subservient workers. When conflict occurs and a power inequality is perceived, students feel disempowered. Since education precedes practice, nurse leaders and nurse educators need to be aware of power imbalances and whether bullying exists in order to squelch such behaviours.

Bullying is the result of "an imbalance in strength (or an asymmetrical power relationship)" (Olweus, 2003, p.12). The concepts of power and power imbalances prevail in the literature regarding bullying (Baltimore, 2006; Baumann & Del Rio, 2006; Chapell et al., 2004; Gillen, Sinclair, & Kernohan, 2004; Lewis, 2006; Quine, 2001; Randle, 2003; Smith, Cowie, Olafsson, & Liefoghe, 2002). While power in the nursing context has historically had a negative connotation, Kanter (1993) asserts that power does not necessarily mean control over others, but rather is "the ability to get things done" (p. 166). Kanter's theory of organisational empowerment is built on a framework of empowering structures described in terms of (a) formal power, (b) informal power, (c) opportunity, (d) information, (e) support, and (f) resource structures.

In Kanter's theory, formal power structures originate from the significance of one's role to an organisation's processes. Informal power structures are a result of the individual networks one forms with sponsors, peers, and subordinates within and outside of an organisation (Kanter, 1993). Opportunity structures relate to one's autonomy and develop through opportunities that one has to learn and grow in an organisation. The knowledge and expertise one needs to function effectively within an organisation are the foundation for information structures. The support structures are built on feedback and guidance from one's superiors, peers, and subordinates. And finally, resource structures include materials, money, supplies, equipment and time necessary to realise organisational goals (Laschinger & Finegan, 2005; Siu, Lashinger, & Vingilis, 2005). Individual power within an organisation can come from one or more of the types of empowering structures (Kanter, 1993).

Kanter's theory of structural empowerment can be applied to nursing education. For example, Sui and colleagues propose providing learning environments within nursing schools built on empowerment structures that help support professional growth (Sui, Lashinger, & Vingilis, 2005, p. 466). For this study, formal power structures from Kanter's theory served as the framework and may be useful as a guide for nurse leaders and educators in developing structures that respect caring values and create a safe and healthy environment.

Methodology

This descriptive cross sectional study used a questionnaire survey design to assess bullying behaviours by nursing faculty from the nursing students' perspective. The data from this study came from a larger study of all types and sources of bullying behaviours in nursing schools within our sampling frame. The study's target population was all associate and baccalaureate degree seeking nursing students in their final year of nursing school in a southern state in the United States. Selection criterion required that the participant be currently enrolled in an associate or baccalaureate degree nursing program. Students from 16 associate degree schools at 19 locations and 7 baccalaureate schools at 9 locations participated in the study.

Instrumentation

The *Bullying in Nursing Education Questionnaire* (BNEQ) (see Appendix A) was developed for this study to examine student's perception and experiences with bullying in nursing education. Concepts for the BNEQ were extracted from a study by Celik and Bayraktar (2004) and further modified from a version of their nursing student abuse questionnaire.

Briefly, Celik and Bayraktar's (2004) survey contains 36 items that collect demographic data and data on verbal, physical, sexual, and academic abuse from the nursing student's perspective. Additional items for the BNEQ were extracted from the *Negative Acts Questionnaire* (NAQ), developed by Einarsen, Raknes, Mattiesen, and Hellesøy (1994). The NAQ is a 31-item inventory that measures frequency, intensity, and prevalence of workplace bullying. Cronbach's alpha ranged from .87 to .93 for the NAQ (The Bergen Bullying Research Group, 2006). The NAQ has been used in over 60 studies globally.

The BNEQ is a one-page self-administered Likert scaled questionnaire that addresses the frequency and sources of bullying behaviours described in the literature. Source categories are School of Nursing (SON) Classmates; SON Faculty; SON Staff; Physician, Hospital / Clinic Nurse; Other Hospital Staff; Patient; Patient Relative; or SON / Hospital Guest.

The BNEQ presented challenges for using standard measures of stability and internal consistency. Because the BNEQ items measure different types of bullying behaviours, and inter-item correlations were expected to be low, measuring Cronbach's alpha was inappropriate for the BNEQ. Reliability and validity of the BNEQ was established by rigorously holding to the standards for developing a questionnaire that gathers opinion data as described by Borg and Gall (1989).

First, the concepts were drawn from literature. Second, the survey items were drawn from established measures. After developing an initial draft, the BNEQ was reviewed by two advisory panels. The expert panels were asked to evaluate the BNEQ according to (a) readability, (b) language appropriateness to avoid biases, (c) ease of understanding directions, (d) ease of understanding items, (e) typographical errors, (f)

appropriate wording, (g) appropriate length, and (h) over-all structure and appearance. Corrections and adjustments to the BNEQ were made based on the advisory panels' observations and comments.

The revised BNEQ was then pilot tested in two groups of nursing students who were not eligible to be in the study in order to identify any problems with the questionnaire and establish the time involved in completing the survey. The first group reported minimal typographical errors, which were corrected, and that all items were clearly written. No items were deleted or added to the BNEQ as a result of this pretesting. The BNEQ was then administered to the second group of nursing students. Participants indicated the BNEQ was easy to read and understand, no parts were objectionable or offensive, and no additional instructions were required. The investigators observed that no items were left blank and that the BNEQ yielded the desired information. As a result of these procedures no further changes in the BNEQ were indicated.

Procedure

Permission to conduct human studies was obtained from the university's Institutional Review Board (IRB). Participation in this study was voluntary with completion of the questionnaire indicating consent. The purpose of the study, risks and benefits, contact information, ability to withdraw or refuse to answer any questions, and methods to assure confidentiality and anonymity were explained prior to administration of the survey.

After recruiting and training study facilitators at all participating schools, an administration date was designated. On the designated date, the study facilitators distributed and reviewed study narratives and questionnaires. They instructed the participants to place the completed questionnaire in a legal sized envelope that was provided and to seal the envelope before returning it to the facilitator. Study facilitators were instructed to place the sealed envelopes in the mailing envelope that had been provided and return them to the investigator. Questionnaires were maintained in a secure location. The questionnaires were scanned and data analysis was performed.

Data analysis

Descriptive data analysis was performed using Statistical Package for the Social Sciences (SPSS), Version 13.1. The data were used to address the three research questions.

Findings

A total of 1133 students from 28 sites at 20 schools of nursing in the state were invited to participate in the study. A total of 665 completed questionnaires were used for data analysis. Response rate was 64.1%.

The sample included 665 nursing students in the final year of their nursing program. Other characteristics included: 73.4% (n=488) were female, 40.2% (n=267) were

between the ages of 18 and 24, 56.2% (n=374) reported their average grades as “B”, and 68.1% (n=453) indicated they were Caucasian / White.

The first two research questions asked about the types, sources and frequency of bullying behaviours in nursing education reported by nursing students. Nursing students were instructed to indicate the frequency of the bullying behaviours as always, frequent, intermittent, seldom or never. The five response categories were subsequently combined into three categories: never, seldom/intermittent, and frequent/always. All source categories listed on the BNEQ were identified as a source of bullying, albeit at different frequencies. As bullying was defined for this study as occurring repeatedly over time (Cooper et al., 2009) responses listed as frequent/always may best represent bullying behaviours, whereas seldom/intermittent may represent isolated incidences of negative behaviour. Table 1 displays the percentage of students reporting bullying behaviours as occurring frequent/always. The percentage of students reporting the presence of bullying as frequent/always ranged from a low of 0.5% to a high of 9%. Faculty reported as a source of the frequent/always behaviours ranged from 3.3% to 38.5% (see Table 1).

Table 1: Bullying behaviours occurring freq/always and Faculty as source (N=665)

Bullying behaviours	Frequent / always		Faculty as source	
	N	%	N	%
1: Yelling or shouting in rage	191	3.2%	13	6.8%
2: Inappropriate, nasty, rude or hostile behaviour	289	4.8%	21	7.3%
3: Belittling or humiliating behaviour	227	3.8%	50	22.0%
4: Spreading of malicious rumours or gossip	248	4.2%	23	9.3%
5: Cursing or swearing	539	9.0%	29	5.4%
6: Negative or disparaging remarks about becoming a nurse	180	3.0%	18	10.0%
7: Assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes	83	1.4%	20	24.1%
8: A bad grade given as a punishment	40	0.7%	14	35.0%
9: Hostility after or failure to acknowledge significant clinical, research, or academic accomplishment	82	1.4%	20	24.4%
10: Actual / threats of physical or verbal acts of aggression	30	0.5%	1	3.3%
11: Being ignored or physically isolated	310	5.2%	29	9.4%
12: Unmanageable workloads or unrealistic deadlines	325	5.4%	125	38.5%

Table 2 indicates the top three sources of bullying behaviours as reported by nursing students at the frequent/always category. SON faculty were the most frequently reported source for 3 of the 12 behaviours, including (a) assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes, (b) a bad grade given as punishment, and (c) unmanageable workloads or unrealistic deadlines. Faculty were identified as the number two source of “belittling or humiliating behaviour” and “hostility after or acknowledge significant accomplishment” and the number three source of “negative or disparaging remarks about becoming a nurse”.

Table 2: Top three sources of bullying behaviour selected at frequent / always categories (N=665)

Bullying behaviours	Source		
	Number 1	Number 2	Number 3
1. Yelling or shouting in rage	Patient	Classmate	Physician
2. Inappropriate, nasty, rude or hostile behaviour	Classmate	Hospital/Clinic Nurse	Patient
3. Belittling or humiliating behaviour	Classmate	Faculty	Physician
4. Spreading of malicious rumours or gossip	Classmate	Hospital/Clinic Nurse	Other Hospital Staff
5. Cursing or swearing	Classmate	Hospital/Clinic Nurse	Patient
6. Negative or disparaging remarks about becoming a nurse	Classmate	Hospital/Clinic Nurse	Faculty
7. Assignment made for punishment rather than educational purposes	Faculty	Other Hospital Staff	Hospital/Clinic Nurse
8. A bad grade given as a punishment	Faculty	SON Staff	Classmate
9. Hostility after or failure to acknowledge significant accomplishment	Classmate	Faculty	SON Staff
10. Actual / threats of physical or verbal acts of aggression	Classmate	Patient	Patient Relative
11. Being ignored or physically isolated	Classmate	Physician	Hospital/Clinic Nurse
12. Unmanageable workloads or unrealistic deadlines	Faculty	SON Staff	Classmate

Item 13 on the BNEQ was designed to address Research Question 3: What behaviours do nursing students report using to cope with bullying in nursing education? Eleven possible behaviours were listed on the BNEQ. Table 3 shows the responses to Item 13.

The most frequent passive responses to the behaviour were “did nothing” (34.9%), “put up barriers (23%) and “pretended not to see the behaviour” (14.9%). The most frequent active response was “spoke directly to the bully (20.8%) and “reported the behaviour to a superior/authority” (14.7%). Almost a tenth reported an aggressive response:

“shouted or snapped at the bully (5.9%) and “demonstrated similar behaviour (3.2%). Nine percent responded “increased my use of unhealthy coping behaviour”, yet only 1.4 percent reported “went to a doctor”.

Table 3: Behaviours used to cope with bullying in nursing education

Behaviours	Frequency		Ranking
	N	%	
Did nothing	232	34.9	1
Put up barriers	153	23.0	2
Spoke directly to the bully	138	20.8	3
Pretending not to see the behaviour	99	14.9	4
Reported the behaviour to a superior / authority	98	14.7	5
Increased my use of unhealthy coping behaviour	60	9.0	6
Warned the bully not to do it again	44	6.6	7
Shouted or snapped at the bully	39	5.9	8
Demonstrated similar behaviour	21	3.2	9
Went to a doctor	9	1.4	10
Perceived the behaviour as a joke	4	0.6	11

Respondents were given the opportunity to write additional comments on the instrument. Two themes were noted in the comments, power struggles and powerlessness. Selected responses from the BNEQ are listed in Table 4.

Table 4: Comments related to student response to bullying

Power struggles	Powerlessness
We tried to get things changed, but no one ever really does anything!!	We really can't say much or we'll get kicked out for being disrespectful.
Staff advisor bullied me, through harassment, and personally degrading me in front of my peers. Addressed issue with advisor and asked if she had a problem with me. Then went to the chain of command. I nearly got kicked out. Now I bite my tongue.	It was mostly to me racism that I acknowledged and I did nothing because teachers stick with each other regardless if you are a student or not.
I persevered and stuck with my studies, I wanted to quit but refused to give up because of my teacher.	I usually just let it go because it isn't worth jeopardising my position in order to retaliate.

These accounts reflect power struggles as discussed in the literature and the feeling of powerlessness expressed by nurses in the workplace. They also support Kuokkanen and Leino-Kilpi's (2000) position that the hierarchy of healthcare settings, including schools of nursing, restricts access to power and creates unequal power relationships that emphasise the hierarchy.

Discussion

This study documents nursing students' perception of the presence of bullying behaviour in nursing education in the schools we surveyed. Previous research has not examined the occurrence of this phenomenon during the senior year of nursing education, although literature on bullying in the nursing workplace and academic setting has increased in the past decade because of the connection between bullying and untoward effects such as nursing turnover, stress related illness, and medical errors. This study begins to fill the gap about the problem in higher education, particularly in nursing schools during the final year of studies.

Research question 1

Research question 1 asked, what are the types and frequencies of bullying behaviours in nursing education reported by nursing students? The results of the study indicated the most frequent types of behaviours experienced from all sources were cursing, swearing, inappropriate, nasty, rude, or hostile behaviours, and belittling or humiliating behaviour.

As previously noted, for this study bullying was defined as occurring repeatedly over time (Cooper et al, 2009). Responses listed as frequent/always may best represent bullying behaviours, whereas seldom/intermittent may represent isolated incidences of negative behaviour. Although the percentage of students reporting the presence of bullying as frequent/always ranged from a low of 0.5% to a high of 9%, when the behaviour was reported, students often listed SON faculty as a source of the bullying behaviour. That bullying of any type or at any frequency occurs in schools of nursing may not be surprising, but the presence of these behaviours is unacceptable.

Research question 2

Research Question 2 asked: Who are the sources of bullying behaviours in nursing education and what is the frequency of bullying from these sources as reported by nursing students? Faculty reported as a source of bullying behaviours as frequent/always ranged from 3.3% to 38.5% out of the nine sources listed on the BNEQ.

SON faculty were the most frequently reported source of 3 of the 12 bullying behaviours. These were (a) assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes, (b) a bad grade given as punishment, and (c) unmanageable workloads or unrealistic deadlines. It is possible that these behaviours would naturally be higher in the academic setting or that students don't

understand assignments, workload and deadlines as part of the learning environment. Responses were based upon student perceptions and thus it is unknown whether the behaviours are actually occurring or whether grades and workloads which are fairly given are perceived by students as being punitive. Either way, student perceptions that faculty are a source of bullying behaviour is of concern given the potential negative impact on student health and academic performance.

Faculty were identified as the number 2 source of "belittling or humiliating behaviour". Given that faculty are the most frequent point of contact that students encounter in the learning environment, faculty incivility, if present, may negatively affect student socialisation into the nursing profession. With 5.9% of students responding to bullying with "shouted or snapped at the bully" and 3.2% responding with "demonstrated similar behaviour", the academic experience may not be effectively preparing students to respond appropriately to negative behaviour and may be graduating student nurses who will repeat bullying behaviour upon entering the workforce.

Compounding the issue is that schools of nursing are facing a faculty shortage. To abate the shortage, master prepared nurses are actively recruited into faculty positions. Since bullying is well documented among nurses in the workplace, it is possible that nurses bring bullying from the practice setting into the educational setting. It is up to nurse educators and nurse leaders to demand that the teaching, learning, and work environments are free of bullying. This will require individual and organisational awareness and change.

Research question 3

Research question 3 asked: What behaviours do nursing students report using to cope with bullying in nursing education? The most frequent response was "Did Nothing" followed by "Put up Barriers." This response is problematic when reports indicate hostility and violence in the workplace is on the rise.

Others (Celik & Bayraktar, 2004; O'Connell, Young, Brooks, Hutchings & Lofthouse, 2000; Sofield & Salmond, 2003) reported that nurses felt unable to handle verbally abusive situations, did nothing, or engaged in unhealthy coping behaviours such as drinking or taking medications. Respondents in this study also reported an increase in the use of unhealthy coping behaviours.

Reflecting on the responses to question 3, the investigator considered three categories of behaviour or coping responses. Did nothing, put up barriers, pretended not to see the behaviour, and perceived the behaviour as a joke were considered passive responses. Reported the behaviour to a superior / authority, went to a doctor, warned the bully not to do it again, and spoke directly to the bully were considered active responses. Demonstrated similar behaviour, shouted or snapped at the bully and increased use of unhealthy coping behaviours were considered aggressive behaviours. A total of 73.4% of the respondents indicated they used passive behaviours in response to bullying, 43.5% indicated they used active behaviours, and 18.1% indicated aggressive

behaviours. These reports emphasise the urgent need for educating nursing students and providing training for coping with bullying in nursing education.

Strengths and limitations of the study

The strengths of this study are the large number of respondents from both associate and baccalaureate programs. The BNEQ was easy to complete in a short time frame, decreasing the respondents' burden of completing it. The qualitative section also allowed the respondents to give more information that was not captured on the forced response portion. This provided more richness to the data and substantiated the quantitative responses. And finally, data collection was conducted by trained research assistants to assure consistency across the sites.

There are several limitations to this study. In this descriptive study of bullying behaviours in schools of nursing, hypothesis testing was not undertaken. This methodology restricts analysis and implication of the study findings. At best, this study described the phenomenon of bullying in nursing education and did not assume causality or seek to define any relationship between the variables.

The issue of reliability and validity of the new instrument was addressed by rigorously following standard procedures for questionnaire development, including review by experts and pilot testing in a sample of nursing students that were not eligible for the study. Although procedures to assure confidentiality, anonymity, and ability to refuse to participate without harm were in place and communicated to respondents, there is the possibility that students may have felt intimidated or that responses may have not been truthful because of fear of retaliation. Since the participants in this study were nursing students, care was taken to avoid any semblance of coercion in the recruitment of participants. As well, there is the potential for inaccurate results due to the possibility of over reporting. Because the survey was completed by student groups from 28 nursing school sites, students were exposed to many of the same faculty. Therefore numerous students could be reporting on the behaviour of a single faculty member. And finally, generalisability is limited by the nature of the study and the study sample. The volunteer nature of the sample, which could affect its representativeness, is also a limitation. Participants were from one southern state in the United States, and because the sample was limited to students in the final year of nursing school, the sample is not representative of all nursing students in the state.

However, the results of the study indicate a critical need in nursing and nursing education for a better understanding of bullying behaviours. Nursing students need increased support in order to cope with and address bullying behaviours. This may result in enhanced student well-being, better integration into the profession, increased satisfaction with nursing and reduce their propensity to leave the profession (Celik & Bayraktar, 2004).

Baltimore's (2006) proposal that dysfunctional nurse-to-nurse behaviour may be bred in nursing education was not supported by the findings from this study. Although it is unknown whether students learn bullying behaviours prior to entering nursing school,

the results of this study indicate that many students perceive that they experience bullying while completing their academic program. That nursing students are in a power struggle with faculty and feel powerless is evident, especially from the qualitative responses. Nursing education and educators strive to guide and support students to a successful beginning of a professional career (Wieck, 2003). If the environment of nursing education is not positive and healthy, this may ultimately prove detrimental to student development and the profession (Block & Sredl, 2006).

While the focus of this paper is on nursing faculty behaviours, previous findings indicated that the problem is widespread. Classmate to classmate bullying is the most frequent source of bullying behaviour. (Cooper et al, 2009). One explanation is that students bring these behaviours with them, making it even more crucial to have strategies in place to break the cycle of bullying. Hutchinson (2009) stressed that nurses must become empowered to deal with the presence and effect of the stressors of violent behaviours, such as bullying, in the environment. It seems essential that this empowerment should begin with nursing education.

Recommendations

While unhealthy environments lead to ineffectiveness and conflict, healthy environments are characterised by teamwork and a sense of community (Snow, 2002; Ulrich, Buerhaus, Donelan, Norman, & Dittius, 2005). Jackson, Firtko, and Edenborough (2007) emphasised the importance of fostering skills necessary to cope with adversity experienced in the workplace. These themes have relevance for the educational setting as well. The following recommendations are made to schools of nursing to diminish bullying.

As Yildirim, Yildirim and Timucin (2007) pointed out, definitions and potential disciplinary actions must be clearly articulated. A clear statement of which behaviours will not be tolerated within in the educational environment must be established and should be considered a first step against eradicating bullying.

In a recent study, Clark and Springer (2010) concluded that respondents supported strategies to increase SON faculty and nursing student awareness regarding accountability for professional behaviours and creating a culture of respect. Training through faculty development sessions is one way to raise awareness of and increase sensitivity to the problem of bullying in nursing education. Not only should faculty treat students with respect, they must be trained to recognise situations where staff or other students are bullying.

Formal student orientation sessions, and reinforcement in the curriculum through professional behaviour courses will assist SON faculty and students to remain aware of bullying. Additionally, educational content focused on skill building to help student nurses respond appropriately when they are a victim of bullying as well as when they witness bullying of another could help break the cycle of abuse. Open forums between faculty and students should be encouraged to express concerns regarding behaviours and developing additional strategies for increasing understanding and supporting the

culture of respect (Clark & Springer, 2010). Formal power structures, such as those from Kanter's (1993) theory may be useful as a guide for developing structures that respect caring values and create a safe and healthy environment.

Replication of the study is warranted. While this study was descriptive, additional research on bullying in nursing education should provide a more in-depth exploration of the phenomenon and test relationships between concepts. Expanding the study sample to include nursing students at all levels (i.e., first through final semester of nursing school) would provide an additional perspective to the presence of bullying in nursing education. A longitudinal follow-up with the participants in this study would be helpful in tracking long-term outcomes of bullying in nursing education.

Conclusion

Nursing students do encounter bullying behaviours in associate and baccalaureate nursing schools which leave them feeling powerless and frustrated and create a hostile environment. One hundred percent of the respondents in this study had encountered at least one bullying behaviour Faculty were cited as the primary source of three of the behaviours, and while it is not known whether the behaviours actually occurred, students' perceptions that the behaviours occurred could potentially interfere with a student's professional development. School of Nursing faculty hold the keys to modifying the learning environment to facilitate respectful interactions and to teach students how to respond appropriately when bullying behaviour occurs. This study underscores a critical need to change the dynamics of that environment now.

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Appendix A Bullying in Nursing Education Questionnaire

BULLYING IN NURSING EDUCATION QUESTIONNAIRE (BNEQ)

Listed below are 12 behaviors that are identified as "bullying behaviors." Under each behavior are categories of personnel that you encounter in your classroom or clinical course work.

INSTRUCTIONS:
During the past year, mark the category that best fits the frequency of the behavior you experienced for each category of person.

	Never	Seldom	Intermittent	Frequent	Always		Never	Seldom	Intermittent	Frequent	Always
1. Yelling or shouting in rage											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
2. Inappropriate, nasty, rude, or hostile behavior											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
3. Belittling or humiliating behavior											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
4. Spreading of malicious rumors or gossip											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
5. Cursing or swearing											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
6. Negative or disparaging remarks about becoming a nurse											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
7. Assignments, tasks, work, or rotation responsibilities made for punishment, rather than educational purposes											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
8. A bad grade given as a punishment											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
9. Hostility after or failure to acknowledge significant clinical, research, or academic accomplishment											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
10. Actual / threats of physical or verbal acts of aggression											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
11. Being ignored or physically isolated											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					
12. Unmanageable workloads or unrealistic deadlines											
SON Classmate						SON Classmate					
SON Faculty						SON Faculty					
SON Staff						SON Staff					
Physician						Physician					
Hospital / Clinic Nurse						Hospital / Clinic Nurse					
Other Hospital Staff						Other Hospital Staff					
Patient						Patient					
Patient Relative						Patient Relative					
SON / Hospital Guest						SON / Hospital Guest					

Please add additional comments for questions 1 through 12 on the back.

Section B

INSTRUCTIONS . If you answered never to all questions on page one, skip to Section C.

Indicate ALL that are applicable.

13. To cope with the bullying behaviors I experienced, I:

- did nothing
- put up barriers
- pretended not to see the behavior
- reported the behavior to a superior / authority
- went to a doctor
- perceived the behavior as a joke
- demonstrated similar behavior
- shouted or snapped at the bully
- warned the bully not to do it again
- spoke directly to the bully
- increased my use of unhealthy coping behaviors (smoking, overeating, increased alcohol consumption)



Section C

14. Does your school of nursing have a formal policy / procedure concerning bullying you have encountered in you classroom or clinical course work?

- Yes, go to question 15
- No, go the demographics section
- I do not know, go to demographics section



If you answered yes to question 14, answer question 15.

15. Does your nursing program:

- provide education programs / pamphlets on coping with bullying behaviors?
- have a designated person (i.e. ombudsman / counselor) to assist with coping with bullying behaviors?
- provide support groups for coping with bullying behaviors?
- provide encouragement or suggestions for coping with bullying behaviors?



Demographic Section

Select ONLY ONE for each demographic feature.

- | | | |
|---------------------------------|--------------------------------------|--|
| Gender | Age Group | In nursing school, my grades average: |
| <input type="checkbox"/> Male | <input type="checkbox"/> 18-24 | <input type="checkbox"/> A |
| <input type="checkbox"/> Female | <input type="checkbox"/> 25-34 | <input type="checkbox"/> B |
| | <input type="checkbox"/> 35-44 | <input type="checkbox"/> C |
| | <input type="checkbox"/> 45-54 | |
| | <input type="checkbox"/> 55 or older | |



My ethnicity

- American Indian / Alaskan Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Caucasian / white



Optional:

Tell me how you dealt with a challenging situation involving bullying in your nursing school.

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