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The Effects of Bullying Behaviours on Student Nurses in the Clinical Setting

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THE EFFECTS OF BULLYING BEHAVIOURS ON STUDENT NURSES IN THE CLINICAL SETTING

by

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ABSTRACT

A descriptive study (N=674) was undertaken to examine the state of bullying in clinical nursing education. Results suggest that student nurses are experiencing and witnessing bullying behaviours at various frequencies, most notably by clinical instructors and staff nurses. Third and fourth year students are experiencing more bullying behaviours than first and second year students, with first year students reporting the least amount of bullying behaviours. Most students did not tell anyone about their experiences. Students who experienced more bullying behaviours had lower self-esteem and lower self-confidence in their ability to care for their patients. In addition, students who experienced more bullying behaviours were more likely to have considered leaving the nursing program and used more maladaptive strategies to cope with experiences of bullying behaviours. Implications for practice include ensuring that clinical instructors are well prepared for their role as educators and implementing policies that address the issue of bullying.

DEDICATION

I wish to dedicate this work to my parents who taught me the value of human life, hard work and the importance of believing in your convictions.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Problem Statement

Bullying in nursing has existed for decades and appears to be a growing concern as nurse retention and recruitment become crucial factors in sustaining Canada's health care system. International studies have also noted the phenomenon of bullying in nursing workplaces. While varying prevalence rates exist, current research has unanimously demonstrated the negative impact of bullying on nurses. Anecdotally, nurses have likened their clinical setting to that of a battlefield and describe the environment in which they work as a place of professional terrorism (Farell, 2001). Nursing students must share that same precarious nursing environment with professional nurses who are disgruntled with their work environment. Disturbingly, a qualitative study revealed that suicide was the result of one colleague's experiences with bullying (Hutchinson, Wilkes, Vickers & Jackson, 2008).

Several nursing workplace studies have reported devastating adverse reactions to bullying that include, but are not limited to hurt, fear, loss of self-esteem, anxiety, sleeplessness, depression, elevated blood pressure, panic attacks (Hutchinson et. al, 2008), feelings of worthlessness, an increase in smoking and drinking and increased stress levels (Quine, 2001). Bullying has repeatedly shown to have such negative impacts on health outcomes, and a health promotion approach to the problem of bullying has been suggested to tackle the issue of bullying in the workplace (Hodgins, 2008).

Nursing is a caring profession, deeply rooted in ethics, yet studies have repeatedly described a culture that perpetuates intimidation and a notion that nurses eat their young (Meissner, 1986). Although a limited number of studies have focused on bullying in nursing education, all studies to date demonstrate the existence of bullying in the clinical settings where student nurses undertake a significant amount of their nursing education. Meissner describes what is happening to young nurses as forms of genocide and cannibalism. Sadly, student nurses expect to be bullied in the clinical setting (Foster, Mackie & Barnett, 2004). In an effort to strengthen nursing as a compassionate and supportive profession, and ensure that we are protecting our colleagues and future nurses, we must first be able to accurately describe the phenomenon of bullying within nursing education. Once this has been identified, policy must be implemented that will eradicate the occurrence of bullying in the workplace.

In Ontario, the average age of working Registered Nurses (RN) is 46.1 years (CNO, 2008). This translates into a significant number of nurses contemplating retirement within the next 10 to 15 years. In 2006, 20.8% of Canada's nursing workforce was of typical age of retirement and in Ontario, nearly one quarter of nurses were eligible to retire (CIHI, 2007). Canada is expected to be short 60,000 full time equivalent RNs by 2022 (CNA, 2009). Nurses are commonly referred to as the backbone of the health care industry and as such, a shortage of nurses will place a burden on an already encumbered health care system. We must rely on new nurses to fill the shoes of those experienced nurses leaving the workforce as a result of retirement. Student nurses (90%) who have experienced or witnessed bullying behaviours in their clinical placements have reported being adamant about not wanting to work in similar areas upon graduation (Curtis,

Bowen & Reid, 2007). All areas of nursing must be free of bullying behaviours in an effort to preserve adequate staffing and patient care well into the future.

According to a College of Nurses of Ontario (CNO, 2008) report, 4.4% of Ontario's 2007 graduates did not renew their registration in 2008. In addition, the Canadian Institute for Health Information (CIHI, 2008) reported that 6.6% of Canadian RNs under the age of thirty did not maintain their registration for 2007. Although we cannot conclude a causal relationship between exit numbers and experiences of bullying in the workplace, current research has demonstrated that nursing students and new graduate nursing students have either considered leaving the profession or have left as a result of falling victim to bullying behaviours (McKenna, Smith, Poole, & Coverdale, 2002).

Although international studies have demonstrated that nursing students experience bullying during their nursing education, generalizations cannot be made about the rate of incidence in Canada. It is imperative, that a Canadian sample be used to determine the extent and nature of bullying in nursing education in Canada, so that we may compare it to other international studies. If bullying involves "Persistent criticism and personal abuse in public or private, which humiliates and demeans the person" (Adams, 1992, as cited by Stevenson, Randle, & Grayling, 2006, p.2), then we have a moral obligation to advocate for student nurses, address the issues and intervene.

Significance to Nursing

In a profession known for its caring capacity and ethical obligations, it is disturbing to confront the notion that nurses are treating one another with disrespect and

disregard. This behaviour jeopardizes the nurse's role as mentor and role model for nursing students. Nurses enter the profession of nursing because of a desire to care for the sick and to assist patients and their families in attaining or maintaining well-being. Student nurses enter the academic world of nursing for those same reasons (Rhéaume, Woodside, Fautreau & Ditommaso, 2003), and yet witness and are subjected to acts of bullying by those same nurses who entered a profession in which caring is the epitome of the practice. Hoel, Giga and Davidson (2007) highlight the significant disappointment felt by nursing students who witnessed indifference, hostility and intimidation by nurses who were purportedly attracted to a profession for its caring nature.

Nurses are paramount in the provision of health care, and therefore greatly impact the health of societies. Social trends are demonstrating an increasing need for nurses due to an aging population, greater diversification in society, multiculturalism, marginalized populations, increasing technologies, and a health care system requiring personal input, all at the mercy of finite resources. A declining pool of available nurses has led to strained work environments that physically and psychologically bear negative consequences on the nursing workforce. Funding cuts and a move to part-time and casual work has resulted in nurses leaving the country to practice elsewhere or leaving the profession altogether (RNAO, 2008).

Of particular concern is the nursing workforce in Ontario. The average age of RNs working in Ontario is 46.1 years (CNO, 2008). This translates into a significant number of nurses contemplating retirement within the next 10 to 15 years. It is imperative that research identify those factors contributing to the retention and recruitment of nurses and nursing students. Although bullying has been identified in

other countries as a factor contributing to nurses' and student nurses' intentions to leave nursing (McKenna, et al., 2002), no Canadian studies have investigated the phenomenon of bullying in nursing education. If bullying is identified as a factor which contributes to nurse and student nurse retention and recruitment, we can then move forward and identify future areas of research for the development of strategies to minimize bullying in education and in the workplace setting, thus preserving precious human health care resources.

A baccalaureate nursing education in Ontario consists of four years of formal education. A significant portion of that education is spent in clinical settings where student nurses gain experience with providing hands on care to various clients, while integrating knowledge gained in the classroom setting. The nature of relationships with staff in student nurses' clinical placements is crucial to the outcome of their clinical experience (Dunn & Hansford, 1997). If bullying is identified as negatively impacting the self-confidence and self-esteem of student nurses, we must then look at what effect damaged self-esteem and self-confidence has on patient care outcomes in an effort to ensure that our patients' well-being is not jeopardized as a product of bullying behaviours. The Canadian Nurses Association (2009) sets forth codes that govern the ethical behaviours of Registered Nurses and mandates that:

> Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way. (Code, D10,)
>
> Nurses share their knowledge and provide feedback, mentorship and

> guidance for the professional development of nursing students, novice nurses and other health-care members. (Code, G9)

If this code of ethics is in perpetual violation as a result of bullying behaviours, it is our professional and ethical responsibility to contribute to awareness, suggest possible strategies for resolution and support facilitating change.

Purpose of the Study

The purpose of this study is to gain an insight into the phenomenon of bullying in nursing education as it relates to student nurses' experiences in the clinical setting. There is no research in Canada regarding the phenomenon of bullying in nursing education. This study will add to a limited body of knowledge for purposes of professional and academic development and understanding.

Conceptual Framework

The Theory of Self-Efficacy

Social cognitive theory is concerned with the developmental and psychosocial changes that people undergo throughout their lives. Social cognitive theory is based on "triadic reciprocal determinism" where personal characteristics/cognition, behaviour and the environment interact and influence one another bi-directionally (Bandura, 1989, p.2). The sources of influence may be of different strengths, and do not necessarily occur simultaneously. The interactional links within the model of reciprocal causation are of interest to the phenomenon of bullying and nursing students, in that nursing students must

engage in reciprocal interactions with registered nurses, physicians, faculty and classmates in clinical placements (Bandura).

The first of three major interactional links that exist in the model of reciprocal causation is a relationship between cognition/personal factors (thought patterns, emotional reactions, and biological properties) and behaviour (expectations, beliefs, self perceptions, goals, intentions). The second interactive and reciprocal relationship exists between cognition/personal factors and environmental influences. The third relationship exists between the environment and behaviour. Human expectations, beliefs, emotions and cognition are modified by social influences that provide the information required to stimulate emotional reactions. This is accomplished through modeling, instruction and social persuasion (Bandura, 1989).

Based on social cognitive theory, the theory of self-efficacy assumes that people have the ability to influence what they do and thus have the abilities to judge their capabilities in performing actions. The concept of "self-efficacy expectations" (Resnick, 2008, p. 183), being able to judge one's ability to accomplish a task and the concept of "outcome expectations" (Resnick, p. 183), being able to judge the consequences of the successfully accomplished task, form the basis of the theory of self-efficacy. These two components of the theory are identified separately, since a person may value the outcome of an action (outcome expectation), but may not believe that they are capable of achieving it (self-efficacy expectations). Favourable outcome expectations are largely dependent on positive self-efficacy expectations.

Bandura (1997) suggests that people's beliefs about their personal efficacy are based on four main sources of information: enactive mastery experiences; vicarious experiences; verbal persuasion and physiological feedback. Enactive mastery experiences, the most influential of the four sources, involves the actual performance of the proposed activity and one's positive or negative outcome of the activity. In addition to past experience, preconceptions, perceived difficulty, effort required, help received and the situational context all impact the ability to evaluate one's self-efficacy. Vicarious experience, the second source of information, impacts one's self-efficacy by viewing others successfully accomplishing the desired task, particularly when the viewer has not had previous experience or instruction with said task. Verbal persuasion serves to strengthen the belief in one's capabilities. Verbal influence is used to persuade feelings of self-efficacy, by verbalizing faith in someone's capabilities rather than verbalizing doubt. Physiological feedback, the last source of information, and affective states are used as a cue in judging one's ability to perform a certain activity and therefore, may positively or negatively influence one's confidence in performing a task. Physiological and emotional indicators such as mood states, autonomic arousal, and physical inefficacy may all interfere in the judgment of perceived self-efficacy and self-efficacy itself.

Due to the diverse interpersonal nature of nursing education, student nurses are exposed to all four sources of information that generate self-efficacy beliefs. According to several researchers, bullying has been partially defined as repeated unwanted offenses (Hoel, Cooper & Faragher, 2001; Einarsen & Skogstad, 1996). As such, previous and repeated experiences of bullying in the clinical setting may allow the concept of enactive mastery experiences to negatively impact student nurses' abilities to successfully perform

in clinical practice. The witnessing of bullying has been shown to have detrimental effects to the observer (Hoel, Faragher & Cooper, 2004, Rogers & Kelloway, 1997). Vicarious experiences of bullying may serve to undermine student nurses' sense of personal efficacy. Bandura suggests that although vicarious experiences are typically less impactful than direct experiences, under certain conditions, vicarious experiences can supersede those of a direct nature (1997). In addition to jeopardizing self-efficacy, student nurses who experience or witness intimidating acts are at risk of becoming bullies themselves thus perpetuating the phenomenon of bullying (Randle, 2003).

Bandura posits that positive affirmation promotes the development of skills and a sense of self efficacy (1997). Bullying behaviours including being yelled at or shouted at, being belittled or humiliated have been shown to negatively impact the experiences of nursing students in their clinical placements (Celik & Bayraktar, 2004). Physiological reactions to bullying behaviours such as stress, decreases self-esteem and has been shown to negatively impact student nurses (Randle, 2001).

Research Questions

1. What is the state of bullying in nursing education in the practice setting?
2. What are the types and frequencies of bullying behaviours experienced by student nurses?
3. Who are the sources of bullying behaviours in nursing education?
4. Do experiences of bullying behaviours impact student nurses' intentions to leave the nursing program?
5. What are the reporting practices of student nurses?

6. If student nurses are not reporting experiences of bullying behaviours, then why are they not?
7. Is there a relationship between experiences of bullying behaviours and self-esteem in the practice setting?
8. What are the relationships between demographic characteristics and the frequency of bullying behaviours experienced by student nurses?
9. Is there a relationship between experiences of bullying behaviours and self-confidence in the practice setting?
10. What coping strategies are student nurses using to deal with bullying behaviours?

CHAPTER II

THE REVIEW OF THE LITERATURE

The Review

Although the phenomenon of bullying dates back decades, it is only in recent years that it has been at the forefront of research. Bullying has been commonly associated with school yard settings and more recently places of work; however, bullying in the health care setting appears to be a growing concern. Acts of bullying have been referred to as horizontal violence, relational aggression, incivility, mobbing, harassment and interpersonal conflict. Regardless of the label, all terms encompass negative and unwanted acts towards others.

It is well documented that horizontal and hierarchal aggression exists in the health care workplace internationally (McKenna, et al., 2003; Jackson, Clare, & Mannix, 2002). It is duly noted that nurses are at great risk of experiencing aggressive behaviour by colleagues and physicians (Rowe & Sherlock, 2003). Health care professionals are among the largest groups to report problems associated with bullying. The rising prevalence of violence and abuse in health care workplace settings compromises quality of care and jeopardizes the self-esteem and the self-worth of health care providers (ICN, 2007). Although nurses are subject to aggression from patients and their families (May & Grubbs, 2002), they are more concerned about aggression between colleagues (Farrell, 2001). More recently, studies have been undertaken to investigate the phenomenon of bullying in nursing education.

Types and Frequencies of Bullying Behaviours

Although rates of incidence vary between studies, it is clear that bullying in nursing education exists and the types of bullying behaviour experienced by student nurses remains comparable across studies. In a qualitative study, 57% of student nurses either witnessed or experienced horizontal violence (Curtis et al., 2007). The following five themes were identified: humiliation and lack of respect; powerlessness and becoming invisible; the hierarchical nature of horizontal violence, and impacted coping strategies and future employment choices. Similarly, Stevenson et al. (2006) reported that 53% of student nurses surveyed indicated that they had experienced negative interactions during their clinical placements.

Consistent with studies investigating workplace violence in the health care sector, verbal abuse appears to be the most predominant form of bullying experienced by nurses and nursing students alike. In a survey of 156 third year nursing students, Ferns and Meerabeau (2008) reported that 45.1% of respondents experienced verbal abuse. Despite a small sample of 40 nursing students, Foster et al. (2004) identified that 90% of students reported experiencing some form of bullying while on clinical placement. Alarmingly, 100% of nursing students surveyed in a study investigating the state of abuse in nursing education in Turkey, reported being yelled at or shouted at, were behaved toward in an inappropriate, nasty, rude or hostile way, or were belittled or humiliated. Seventy four percent had vicious rumours spread about them (Celik & Bayraktar, 2004). In this same study, 83.1%, (n=187) of student nurses reported experiencing academic abuse which included being told negative remarks about becoming a nurse, were assigned responsibilities as punishment rather than for educational purposes, were punished with

poor grades or were shown hostility following an academic accomplishment. Supporting these results, a U.S. study revealed that 95.6% of fourth year nursing students surveyed, reported experiences of bullying behaviours. The most frequently reported behaviours perceived to be bullying included cursing or swearing (41.1%), inappropriate, nasty, rude or hostile behaviours (41%) and belittling or humiliating behaviour (32.7%) (McAdam Cooper, 2007).

The Victim

In a Turkish study, statistical significance was noted in that third and fourth year students experienced verbal and academic abuse more often than first and second year students (Celik, & Bayraktar, 2004). Conversely, a New Zealand sample (N=40) of student nurses revealed that the majority of student nurses who were bullied, were in their first year (27.7%) and second year (61%) (Foster, et al., 2004). In a U.S. study investigating student nurses' perceptions of bullying behaviours, nearly all categories of bullying behaviours as identified on the research survey were most frequently experienced by student nurses whose ages ranged from 18 to 24. Conversely, Stevenson et al. (2006) reported that students over the age of 35 were more frequently exposed to negative interactions.

The Bully

Student nurses have reported being bullied by nurses, nursing aids, doctors, patients, faculty and classmates with varying rates among the offenders. In one study involving 225 participants, nursing students identified their classmates as the primary offender with 100% of student nurses having experienced verbal abuse at the hands of

classmates, followed by faculty (41.3%), patients (34.2%), nurses (33.8%) and physicians (31.6%) (Celik & Bayraktar, 2004). Similarly, in a study investigating student nurses' perceptions of bullying behaviours, students of nursing were identified as the most frequent source of 8 of the 12 bullying behaviours identified by the researcher (McAdam Cooper, 2007). In Celik and Bayraktar's research, nurses (68.4%) were cited as the most frequent offenders of academic abuse, followed by nursing school faculty (63.1%), patients (55.6%) and physicians (47.6%). Although a small sample was used, Foster et al., (2004) likewise reported that student nurses identified nurses as being the largest source of bullying (88%). Ferns and Meerabeau (2008) reported patients (64.7%) to be the greatest perpetrators of verbal abuse against student nurses in a U.K. study, followed by health care workers (19.6%) and visitors or relatives (15.7%).

Adverse Effects

The consequences to bullying are numerous in the healthcare setting and include frustration, anger, fear and emotional hurt (O'Connell, Young, Brooks, Hutchings & Lofthouse, 2000), feelings of powerlessness, decreased morale and productivity, an increase in errors (Sofield & Salmond, 2003) and symptoms associated with Post Traumatic Stress Disorder (Rippon, 2000). As a result of the distressing nature of bullying, nurses have reported having to take days off of work (McKenna, et al., 2002). In addition, Randle identified that student nurses exhibited signs of burn out, apathy, passive anger and distancing themselves from colleagues and patients (2001). Nurses have compared the clinical setting to that of a battlefield and described their environment as hostile (Farrell, 2001). Similarly and across studies, nursing students have reported both psychological and physical reactions such as, feelings of helplessness, feeling

depressed, fear and guilt (Celik & Bayraktar, 2004), sleeplessness, anger, anxiety, worrying, stress, self-hatred, a decrease in confidence, and an increase in absence or sickness (Randle, 2001; Foster, et al., 2004). Not only are nurses and nursing students experiencing the ill effects of bullying, but patients are too. Of more than 2000 healthcare providers surveyed, 7% reported that they had been involved in a medication error as a result of intimidating behaviour (Medication Safety Alert, 2004).

Under-reporting

It appears that retribution (McKenna et al., 2002) and lack of support by management (Farrell, 2001) may be at the heart of under-reporting of bullying in the profession of nursing. In a study of 551 newly registered nurses, only half of the horizontal violence incidents described were reported. Little is known about why nursing students fail to report bullying behaviours (McKenna, et al.) Nursing students in one study identified that reporting bullying was not worth the effort, wished not to jeopardize their assessment and that it is something that you must simply put up with (Stevenson, et al., 2006). In a U.S. study of nursing students' perceptions of bullying behaviours, 34.9% (n=232) reported doing nothing following the event, 23.0% (n=153) reported putting up barriers, 20.8% (n=138) reported speaking directly to the bully, 14.9% (n=99) reported ignoring the behaviour and 14.7% (n=98) indicated that they reported the incident to a superior (McAdam Cooper, 2007). Of those nursing students in a small (N=40) New Zealand study who reported an incident of bullying, action to rectify the problem was taken in only 3.8% of the cases (Foster, et al., 2004), which may explain the hesitancy to report. It would appear that in some instances, student nurses who are experiencing bullying behaviours are sharing their experiences with classmates, as the majority

(65.5%) of students in a U.K. study indicated that they were aware of other students' experiences of verbal abuse (Ferns & Meerabeau, 2008).

Retention

With a shortage of nurses looming, we cannot afford to lose nurses or nursing students to bullying. Threats to nurse retention have been reported in recent literature. A New Zealand study revealed that of 551 new graduates surveyed, one in three respondents (n=34, 58%) considered leaving nursing and 14 intended to leave nursing as a result of horizontal violence (McKenna, et al., 2002). A survey of nursing students revealed that of those students that experienced verbal and academic abuse, 57.7% and 69.5% respectively, thought about leaving the profession (Celik, & Bayraktar, 2004). Randle supports these findings as student nurses' psychological reactions to bullying included the intention to leave the profession (2001). Similarly, an Australian study found that a bullying culture was to blame for many nurses deciding to leave their organizations, and some even to leave the profession altogether (Stevens, 2002).

Self-Efficacy

Self-efficacy is the belief in one's capabilities (Bandura, 1997). Although one would theoretically postulate that a relationship would exist between bullying and self-efficacy, a study of 433 Danish manufacturing employees found no association between exposure to bullying behaviours and self-efficacy (Mikkelsen & Einsarsen, 2002). The utilization of a generalized rather than specific self-efficacy scale may account for those surprising results. In a study investigating the relationships between stress, self-efficacy, and burnout among nurses, self-efficacy was negatively related to emotional

exhaustion and depersonalization and positively associated with personal accomplishments (Pons, 1995). If bullying is shown to interfere with personal accomplishments, then one would hypothesize that so too would self-efficacy be negatively impacted by bullying. Although no studies have been undertaken to investigate the relationship between bullying in nursing education and perceived self-efficacy of nursing students in the clinical setting, up to 69% of student nurses have reported shattered self-confidence as a result of bullying behaviours (Randle, 2001; Foster, et al., 2004). Shelton (2003) supports the view that external supports impact perceived self-efficacy, as those nursing students who perceived more psychological and functional support from faculty persisted to the end of their nursing program.

Self-Esteem

Self-esteem is concerned with an evaluation of one's self and refers to an individual's like or dislike of themselves (Brockner, 1988). Self-esteem is understood to be a predictor of behaviour and is of unique concern in nursing, as the behaviour of registered nurses and student nurses may directly impact the well-being of patients while in their care. Social interactions may either positively or negatively impact one's self-esteem (Randle, 2003). Social interactions for student nurses frequently include dyadic interactions with a nursing educator, staff nurse, other hospital staff, classmate, physician or patient and or patient's families. In view of the fact that student nurses are frequently being judged on their skill performance, feedback has the potential to either damage or support self-esteem. Because student nurses straddle the education-workplace divide, Brockner suggests that self-esteem as it relates to occupational performance is important in influencing attitudes and behaviours. Brockner also explains that self-esteem is

directly related to self-efficacy, in that expectations for success are correlated with motivation, which is a determinant of performance. Thus, those with higher levels of self-esteem will outperform those with lower self-esteem.

Newly registered nurses reported feelings of diminished self-esteem and self-confidence as a result of experiences of horizontal violence (McKenna et al., 2003). In a qualitative study (Randle, 2001), nursing students identified negative experiences associated with clinical placements. They described being devalued and felt that nurses used the power associated with their position to undermine their self-esteem. Student nurses also reported witnessing nurses humiliate patients. Nursing students felt powerless to intervene for fear of repercussion and admitted to eventually participating in the intimidating behaviour themselves. Shockingly, quantitative findings demonstrated that 95% of student nurses had below average self-esteem by the end of their nursing education, in contrast to the outset of their education, where all of them had average or above average self-esteem scores (Randle, 2003). Among other manifestations of bullying, student nurses consistently identified damage to their self-esteem as a result of bullying behaviours (Stevenson, et al., 2006; Foster, et al., 2004).

Coping

Various coping strategies have been identified in the literature. Registered nurses who have experienced bullying behaviours in the workplace have reported taking days off of work, changing areas of practice, leaving nursing (McKenna, et al., 2002), dealing directly with the nurse, calling in sick, and attempting to clear the misunderstanding (Rowe & Sherlock, 2005). Hoel et al., (2007) report that student nurses rationalized

nurses' bullying behaviours, by blaming it on stress and pressure in the workplace. Students described having to develop a thicker skin to cope.

In a similar study, nursing students made excuses for the perpetrators' behaviours and accepted bullying behaviour as a normal part of their experiences as a student. Students also reported putting up with it as a means of coping (Stevenson, et. al, 2006). Speaking to someone about the incident is most frequently reported in the literature as a method of coping. Foster et al. (2004) identified that 86% of student nurses typically spoke to a lecturer/tutor or classmate, while Longo (2007) reported that 66% discussed the incident with a peer. In a U.S. study, behaviours used to cope with bullying included doing nothing (34.9%), putting up barriers (23.0%), speaking to the bully (20.8%), pretending not to see the behaviour (14.9%), reporting the behaviour to a superior (14.7%) and increasing the use of unhealthy coping behaviours (9.0%) (McAdam Cooper, 2007). A qualitative study revealed that student nurses who were subjected to horizontal violence resorted to accepting that nursing is a difficult profession to survive, with unavoidable negative experiences. Student nurses reported having to develop a tough exterior to carry on (Curtis et al., 2007). Randle (2003) even describes student nurses who adopted the bullying behaviours of staff nurses as a way of assimilating into the culture of nursing, which they are required to be a part of for successful completion of their program of study.

Summary

The current literature clearly identifies that bullying in nursing not only exists in the health care workplace internationally, but in nursing education as well. Although the

literature exists, fewer studies examining bullying in nursing education, as opposed to bullying or horizontal violence in the healthcare workplace have been undertaken. As a result of the limited literature surrounding bullying in nursing education specifically, the identification of sources of bullying, reporting practices, the effect of bullying behaviours on students' abilities to tolerate the experiences and persevere through their nursing education must be explored. In addition, an examination of coping methods used to deal with experiences of bullying behaviours is needed to gain a clearer picture of the phenomenon of bullying in nursing education.

Varying types and frequencies of bullying behaviours have been reported, however there is little empirical evidence as to the effects of such experiences on student nurses and the patients for whom they care. In addition, it is unknown whether or not bullying exists and to what degree in nursing education in Canada. The intent of this study is to examine the state of bullying and the effects of bullying behaviours on a Canadian sample of nursing students enrolled in a four year baccalaureate nursing program within one university and three college campuses.

CHAPTER III

METHODOLOGY

This chapter discusses the research design, setting and sample used in this study. In addition, the use of instruments, data collection, conceptual and operational definitions and the protection of participant rights will be discussed.

Research Design

Since little information is known about the state of bullying in Canadian nursing educational institutions, a descriptive methodology was chosen. According to Burns and Grove, descriptive study design allows for a collection of information regarding a particular phenomenon with an interest in examining relationships among variables, with no intent to establish causality (2005). A cross sectional design is appropriate for this research as the collection of data will be gathered at one point in time, with the intention of describing a phenomenon of interest and or the relationships that exist among the phenomenon (Polit & Beck, 2006).

This descriptive study used a questionnaire to survey nursing students about their experiences with bullying behaviours, reporting practices, demographics, intention to leave the profession, and perceived self-confidence in the clinical setting. A coping inventory was used to assess coping strategies used to deal with bullying behaviours. In addition, a self-esteem questionnaire was used to determine global self-esteem. Questionnaires carry with them several advantages including being able to reach large samples, a lesser opportunity for bias, more economical than personal interviews and an opportunity for complete anonymity (Burns & Grove, 2005; Polit & Beck, 2006). Polit

and Beck suggest that mailed questionnaires pose a threat of bias as response rates may be low. In an effort to compensate for this, on-site questionnaires were provided to students during class time. The questionnaires were administered within a four week period and were also posted on a website for convenient and remote access.

Setting and Sample

Convenience sampling was used as part of the descriptive research design. This method of sampling is non random and as Burns and Grove points out, decreases the likelihood that the sample is representative of the population (2005). Due to factors such as time and cost involved in a random sampling of the entire population of interest, convenience sampling is determined to be the most efficacious and practical sampling procedure.

In the province of Ontario, there are 14 universities that offer a BScN undergraduate nursing program and 22 colleges that offer and participate in a collaborative baccalaureate nursing program (College of Nurses of Ontario, 2007). One moderately sized university was chosen as well as one mid-sized college with two separate campuses and another mid-sized college with one campus. These were chosen on the grounds of similar enrollment numbers and proximity to the researcher.

The target population for this study included all first, second, third and fourth year students enrolled in a baccalaureate nursing program at one mid-sized Ontario university and in two Ontario colleges, one having two campuses. Inclusion sampling criteria included being enrolled as a full-time nursing student in the baccalaureate nursing program. Exclusion criteria included those students who were diploma graduated

Registered Nurses returning to complete their BScN degree. These students do not partake in the same clinical component that undergraduate nurses engage in.

Variable Definitions

Bullying

There appears to be no doubt that bullying exists in the health care profession and in nursing education; however, bullying has been difficult to define and thus varies from study to study. Various definitions of bullying have included concepts of time, duration, intent, frequency, types of behaviours, power imbalances and harm to the victim. For the purposes of this study, the conceptual definition of bullying includes repeated negative acts over time that are directed at someone who finds it difficult to defend themselves against these acts and who perceives an inequity in power (Hoel, et al., 2001; Einarsen & Skogstad, 1996).

Common to all definitions of bullying found in the literature, is the notion that one time occurrences do not fit the definition of bullying. The witnessing of one time incidents of rude behaviour, however, have been noted to negatively affect skill performance and decrease helping behaviours (Porath & Erez, 2009), which have grave practical implications in the nursing profession. Randle (2003) points out that even bullying behaviours that are classified as subtle caused feelings of powerlessness and diminished self-esteem for pre-registration nurses in the U.K. Regardless of the frequency, duration and severity of behaviours experienced, even a single negative act is intolerable and speaks to a need to intervene.

Student nurses differ from registered nurses in the amount of time spent in the clinical setting. Nursing students at the university and college from whom the population was drawn for this study typically spend no more than 12 weeks in any one clinical placement and spend from 8 to 12 hours per week in a clinical setting, until fourth year, where they spend 36 hours in the clinical setting in fulfillment of their consolidation requirements. Definitions of bullying that comprise lengthy time frames were inappropriate to include for such reasons.

Coping

According to Lazarus and Folkman (1984), coping is defined as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p.141).

Within the Brief Cope Scale (Carver, 1997) there are 14 ways of coping that are characterized by the actions student nurses take to deal with their experiences of bullying behaviours. The following table outlines Carter's definition of ways of coping.

Coping Strategy	Definition
Self-distraction	Turning to work or other activities to take your minds off things and or doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
Active coping	Concentrating efforts on doing something about the situation and or taking action to try to make the situation better
Denial	Saying to yourself "this isn't real" and or refusing to believe that it has happened
Substance use	Using alcohol or other drugs to make you feel better and or get through it.

Emotional support	Getting emotional support from others and or getting comfort and understanding from someone
Instrumental support	Getting help and advice from other people and or trying to get advice or help from other people about what to do
Behavioural disengagement	Giving up trying to deal with it and or giving up the attempt to cope
Venting	Saying things to let unpleasant feelings escape and or expressing negative feelings
Positive reframing	Trying to see it in a different light to make it seem more positive and or looking for something good in what is happening
Planning	Trying to come up with a strategy about what to do and or thinking hard about what steps to take
Humour	Making jokes about it and or making fun of the situation
Acceptance	Accepting the reality of the fact that it has happened and or learning to live with it
Religion	Trying to find comfort in religion or spiritual beliefs and or praying or meditating
Self-blame	Criticizing one's self and or blaming one's self for things that happened

Perceived Self efficacy

According to Bandura (1999), perceived self efficacy refers to "beliefs in one's capabilities to organize and execute the course of action required to manage prospective situations" (p.2). In addition, Bandura posits that efficacy beliefs influence how people behave, think, feel and motivate themselves and influence human attainment.

Self-esteem

For the purposes of this study self-esteem will be defined as "a positive or negative attitude toward a particular object, namely, the self" (Rosenberg, 1989, p.30).

Rosenberg further defines someone who has high self-esteem as someone who respects self, does not consider oneself perfect and therefore acknowledges one's limitations and wishes to continue developing. Conversely, someone with low self-esteem lacks self-respect, but wishes otherwise. A person with low self-esteem subsumes self-rejection, self-dissatisfaction and self-contempt.

Instrumentation

This study investigates the relationship between the phenomenon of bullying and self-confidence and self-esteem, in addition to multiple demographic variables and ways of coping. To date, no standardized measures have been developed to measure bullying in the workplace. More commonly measured are the behaviours associated with bullying. The Leymann Inventory Psychological Terrorization (LIPT), (Leymann, 1990) and the Negative Acts Questionnaire (NAQ), (Einarsen & Raknes, 1997) have been used in occupational settings, but unmodified appear to be inappropriate for the health care setting. Although a revised NAQ was used as an instrument to measure bullying behaviours in a Canadian study that explored the process of self-labeling and how nurses attached meaning and significance to workplace bullying, the revised instrument appears to be unsuitable for student nurses' clinical setting (Out, 2005). Questions focus on the relationships between nurses, co-workers and their managers as they relate to the professional workplace experience and consequently are not suitable for this study.

Two questionnaires were found in the literature that addressed the questions to be answered in this study. The first is a 36 item, ten page survey developed by Celik and Bayraktar used to identify the abuse experiences of nursing students in Turkey (2004).

Although the questionnaire addressed relevant issues for this study, the questionnaire is lengthy and includes variables not included in the current proposed study. McAdam Cooper (2007) developed a questionnaire by modifying and combining the unnamed questionnaire developed by Celik, and Bayraktar and the NAQ developed by Einarsen and Raknes in a study investigating student nurses' perceptions of bullying behaviours. Although many of the bullying behaviours identified in the survey are supported by findings in the literature, some behaviours identified in the survey are redundant and may cause ambiguous responses, therefore both questionnaires were considered to be inappropriate for use in the present study.

Stevenson et al. (2001) developed a questionnaire to investigate student nurses' experiences of bullying. This survey was based on a questionnaire developed by Quine which has previously been used to investigate bullying in the workplace of health care professionals (Quine, 2000). The survey tool comprises 25 statements associated with the phenomenon of bullying, in which students are asked to indicate behaviour frequency based on a Likert- type scale.

In a summary review of the literature relating to workplace bullying, Rayner and Hoel (1997) identified five categories of bullying behaviours found in the workplace. The questionnaire developed by Quine (2000) and Stevenson et al. (2001), supports these findings as questions included in the survey address the following categories as identified by Rayner and Hoel: threat to professional status; threat to personal standing; isolation; overwork and destabilization.

There are few tools identified in the literature used to measure bullying behaviours in the unique setting of nursing education. The questionnaire developed by Stevenson et al. (2001) was used with minimal modifications. Some questions were revised, reworded or removed in an effort to reduce redundancy, to improve conciseness and reduce potential ambiguity of answers. Additions to the questionnaire will serve to document the types and frequency of bullying behaviours, the perpetrators, the intent to leave the program of study, reporting practices, perceived self-confidence, coping strategies, self-labeling, and vicarious experiences of bullying behaviours. An open-ended question at the end of the questionnaire will provide participants the opportunity to provide comments, expand upon and or provide clarification to an answer (see Appendix A).

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to measure global self-esteem. The scale is a ten item Likert scale with a four point scale for answers; from strongly agree to strongly disagree. The measurement of global self-esteem addresses a variety of general situations (Brockner, 1988). This scale has been used successfully with numerous populations in various settings. The scale was originally developed using a large sample (N=5,024) high school students from ten schools in New York State. The scale was scored as a Guttman scale with test-retest correlations in the range of .82 to .88 and Cronbach's alpha in the range of .77 to .88. The scale may be used without explicit permission if it is being used for academic or research purposes (Morris Rosenberg Foundation). (see Appendix B).

The Brief COPE scale was used to capture adaptive and maladaptive coping strategies used to deal with bullying. The Brief COPE scale has been used extensively in

the literature. Fourteen subscales represent fourteen separate coping mechanisms with 2 items per scale. Scales include items of self-distraction, active coping, denial, substance abuse, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame (Carver, Weintraub, & Scheier, 1989). (see Appendix C). In a study examining the coping strategies of Malaysian women undergoing a mastectomy or lumpectomy, Cronbach's alpha ranged from 0.51 to 0.99 and the test re-test Intraclass Correlation Coeffiecient (ICC) ranged from <.000 to 0.98 (Yussoff, Low & Yip, 2009). A 2008 study examining the factorial structure of the brief cope scale with a sample of international college students, internal consistency was measured by Coefficient alphas, of which five out of seven factors had coefficients above .80 and two of them ranged from .60 to .70 (Miyazaki, Bodenhorn, Zalaquett & Ng).

Participants were asked to complete a demographic survey which included information about age, year of study, gender, place of study and ethnicity (see Appendix D).

Data Collection

Approval from the University of Windsor Research Ethics Board (REB), Lambton College REB and program chairs from both St. Clair College campuses was obtained prior to initiation of the research project. The level coordinator for each year of study and campus provided the investigator with the number of potential participants and a master class schedule so that all students were given the opportunity to participate in the research study. Nursing educators were contacted to make them aware of the study

and to collaboratively schedule a convenient class time for student nurses to participate in the study.

Students were offered two methods to participate, a) in class, b) on-line. In an effort to maximize participation, students were notified by university/college e-mail of the approaching study to be held during their regularly scheduled class time at the end of class or on-line. A brief explanation of the research study was provided in the e-mail (see Appendix E) as well as prior to the administration of the questionnaire (see Appendix F) and on-line. If students chose to participate during class time, questionnaires were packaged in a legal sized envelope and one envelope was distributed to each participant on the designated date by the investigator and educator. Students were given the time it took to complete the questionnaire and sealed envelopes were collected once they were completed and before students left the classroom. Collected envelopes were kept in a secure location by the investigator until data analysis was complete. If students chose to participate in the study on-line, instructions were posted on the website.

Regardless of method of participation, participants were eligible to be entered in one of two $100 draws for mall gift cards in appreciation for the students' time spent participating in the study. A postcard was included in every envelope. Students were asked to provide contact information on the postcard for the sole purpose of contacting the winner of the draw. The postcards were deposited in a sealed box upon leaving the classroom separate from the surveys. The post cards were shredded once a winning postcard was drawn and the winner was contacted. A method for providing contact information for those students who chose to participate on-line was posted on the website

so that they too may have entered in the draw. All contact information was kept separate from the surveys.

Data Analysis

Descriptive data analysis was performed using Statistical Package for the Social Sciences (SPSS), Version 16. Data were screened and cleaned for missing data and outliers. Descriptive information was reported by way of frequencies and percentages. Univariate statistical analysis included t-tests, Spearman correlation and chi-square analysis. Mulitavariate analysis consisted of Analysis of Variance (ANOVA), Factorial ANOVA and Regression analysis.

Protection of Participant Rights

Inherent in all research involving human subjects, is the requirement that ethical conduct be used to guide the research process in an effort to protect participants. REB approval was obtained from the University of Windsor and Lambton College as well as from the program chairs of both St. Clair College campuses. Ethical considerations included the right to self-determination, the right to privacy, confidentiality, beneficence and justice. This research study upheld all of the aforementioned tenets.

Participation in the study was voluntary. Participants were given information about the study via university e-mail and immediately prior to the administration of the questionnaire, while in the classroom setting. Participants were given the opportunity to ask questions and the investigator's contact information was provided. Participants were given the right to refuse to participate or to refuse to answer any survey question. Participants were informed that they may withdraw from the research study at any time.

Returned and completed surveys implied consent by the participant. Anonymity and confidentiality was established, as no identifying information was sought as part of the research study.

Limitations

Because of low response rates associated with questionnaires, the investigator administered the questionnaires on site and in person to the participants during regularly scheduled class times as well as provided students the option of participating on-line. Envelopes were collected upon immediate completion of the questionnaire to maximize return rates. Generalizability will be limited by the sample.

CHAPTER IV

RESULTS

This chapter provides results from statistical analysis as well as a description of participant characteristics. Details of data screening are also discussed.

Data Screening and Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) 16.0. A two tailed alpha of 0.5 was used to determine the significance of the statistical findings. Data were screened for missing data, normality and outliers. Extreme univariate outliers across multiple variables were removed and included outliers from the: *total bully score*, composite bullying scores for sources of bullying which included, *staff bully, clinical instructor bully, classmate bully, physician bully, patient/family bully, other staff bully* and *preceptor bully.* Additional extreme univariate outliers were removed from *self esteem* scores and *self confidence* scores, leaving an N=647 for statistical analysis. Univariate statistical analysis included t-tests, Spearman correlation and chi-square analysis. Multivariate analysis consisted of Analysis of Variance (ANOVA), Factorial ANOVA and Regression analysis.

The focus of the study was to determine if student nurse are experiencing bullying behaviours in nursing education. For parametric statistical analysis, a total bullying score was used whereby all reported experiences of bullying behaviours were summed. This variable did not meet the assumptions of normally distributed data, but as Fitzgerald, Gelfand and Drasgow (1995) point out when discussing sexual assault scores, the skewness of data is simply a reflection of reality (1995). Based on evidence in the

literature, it would not be expected for experiences of bullying to assume a normal distribution; therefore due to the nature of the variable, it was considered acceptable that the *total bully score* be included in parametric analysis. Similarly with self-esteem scores, it would be anticipated that nursing students who have been successful in the entrance process of a nursing program should hold above average self-esteem scores. It would therefore stand to reason that self-esteem scores would not be normally distributed, but rather be skewed positively. For non-parametric analysis, the variable *total bullying score* (the sum of never, occasionally, frequently and all the time) was collapsed into actual *bullied* and actual *not bullied* to represent whether or not student nurses had experienced bullying behaviours at all or never. The variable *not bullied* consisted of total bullying scores of zero and the variable *bullied,* consisted of any score greater than zero. The conceptual definition of bullying that was used for this study is: repeated negative acts over time that are directed at someone who finds it difficult to defend themselves against these acts and who perceives an inequity in power (Hoel, Cooper & Faragher, 2001; Einarsen & Skogstad, 1996), therefore, anyone who has identified themselves as having experienced bullying experiences more than never will be included in the analysis.

Students were asked how frequently they had been bullied as single self-labeling item (*never, occasionally, frequently* and *all the time*). For purposes of statistical analysis, this question was collapsed into *bullied* and *not bullied*. Those who were considered not to have been bullied were those students who answered never and those who answered either *occasionally, frequently* or *all the time*, were considered to have been bullied.

Students were asked how frequently they had witnessed a classmate being bullied (*never*, *occasionally*, *frequently* and *all the time*). For purposes of statistical analysis, this question was collapsed into *witnessed* and *not witnessed*. Those who were considered to have not witnessed classmates being bullied were those who answered *never* and those who were considered to have witnessed classmates being bullied were those who answered either *occasionally*, *frequently* or *all the time*.

Age was captured as a continuous variable and was re-categorized into four categories for statistical analysis from 18-24 years, from 25-34 years, from 35-44 years and 45 years and older.

From a possible 1167 students from one mid-sized university and two colleges, one having two campuses, a total of 674 nursing students participated in the study, generating a 58% response rate. Percentages and frequencies of reported experiences of bullying behaviours have been reported on the total population of 674 participants. After removing extreme univariate outliers across multiple variables, a total of 647 participants were included for statistical analysis.

Demographics

Table 1 provides details on demographic information according to sex, age, year of study and ethnicity. The mean age of participants was 24 years of age (SD +/- 5.85). The majority of participants identified themselves as Caucasian (n=522) and 83% of participants were female.

Table 1

Participant Demographic Characteristics, N=674

Chararacteristic	Frequency	Percentage (%)
Gender		
Male	112	16.20
Female	558	82.79
Intersex	0	0.00
Transexual	1	0.15
Age		
18-24	477	70.80
25-34	126	18.70
35-44	48	7.10
45 and older	23	3.41
Current Year of Study		
First year	202	29.97
Second year	250	37.09
Third year	150	22.26
Fourth year	71	10.53
Ethnicity		
Caucasian	522	77.45
Black/African/Caribbean	33	4.90
Latin/South American	9	1.34
East Asian/Chinese/Japanese	35	5.19
South Asian/Indian/Pakistani	26	3.86
Aboriginal/Métis/First Nations	6	0.89
Middle Eastern	19	2.82
Bi/Multiracial	2	0.30
Other	16	2.37

The State of Bullying in Nursing Education in the Practice Setting

The first research question examines the state of bullying in nursing education in the practice setting. Of 674 student nurses, 88.72% (n=598) reported experiencing at least one act of bullying. Independent *t* tests revealed that those who self-labeled as being bullied according to a single self-labeling item, had higher mean total bullying

scores (*M*=25.85, SD=21.05) than those who self-labeled as being not bullied (*M*=10.51, SD=12.65, $p<.001$).

Among participants who self-reported according to a single self-labeling item that they had never been bullied, (n=486), 85.2% (n=414) of students nurses actually identified that they had experienced bullying behaviours according to the individual bullying behaviours identified in the questionnaire. Among those participants who self-labeled that they had been bullied according to the single self-labeling item, (n=188), only 2.1% (n=4) reported that they had not experienced bullying behaviours according to the individual bullying behaviours identified in the questionnaire (X^2 =21.81, $p<.001$). See Table 2 for *Chi Square* table.

Table 2

Prevalence of Self-labeled Students According to Single Self-labeled Item who Experienced Individual Bullying Behaviours in the Questionnaire

Experiences of Bullying Behaviours	Self-labeled bullied n=188	Self-labeled not bullied n=486	X^2	*p*
Bullied per actual experiences	72	414	21.81	<.001
Not bullied per actual experiences	4	184		

According to year of study, 97.18% (n=69) of fourth year students reported having experienced at least one bullying behaviour, 94.0% (n=141) of third year students reported experiencing at least one bullying behaviour, 92.40% (n=231) of second year students reported experiencing at least one bullying behaviour and 77.23% (n=156) of nursing students in first year reported experiencing at least one bullying behaviour.

Of the 112 male participants, 84.80% (n=95) reported having experienced at least one bullying behaviour. According to the self-labeling item however, only 17% (n=19) considered themselves to have been bullied. Of the 558 female participants, 89.20% (n=498) reported having experienced at least one bullying behaviour. According to the self-labeling item, 30.3% (n=169) considered themselves to have been bullied. Chi Square analysis revealed that females labeled their experiences as bullying significantly more than males (X^2=.67, p=.01).

Table 3 highlights the number of participants who have experienced at least one bullying behaviour according to self reported ethnicity.

Table 3

Participants Who Have Experienced at Least One Bullying Behaviour Identified in the Questionnaire According to Ethnicity

Ethnicity	N=674	Percentage (%)
White/European	464	88.90
Black/African/Caribbean	29	87.90
Latin/South American	8	88.90
East Asian/Chinese/Japanese	30	85.70
South Asian/Indian/Pakistani	22	84.60
Aboriginal/Métis/First Nations	5	83.30
Middle Eastern	17	89.50
Bi/Multiracial	2	100.00

For reporting purposes, age was re-categorized into 4 categories. Table 4 describes the reported experiences of bullying according to age. Of those participants aged 18-24, 88.9% (n=427) reported having experienced at least one bullying behaviour. Of those participants aged 25-34, 88.9% (n=112) reported having experienced at least one

bullying behaviour. Of those aged 35-44, 87.5% (n=42) reported having experienced at least one bullying behaviour and of those participants aged 45 and older, 82.6% (n=19) reported having experienced at least one bullying behaviour according to the nursing student questionnaire.

Table 4

Reported Experiences of Bullying Behaviours According to Age

Ages	N=674	Percentage (%)
18-24	427	88.9
25-34	112	88.9
35-44	42	87.5
45 and older	19	82.6

When students were asked whether or not they had witnessed other students being bullied, 48.1% (n=324), reported that they had witnessed others being bullied. Of 674 participants, 41.8% (n=282) reported that they occasionally witnessed others being bullied, 5.5% (n=37) reported that they frequently witnessed others being bullied, and 0.6% (n=4) reported that they witnessed other students being bullied all the time.

Types and Frequencies of Bullying Behaviours Experienced by Student Nurses

The second research question explores the types and frequencies of bullying behaviours as reported by student nurses. Table 5 presents the number of students who have reported bullying behaviours according to individual behaviours. The undervaluing of efforts (60.24%) is the most frequently reported bullying behaviour as reported by student nurses in the clinical setting. Of 674 students, 45.25% (n=305) reported being subjected to negative remarks about becoming a nurse, 43.03% (n=290) reported feeling

that impossible expectations were set for them, 42.14% (n=284) reported being treated with hostility, 41.84% (n=282) reported being placed under undue pressure to produce work, 41.54% (n=280) reported being frozen out, ignored or excluded and 40.36% (n=272) reported being unjustly criticized. Table 5 provides a detailed account of the types and frequencies of 26 individual bullying behaviours experienced as reported by nursing students.

Table 5

Individual Bullying Behaviours Experienced by Student Nurses According to Questionnaire

Bullying Behaviour	N=674	Percentage (%)
I had threats of physical violence made against me	106	15.73
I was intimidated with disciplinary measures	216	32.05
I was threatened with a poor evaluation	160	23.74
I felt impossible expectations were set for me	290	43.03
Inappropriate jokes were made about me	176	26.11
Malicious rumours/allegations were spread about or against me	83	12.31
I was unjustly criticized	272	40.36
Necessary information was withheld from me purposefully	102	15.13
Attempts were made to belittle or undermine my work	239	35.46
I was treated poorly on grounds of race	41	6.08
I was treated poorly on grounds of disability	14	2.08
I was treated poorly on grounds of gender	105	15.58
Expectations of my work were changed without me being told	183	27.15
Areas of responsibility were removed from me without warning	95	14.09

I was placed under undue pressure to produce work	282	41.84
I was physically abused	52	7.72
I was verbally abused	221	32.79
I was treated with hostility	284	42.14
Attempts were made to demoralize me	139	20.62
I was teased	225	33.38
I felt my effort were undervalued	406	60.24
I was humiliated in front of others	234	34.72
I experienced resentment towards me	242	35.91
I experienced destructive criticism	241	35.76
I was frozen out/ignored/excluded	280	41.54
I was told negative remarks about becoming a nurse	305	45.25

The types of bullying behaviours experienced were further explored according to year of study (see Table 6). The top six reported bullying behaviours for first year students included efforts being undervalued (38.61%), having impossible expectations set for them (30.20%), being frozen out or ignored (27.33%), being told negative remarks about becoming a nurse (25.74%), being treated with hostility (25.74%) and experiencing resentment (24.26%). Second year students reported most frequently that their efforts were undervalued (67.20%), being told negative remarks about becoming a nurse (51.60%), being frozen out or ignored (44.0%), having undue pressure put upon them (45.20%), being unjustly criticized (42.40%) and being treated with hostility (41.20%). Third year students reported most frequently their efforts were undervalued (73.0%), the setting of impossible expectations (58.0%), receiving destructive criticism (56.67%), being told negative remarks about becoming a nurse (56.67%), being treated with

hostility (56.0%), and being placed under undue pressure (54.0%). Fourth year students reported most frequently their efforts were undervalued (69.01%), being treated with hostility (61.97%), the setting of impossible expectations (56.34%), being placed under undue pressure (54.93%), being frozen out or ignored (53.52%) and being told negative remarks about becoming a nurse (53.52%).

Table 6

Individual Bullying Behaviours Experienced According to Year of Study

	1st year		2nd year		3rd year		4th year	
	n=202	%	n=250	%	n=150	%	n=71	%
Threats of physical violence	23	11.39	23	9.20	39	26.00	20	28.17
Intimidated with disciplinary measures	38	18.81	80	32.00	62	41.33	35	49.30
Threatened with a poor evaluation	27	13.37	66	26.40	43	28.67	23	32.39
Impossible expectations were set for me	61	30.20	101	40.40	87	58.00	40	56.34
Inappropriate jokes were made about me	36	17.82	62	24.80	52	34.67	26	36.62
Malicious rumours were spread about me	14	6.93	37	14.80	21	14.00	10	14.08
Unjustly criticized	48	23.76	106	42.40	81	54.00	36	50.70
Information was withheld from me purposefully	21	10.40	34	13.60	28	18.67	19	26.76
Attempts were made to belittle/undermine my work	35	17.33	98	39.20	74	49.33	31	43.66
Treated poorly on grounds of race	5	2.48	19	7.60	6	4.00	11	15.49
Treated poorly on grounds of disability	2	0.99	5	2.00	5	3.33	2	2.82

Treated poorly on grounds of gender	24	11.88	27	10.80	38	25.33	16	22.54
Expectation of work were changed without notice	40	19.80	66	26.40	56	37.33	20	28.17
Responsibilities were removed without warning	14	6.93	44	17.60	29	19.33	8	11.27
Placed under undue pressure to produce work	48	23.76	113	45.20	81	54.00	39	54.93
Physically abused	13	6.44	17	6.80	16	10.67	6	8.45
Verbally abused	43	21.29	78	31.20	67	44.67	32	45.07
Treated with hostility	52	25.74	103	41.20	84	56.00	44	61.97
Attempts were made to demoralize me	20	9.90	52	20.80	49	32.67	18	25.35
Teased	47	23.27	89	35.60	56	37.33	33	46.48
Efforts were undervalued	78	38.61	168	67.20	110	73.33	49	69.01
Humiliated in front of others	36	17.82	92	36.80	73	48.67	32	45.07
Resentment towards me	49	24.26	93	37.20	67	44.67	32	45.07
Destructive criticism	28	13.86	91	36.40	85	56.67	36	50.70
Frozen out/Ignored	55	27.23	110	44.00	76	50.67	38	53.52
Negative remarks about becoming a nurse	52	25.74	129	51.60	85	56.67	38	53.52

The Sources of Bullying Behaviours in the Clinical Setting

The fourth research question addresses the source of bullying behaviours in the clinical setting in nursing education. Table 7 (see Appendix G) identifies the types of bullying behaviours according to the source or perpetrator and according to the frequency of the bullying behaviours experienced.

According to self reported experiences of bullying behaviours, student nurses identified clinical instructors as the most frequent perpetrators of undervaluing efforts (40.65%), placing undue pressure to produce work (35.01%), setting impossible expectations (33.68%), intimidation with disciplinary measures (24.63%), unjustly criticizing (24.63%), changing work expectations without notice (21.36%), threatening with a poor evaluation (21.22%), removing areas of responsibility without warning (9.05%), withholding necessary information purposefully (7.42%), and being treating poorly on grounds of disability (1.34%).

Student nurses identified staff nurses as the most frequent perpetrators of expressing negative remarks about becoming a nurse to students (29.67%), freezing out, ignoring or excluding (27.89%), treating students with hostility (23.0%), displaying resentment (19.14%), attempting to belittle or undermine student work (18.5%), attempting to demoralize (11.42%), and withholding necessary information purposefully (7.42%). Classmates were identified as the most frequent perpetrators of teasing (22.40%), making inappropriate jokes (15.13%), spreading rumours or making allegations (8.16%), and treating poorly on grounds of race (3.26%). Student nurses identified patients and or their family members as the greatest perpetrators of verbal abuse (16.77%), physical violence threats (12.91%), being treating poorly on grounds of gender (9.20%), and physical abuse (6.68%).

Although physicians, other staff members and preceptors were not a most frequently reported source of any single bullying behaviour, physicians and other staff were most frequently reported to have undervalued students' efforts, ignored students and made negative remarks about becoming a nurse. Preceptors were mostly noted for

undervaluing students' efforts. Equal amounts of fourth year students reported preceptors placing students under undue pressure to produce work and setting impossible expectations.

Table 8 (see Appendix H) identifies the perpetrator and summarizes the rate of occurrence according to the 26 individual bullying behaviours without regard to frequency (never, occasionally, frequently, all the time) of bullying behaviour experienced by the student.

The types of bullying behaviours experienced were further explored according to year and source. Of particular interest were fourth year students, as they have an additional potential source of bullying behaviours by preceptors with whom they work with, in the clinical setting for the entire final semester of the nursing program. Tables 9 to 9.4 display the sources of bullying behaviours for the 26 individual bullying behaviours according to year of study.

Table 9

Sources of Bullying Behaviours Reported by First Year Students

Source	N=674	Percentage (%)
Staff nurse	259	18.62
Clinical Instructor	286	20.56
Classmate	277	19.91
Physician	21	1.51
Patient/Family member	288	20.70
Other hospital staff	260	18.69
Preceptor	0	0.00

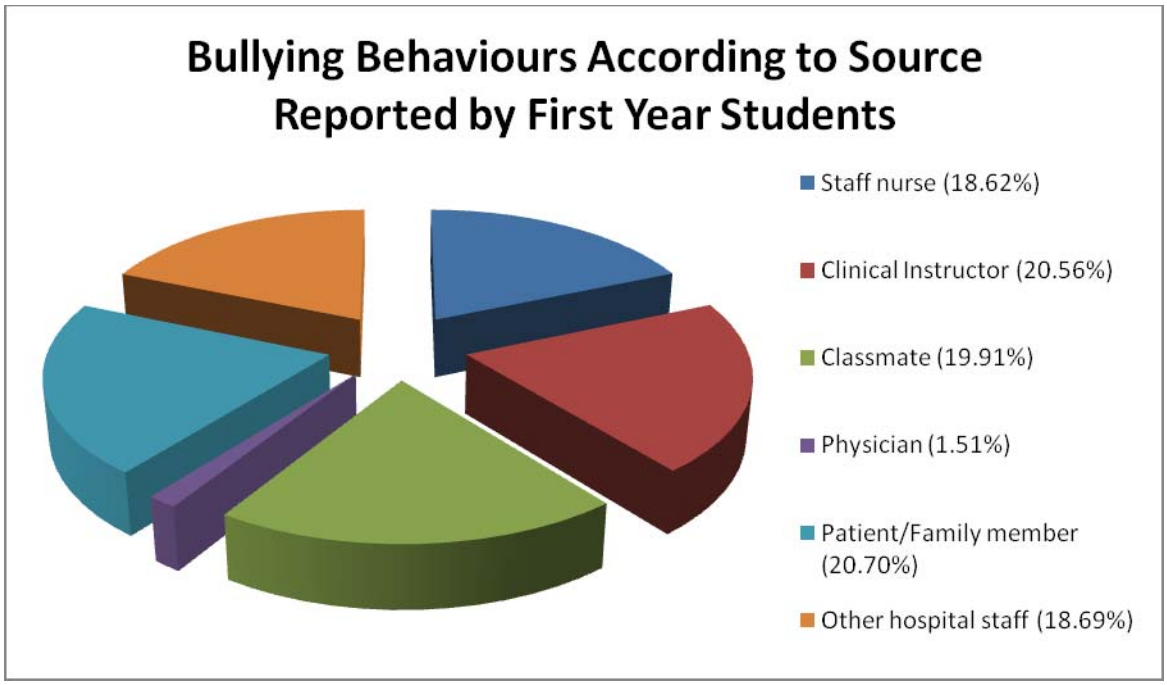


Table 9.1

Sources of Bullying Behaviours Reported by Second Year Students

Source	N=674	Percentage (%)
Staff nurse	947	27.88
Clinical Instructor	1166	34.32
Classmate	558	16.43
Physician	149	4.39
Patient/Family member	367	10.80
Other hospital staff	210	6.18
Preceptor	0	0.00

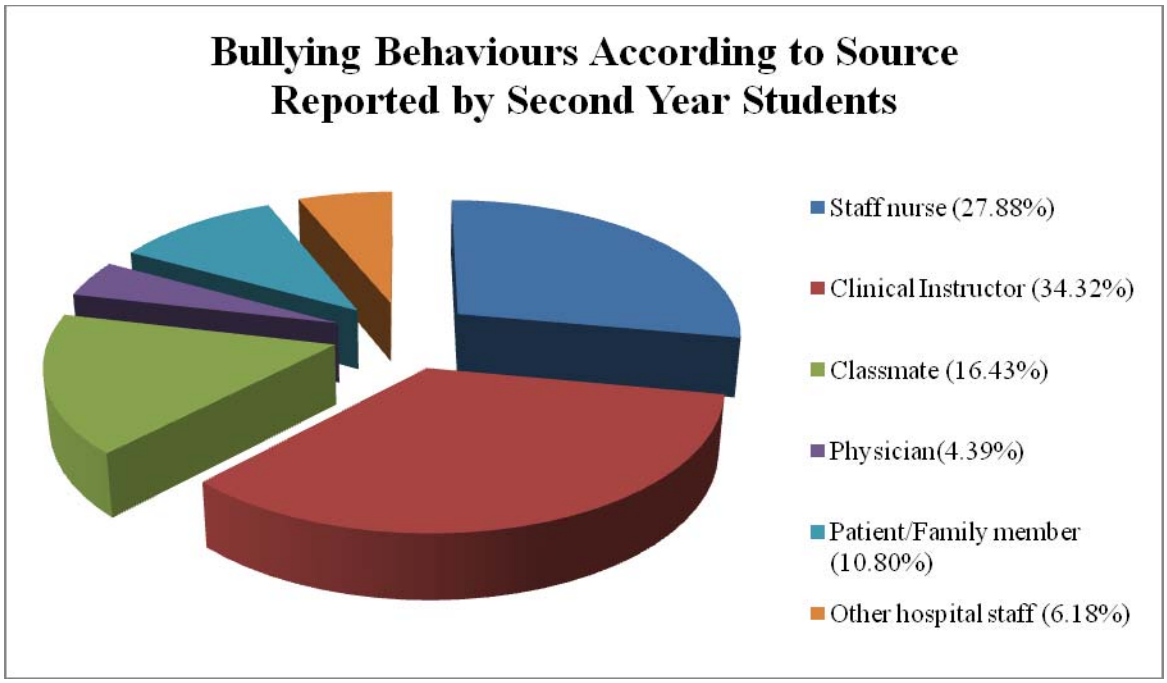


Table 9.2

Sources of Bullying Behaviours Reported by Third Year Students

Source	N=674	Percentage (%)
Staff nurse	812	29.15
Clinical Instructor	886	31.80
Classmate	318	11.41
Physician	206	7.39
Patient/Family member	401	14.39
Other hospital staff	163	5.85
Preceptor	0	0.00

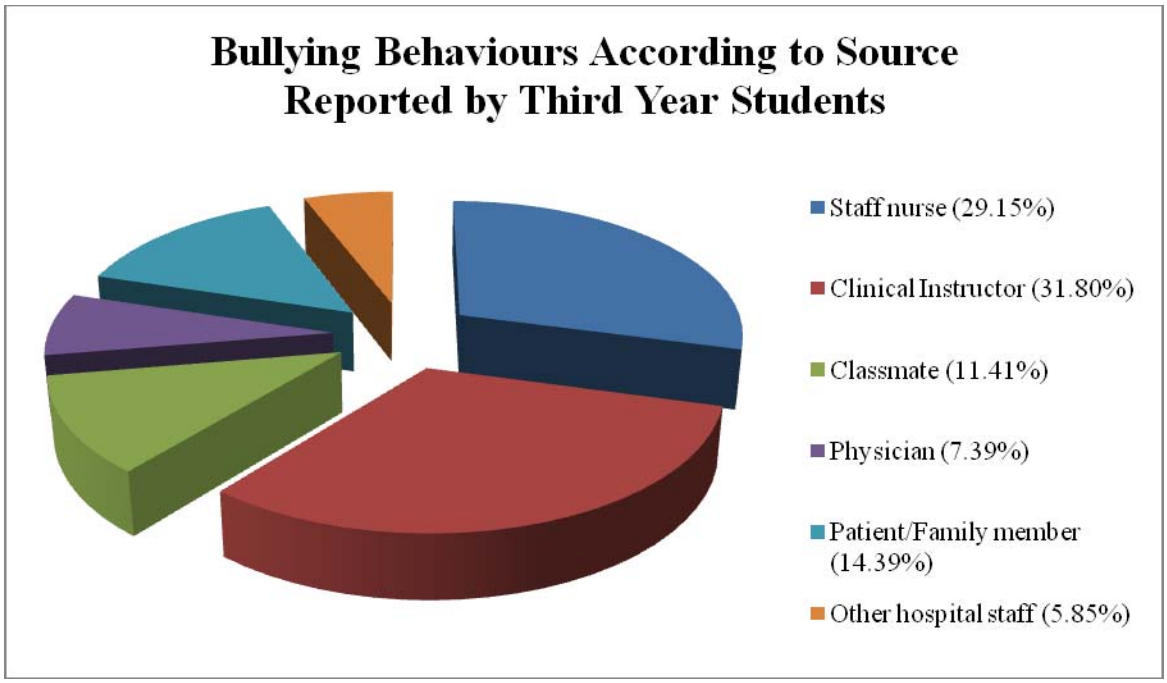
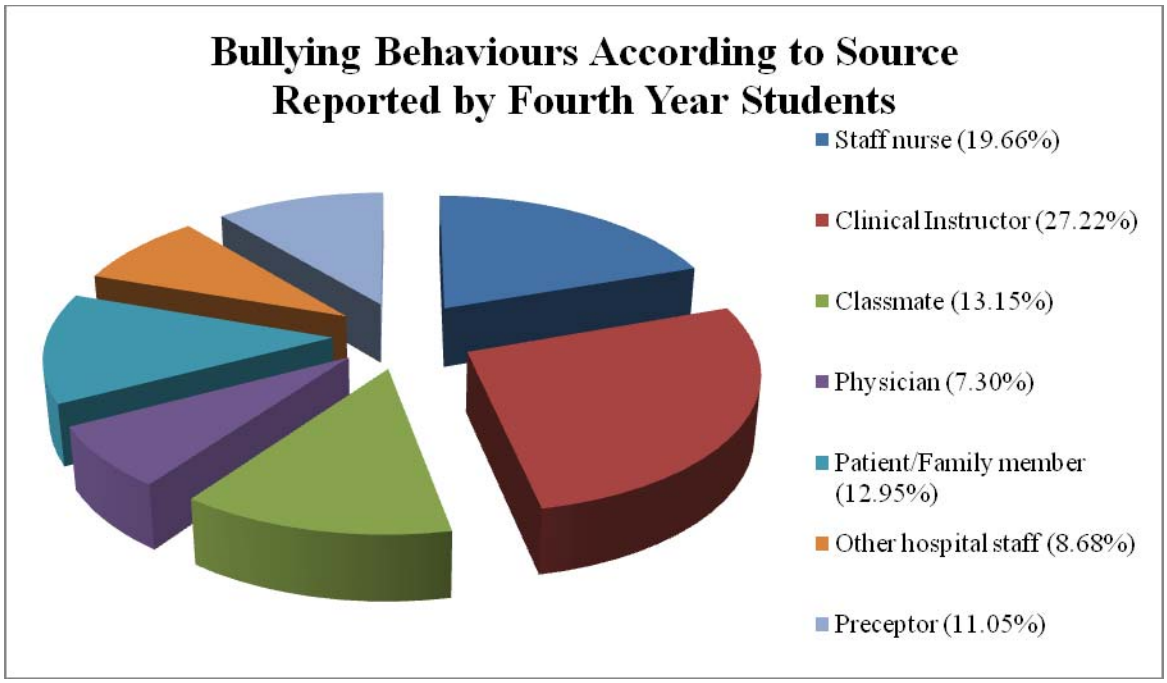


Table 9.3

Sources of Bullying Behaviours Reported by Fourth Year Students

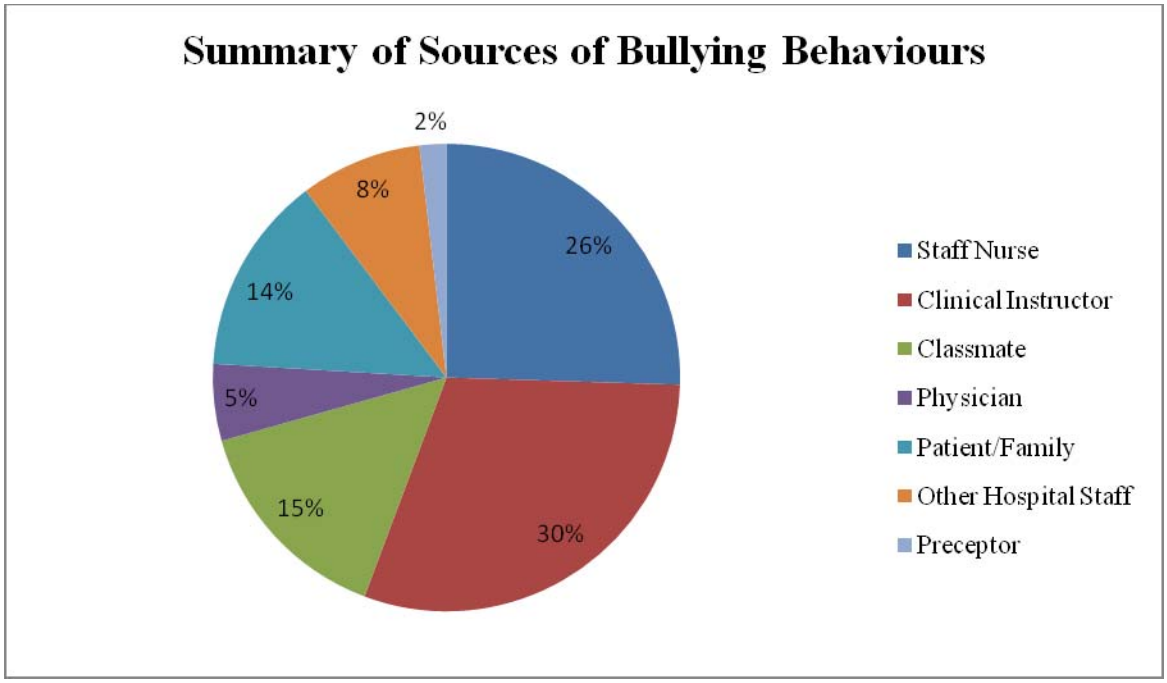
Source	N=674	Percentage (%)
Staff nurse	299	19.66
Clinical Instructor	414	27.22
Classmate	200	13.15
Physician	111	7.30
Patient/Family member	197	12.95
Other hospital staff	132	8.68
Preceptor	168	11.05



According to self-reported experiences of student nurses, clinical instructors (30.22%) were identified as the greatest source of bullying behaviours in the practice setting, followed by staff nurses (25.49%). Closely reported were classmates and patients and their families, accounting for 15% and 14% respectively of the bullying behaviour experienced by student nurses in the clinical setting. Table 10 is a summary of sources of bullying experiences as reported by student nurses.

Table 10

Summary of Sources of Bullying Behaviours



Experiences of Bullying Behaviours and Intentions to Leave the Nursing Program

A t-test was performed to determine if there was a difference in mean total bullying scores between student nurses who had considered leaving the nursing program and those who had not. The data suggests that the mean total bullying score is higher (M=29.21, SD=23.86) for those students who have considered leaving the nursing program than for those students who have not considered leaving the nursing program (M=13.11, SD=15.05, p<.001).

Total bullying scores according to self-reported experiences of individual bullying behaviours were re-categorized into bullied (any bullying behaviour experienced) and not bullied (no bullying behaviours experienced). There was no significant association

between being bullied or not bullied as a dichotomous variable based on total bullying scores and intentions to leave the nursing program. Among those participants who said that they had considered leaving the nursing program (n=88), 94.3% (n=83) were bullied based on total bullying scores. Among the participants who said they had not considered leaving the nursing program (n=454), 87.7% (n=398) had been bullied according to total bullying scores as a dichotomous variable (see Table 11).

There was a significant association between being self-labeled as bullied or not bullied and intentions to leave the nursing program ($X^2 = 1.40$, $p<.001$). Among those participants who said that they had considered leaving the nursing program (n=83), 76.1% (n=67) reported being bullied according to a self-labeling item. Among the participants who said they had not considered leaving the nursing program (n=454), only 25.8% (n=117) had reported being bullied and 74.2% (n=337) had reported not being bullied (see Table 12).

Table 11

Prevalence of Nursing Students Considering Leaving the Nursing Program and Experiences of Bullying Behaviours Based on Total Bullying Scores

	Experiences of bullying	No experiences of bullying	X^2	p
Considered leaving the nursing program	83	5	3.39	.335
Not considered leaving the nursing program	398	56		

Table 12

Prevalence of Nursing Students Considering Leaving the Nursing Program Based on a Single Self-labeling Bullying Item

	Self-labeled bullied	Self-labeled not bullied	X^2	*p*
Considered leaving the nursing program	67	21	1.40	<.001
Not considered leaving the nursing program	117	337		

The Reporting of Bullying Behaviours and to Whom?

Students were asked to identify who they told if they experienced bullying behaviours. Results do not suggest or reflect that formal reports were made, but rather that students told someone of their experiences. Of 598 participants, who according to the total bullying score were considered to have been bullied, 22.6% (n=135) reported that they told someone about their bullying experiences. Of 188 students who identified themselves as having been bullied according to the self-labeling item, 52.1% (n=98) reported that they told someone about their experiences of bullying behaviours and 36.7% (n=69) reported that they told no one. Of the 135 student nurses who reported that they told someone of their bullying experiences, clinical instructors (65.19%) and classmates (77.03%) were most frequently identified as confidants. Students also reported telling family members and friends (see Table 13).

Table 13

Who Student Nurses Chose to Tell Their Experiences of Bullying Behaviours to

Confidant	n=135	Percentage (%)
Clinical Instructor	88	65.19
Classmate	104	77.03
Staff Nurse	10	7.40
Faculty	27	20.0
Hospital Manager	5	0.74
Other	26	3.86

When the reporting of bullying behaviours was further examined according to sex, it was noted that females were more likely to report incidents of bullying behaviours than males (X^2=4.00, p=0.45). See Table 14 for *Chi Square* analysis results.

Table 14

Prevalence of Confiding in Someone about Bullying Behaviours Experienced Between Males and Females

	Reported	Not reported	X^2	p
Males	14	28	4.00	.045
Females	109	108		

Why Students are Not Reporting Experiences of Bullying Behaviours

Among 143 participants who did not report bullying behaviours, the belief that nothing would be done if the bullying behaviour were to be reported (38.46%) and fear of a poor evaluation (30.07%) were most commonly reported reasons why students did not

report their experiences of bullying behaviours. Tables 15 and 15.1 highlight reasons why students chose not report their experiences of bullying behaviours.

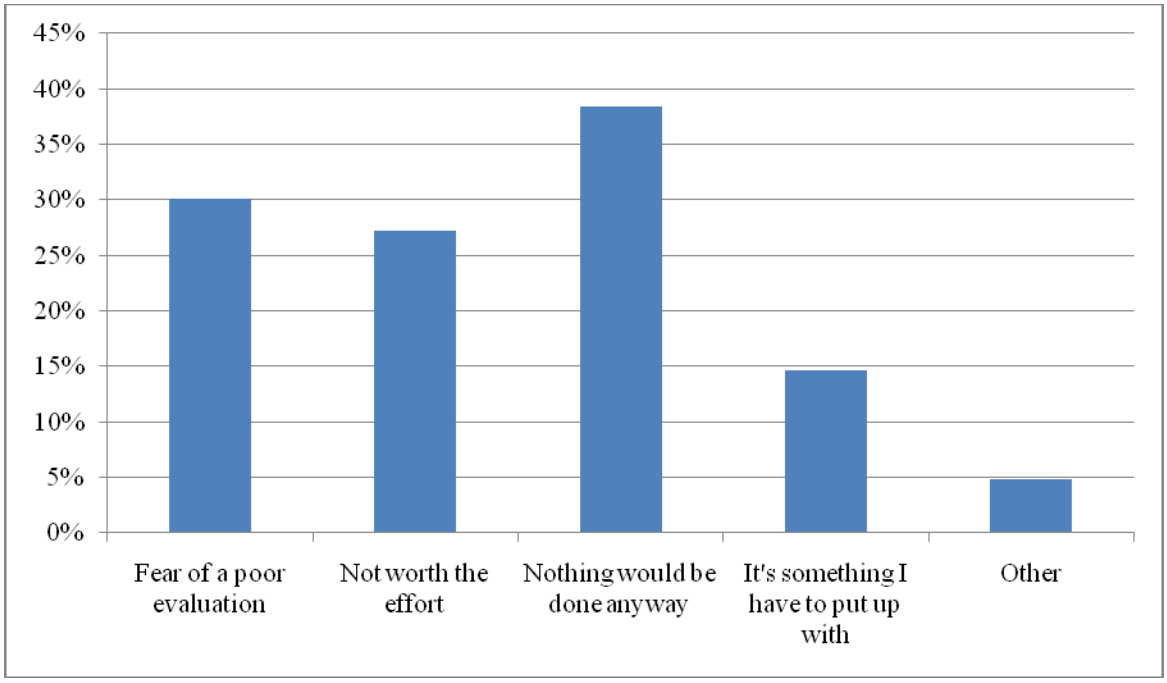
Table 15

Reasons why Students Chose not to Report Experiences of Bullying Behaviours

Reasons	n=143	Percentage (%)
Fear of a poor evaluation	43	30.07
Not worth the effort	39	27.27
Nothing would be done anyway	55	38.46
It's something that I just have to put up with	21	14.68
Other	7	4.90

Table 15.1

Reasons for Not Reporting Experiences of Bullying Behaviours



Student Characteristics and Frequency of Bullying Behaviours

To explore relationships between the extent of bullying behaviours experienced and participant characteristics, a t-test was performed between total bullying scores and males and females and ANOVAs were performed between total bullying scores and age, ethnicity, and year of study respectively.

The data suggest that there is no difference between males and females and mean bullying scores (F=1.76, p=.681), between age and mean bullying scores (F=1.071, p=.361), and between ethnicity and mean bullying scores (F=1.61, p=.120). The data does suggest that a difference exists between year of study and frequency of bullying behaviours experienced (F=24.27, p<.001). Post hoc testing using a Bonferonni procedure revealed a significant difference between first year and second year students (p<.001), between first year and third year students (p<.001), between first year and fourth year students (p<.001), between second year and third year students (p=.032), and between second and fourth year students (p<.001) with respect to mean bullying scores. The data suggests that there is no difference in mean bullying scores between third and fourth year students (p=1.00). Students in first year had the lowest mean bullying scores, followed by second year students, and third year students. Fourth year students reported the highest mean bullying scores; however, not significantly higher than third year students. See Table 16 for ANOVA summary for year of study and total experiences of bullying behaviours.

Table 16

Analysis of Variance Summary for Year of Study and Total Experiences of Bullying Behaviours

Year of Study	M, SD	*F*	*p*
Year 1	7.31, 9.81		
Year 2	15.15, 17.01	24.27	<.001*
Year 3	19.82, 18.95		
Year 4	22.51, 18.88		

Experiences of Bullying Behaviours and Self-Esteem

The data suggest that there is a significant but weak inverse relationship between experiences of bullying behaviours and self-esteem. Those who had higher mean bullying scores had lower mean self-esteem scores (r=-.198, p<.001). T-tests were performed to examine if there was a difference in mean self-esteem scores between students who had self-labeled themselves as being bullied (n=174) and students who had self-labeled themselves as being not bullied (n=462). The data suggest that those students who were not bullied according to the self-labeling item had higher mean self-esteem scores (M=33.25, SD= 4.68) than those students who self-labeled themselves as being bullied (M=0.55, SD=4.73, t=6.46, p<.001).

To address the issue of which source of bullying behaviours is a stronger predictor of self-esteem measures, standard multiple regression analysis was conducted with self-esteem scores as outcome measures and sources of bullying behaviours as predictors. The final regression model is presented in Table 17. The overall regression model for self-esteem was significant, R^2 =.055, F=12.34, p<.001. Examination of the

squared semi-partial correlation coefficients indicates that staff nurses (sr^2 =.007), and clinical instructors (sr^2 =.007) and patients/families (sr^2 =.010) made significant unique contributions to the prediction of self-esteem.

Table 17

Regression Analysis for Source of Bullying Behaviours Predicting Self-Esteem

Outcome Variable	Predictor Variable	β	t	sr^2	R^2
Self -esteem	Staff nurse	-.099	-2.11*	.007	.055
	Clinical instructor	-.098	-2.22*	.007	
	Patients/Families	-.112	-2.62*	.010	

*p<.05

Experiences of Bullying Behaviours and Perceived Self-Confidence

Students answered a baseline question indicating whether or not they felt confident performing most of the skills needed to care for their clients based on a likert scale of *strongly disagree, disagree, agree* and *strongly agree*. A bivariate Spearman correlation was performed to explore the relationship between experiences of bullying behaviours and student nurses perceptions of confidence to perform the skills necessary to care for their clients in the clinical setting. The data suggest that there is a weak but significant relationship between students' baseline perception of ability to care for their clients and actual bullying behaviours experienced (r=-.082, p=.037).

Students were asked whether or not being on the receiving end of bullying behaviours would negatively impact their ability to provide care to their patients. The Likert scale used (*totally disagree, disagree, agree, totally agree*) was collapsed to

capture either *agree* or *disagree*. At minimum, 88.09% of students agreed that being belittled, being yelled at, being excluded and or being unjustly criticized would negatively impact patient care. Overwhelmingly student nurses reported that they felt experiencing bullying behaviours would negatively impact their ability to care for their clients, causing a ceiling effect, thereby creating low variability for this measure.

Experiences of Bullying Behaviours and Coping

According to mean subscale coping scores, student nurses reported using reframing coping strategies most frequently (M=5.23, SD=1.86), followed closely by emotional support coping (M=5.22, SD=1.86), active coping (M=5.19, SD=1.87) and instrumental coping (M=5.01, SD=1.92). A Spearman correlation was performed to explore which coping strategies were being used by students who experienced more bullying behaviours according to the total bullying scores. The data suggests that all forms of coping strategies are significantly being used to cope with bullying behaviours. Table 18 provides a detailed description of the relationship between the 14 subscales for coping and the total bullying score. The data also suggests that those students who are experiencing greater amounts of bullying behaviours are using self blame (r=.30, p<.001), disengagement (r=.30, p<.001), venting (r=.27, p<.001), and self-distraction (r=.26, p<.001) most frequently and use humour (r=-.24, p<.001) less often.

Table 18

Correlation Between Coping Strategies and Total Bullying Scores

Coping Subscales	*r*	*p*
Self distraction	.26	<.001
Active Coping	.08	.045
Denial	.21	<.001
Substance Abuse	.18	<.001
Emotional Support	.16	<.001
Instrumental Support	.19	<.001
Disengagement	.30	<.001
Venting	.27	<.001
Reframing	.13	.001
Planning	.15	<.001
Humour	.24	<.001
Acceptance	.16	<.001
Religion	.12	.002
Self-blame	.31	<.001

When coping strategies were further explored based on self-esteem scores, it was noted that those students with lower mean self-esteem scores significantly used self-blame as a coping strategy more frequently than any other coping strategy (r=.43, p<.001).

CHAPTER V

DISCUSSION

Chapter V provides a summary and discussion of the study findings. Recommendations are provided for future practice and suggestions are made for future research.

The State of Bullying in the Clinical Setting

The survey administered to nursing students (N=674) listed 26 possible negative experiences one may encounter in the clinical setting. Although all 26 behaviours are based on literature related to bullying in nursing education or bullying in the workplace, the term bullying was not used to describe any of the behaviours in the actual questionnaire.

The results of this study are consistent with previous literature, wherein the vast majority of nursing students (88.72%) reported experiencing negative behaviours, otherwise recognized as bullying behaviours in the clinical setting. These results are consistent with other international studies where upwards of 90% of student nurses reported experiencing bullying behaviours in the clinical setting (Foster et al., 2004; Celik & Bayraktar, 2004; McAdam Cooper, 2007), however much higher than a U.K. study that reported only 53% of students had experienced one or more negative interactions (Stevenson et al., 2006). Student nurses reported experiencing all 26 identified behaviours in the questionnaire at varying frequencies. For purposes of discussion, it is difficult to adequately compare empirical results of the current study with other studies that examine the state of bullying in nursing education. The reasons for this

are because of incomparable sample sizes, incompatible methodology or previously unexamined relationships between variables.

Unique to this study, is the self-label bully item, where students were asked to indicate how frequently they had been bullied. Results of the self-labeling item against actual experiences of bullying behaviour revealed that students are not considering themselves to have been bullied, despite experiencing bullying behaviours as identified in the questionnaire. The fact that overwhelmingly students are not recognizing these negative experiences as bullying contributes to the underreporting of such behaviours and potentially perpetuates unacceptable behaviour. If educational institutions are gauging the severity of bullying on reports of students, they may well be underestimating the state of bullying in their organization.

The underreporting of abuse in the health care workplace setting has been well established in the literature. Rates of under reporting are alarming and may in part be due to the societal trend toward tolerance for increasing levels of violence (Duncan, Hyndman, Estabrooks, Hesketh, Humphrey, & Wong et al, 2001) often leaving nurses to feel that they must endure a certain level of personal violence as they practice nursing (ICN, 2008; Duncan et al.; Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Humphrey, & Wong, et al., 2001; May & Grubbs, 2002). This finding is similar to other forms of victimization, where only one in ten sexual assaults are reported to police (Statistics Canada, 2008), supporting the reality of the underreporting of victimization.

The results also support low false report rates of bullying. The results suggest that if students are reporting that they have been bullied, then they likely have

experienced bullying behaviours. Students must not then be dismissed when bullying is reported, but rather they must be provided with a non-threatening means of reporting bullying and be provided with support during the process. One nursing student commented, “There is no one to turn to. All staff members are friends and will back each other up. I would not be believed and would feel judged”.

Independent *t* tests revealed that students who are experiencing more bullying behaviours according to higher mean total bullying scores are labeling their experiences as bullying, more than those students who are reporting less experience of bullying behaviours according to the total bullying score. This finding speaks to two issues. Firstly, although the questionnaire used in the study bears no psychometric properties, it appears to be capable of capturing what student nurses consider to be bullying based on individual experiences and frequency of behaviours. Secondly, at some point of frequency of bullying behaviours experienced, students are considering themselves to have been bullied. Further research is needed to establish a threshold where students appraise their individual experiences of bullying behaviours as having either been bullied or not bullied. Results from the current study, suggest that the subjective experience alone and or in combination with actual experiences of bullying behaviours may have the potential to negatively impact students’ self-esteem, despite the frequency of actual experiences of bullying behaviours. Further research examining the appraisal of actual versus perceived bullying behaviours and their impact on students’ self-esteem is needed to fully understand the phenomenon of bullying in nursing education.

Similar rates of bullying behaviours were experienced by males and females as identified by individual experiences of bullying. When these students were asked, “have

you been bullied?" females were nearly twice as likely as males to identify themselves as having been bullied according to the single self-labeling item. Contrary to the results in the current study, results from a 2005 study of 18,676 Canadian nurses, revealed that males were more likely (46.1%) to experience violence than females (33.0%) (Shields & Wilkins, 2009). The authors suggest that the recruitment of male nurses to handle difficult and or aggressive patients may account for the increase in experiences of violence. In this present study, students aged 18-24 and aged 25-34, marginally experienced more bullying behaviours than those students aged 35-44. Students older than 45 year of age reported the least frequent amount of bullying behaviours experienced, despite over three quarters of those students having reported experiences of bullying behaviours, reinforcing the idea that bullying knows no age limit.

Fourth year students on average reported experiencing the greatest amount of bullying behaviours, followed by third year and second year students. These findings are reasonable considering the fact that fourth year student have accrued the most amount of clinical experience overall. First year students reported the least frequent experiences of bullying behaviours. It is logical that first year students reported the least amount of bullying behaviours, as they have only spent one semester thus far in the clinical setting. These results remain alarming, because despite their minimal exposure to the clinical setting, 77% have already reported experiences of bullying behaviours. Students of varied ethnicities similarly reported experiences of bullying behaviour in the clinical setting.

Nearly half of all nursing students reported that they witnessed others being bullied, yet only 28% reported being bullied according to the self-labeling item. This

finding suggests that when students witness others experience bullying behaviours, they are more likely to appraise those behaviours as bullying, whereas those students who experience bullying behaviours first hand, are less likely to appraise those experiences as bullying. It is important to assess the frequency with which students are observing bullying behaviours, as Rogers and Kelloway (1997) report that vicarious victims, as well as actual victims experience adverse effects associated with violence in the workplace. Witnessing rude behaviour from either a peer or an authority figure has been shown to negatively impact performance and creativity and has the potential to increase dysfunctional and aggressive thoughts (Porath & Erez, 2009). In addition, Rayer, et al. (2002) suggest that the negative effects associated with the witnessing of bullying behaviours may extend far beyond the victim themselves and include negative effects on home and social life. Since student nurses report experiencing bullying behaviours in the health care workplace setting, it seems reasonable that those same associations could apply. Further studies are needed to generate empirical evidence to substantiate such a link, more specifically for the witnessing of bullying behaviours in the clinical setting.

Types and Frequencies of Bullying Behaviours

Student nurses reported having experienced all 26 behaviours to some degree of frequency. Student nurses reported most frequently that they felt undervalued. One student commented in an open ended question:

> There is more a deep sense of ungratefulness from the nurses we worked with this semester. We did all their routine work with little or no thanks or recognition. It would be nice if once in a while they said thanks you really helped me today.

Another student similarly remarked that “people make you feel like you do not matter”. Student nurses also reported being on the receiving end of negative remarks about becoming a nurse. One student nurse commented that “After writing my journal improperly, my clinical teacher told me not to be a nurse”. Another student commented that “Sometimes I felt that my clinical instructor would always pick on me. She once asked me "Do you think nursing is for you?" That was so discouraging.” Although questioning the fit of a career choice for any student by an educator is not deemed inappropriate, the context, environment and way in which that observation is made can affect the effectiveness and perception of the message.

Student nurses reported that impossible expectations and pressures were set for them. One student commented:

> I have an instructor that has the expectation that I have had all this previous experience. It is very intimidating and I am too scared of a poor clinical evaluation or to fail to admit that I don't know how to perform certain tasks that are expected. The clinical setting feels like an opportunity to prove your skills not develop them. It is all very nerve-racking.

Students also reported being treated with hostility, being frozen out or ignored and being unjustly criticized. The following narrative comments support the quantitative responses of students.

> Often hospital staff is annoyed by our presence.

> Staff would talk amongst each other and say that their student was "dumb and didn't know anything" and how much they dislike having students around!

> In general staff nurses have no respect for nursing students, which makes it really hard in the clinical experience. They are extremely intimidating which at times turns me away from wanting to go to the clinical experience.
>
> Our clinical professor treated our group very unprofessionally. She would give us destructive criticism in an angry way in front of other nursing staff, patients and families. She would make fun of physical disabilities of a fellow student. She would call us names and demoralize us constantly.

The fact that some bullying behaviours were much less frequently reported, does not make the frequency of the behaviour more tolerable. Fifty-two (7.2%) student nurses reported having been physically abused and 87 students (12.91%) reported having been threatened with physical harm. The physical abuse of one student nurse is intolerable; the physical abuse of 52 student nurses is unbearable. Although these numbers are alarming, a report on aggression in British Columbia revealed that more than 60% of nurses experienced six or more assaults during a five year period, and 25% reported having experienced more than 100 or more assaults during the same five year period (Boyd, 1995). Of those 52 students who in the current study reported experiencing physical abuse, 45 students experienced physical abuse at the hands of patients and or their families. In a study examining violence in the Emergency Department, patients and or their families accounted for 92% of the violence experienced by nurses (Lyneham, 2000). Of 674 nursing students in the current study, 15.58% (n=105) reported being discriminated against on grounds of gender, race (n=41) and disability (n=14). Considering the unlikely number of students with disabilities, this result is alarming.

A similarly large study of nursing students in the U.K (Stevenson et al., 2006), using a comparable questionnaire, revealed four common threads when comparing those behaviours most frequently reported from the current study and the U.K. study. Being frozen out or ignored, receiving negative criticism, being humiliated and feeling undervalued were commonly reported as most frequently experienced behaviours between the two studies. Surprisingly, the current study reported that student nurses experienced over six times the amount of threats of physical violence as did students in the U.K. study. Other than experiences of hostility, no commonalities were found between the current study and those reported by fourth year nursing students (McAdam Cooper, 2007), where most commonly reported behaviours included experiences of verbal abuse, belittling and humiliating behaviour.

When bullying behaviours were further explored by year of study, it was noted that overall the following frequently reported behaviours were common threads identified across all years of study: being treated with hostility, feeling efforts were undervalued and being told negative remarks about becoming a nurse. Particularly distressing is the fact that student nurses from year one to year four are frequently being subjected to harmful comments about the nursing profession or a nursing student's ability to become a nurse. This coupled with feeling undervalued and being treated with hostility throughout the duration of the nursing program, could make for a stressful learning environment. Further research is required to measure the levels of stress in the clinical setting, particularly for those experiencing bullying behaviours.

The Sources of Bullying Behaviours

Clinical instructors and staff nurses have been identified as the greatest source of bullying behaviours, as they are in frequent contact with student nurses while in clinical placement. According to the reports of most frequently experienced bullying behaviours according to source, clinical instructors displayed bullying behaviours that support an authoritarian and evaluative position. These results support Baltimore's (2006) proposal that the root of bullying behaviour in the nursing workplace is bred in the academic setting. Nurse educators often sit in critical judgment of students, thereby satisfying a need for superiority. These results are contrary to those found in an equally large scale study of fourth year student nurses (N=636) in Mississippi, where classmates were identified as the greatest source of bullying behaviours (McAdam Cooper, 2007) and in a U.K. study where doctors and non-nurse trained Health Care Assistants were most often reported as perpetrators of bullying (Stevenson et al., 2006). Magnussen and Amundson (2003) point out that although student nurses recognized and appreciated the crucial role that clinical instructors play in impacting the clinical environment, they were occasionally concerned about the manner in which they were treated.

Emerson (2006) suggests that the learning of psychomotor skills in the clinical setting is not limited to, but is dependent upon the quality of teacher-student relationship, the student's self-confidence, the reduction of distracting stimuli and quality feedback, all of which are compromised if bullying behaviours ensue. Rayner, et al. suggest that those in positions of authority may unintentionally abuse power as a result of lack of preparation in assuming certain duties (2003). All clinical instructors at the institutions surveyed for the current study, have at minimum a baccalaureate degree, some are

masters prepared and a few are doctorally prepared. Although some clinical instructors are educated beyond the undergraduate level, the focus of advanced practice nursing is based on discipline specific knowledge and skills and not on education. Clinical instructors are typically experts in their clinical field and therefore are not familiar with theories of teaching and learning in higher education and more specifically in the clinical setting. Clinical instructors are most often nurses who divide their time between teaching and part time clinical work elsewhere in the healthcare setting. Because of their workplace divide, it is challenging for clinical instructors to partake in additional training that would enhance their capacities as an educator. It is of utmost importance to examine the orientation and preparation of clinical instructors in assuming their role as educator in the clinical setting, prior to placing them in a position of authority and influence. One student wrote,

> The teacher (clinical instructor) makes a huge difference in the experience. A teacher who is willing to go out of their way to educate and who is approachable makes for a good experience. Those who are unapproachable and whose students fear them make for an awful, stressful environment and decrease learning.

According to reports of bullying behaviours, it appears that staff nurses may be somewhat resentful of having student nurses occupy their workplace, as students report being treated with hostility and resentment, being ignored and demoralized. These quantitative findings are consistent with several anecdotal comments made by student nurses in an open-ended question. One student nurse commented, “The nurses sometimes felt as though we were more of a burden to them and they didn't want us there. I think they forget what it is like to be a student. They seemed really frustrated with us”.

Another student commented, “In general staff nurses have no respect for nursing students, which make it really hard in the clinical experience. They are extremely intimidating which at times turns me away from wanting to go to the clinical experience”. These remarks are consistent with a study of first year students, where reports of more passive and unhelpful behaviour from staff included making students feel unwelcome and intrusive (Jackson & Mannix, 2001).

It is well known that nurses are frustrated with their work environment, due in part to shortages of staff, increased workloads, the critical nature of their patients and advances in technology (Lambert & Lambert, 2008). The addition of students to an existing stressful environment has the potential to create greater stress in the workplace. Although responses are based on a small sample (N=40) and clinical instructors were not an option as a source of bullying in the questionnaire, Foster et al. (2004) reported that registered nurses were reported as the most frequent perpetrators of bullying behaviours. Further research is warranted to capture the unique relationship between staff nurses and the students with whom they share their work environment.

In the current study, student nurses reported classmates as being the greatest perpetrator of teasing, spreading rumours, making jokes and discrimination based on race, reminiscent of bullying behaviours found in school playgrounds. Similarly, McAdam Cooper (2007) reported that classmates were the most frequent sources of spreading rumours and acting in a nasty manner. Classmates were perpetrators of cursing or swearing, making negative remarks about becoming a nurse, actual or threats of physical or verbal aggression and being ignored.

Patients and their families were identified as the greatest source of the more aggressive bullying behaviours, including verbal abuse, physical threats and actual physical abuse. This finding is consistent with studies on violence in health care settings, where patients have been identified as the number one offender of both verbal and physical abuse (Gerberich, Church, McGovern, Hansen, Nachreiner, & Geisser,et al, 2004; Findorff, McGovern, Serverich, & Alexander, 2004, Hesketh, et al., 2003; May & Grubbs, 2002; Duncan et al., 2001). Although not entirely excusable, it stands to reason that patients in particular, may become aggressive dependent upon their diagnosis and medical circumstances. One student in the current study commented that "patients with dementia were sometimes abusive". Family members have also been known to become aggressive when facing highly stressful situations in which the well-being of their loved ones is threatened. According to May and Grubbs (2002), nurses overlook assaults by patients who have a cognitive impairment or who are in drug withdrawal. Danesh, Malvey and Fottler (2008) refer to this behaviour as a masked type of workplace violence that goes unnoticed by management, but may carry with it devastating effects on the healthcare provider. Contrary to current findings, Celik and Bayraktar (2004) reported classmates as the greatest source of physical, academic and sexual abuse.

Physicians and other staff members were not identified as the most common source of any single bullying behaviour, although they did contribute to the bullying of student nurses. Preceptors as well, were not identified as the greatest sources of any single bullying behaviour. Similar to clinical instructors, preceptors were most noted for bullying behaviours pertaining to work load and performance, notably setting impossible expectations, placing undue pressure on students and undervaluing their efforts. In a

study investigating the perceptions of a preceptor model, student nurses identified negative characteristics of preceptors based on experiences with preceptors that negatively impacted their learning, and included occurrences, that according to the current study would be interpreted as bullying behaviours. Such behaviour included being isolated and ignored, being told negative remarks about becoming a nurse and being treated with hostility (Price, 2006).

Preceptors play an important role in the socialization of nursing students to the role of nurse. The benefits of preceptorship include, but are not limited to decreasing stress, fostering growth and increasing levels of confidence (RNAO, 2009). In a study examining preceptorship experiences, fourth year students rated the importance of their relationship with their preceptor as important to very important and reported that greater amounts of preceptor interaction led to a greater degree of perceived competence (Kim, 2007). The current study has identified preceptors as sources of bullying behaviours, thereby negating the many positive effects of preceptorship, as noted in previous literature.

When sources of bullying behaviours were further examined according to year of study, it was noted that clinical instructors were the greatest source of bullying behaviours across all years of study. Common to second through fourth was the fact that clinical instructors, staff nurses, classmates and patients all occupied the top four identified sources of bullying behaviours. Other hospital staff and physicians accounted for the two least frequent sources of bullying behaviours. First year reported rankings were unique in that staff nurses accounted for the second least frequently reported source of bullying behaviour, while in second through fourth year, staff nurses accounted for the

second most frequent source of bullying behaviour. This may be explained by the absence of nurses in the clinical settings most often used for first year clinical placements. First year nursing students have considerably more interactions with personal support workers than they do with nurses in the nursing home setting. This source of bullying behaviour may have been overlooked in the questionnaire, as one first year student commented, "I felt health care aids /personal support workers were very hostile to us and did not make us feel welcome in the clinical setting", supporting the idea that the hierarchical nature of the healthcare setting is conducive to bullying behaviours (Sweet, 2005). Students in an Australian study identified a pecking order in that those who found themselves on the lower rung of the ladder were abused by those who sat higher than them, whether it is RNs, Assistants in Nursing (AIN) or ENs (Enrolled Nurses). Hierarchical differences contributing to horizontal violence were also noted between those nurses who were educated at the University level and those who were hospital trained (Curtis et al., 2006). One nursing student in the current study commented that University students feel as though they are better nurses than the College prepared nurse. A second year student commented that third and fourth year students are not necessarily pleasant to work with when sharing clinical space.

In summary, it is not surprising that clinical instructors and staff nurses accounted for the majority of bullying behaviours experienced by student nurses overall, considering the frequency of interaction with students. That this occurs at all, is an issue that must be addressed. These results provide researchers with an opportunity to focus on understanding the unique relationship between clinical educators, staff nurses and

students in an effort to improve the rapport between all parties involved, and ultimately improve the experiential learning of student nurses.

Experiences of Bullying Behaviours and Intentions to Leave the Nursing Program

The results demonstrate that students who experienced more bullying behaviours were more inclined to consider leaving the nursing program. In an article recounting the effects of bullying on retention, Sweet (2005) describes how many nurses who have been bullied felt as though their only recourse was to leave. Although the reports of student nurses who considered leaving the nursing program in the current study are alarming (13.06%), they are far less than those reported by Celik and Bayraktar (2004). In their study, 57.7% of nursing students had considered leaving the program as a result of verbal abuse and 69.5% had considered leaving the nursing program because of academic abuse. It is well noted that recruitment and retention in nursing is a serious issue, placing an additional strain on an existing shortage of nurses (RNAO, 2009). Setting aside the ethical implications surrounding the experiences of bullying behaviours, for purposes of recruitment alone, nursing educators must consider strategies to diminish experiences of bullying behaviour as an approach to alleviating the sting of a current and future nursing shortage. If bullying behaviours persist in nursing education, the nursing workforce is in jeopardy of losing precious resources.

The data suggest that perceptions of having been bullied have a greater impact on intentions to leave the nursing program than do actual experiences of bullying behaviours as identified in the questionnaire. Lazarus and Folkman (1984) speak of a long standing belief supported by several psychological theorists and researchers that the perception or

interpretation of objects is significant in the formation of the subjective meaning of a situation. This finding may also suggest that not all bullying behaviours have been captured in the bullying questionnaire and perhaps a qualitative accompaniment to this study would further identify other types of behaviours that student nurses are appraising as bullying behaviours.

The Reporting of Bullying Behaviours

More students confided in someone about their experiences of bullying behaviours if they self-labeled themselves as having been bullied. Nearly half of those who self-identified themselves as having been bullied, told someone about their experiences. Conversely, not even a quarter of those who were identified as having experienced bullying behaviours, reported their experiences to someone. This once again supports the idea that the subjective experience is perhaps more influential than actual experiences of bullying behaviours. Although reporting rates are higher for those who self-labeled, when reporting rates are compared to other studies using similar criteria for identifying those who have been bullied, the reporting rates for the current study were lower than those reported by other studies. Stevenson et al. (2006) and McAdam Cooper (2007) reported that nearly 35% of students in their respective studies did nothing and Longo (2007) reported that 49% of students did not report their experiences of bullying behaviours.

It is promising to note that based on the single self-labeling item, reporting rates were higher in the current study than in the previous studies mentioned, yet it remains under reported and is consistent with previous literature that supports the underreporting

of victimization in the health care setting (McKenna, et al., 2002, Hesketh, et al., 2003, May & Grubbs, 2002, Duncan et al., 2001). The underreporting of physical aggression may in part, be due to the fact that nurses have been reported to justify and excuse physical aggression as a result of a patient's mental status (McKenna, Poole, Smith, Coverdale & Gale, 2003).

Consistent with a large U.K. study (Stevenson et al., 2006), and a smaller U.S. study (Longo, 2007), students identified classmates as the most frequent confidant for the reporting of bullying experiences. The finding that students chose most frequently to confide in their classmates, may be explained by the fact that nearly 40% of students in the current study did not believe that anything would be done if they reported the behaviour. Similarly, and according to the 2004 General Social Survey, sexual assault victims chose most frequently informal sources, such friends (72%) and family members (41%) when reporting their experiences of victimization (Statistics Canada, 2008).

While males and females experienced similar amounts of bullying behaviours, females were significantly more likely to report the event to someone. Reporting practices between the sexes have not been examined in previous studies examining bullying in nursing education; however, in a study of barriers to reporting sexual assault among college students (Sable, Danis, Mauzy & Gallagner, 2006) males were significantly more concerned about shame, guilt and embarrassment, issues surrounding confidentiality and fear of not being believed. These results support society's prevailing misconception that males are innately strong and assertive and are in no need for protection or support. This may be in part due to the fear of stigmatization that accompanies the reporting of male victimization (Victims of Violence, 2008).

Why Students are Not Reporting Experiences of Bullying Behaviours

In addition to students reporting that nothing would be done if they reported experiences of bullying, they also reported fearing a poor evaluation Students also felt it was not worth the effort, which again is consistent with previous studies, where similar responses for not reporting bullying behaviours were identified (Stevenson, et al., 2006). Similarly, 58% of victims of sexual assault reported that that the incident was not important enough to report (Statistics Canada, 2008). Nursing students in a larger U.K. study justified not taking action as a result of experiencing bullying behaviours by making excuses for the poor behaviour, minimizing the event and its impact, normalizing the behaviour and fearing a poor evaluation. Similarly in a qualitative study examining the realities and expectations of nursing students, Hoel, et al., (2007) reported that students defended the poor behaviour of staff nurses, to the extent of suggesting that it may serve a purpose or that it was due to pressure and or workload or previous experiences of bullying (2007). Gray and Smith (2000) suggest that it is perhaps in an attempt to ease the process of socialization and become accepted within the nursing circle.

Experiences of Bullying Behaviours and Perceived Self-Confidence

Although the results are based on a single baseline question, the results suggest that there is an relationship between having experienced bullying behaviours and student nurses' confidence in caring for their patients. Previous studies have demonstrated that a relationship exists between mood states and self-efficacy, wherein nursing students who were happier had greater self-confidence in the clinical setting (Salyer, 1992). If bullying

behaviours are negatively impacting mood states, as one would hypothesize, then the self-confidence of those who have experienced bullying behaviours would too be negatively impacted. According to the theory of self-efficacy, negative emotions can damage self-confidence (Bandura, 1997). Considering the fact that those with low self-esteem can be characterized by unhappiness, withdrawal, and anger (Rosenberg, 1989), those students who are recipients of bullying behaviours, which have been identified as negatively impacting self-esteem, will lack confidence in the clinical setting.

In a study investigating student nurses' perceptions of their learning environment, a positive relationship was shown to exist between student nurses' self-efficacy beliefs and the frequency of student faculty interactions. We know from the current study that student nurses have identified clinical instructors, who are part of faculty, as the greatest sources of bullying behaviours. The knowledge that interactions are integral to the self-confidence of students, further supports the need to reconcile the nature of relationship that currently exists between clinical instructors and student nurses as identified in the current study.

Low self-confidence in the clinical setting has been suggested by student nurses to negatively impact and or limit learning (Hine, 2006). Student nurses in the current study have overwhelmingly perceived that bullying behaviours would indeed compromise their abilities to provide adequate care to their clients. In an effort to support or dispute the current findings, the General Perceived Self-Efficacy Scale (Schwarzer & Jerusalem, 1993) could be used to provide a more reliable picture.

Experiences of Bullying Behaviours and Self-Esteem

Results suggest that an inverse relationship exists between self-esteem and experiences of bullying behaviours. Those with higher mean bullying scores had lower mean self-esteem scores. If experiencing bullying behaviours is considered to be a negative life event, then this relationship supports Carver's findings that adverse interpersonal events are a significant and unique predictor of global self-esteem in undergraduate students in their first year of college (2004). Although the current study revealed a somewhat weak relationship between self-esteem and experiences of bullying behaviours, Rosenberg (1989) points out that several factors may be related to one's self-esteem, and include social group membership, birth order, parental involvement, family dissolution and neighbourhood dissonance. In a study investigating the effects of a nursing program on self-esteem, Randle (2001) reported that students' levels of self-esteem were fragmented as a result of several factors, one of which was identified through grounded theory analysis as bullying type behaviours by nurses. This is consistent with the current study, suggesting that staff nurses are a significant and unique contributor to the variance in the self-esteem of student nurses. Inconsistent with the current study is the finding by Randle (2003) who reported that the self-esteem of student nurses dramatically decreased over the three year period of their nursing education program. Ninety five percent of students had below average self esteem scores according to the Tennessee Self-Concept Scale (TSCS) by the end of their nursing education.

In addition, Rosenberg (1989) points out that it is possible for extreme self-consciousness to bear impact on self-esteem. Rosenberg speaks of parents frequently sitting in judgment of their children, which invariably highlights faults. Rosenberg adds

that in the more self-conscious person, this may lead to low self-esteem. In the current study, clinical instructors and staff nurses have been identified as the most frequent perpetrators of bullying behaviours. It would seem logical that clinical instructors and or staff nurses who similarly stand in judgment for evaluative purposes, have the same potential to heighten the self-consciousness of nursing students, and thereby, negatively impact self-esteem. Harsh and judgmental comments reported by nursing students, by those in authoritative positions; therefore, have the potential to jeopardize self-esteem. One student nurse reported,

> My clinical instructor picked sterile gloves out for me. They did not fit and I started to flail the glove to get them on, in front of a patient she yanked off the gloves and through them on my field and yelled "you broke sterile technique" and stormed out of the room. The patient was mortified and I was humiliated.

It was also noted that students who self-labeled themselves as being bullied had lower self esteem scores than those who labeled themselves as not having been bullied. Once again, this supports the idea that the perception or subjective appraisal of an event may play a part in the impact of bullying on self-esteem.

In a study of senior high school students, it was noted that students with low self-esteem encompassed qualities that were negatively associated with leadership (Rosenberg, 1989). The fostering of leadership qualities in the nursing profession is of upmost importance in an effort to support excellence in nursing practice. All nurses are in a position to be leaders within their profession, by demonstrating leadership traits through decision making, patient care, accountability, advocating, collaborating,

mentoring, having knowledge, and research utilization (CNA, 2002). Having an understanding that there exists a relationship between experiences of bullying behaviours in the clinical setting and the self-esteem of student nurses, identifies a potential barrier for the fostering of leadership among student nurses, thereby limiting the pool of prospective future nurse leaders.

Experiences of Bullying Behaviours and Student Nurse Characteristics

According to the data, sex, ethnicity and age did not appear to be related to the amount of bullying behaviours experienced. There was however, a relationship between year of study and the amount of bullying behaviours experienced. According to the data, third and fourth year students experienced significantly more amounts of bullying behaviours than those nursing students in first and second year, while first year students experienced significantly less bullying behaviours than second year students. This finding is consistent with results from a 2004 study in Turkey, where third and fourth year students were more likely to be exposed to verbal and academic abuse (Celik & Bayraktar). The fact that fourth year students in the current study recounted experiences for the greatest length of time (four years); it stands to reason that they should report higher levels of bullying behaviours. It appears as though experiences of bullying behaviours peaked in third year, as there was no significant difference in the amount of bullying experiences between third and fourth year students. Although fourth year students are reflecting on more years of study in the clinical setting, degree of recall may interfere in the accuracy of reporting. On the other hand, colleagues have acknowledged anecdotally, specific bullying events dating back some thirty years ago with vivid recall.

It is not surprising that first year students reported the least frequent amount of bullying behaviours, since they have only spent one semester in the practice setting.

Coping with Bullying Behaviours

Overall, students have reported using adaptive coping methods such as reframing, seeking emotional support, using active coping and seeking instrumental support. Based on the study results, it appears though, that as bullying experiences increase, the methods for coping change from positive coping strategies to include coping strategies, such as disengagement (Carver, Weintraub and Scheier, 1989) and self-blame (Holahan, Moos and Schaefer, 1996) which are considered to be more dysfunctional. According to Lazarus and Folkman (1989), coping strategies can be divided into two forms of coping, emotion-focused coping, which aims at regulating emotions, and problem-focused coping, which aims at doing something to change the problem. Menninger (1954), with respect to emotion focused coping states that, “minor stresses are usually handled by relatively “normal” or “healthy” devices. Greater stresses or prolonged stress excite the ego to increasingly energetic and expansive activity in the interest of homeostatic maintenance (p.280).

This statement is consistent with the results of this study, wherein students who experienced greater amounts of bullying, used emotion focused coping to a greater degree. It is important to note what types of behaviours student nurses are using to deal with bullying behaviours, as it may assist in the identification of students facing stressful experiences. Alternatively, it may serve nursing educators as a guide for implementing into the nursing curriculum alternative strategies for coping, not only with bullying, but

with other stressful events encountered in the life of a student nurses; for example, errors in clinical judgment or the death of a patient.

When coping strategies and self-esteem were examined, a relationship was noted between students with low self-esteem and the use of self-blame as a method of coping with bullying behaviours. Rosenberg points out that people with low self-esteem are likely to say that negative experiences were hurtful and then proceed to appraise their critics as being right, as a result of lack of self-confidence in their own judgment (1989). This idea is supported by the findings in this study, whereby those students with lower self-esteem significantly used the coping subscale of self-blame more frequently than any other forms of coping.

Celik and Bayraktar (2004) revealed that students either did nothing, put up barriers or pretended not to see the abuse most frequently. Similarly, fourth year students in a large study in Mississippi reported most frequently doing nothing and putting up barriers (McAdam Cooper, 2007). In Stevenson et al.'s study (2006), students chose to talk to someone about the event in an effort to resolve the issue which is consistent with the current study, where students chose most frequently to seek emotional support, second only to reframing as a means of coping with bullying behaviours.

Implications for Practice

It is apparent that student nurses are indeed experiencing various bullying behaviours from multiple sources within their clinical setting. What is not yet apparent is how to minimize the occurrence. Although the detrimental effects of bullying in nursing education have yet to be sufficiently examined empirically, the deleterious effects of

bullying in the workplace have been well established in the current and past literature. Regardless of the scant empirical evidence to date that suggests bullying in nursing education is harmful, student nurses share a workplace environment with staff nurses, patients, physicians, clinical instructors, classmates and other hospital staff members, where the negative effects of bullying have been duly confirmed.

Bullying must be addressed at the interpersonal, organizational and societal level. If as Baltimore (2006) proposes, the root of bullying in healthcare exists in academia, then we must first look towards institutions of higher learning to implement and enforce policies that protect students from experiences of bullying behaviours. Multiple sources of bullying behaviours have been identified in the practice setting. Most frequently noted were clinical instructors who not only have the authoritative capacity to serve as advocates against the mistreatment of student nurses, but have the potential to positively impact the experiential learning environment. Nursing students have identified effective clinical environments, where student nurses feel appreciated, supported by staff and clinical instructors, sense cooperation between staff and faculty and share visions for quality patient care with staff and mentors (Papp, Markkanen & von Bonsdorff, 2003).

Faculties of nursing must ensure that clinical instructors are equipped with the knowledge and skills to effectively interact with students in the clinical setting. Clinical instructors must be able to provide helpful and ongoing feedback, evaluate student performance for purposes of building upon and strengthening nursing knowledge and skill and support and recognize students' efforts. Many institutions of higher learning have in-house centres for teaching and learning, whereby faculty have access to workshops, information, and various resources pertaining to diverse aspects of teaching.

Resources for effective communication and feedback, teaching and evaluation strategies may be useful for clinical instructors and should be encouraged within the Nursing Faculty as a strategy for minimizing bullying.

Institutions of higher learning have a responsibility for defining bullying and implementing policies and procedures that address this issue. Students must be aware of procedures for reporting experiences of bullying and be able to do so in a non-threatening environment. Support must be provided for students experiencing distress and their confidentiality must be maintained.

Nursing educators are in a position to enforce a zero tolerance for bullying, whether it is at the hands of clinical instructors, staff nurses, patients, physicians or classmates. Nurse educators have the ability to influence the content of nursing curriculum. This must include discussions about bullying to provide students with strategies for coping with negative experiences. This will dually serve them well in their professional career, as it has been established that the health care workplace in particular, is not without aggression.

Registered nurses have a moral, ethical and legal obligation to support initiatives that foster the effective mentoring of students as they pursue clinical nursing education (CNA, 2008). Staff nurses have the opportunity to set exemplary models of behaviour and practice and mentor novice nurses. They have an opportunity in the clinical setting to teach, inspire, encourage and assist in the socialization of nursing students into their professional roles. Participating in bullying behaviour has the potential to jeopardize student nurses' self-esteem and self-confidence and ultimately compromise patient care.

Not only must staff nurses be held accountable in upholding their individual institution's policies surrounding workplace violence, but they must be held equally ethically accountable to a profession that prides itself on the caring and nurturing of human beings.

Health care organizations have a responsibility in extending their non-violent policies and procedures to include nursing students and making staff and visitors aware of this inclusion. Approaches to zero tolerance in health care settings and reporting policies must be communicated to nursing students during orientation to the hospital setting to promote the safety and well-being of student nurses.

It is not without great challenge that the nursing profession is faced with addressing the phenomenon of bullying, not only in the healthcare workplace, but in nursing education. The danger to say the least is to turn a blind eye, as Randle has established that although students initially find bullying behaviours disturbing, they eventually come to recognize them as part of becoming a nurse (2003) and thus a perpetual cycle of bullying is ripe for ongoing damage. The nursing profession must find a way to strive for a delicate balance between demanding excellence from student nurses because of the critical nature of their educational focus, and doing so in a supportive, non-threatening manner that supports the healthy growth and development of the future nursing force.

Recommendations for Future Research

In an effort to support generalizable findings, it would be advantageous for researchers to develop a psychometric and standardized tool that measures bullying in nursing education, in an effort to identify bullying more accurately and move forward

internationally. A unified definition of bullying in the literature is non-existent and therefore creates a challenge in measuring the phenomenon. Future research is required to establish what student nurses conceptualize as bullying behaviours and therefore constitutes bullying in the eye of the student.

Due to the scarcity of empirical evidence and the descriptive nature of current published literature surrounding the issue of bullying in nursing education, future studies need to examine relationships between the variables involved in bullying and could include, stress, absenteeism in the clinical setting, physiological and psychological health outcomes for student nurses and perceived self-efficacy in the clinical setting. The focus of nursing remains patient-centered, yet we know that those caring for patients are sometimes doing so under unhealthy circumstances as a result of bullying experiences. It is imperative that future research include an examination of patient outcomes, as it relates to care-givers experiences of bullying behaviours.

The current study has focused on student nurses' subjective, self-reported experiences in the clinical setting. In an attempt to further understand the dynamics involved in the experiential learning environment, an exploration of the challenges that nurses and clinical instructors face when assuming the role of educator and or mentor will add to a limited body of knowledge surrounding the student/educator relationship as it relates to perceived experiences of bullying behaviours.

Conclusions

The CNA (2009) suggests that it is a shared responsibility between multiple stakeholders including practitioners, employers, governments, regulatory bodies,

professional associations, educational institutions, unions and the public to restore humanism to the workplace and ensure a safe and ethical workplace for nurses. This same tenet must extend to students nurses who share this same work environment as part of their clinical practice in the baccalaureate nursing program. It has been established in this study and in previous studies that the self-esteem and self confidence of student nurses is in jeopardy, if we continue to tolerate the mistreatment of student nurses. Students who are bullied, consider leaving nursing altogether, which further endangers the existing fragile state of nursing human resources.

With caring as the central core of nursing, we choose to care about our patients, but not one another, and least of all those who aspire to become a part of this so-called caring profession. It is within the nursing profession's capacity to take a public stand against the abuse of nursing students at both the interpersonal, organizational and societal level. The nursing profession as a whole must regain strength, by adopting strategies that assist in creating an improved nursing environment that fosters a culture of acceptance, patience and understanding, rather than a culture of indifference and hostility, ultimately perpetuating the cycle of bullying and the socialization of negative practices.

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APPENDIX A

Student Nurse Questionnaire

1. I had threats of physical violence made against me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

2. I was intimidated with disciplinary measures	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

3. I was threatened with a poor evaluation	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

4. I felt impossible expectations were set for me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

5. Inappropriate jokes were made about me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

6. Malicious rumours/allegations were spread about or against me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

7. I was unjustly criticized	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

8. Necessary information was witheld from me purposefully	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

9. Attempts were made to belittle or undermine my work	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

10. I was treated poorly on grounds of race	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

11. I was treated poorly on grounds of disability	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

12. I was treated poorly on grounds of gender	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

13. Expectations of my work were changed without me being told	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

14. Areas of responsibility were removed from me without warning	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

15. I was placed under undue pressure to produce work	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

16. I was physically abused	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

17. I was verbally abused	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

18. I was treated with hostility	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

19. Attempts were made to demoralise me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

20. I was teased	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

21. I felt my efforts were undervalued	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

22. I was humiliated in front of others	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

23. I experienced resentment towards me	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

24. I experienced destructive criticism	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

25. I was frozen out/ignored/excluded	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

26. I was told negative remarks about becoming a nurse	never	occasionally	frequently	all the time
By a staff nurse	○	○	○	○
By my clinical instructor	○	○	○	○
By a classmate	○	○	○	○
By a physician	○	○	○	○
By a patient/family member	○	○	○	○
By other hospital staff	○	○	○	○
By Preceptor (4th yr. only)	○	○	○	○

27. How frequently have you been bullied?

- never ○
- occasionally ○
- frequently ○
- all the time ○

28. How frequently have you witnessed a classmate being bullied?

- never ○
- occasionally ○
- frequently ○
- all the time ○

29. Have you ever considered leaving the nursing program because of having experienced bullying behaviours?

- yes ○
- no ○
- n/a ○

30. If you have experienced bullying behaviours during your clinical placement, did you tell anyone about it?

- yes ○
- no ○
- n/a ○

31. If you did, who did you tell?

- Clinical instructor ○
- Classmate ○
- Staff nurse ○
- Faculty ○
- Hospital manager ○
- Other (please specify) ○ _____

32. If you did not tell anyone, why not?

- Fear of a poor evaluation ○
- Not worth the effort ○
- Nothing would be done anyway ○
- It's something that I just have to put up with ○
- Other ○ _____

Please feel free to provide any additional comments:

Appraisal Inventory – Student Nurse Questionnaire

Student nurses have many feelings about their abilities in their clinical placements. Below are some sentences that describe possible situations. Please read each question carefully and think about yourself in these situations. Please circle one response for each situation.

There are no right or wrong answers. Please be as honest and accurate as you can about your feelings.

Please circle your degree of agreement with the following statements.

1. I feel confident that I can perform most of the skills needed to care for my patients.

   Totally disagree somewhat disagree somewhat agree totally agree

2. I feel that being belittled negatively impacts my ability to provide care to my patients.

   Totally disagree somewhat disagree somewhat agree totally agree

3. I feel that being yelled at negatively impacts my ability to provide care to my patients.

   Totally disagree somewhat disagree somewhat agree totally agree

4. I feel that being excluded negatively impacts my ability to provide care to my patients.

   Totally disagree somewhat disagree somewhat agree totally agree

5. I feel that being unjustly criticized negatively impacts my ability to provide care to my patients.

   Totally disagree somewhat disagree somewhat agree totally agree

APPENDIX B

Rosenberg Self-Esteem Scale

Circle the appropriate number for each statement depending on whether you strongly agree, agree, disagree, or strongly disagree with it.

	Strongly agree	Agree	Disagree	Strongly Disagree
On the whole, I am satisfied with myself.	1	2	3	4
At times I think I am no good at all.	1	2	3	4
I feel that I have a number of good qualities.	1	2	3	4
I am able to do things as well as most other people.	1	2	3	4
I feel I do not have much to be proud of.	1	2	3	4
I certainly feel useless at times.	1	2	3	4
I feel that I'm a person of worth, at least on an equal plane with others.	1	2	3	4
I wish I could have more respect for myself.	1	2	3	4
All in all, I am inclined to feel that I am a failure.	1	2	3	4
I take a positive attitude toward myself.	1	2	3	4

APPENDIX C

COPE Inventory

The following items are possible ways that you have been coping with experiences of bullying in your clinical setting as part of your nursing education. There a many ways to deal with problems. Everyone deals with things in different ways. I am interested in how YOU have tried to deal with bullying. I would like to know to what extent you have been doing what the item says. Don't answer on the basis of how effective the strategy has been, but rather on whether or not you are doing it. Choose from the following response choices. Try to consider each item separately. Make your answers as true for YOU as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

I've been turning to work or other activities to take my mind off things.

1 2 3 4

I've been concentrating my efforts on doing something about the situation I'm in.

1 2 3 4

I've been saying to myself "this isn't real.".

1 2 3 4

I've been using alcohol or other drugs to make myself feel better.

1 2 3 4

I've been getting emotional support from others.

1 2 3 4

I've been giving up trying to deal with it.

1 2 3 4

I've been taking action to try to make the situation better.

1 2 3 4

I've been refusing to believe that it has happened.

1 2 3 4

I've been saying things to let my unpleasant feelings escape.

1 2 3 4

I’ve been getting help and advice from other people.

1 2 3 4

I've been using alcohol or other drugs to help me get through it.

1 2 3 4

I've been trying to see it in a different light, to make it seem more positive.

1 2 3 4

I’ve been criticizing myself.

1 2 3 4

I've been trying to come up with a strategy about what to do.

1 2 3 4

I've been getting comfort and understanding from someone.

1 2 3 4

I've been giving up the attempt to cope.

1 2 3 4

I've been looking for something good in what is happening.

1 2 3 4

I've been making jokes about it.

1 2 3 4

I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

1 2 3 4

I've been accepting the reality of the fact that it has happened.

1 2 3 4

I've been expressing my negative feelings.

1 2 3 4

I've been trying to find comfort in my religion or spiritual beliefs.

1 2 3 4

I’ve been trying to get advice or help from other people about what to do.

1 2 3 4

I've been learning to live with it.

1 2 3 4

I've been thinking hard about what steps to take.

1 2 3 4

I’ve been blaming myself for things that happened.

1 2 3 4

I've been praying or meditating.

1 2 3 4

I've been making fun of the situation.

1 2 3 4

APPENDIX D

Demographics

1. **Gender:**
   - O Male
   - O Female

2. **Age: _____**

3. **Year of Study:**
   - O 1st year
   - O 2nd year
   - O 3rd year
   - O 4th year

4. **Place of Study:**
   - O University of Windsor
   - O St. Clair College – Windsor Campus
   - O St. Clair College – Chatham Campus
   - O St. Clair College – Lambton Campus

5. **Ethnicity:**
   - O Caucasian
   - O African Canadian
   - O Asian
   - O Other _____

APPENDIX E

Information E-mail to Nursing Students

Dear Nursing Student,

I am a graduate nurse at the University of Windsor working on my thesis as part of my Master of Science in Nursing degree, and I am requesting your assistance as a volunteer participant in a study about Student Nurses' experiences in the clinical setting.

In the next couple of weeks, I will be making my way to your class to explain my study and ask you to participate by completing a survey that should take no longer than 15 minutes. You are not obligated to participate and you may withdraw from the study at any time. You are also not expected to answer any questions that you do not wish to. Should you consent to participate, your answers will remain confidential. There will be no identifying information on the questionnaire.

If you are not able to be in class and would like to participate in the study, the survey will be posted on the University's CLEW website. You may access the survey by logging onto CLEW, beginning March 30th, 2009. Your survey will remain anonymous.

In appreciation of your time and effort in participating in the study, whether in class or on-line, your name will be entered in a draw to win one of two $100 gift cards. If you choose to participate via the CLEW website, please follow the on-line directions for providing your name and contact information. All information is kept confidential and there is no way of linking your contact information to your survey.

Please feel free to contact me or my faculty advisor, Dr. Debbie Kane, should you have any questions, concerns or comments. I look forward to speaking to you in class about this important study.

Sincerely,

Colette Clarke, RN, BScN
Faculty of Nursing
University of Windsor
clarke13@uwindsor.ca

Dr. Debbie Kane
Faculty of Nursing
University of Windsor
dkane@uwindsor.ca
519-253-3000 ext 2268

APPENDIX F

Information Letter

Dear Nursing Student,

I am a graduate nurse at the University of Windsor working on my thesis as part of my Master of Science in Nursing degree, and I am requesting your assistance as a volunteer participant in a study about Student Nurses' experiences in the clinical setting.

The purpose of the study is to learn about the interactions with fellow students, staff nurses, physicians, faculty and clinical teachers that contribute to your clinical experiences. In an effort to ensure that clinical placement environments remain a source of positive student centered learning, a more in-depth appreciation of the experiences of student nurses is needed.

Students from the University of Windsor undergraduate Baccalaureate Nursing program were chosen to participate as a result of practicality and proximity to the researcher. This study is not intended to isolate negative clinical experiencing encountered while studying particularly at the University of Windsor or St. Clair College, but rather to gather a broader picture of student nurses experiences in the clinical setting in general.

If you agree to participate in the study, you will be asked to complete a survey containing questions about your experiences in the clinical setting, overall level of self-esteem and self-efficacy. It should take you approximately 15 minutes to complete the survey.

Your answers to the survey are completely confidential as no identifying information will be collected on your survey. Your participation is completely voluntary and you may withdraw from the study at any time. You are not obligated to answer any questions that you wish not to. The return of the completed questionnaire implies your consent to participate in the study. Once completed, please place the completed questionnaire in the envelope provide and return to the researcher before leaving class. This data may also be used in subsequent studies.

In appreciation of your time and effort in participating in the study, your name will be entered in a draw to win one of two $100 gift cards. Please fill out the postcard in your envelope and deposit it in the box located at the back of the classroom.

Please feel free to contact me or my faculty advisor, Dr. Debbie Kane, should you have any questions, concerns or comments. Our contact information can be found on the consent form.

If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

Thank you for your kindness in contributing to this important study.

Sincerely,

Colette Clarke, RN, BScN
Faculty of Nursing
University of Windsor

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

APPENDIX G

Table 7

Frequency of Individual Bullying Behaviours Experienced According to Source

I had threats of physical violence made against me

Source	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	672	99.70	1	0.15	0	0.00	0	0.00
Clinical Instructor	668	99.11	5	0.74	0	0.00	0	0.00
Classmate	649	96.28	22	3.26	2	0.30	0	0.00
Physician	665	98.66	4	0.59	0	0.00	0	0.00
Patient/Family	584	86.65	82	12.17	4	0.59	1	0.15
Other hospital staff	669	99.26	3	0.45	0	0.00	0	0.00
Preceptor	71	100.00	0	0.00	0	0.00	0	0.00

I was intimidated with disciplinary measures

Source	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	593	87.98	69	10.24	9	1.34	1	0.15
Clinical Instructor	507	75.22	143	21.22	18	2.67	5	0.74
Classmate	649	96.29	23	3.41	1	0.15	0	0.00
Physician	643	95.40	22	3.26	3	0.45	2	0.30
Patient/Family member	624	92.58	45	6.68	2	0.30	0	0.00
Other hospital staff	636	94.36	32	4.75	4	0.59	0	0.00
Preceptor	65	91.55	4	5.63	0	0.00	0	0.00

I was threatened with a poor evaluation

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	648	96.14	22	3.26	1	0.15	2	0.30
Clinical Instructor	531	78.87	122	18.10	17	2.52	4	0.59
Classmate	658	97.63	13	1.93	0	0.00	1	0.15
Physician	670	99.41	0	0.00	0	0.00	1	0.15
Patient/Family member	661	98.07	11	1.63	0	0.00	1	0.15
Other hospital staff	666	98.81	6	0.89	1	0.15	1	0.15
Preceptor	65	91.55	5	7.04	0	0.00	1	1.41

I felt impossible expectations were set for me

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	539	79.97	116	17.21	12	1.78	6	0.89
Clinical Instructor	445	66.02	188	27.89	32	4.75	7	1.04
Classmate	646	95.85	25	3.71	1	0.15	1	0.15
Physician	642	95.25	26	3.86	2	0.30	2	0.30
Patient/Family member	594	88.13	63	9.35	14	2.08	2	0.30
Other hospital staff	621	92.14	43	6.38	7	1.04	2	0.30
Preceptor	55	77.46	12	16.90	2	2.82	1	1.41

Inappropriate jokes were made about me

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	621	92.14	47	6.97	4	0.59	1	0.15
Clinical Instructor	614	91.10	48	7.12	6	0.89	3	0.45
Classmate	572	84.87	85	12.61	12	1.78	5	0.74
Physician	658	97.63	12	1.78	2	0.30	1	0.15
Patient/Family member	623	92.43	44	6.53	5	0.74	2	0.30
Other hospital staff	652	96.74	18	2.67	3	0.45	1	0.15
Preceptor	65	91.55	3	4.23	1	1.41	0	0.00

Malicious rumours/allegations were spread about or against me

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	656	97.33	16	2.37	2	0.30	0	0.00
Clinical Instructor	650	96.44	21	3.12	1	0.15	1	0.15
Classmate	618	91.69	50	7.42	4	0.59	1	0.15
Physician	672	99.70	2	0.30	0	0.00	0	0.00
Patient/Family member	660	97.92	11	1.63	1	0.15	0	0.00
Other hospital staff	670	99.41	2	0.30	0	0.00	0	0.00
Preceptor	70	98.59	0	0.00	0	0.00	0	0.00

I was unjustly criticized

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	544	80.71	122	18.10	7	1.04	1	0.15
Clinical Instructor	506	75.07	147	21.81	13	1.93	6	0.89
Classmate	600	89.02	72	10.68	1	0.15	0	0.00
Physician	657	97.48	12	1.78	5	0.74	0	0.00
Patient/Family member	625	92.73	43	6.38	5	0.74	1	0.15
Other hospital staff	637	94.51	33	4.90	4	0.59	0	0.00
Preceptor	61	85.92	8	11.27	1	1.41	1	1.41

Necessary information was withheld from me purposefully

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	624	92.58	43	6.38	6	0.89	1	0.15
Clinical Instructor	624	92.58	42	6.23	5	0.74	3	0.45
Classmate	638	94.66	30	4.45	4	0.59	1	0.15
Physician	666	98.81	8	1.19	0	0.00	0	0.00
Patient/Family member	651	96.59	20	2.97	1	0.15	0	0.00
Other hospital staff	662	98.22	10	1.48	2	0.30	0	0.00
Preceptor	67	94.37	4	5.63	0	0.00	0	0.00

Attempts were made to belittle or undermine my work

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	543	80.56	116	17.21	8	1.19	1	0.15
Clinical Instructor	545	80.86	104	15.43	14	2.08	4	0.59
Classmate	593	87.98	71	10.53	4	0.59	0	0.00
Physician	653	96.88	14	2.08	0	0.00	0	0.00
Patient/Family member	632	93.77	34	5.04	2	0.30	0	0.00
Other hospital staff	636	94.36	28	4.15	3	0.45	0	0.00
Preceptor	62	87.32	7	9.86	0	0.00	2	2.82

I was treated poorly on grounds of race

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	648	96.47	16	2.37	2	0.30	2	0.30
Clinical Instructor	647	95.99	16	2.37	3	0.45	2	0.30
Classmate	644	95.55	16	2.37	3	0.45	3	0.45
Physician	663	98.37	3	0.45	0	0.00	2	0.30
Patient/Family member	655	97.18	10	1.48	1	0.15	2	0.30
Other hospital staff	661	98.07	4	0.59	0	0.00	2	0.30
Preceptor	68	95.77	2	2.82	1	1.41	0	0.00

I was treated poorly on grounds of disability

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	664	98.52	3	0.45	0	0.00	0	0.00
Clinical Instructor	658	97.63	8	1.19	1	0.15	0	0.00
Classmate	660	97.92	7	1.04	0	0.00	0	0.00
Physician	666	98.81	1	0.15	0	0.00	0	0.00
Patient/Family member	666	98.81	2	0.30	0	0.00	0	0.00
Other hospital staff	667	98.96	1	0.15	0	0.00	0	0.00
Preceptor	70	98.59	1	1.41	0	0.00	0	0.00

I was treated poorly on grounds of gender

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	631	93.62	33	4.90	4	0.59	0	0.00
Clinical Instructor	637	94.51	27	4.04	1	0.15	1	0.15
Classmate	649	96.29	15	2.23	2	0.30	0	0.00
Physician	647	95.99	19	2.82	0	0.00	0	0.00
Patient/Family member	604	89.61	55	8.16	5	0.74	2	0.30
Other hospital staff	651	96.59	15	2.23	2	0.30	0	0.00
Preceptor	69	97.18	2	2.82	0	0.00	0	0.00

Expectations of my work were changed without me being told

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	585	86.80	73	10.83	10	1.48	1	0.16
Clinical Instructor	525	77.89	120	17.80	20	2.97	4	0.59
Classmate	648	96.14	17	2.52	2	0.30	1	0.15
Physician	658	97.63	7	1.04	2	0.30	1	0.15
Patient/Family member	650	96.44	15	2.23	2	0.30	1	0.15
Other hospital staff	647	95.99	18	2.67	4	0.59	0	0.00
Preceptor	62	87.32	8	11.27	0	0.00	1	1.41

Areas of responsibility were removed from me without warning

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	611	90.65	49	7.27	7	1.04	1	0.15
Clinical Instructor	608	90.21	53	7.86	6	0.89	2	0.30
Classmate	649	96.29	17	2.52	2	0.30	0	0.00
Physician	663	98.37	5	0.74	1	0.15	0	0.00
Patient/Family member	657	97.48	12	1.78	0	0.00	0	0.00
Other hospital staff	657	97.48	11	1.63	0	0.00	0	0.00
Preceptor	66	92.96	4	5.63	0	0.00	0	0.00

I was placed under undue pressure to produce work

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	535	79.38	106	15.73	23	3.41	3	0.45
Clinical Instructor	431	63.95	184	27.30	39	5.79	13	1.93
Classmate	613	90.95	48	7.12	3	0.45	1	0.15
Physician	637	94.51	24	3.56	4	0.59	1	0.15
Patient/Family member	615	91.25	43	6.38	9	1.34	1	0.15
Other hospital staff	622	92.28	37	5.49	5	0.74	3	0.45
Preceptor	56	78.87	12	16.90	1	1.41	2	2.82

I was physically abused

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	668	99.11	0	0.00	0	0.00	0	0.00
Clinical Instructor	662	98.22	5	0.74	1	0.15	0	0.00
Classmate	665	98.66	2	0.30	0	0.00	0	0.00
Physician	667	98.96	0	0.00	0	0.00	0	0.00
Patient/Family member	623	92.43	41	6.08	4	0.59	0	0.00
Other hospital staff	668	99.11	0	0.00	0	0.00	0	0.00
Preceptor	71	100.00	0	0.00	0	0.00	0	0.00

I was verbally abused

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	596	88.43	64	9.50	5	0.74	1	0.15
Clinical Instructor	577	85.61	76	11.28	10	1.48	3	0.45
Classmate	611	90.65	50	7.42	3	0.45	1	0.15
Physician	648	96.14	15	2.23	3	0.45	0	0.00
Patient/Family member	552	81.90	107	15.88	6	0.89	0	0.00
Other hospital staff	647	95.99	13	1.93	2	0.30	0	0.00
Preceptor	69	97.18	0	0.00	0	0.00	1	1.41

I was treated with hostility

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	510	75.67	134	19.88	19	2.82	2	0.30
Clinical Instructor	556	82.49	93	13.80	14	2.08	1	0.15
Classmate	597	88.58	61	9.05	7	1.04	2	0.30
Physician	637	94.51	28	4.15	1	0.15	1	0.15
Patient/Family member	543	80.56	113	16.77	8	1.19	2	0.30
Other hospital staff	606	89.91	47	6.97	11	1.63	1	0.15
Preceptor	63	88.73	6	8.45	1	1.41	1	1.41

Attempts were made to demoralize me

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	589	87.39	72	10.68	5	0.74	0	0.00
Clinical Instructor	590	87.54	62	9.20	11	1.63	2	0.30
Classmate	631	93.62	30	4.45	5	0.74	0	0.00
Physician	654	97.03	10	1.48	1	0.15	0	0.00
Patient/Family member	640	94.96	25	3.71	1	0.15	0	0.00
Other hospital staff	644	95.55	19	2.82	3	0.45	0	0.00
Preceptor	66	92.96	4	5.63	0	0.00	1	1.41

I was teased

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	571	84.72	90	13.35	4	0.59	2	0.30
Clinical Instructor	565	83.83	93	13.80	7	1.04	2	0.30
Classmate	516	76.56	132	19.58	17	2.52	2	0.30
Physician	646	95.85	18	2.67	2	0.30	1	0.15
Patient/Family member	607	90.06	58	8.61	1	0.15	1	0.15
Other hospital staff	630	93.47	35	5.19	1	0.15	1	0.15
Preceptor	59	83.10	10	14.08	0	0.00	1	1.41

I felt my efforts were undervalued

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	405	60.09	201	29.82	52	7.72	9	1.34
Clinical Instructor	392	58.16	223	33.09	44	6.53	7	1.04
Classmate	563	83.53	89	13.20	13	1.93	1	0.15
Physician	603	89.47	52	7.72	9	1.34	3	0.45
Patient/Family member	562	83.38	85	12.61	17	2.52	2	0.30
Other hospital staff	571	84.72	75	11.13	18	2.67	3	0.45
Preceptor	50	70.42	16	22.54	3	4.23	0	0.00

I was humiliated in front of others

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	573	85.01	86	12.76	5	0.74	2	0.30
Clinical Instructor	507	75.22	136	20.18	19	2.82	4	0.59
Classmate	604	89.61	59	8.75	4	0.59	0	0.00
Physician	646	95.85	17	2.52	3	30.45	0	0.00
Patient/Family member	634	94.07	31	4.60	1	0.15	0	0.00
Other hospital staff	640	94.96	25	3.71	1	0.15	0	0.00
Preceptor	61	85.92	6	8.45	0	0.00	2	2.82

I experienced resentment towards me

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	538	79.82	106	15.73	19	2.82	4	0.59
Clinical Instructor	574	85.16	76	11.28	16	2.37	1	0.15
Classmate	583	86.50	66	9.79	11	1.63	4	0.59
Physician	647	95.99	19	2.82	0	0.00	0	0.00
Patient/Family member	612	90.80	50	7.42	4	0.59	0	0.00
Other hospital staff	619	91.84	38	5.64	8	1.19	1	0.15
Preceptor	63	88.73	5	7.04	0	0.00	2	2.82

I experienced destructive criticism

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	550	81.60	99	14.69	12	1.78	4	0.59
Clinical Instructor	493	73.15	143	21.22	20	2.97	8	1.19
Classmate	625	92.73	34	5.04	6	0.89	1	0.15
Physician	650	96.44	13	1.93	3	0.45	0	0.00
Patient/Family member	636	94.36	28	4.15	2	0.30	0	0.00
Other hospital staff	644	95.55	19	2.82	4	0.59	0	0.00
Preceptor	62	87.32	6	8.45	0	0.00	2	2.82

I was frozen out/ignored/excluded

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	486	72.11	154	22.85	28	4.15	6	0.89
Clinical Instructor	551	81.75	104	15.43	16	2.37	2	0.30
Classmate	562	83.38	95	14.09	11	1.63	4	0.59
Physician	614	91.10	43	6.38	11	1.63	6	0.89
Patient/Family member	624	92.58	48	7.12	1	0.15	1	0.15
Other hospital staff	616	91.39	46	6.82	10	1.48	2	0.30
Preceptor	61	85.92	8	11.27	0	0.00	1	1.41

I was told negative remarks about becoming a nurse

	Never		Occasionally		Frequently		All the time	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Staff nurse	473	70.18	135	20.03	57	8.46	8	1.19
Clinical Instructor	568	84.27	85	12.61	16	2.37	5	0.74
Classmate	583	86.50	79	11.72	8	1.19	2	0.30
Physician	632	93.77	32	4.75	5	0.74	2	0.30
Patient/Family member	599	88.87	62	9.20	6	0.89	2	0.30
Other hospital staff	590	87.54	65	9.64	14	2.08	3	0.45
Preceptor	62	87.32	4	5.63	1	1.41	2	2.82

APPENDIX H

Table 8

Individual Bullying Behaviours Experienced According to Source

I had threats of physical violence made against me

Source	N=674	Percentage (%)
Staff nurse	1	0.15
Clinical Instructor	5	0.74
Classmate	24	3.56
Physician	4	0.59
Patient/Family member	87	12.91
Other hospital staff	3	0.45
Preceptor	0	0.00

I was intimidated with disciplinary measures

Source	N=674	Percentage (%)
Staff nurse	79	11.72
Clinical Instructor	166	24.63
Classmate	24	3.56
Physician	27	4.01
Patient/Family member	47	6.97
Other hospital staff	36	5.34
Preceptor	4	5.63

I was threatened with a poor evaluation

Source	N=674	Percentage (%)
Staff nurse	25	3.71
Clinical Instructor	143	21.22
Classmate	14	2.08
Physician	1	0.15
Patient/Family member	12	1.78
Other hospital staff	8	1.19
Preceptor	6	8.45

I felt impossible expectations were set for me

Source	N=674	Percentage (%)
Staff nurse	134	19.88
Clinical Instructor	227	33.68
Classmate	27	4.01
Physician	30	4.45
Patient/Family member	79	11.72
Other hospital staff	52	7.72
Preceptor	15	21.13

Inappropriate jokes were made about me

Source	N=674	Percentage (%)
Staff nurse	52	7.72
Clinical Instructor	57	8.46
Classmate	102	15.13
Physician	15	2.23
Patient/Family member	51	7.57
Other hospital staff	22	3.26
Preceptor	4	5.63

Malicious rumours/allegations were spread about or against me

Source	N=674	Percentage (%)
Staff nurse	18	2.67
Clinical Instructor	23	3.41
Classmate	55	8.16
Physician	2	0.30
Patient/Family member	12	1.78
Other hospital staff	2	0.30
Preceptor	0	0.00

I was unjustly criticized

Source	N=674	Percentage (%)
Staff nurse	130	19.29
Clinical Instructor	166	24.63
Classmate	73	10.83
Physician	17	2.52
Patient/Family member	49	7.27
Other hospital staff	37	5.49
Preceptor	10	14.08

Necessary information was withheld from me purposefully

Source	N=674	Percentage (%)
Staff nurse	50	7.42
Clinical Instructor	50	7.42
Classmate	35	5.19
Physician	8	1.19
Patient/Family member	21	3.12
Other hospital staff	12	1.78
Preceptor	4	5.63

Attempts were made to belittle or undermine my work

Source	N=674	Percentage (%)
Staff nurse	125	18.55
Clinical Instructor	122	18.10
Classmate	75	11.13
Physician	14	2.08
Patient/Family member	36	5.34
Other hospital staff	31	4.60
Preceptor	9	12.68

I was treated poorly on grounds of race

Source	N=674	Percentage (%)
Staff nurse	20	2.97
Clinical Instructor	21	3.12
Classmate	22	3.26
Physician	5	0.74
Patient/Family member	13	1.93
Other hospital staff	6	0.89
Preceptor	3	4.23

I was treated poorly on grounds of disability

Source	N=674	Percentage (%)
Staff nurse	3	0.45
Clinical Instructor	9	1.34
Classmate	7	1.04
Physician	1	0.15
Patient/Family member	2	0.30
Other hospital staff	1	0.15
Preceptor	1	1.41

I was treated poorly on grounds of gender

Source	N=674	Percentage (%)
Staff nurse	37	5.49
Clinical Instructor	29	4.30
Classmate	17	2.52
Physician	19	2.82
Patient/Family member	62	9.20
Other hospital staff	17	2.52
Preceptor	2	2.82

Expectations of my work were changed without me being told

Source	N=674	Percentage (%)
Staff nurse	84	12.46
Clinical Instructor	144	21.36
Classmate	20	2.97
Physician	10	1.48
Patient/Family member	18	2.67
Other hospital staff	22	3.26
Preceptor	9	12.68

Areas of responsibility were removed from me without warning

Source	N=674	Percentage (%)
Staff nurse	57	8.46
Clinical Instructor	61	9.05
Classmate	19	2.82
Physician	6	0.89
Patient/Family member	12	1.78
Other hospital staff	11	1.63
Preceptor	4	5.63

I was placed under undue pressure to produce work

Source	N=674	Percentage (%)
Staff nurse	132	19.58
Clinical Instructor	236	35.01
Classmate	52	7.72
Physician	29	4.30
Patient/Family member	53	7.86
Other hospital staff	45	6.68
Preceptor	15	21.13

I was physically abused

Source	N=674	Percentage (%)
Staff nurse	0	0.00
Clinical Instructor	6	0.89
Classmate	2	0.30
Physician	0	0.00
Patient/Family member	45	6.68
Other hospital staff	0	0.00
Preceptor	0	0.00

I was verbally abused

Source	N=674	Percentage (%)
Staff nurse	70	10.39
Clinical Instructor	89	13.20
Classmate	54	8.01
Physician	18	2.67
Patient/Family member	113	16.77
Other hospital staff	15	2.23
Preceptor	1	1.41

I was treated with hostility

Source	N=674	Percentage (%)
Staff nurse	155	23.00
Clinical Instructor	108	16.02
Classmate	70	10.39
Physician	30	4.45
Patient/Family member	123	18.25
Other hospital staff	59	8.75
Preceptor	8	11.27

Attempts were made to demoralize me

Source	N=674	Percentage (%)
Staff nurse	77	11.42
Clinical Instructor	75	11.13
Classmate	35	5.19
Physician	11	1.63
Patient/Family member	26	3.86
Other hospital staff	22	3.26
Preceptor	5	7.04

I was teased

Source	N=674	Percentage (%)
Staff nurse	96	14.24
Clinical Instructor	102	15.13
Classmate	151	22.40
Physician	21	3.12
Patient/Family member	60	8.90
Other hospital staff	37	5.49
Preceptor	11	15.49%

I felt my efforts were undervalued

Source	N=674	Percentage (%)
Staff nurse	262	38.87
Clinical Instructor	274	40.65
Classmate	103	15.28
Physician	64	9.50
Patient/Family member	104	15.43
Other hospital staff	96	14.24
Preceptor	19	26.76

I was humiliated in front of others

Source	N=674	Percentage (%)
Staff nurse	93	13.80
Clinical Instructor	159	23.59
Classmate	63	9.35
Physician	20	2.97
Patient/Family member	32	4.75
Other hospital staff	26	3.86
Preceptor	8	11.27

I experienced resentment towards me

Source	N=674	Percentage (%)
Staff nurse	129	19.14
Clinical Instructor	93	13.80
Classmate	81	12.02
Physician	19	2.82
Patient/Family member	54	8.01
Other hospital staff	47	6.97
Preceptor	7	9.86

I experienced destructive criticism

Source	N=674	Percentage (%)
Staff nurse	115	17.06
Clinical Instructor	171	25.37
Classmate	41	6.08
Physician	16	2.37
Patient/Family member	30	4.45
Other hospital staff	23	3.41
Preceptor	8	11.27

I was frozen out/ignored/excluded

Source	N=674	Percentage (%)
Staff nurse	188	27.89
Clinical Instructor	122	18.10
Classmate	110	16.32
Physician	60	8.90
Patient/Family member	50	7.42
Other hospital staff	58	8.61
Preceptor	9	12.68

I was told negative remarks about becoming a nurse

Source	N=674	Percentage (%)
Staff nurse	200	29.67
Clinical Instructor	106	15.73
Classmate	89	13.20
Physician	39	5.79
Patient/Family member	70	10.39
Other hospital staff	82	12.17
Preceptor	7	9.86

VITA AUCTORIS

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