Nursing students' perceptions of bullying behaviours by classmates

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The purpose of this non-experimental descriptive study was to explore types, sources, and frequency of bullying behaviours that nursing students experience while in nursing school. The study also evaluated resources utilised by nursing students to cope with these bullying behaviours. Six hundred thirty-six participants completed the investigator-developed Bullying in Nursing Education Questionnaire (BNEQ). All respondents reported at least one encounter with bullying behaviour. Fifty-six percent reported that the most frequent source of bullying behaviours was School of Nursing (SON) Classmates. Cursing and swearing, inappropriate behaviours, and belittling or humiliating behaviours by classmates were the most frequently reported bullying behaviours. The most frequently reported behaviour used in response to bullying was "Did Nothing." This study provides evidence that bullying by classmates occurs frequently and that strategies to address the problem in schools of nursing are warranted. Recommendations to address bullying include adoption of "Zero Tolerance" policies and education and training for students, faculty, and health care agencies employees.

Introduction

The current shortage of nurses to care for the population and the effect of that shortage on the health care delivery system has received significant attention over recent years. Hassmiller and Cozine (2006) reported that the current shortage is different from other shortages and requires a more complex solution than previously suggested. The authors noted that the current shortage is really a recruitment and retention problem due to unhealthy work environments.

Heath, Johanson, and Blake (2004) cited that unhealthy work environments exist that include day-to-day violence and hostility. Part of this violence and hostility in the workplace is a result of bullying, and the victimisation of nurses. Numerous studies have described the negative impact of bullying on the workplace and the profession of nursing (Jackson, Clare, & Mannix, 2002; Lewis, 2002; McKenna, Smith, Poole, & Coverdale, 2003; Quine, 2001; Randle, 2003; Rayner, 1997). However, there has been little research into bullying in nursing education.

Since education precedes practice, nurse educators need to know if bullying exists in nursing education. Additionally, if bullying does exist, nurse educators need to know the type, source, and frequency of these behaviours and explore effective mechanisms to discourage this form of violence.

This study was conducted to describe: (a) the types, sources, and frequency of bullying behaviours, (b) behaviours used by nursing students to cope with bullying, and (c)

resources provided by nursing programs to cope with bullying encountered in nursing education. This study was guided by four questions.

1. What are the types and frequency of bullying behaviours in nursing education reported by nursing students?
2. What is the source and frequency of bullying behaviours in nursing education reported by nursing students?
3. What behaviours do nursing students report using to cope with bullying in nursing education?
4. What types of resources do nursing students report are provided by nursing programs to cope with bullying?

Conceptual framework

The conceptual framework for this study was derived from the research literature describing power, power imbalances, bullying, and Kanter's Theory of Organisational Empowerment. In particular, Kanter's theory components of opportunity, structure of power, access to resources, and support were used to guide the research questions and instrument development. These components were also utilised to conceptually define bullying as aggressive or negative acts or behaviours that were carried out repeatedly over time. These bullying behaviours were further defined as those directed toward individuals who find it difficult to defend themselves because of a perceived imbalance of power. Behaving badly, behaving in a rude manner, or isolated one-time incidents of negative acts or behaviours were not included in this definition of bullying (Einarsen, Raknes, Matthiesen, & Hellesoy, 1994; Gillen, Sinclair, & Kernohan, 2004; Hoel, Cooper, & Faragher, 2001; Olweus, 2003).

The concepts of power and power imbalances prevail in the literature regarding bullying (Baltimore, 2006; Baumann & Del Rio, 2006; Chappell, Casey, De la Cruz, Ferrell, Forman & Lipkin, 2004; Gillen, Sinclair, & Kernohan, 2004; Lewis, 2002; Quine, 2001; Randle, 2003; Rayner & Hoel, 1997; Smith, 1994; Smith, Cowie, Olafasson, & Liefooghe, 2002). Kuokkanen and Leino-Kilpi (2000) reported power in nursing has more frequently been associated with restricted freedom and the domination of authoritative leadership. They noted that the bureaucratic and hierarchical structure of most healthcare organisations obscures and buries power, leaving nurses feeling powerless. The authors also proposed the use of Kanter's theory to provide a "fundamental model of job-related empowerment" (p. 238). Using Kanter's theory, power remains dynamic, is taken over, given away and provides "well-being at both the individual and organisational level" (p. 240). Laschinger and Finegan (2005) also noted "Kanter's notion of creating conditions of work effectiveness through the establishment of empowering work structures" (p. 6) as a logical base of facilitating professional nursing practice and increasing recruitment and retention of nurses. Therefore, Kanter's theory serves as an appropriate theoretical underpinning for the current study.

Kanter's (1993) theory of organisational empowerment is built upon a framework of empowering structures. Kanter (1977) asserted power is not control over others, but rather, "the ability to get things done" (p. 166). Formal power structures originate from the significance of one's role to an organisation's processes. Informal power structures are a result of individual networks one forms with sponsors, peers, and subordinates within and outside of an organisation (Kanter, 1993). Sui, Lashinger, and Vingilis (2005) proposed providing learning environments that were built on empowerment structures, such as those noted in Kanter's theory, that would provide "support for individualist professional growth" (p. 466). Kanter (1977) also asserted that power allows a person to be committed to and accountable for their own actions. He further purposed that these empowering structures lead to psychological empowerment and serve as a mediator between structural empowerment and positive work behaviours and attitudes (Kanter, 1993).

As part of the structural empowerment theory, Kanter (1977; 1993) believed systemic sources of formal and informal power determined access to empowerment structures. This access leads to individual commitment and effectiveness. Those without access to empowerment structures can perceive themselves as powerless, become more rules-minded, and less committed. These concepts of Kanter's theory provide a solid base for nurse educators to empower and socialise nursing students into professional nursing practice.

Literature review

The literature pertinent to this study includes an overview of research studies on bullying, nursing practice and nursing education, and power. The literature review is presented in three sections that include the definition of bullying from the adult workplace perspective, bullying in nursing practice and nursing education, and a review of the literature on power and nursing.

Definition of adult workplace bullying

In one of the earliest accounts of workplace bullying, Adams (1992) reported that bullying behaviours were an integral part of employee abuse that included harassment, incivility, horizontal violence, interpersonal conflict, interpersonal deviance, mobbing, social undermining, victimisation, workplace abuse, workplace aggression, workplace incivility, and workplace violence. Numerous authors agreed with Adam's assessment of bullying (Gillen, Sinclair, & Kernohan, 2004; Lieper, 2005; McKenna, Smith, Poole, & Coverdale, 2003; Namie & Namie, 2000; Salin, 2003; Sweet, 2005).

Adams (1992) further described bullying as persistent, demeaning, and downgrading acts. The bully's actions include repetitive use of vicious words and cruel acts that gradually undermine the victim's confidence and self-esteem. Additionally, Smith (1997) also described the repetitive nature of bullying "as the systemic abuse of power - persistent and repeated actions . . . of direct and indirect aggressive behaviour" (p. 249). Numerous researchers have established that bullying is a widespread workplace problem that

contributes to a hostile environment (Jackson, Clare, & Mannix, 2002; Lewis, 2002; McKenna, Smith, Poole, & Coverdale, 2003; Quine, 2001; Randle, 2003; Rayner, 1997). Violent acts range from teasing to terrorism, or from sending offensive messages to the extreme form of shootings or bombings. Bullying is just one of the many ways workplace violence and negative workplace behaviours manifest themselves. These behaviours are also manifested in nursing practice and nursing education environments as well.

Bullying in nursing practice and nursing education

According to the American Hospital Association (AHA) (2002), worker safety and security are at the heart of developing successful work relationships and maintaining a viable health care workforce. Jackson, Clare, and Mannix (2002) citied workplace violence as a major obstacle in the recruitment and retention for nurses. Bullying in nursing was identified as a work-based stressor that negatively affected not only the nurse, but also patient care the nurse provided.

In a three-year study conducted in the United Kingdom on nursing students' self-esteem, Randle (2003) discovered bullying was a common theme identified in students' reports and reported bullying was a routine experience in the process of becoming a nurse. Not only were students bullied, but students reported patients were frequently bullied by practicing nurses. Randle concluded that the way a student nurse was treated during training shaped a student's process of becoming a nurse. As Randle pointed out, "learning from a role model is not always beneficial" (p. 400), especially when the students perceive and socialise into a nursing culture that accepts bullying as a routine practice.

Celik and Bayraktar (2004) also studied the incidence of verbal, physical, sexual, and academic abuse experienced by nursing students in Turkey. Verbal abuse was the most frequently reported type of abuse, followed in order by academic, sexual, and physical abuse. All participants reported being yelled at, being behaved toward in an inappropriate, nasty, rude, or hostile way, and being belittled or humiliated. All participants identified their classmates as a primary source of verbal abuse, followed by faculty as the second frequent source. The effects of this abuse were anger, guilt, shame, helplessness, depression, and thoughts of leaving the nursing profession.

Davey (2002) also reported that the process of nursing education often made students feel like they were being "thrown to the wolves" (p. 193). This "sink or swim" approach creates a sense of vulnerability that quickly squelches any enthusiasm the student might have for nursing. Many students complain of being stripped of their dignity and pride, and they feel invisible and inferior. The students also experienced hostility, disrespect, and unfriendliness from peers and faculty alike during the educational process. Davey termed it ironic that members of a caring profession would treat novice students as if they were inferior thereby creating heightened vulnerability. It is perhaps this sense of vulnerability that squelches students' sense of personal power and enables bullying to occur (Davey, 2002).

Power and nursing

The concepts of power and power imbalance prevail in the literature regarding bullying (Smith, 1994; Rayner, & Hoel, 1997; Lewis, 2002; Quine, 2001; Smith, Cowie, Olafasson, & Liefooghe, 2002; Randle, 2003; Chappell et al., 2004; Gillen, Sinclair, & Kernohan, 2004; Baltimore, 2006; Bauman & Del Rio, 2006). While Kuokkanen & Leino-Kilpi (2000) reported power has been associated with restricted freedom and the domination of authoritative leadership, they surmised that this leads to a lack of trust and respect in organisational environments. This lack of trust and respect is the foundation for a culture of violence that fuels the perception of powerlessness by nurses.

Jackson, Clare, and Mannix (2002) contended nurses "participate in the culture of oppression and violence, and allow bullying to occur" (p. 16). Lewis (2006) also noted that the history of nursing, in its hierarchical structure and formality of rules, could contribute to nurses' sense of powerlessness therefore creating opportunity for bullying. Numerous authors (Daiski, 2004; Farrell, 2001; Jackson, Clare, & Mannix, 2002; Stevenson, Randle, & Grayling, 2006) concurred that the disenfranchising work practices and abdication of power by nurses' create an environment for bullying to occur.

In addition, Jackson, Clare, and Mannix (2002), reported that short staffing, increased workloads, and unrealistic expectations made nurses vulnerable to violent outbursts. The competitive nature of healthcare, concern for consumer support, and pressure of organisational changes add to the pressures of the job for nurses (Lewis, 2002). Farrell (1997) also cited that the organisational framework, where nursing care is conducted within strict task / time structures, contributes to nurse-to-nurse conflicts. Even nursing student accounts of the job itself reflect the stress that results from conflicting demands, feeling overworked, unprepared, and powerless (Magnussen & Amundson, 2003). This powerlessness extends to nurses' ability to intervene, stop, or confront violent behaviours in the workplace.

Sofield and Salmond's (2003), conducted a study that included nurses' perceived ability to manage verbally abusive situations. In the study, 56% of the respondents reported they felt unable to handle hostile situations and citied the main problem as the acceptance of the verbal abuse in nursing. The participants cited decreased morale, decreased productivity, ineffective nursing care delivery, increased errors, and the likelihood to leave their job as the outcome of verbal abuse. Sixty-seven percent of the study respondents maintained that verbal abuse significantly contributed to the nursing shortage.

The literature substantiates bullying in nursing as a significant issue both nationally and internationally. Because little is known about bullying in nursing education, this study seeks to provide evidence that bullying does indeed exist during the nursing education process.

Method

This descriptive study used a questionnaire survey design to assess bullying behaviours in nursing education from the nursing students' perspective. This was a cross-sectional survey, with data collected from the sample to describe bullying in nursing education from the student nurse perspective at one point in time.

Target population

This study's target population was associate and baccalaureate degree seeking nursing students in their final year of nursing school in one southern state in the United States. Sixteen (16) associate degree schools at 19 locations and 7 baccalaureate schools at 9 locations agreed to participate in the study. A total of 1133 students from 28 sites at 20 schools of nursing in the state were invited to participate in this study. Six hundred and sixty-five students participated in the study for a response rate of 64.1%. Respondents were predominately Caucasian (68.12%) female (73.38%), and ranged in age from 18 to 24 (40.15%). The majority (56.24%) classified their average grades as "B."

Instrumentation

While two questionnaires related to similar variables in this study were found, neither provided a structure to facilitate data collection or analysis measuring bullying. Therefore, an investigator-modified questionnaire, the Bullying in Nursing Education Questionnaire (BNEQ) (Appendix A), was developed to examine bullying in nursing education from the students' perspective.

The BNEQ was extracted from a study by Celik and Bayraktar (2004) and is a modified version of their unnamed nursing student abuse questionnaire. Permission to use and modify this questionnaire was obtained from the authors. Additional items were extracted from the Negative Acts Questionnaire (NAQ), developed by Einarsen, Raknes, Mattiesen, and Hellesøy (1994). Permission to use and modify both questionnaires was obtained from the authors.

Celik and Bayraktar's (2004) instrument is a 10-page survey based on literature pertaining to abuse in nursing. It contains 36 items that collect demographic data and data on verbal, physical, sexual, and academic abuse from the nursing student's perspective. Celik and Bayraktar did not report psychometric properties for their survey. While Celik and Bayraktar's (2004) questionnaire examined abuse in nursing education, abuse and bullying share common behaviours. The distinction made between the two is that abusive behaviours may only occur one time, while bullying occurs repeatedly over time.

Einarsen, Raknes, Mattiesen, and Hellesøy's (1994) Negative Acts Questionnaire (NAQ) is a 31-item inventory that measures frequency, intensity, and prevalence of workplace bullying. They reported a Cronbach's alpha ranging from .87 to .93 for the NAQ. The Bergen Bullying Research Group (2006) affirmed the NAQ has been used worldwide in over 30 studies with nearly 20,000 respondents.

Bullying in nursing education questionnaire

The BNEQ (Appendix A) is a one-page, self-administered Likert scale questionnaire. The first 12 items address the frequency and sources of bullying behaviours described in the literature. Respondents were instructed to mark the frequency category and source category that best described their encounters during the past year in classroom or clinic course work. In section B of the BNEQ, item 13 addresses behaviours used to cope with bullying behaviours as described in the literature. The 11 coping behaviour responses were (a) did nothing, (b) put up barriers, (c) pretended not to see the behaviour, (d) reported the behaviour to a superior / authority, (e) went to a doctor, (f) perceived the behaviour as a joke, (g) demonstrated similar behaviour, (h) shouted or snapped at the bully, (i) warned the bully not to do it again, (j) spoke directly to the bully, and (k) increased my use of unhealthy coping behaviours (smoking, overeating, increased alcohol consumption). Respondents were instructed to indicate all that were applicable to their encounters.

Section C of the BNEQ included item 14 and item 15, designed to address the students' perception of resources provided by nursing schools to cope with bullying. The final section addressed student demographics and characteristics.

An initial draft of the modified BNEQ was developed and reviewed by two advisory panels. Corrections and adjustments to the BNEQ were made based on the advisory panels' observations and comments. The revised BNEQ was then presented to a group of nursing students, who would not be included in the major study, to identify problems with the questionnaire and to establish how long it would take to complete it. No items were deleted or added to the BNEQ as a result of this pre-testing.

Procedure

Permission to conduct human studies was obtained from the Institutional Review Board (IRB). Permission was obtained from the deans and or the directors to conduct the study at their respective schools. Recommendations for study facilitators at each school were received.

Survey packages were forwarded by mail to the study facilitators at each school. The packages included the appropriate number of copies of the BNEQ, two copies of study narratives detailing the research for each potential participant, one legal sized envelope for each potential participant, the appropriate number of pre-paid mailing envelopes with labels for return of completed questionnaires, and administration instructions. Participation in this study was voluntary and results were made available to participants at the conclusion of the study. Participants were advised of their right to refuse to respond to any survey item. No identifiers were connected to any of the survey tools to safeguard confidentiality and anonymity.

Data description

The data was compiled using the *Statistical Package for the Social Sciences* (SPSS), Version 13.1. The data was used to address the four research questions and reported by frequencies and percentages. Table 1 shows the 12 types of bullying behaviours listed on the BNEQ and the frequency respondents indicated they encountered them in classroom or clinical course work during the past year.

Table 1: Bullying behaviours by frequencies

	Bullying behaviours	Frequency categories (N=665) Never %	Seldom / Intermittent %	Frequent / Always %
1.	Yelling or shouting in rage	66.5%	27.8%	3.2%
2.	Inappropriate, nasty, rude or hostile behaviour	55.8%	36.2%	4.8%
3.	Belittling or humiliating behaviour	63.2%	28.9%	3.8%
4.	Spreading of malicious rumours or gossip	73%	17.7%	4.2%
5.	Cursing or swearing	53.9%	32.2%	9.0%
6.	Negative or disparaging remarks about becoming a nurse	74.9%	16.8%	3.0%
7.	Assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes	84.2%	2.6%	1.4%
8.	A bad grade given as a punishment	88.2%	1.4%	0.7%
9.	Hostility after or failure to acknowledge significant clinical, research, or academic accomplishment	80.5%	11.2%	1.4%
10.	Actual / threats of physical or verbal acts of aggression	85.3%	6.9%	0.5%
11.	Being ignored or physically isolated	73.4%	17.2%	5.2%
12.	Unmanageable workloads or unrealistic deadlines	72.2%	15.5%	5.4%

Research Question 1 asked, what are the types and frequencies of bullying behaviours in nursing education reported by nursing students? A total of 636 respondents (95.6%) indicated they had encountered at least 1 of the 12 behaviours listed on the BNEQ at various frequencies during the past year. The results of the study indicated the most frequent types of behaviours experienced were cursing, swearing, inappropriate, nasty, rude or hostile behaviours, and belittling or humiliating behaviour.

Research Question 2 asked: What are the sources and frequency of bullying behaviours in nursing education reported by nursing students? The respondents indicated all source categories listed on the BNEQ were a source of one or more of the bullying behaviours, albeit at varying degrees. The most frequently reported sources of behaviour 2, inappropriate, nasty, rude or hostile behaviour, were SON Classmates (56.4%). Overall, SON Classmates were reported as the most frequent source for bullying in 6 out of the 12 behaviours.

Table 2: Coping behaviours

Behaviours used to cope with bullying in nursing education (N=665)	Frequency N	%	Ranking
Did nothing	232	34.9	1
Put up barriers	153	23.0	2
Spoke directly to the bully	138	20.8	3
Pretending not to see the behavior	99	14.9	4
Reported the behavior to a superior / authority	98	14.7	5
Increased my use of unhealthy coping behavior	60	9.0	6
Warned the bully not to do it again	44	6.6	7
Shouted or snapped at the bully	39	5.9	8
Demonstrated similar behavior	21	3.2	9
Went to a doctor	9	1.4	10
Perceived the behaviour as a joke	4	0.6	11

Item 13 on the BNEQ was designed to address research question 3: What behaviours do nursing students report using to cope with bullying in nursing education? Eleven possible behaviours were listed on the BNEQ. Table 2 shows the responses to Item 13. "Did Nothing," "Put up barriers," and "Pretending not to see the behaviour" accounted for over 72% of the responses, emphasising the need to provide training for coping with bullying in nursing education.

Table 3: Resources for coping with bullying

Resource - Does your school of nursing have:	Frequency (N=665) Yes	No	I do not know	No response
Education programs / pamphlets on coping with bullying behaviours	5.1%	8.4%	11.6%	74.9%
A designated person to assist with coping with bullying behaviors	9.2%	5.1%	9.3%	76.5%
Support groups for coping with bullying behaviors	3.5%	7.5%	11.6%	77.4%
Encouragement or suggestions for coping with bullying behaviors	7.1%	5.1%	9.5%	78.3%

Items 14 and 15 were designed to address research question 4: What types of resources do nursing students report are provided by nursing programs to cope with bullying? The majority (56.1%) of respondents answered "I Do Not Know" to the question: Does your school of nursing have a formal policy / procedure concerning bullying?

Discussion

The findings represent empirical evidence of the types, frequency, and sources of bullying behaviours experienced by students in nursing schools. The study found that nursing students encountered all 12 bullying behaviours listed on the BNEQ at varying

frequencies. SON Classmates were cited most frequently as a source of bullying behaviours. The results of the study indicate the three most frequently encountered behaviours were "Cursing and swearing", "Inappropriate, nasty, rude, or hostile behaviours", and "Belittling or humiliating behaviour".

These results are consistent with the research findings of Celik and Bayraktar (2004), where the authors found incidence of verbal, physical, sexual, and academic abuse experienced by nursing students in Turkey. Verbal abuse was the most frequently reported type of abuse with all participants reporting being yelled at, being behaved toward in an inappropriate, nasty, rude, or hostile way, and being belittled or humiliated. Participants in the Turkish study also identified classmates as the primary source of verbal abuse.

The results of the current study are also supported by Sofield and Salmond's (2003) study where 56% of the respondents reported being unable to handle hostile situations. In the current study, seventy two percent of the respondents indicated avoidance behaviours when bullied such as "Did Nothing," "Put up barriers," and "Pretended not to see the behaviour". This clearly indicates that nursing students have ineffective means of coping with violent behaviours that are a threat to personal status and professional development. These ineffective patterns of coping begin to emerge early in the educational process and occur in the nursing classroom. These avoidance behaviours may well carry over into the practice setting as noted by the Sofield and Salmond study. If there are no or limited means in nursing education to squelch violent behaviours, then these behaviours can be learned and transferred easily into the practice setting. While it can be argued that these behaviours exist for a number of reasons, bullying remains a threat to students' personal status and professional development.

The evidence is clear; bullying "poisons" the workplace. Since education precedes practice, it is important to explore bullying behaviours in nursing education.

The results of the study indicate a critical need in nursing and nursing education for a better understanding of bullying behaviours. Increasing support to nursing students to cope with and address bullying behaviours may result in enhanced student well-being, as well as reduce their propensity to leave the profession (Celik & Bayraktar, 2004). While the types, frequencies, and sources of bullying vary, the presence of these behaviours at any level is problematic and requires the development of supportive interventions and additional research.

Recommendations

Strategies to increase nursing student awareness of this problem and its potential consequences are indicated. These strategies include the development of written policies and a clear statement of a "Zero Tolerance" approach to any inappropriate behaviours, including bullying, in nursing schools. Within the formal structures, it is also recommended that schools identify a single resource available to students for coping with bullying. Studies showed that nurses didn't report bullying in the workplace, because they

didn't believe that anyone would listen to their seemingly minor negative incidents (Farrell, 2001). A well publicised, active, and supportive resource center would serve to decrease the incidence of bullying in the classroom. It is also further recommended that schools develop student orientation programs, seminars, and clinical conference sessions for the inclusion of formal and informal training on bullying.

Additional strategies to increase nursing school faculty awareness of the problem and the negative consequences that result are also warranted. Faculty development programs should include training to raise awareness of and increase sensitivity to bullying, along with resolutions to the problem in nursing education.

Refinement of the BNEQ is also recommended to capture more data and provide qualitative information that can explore relationships and contribute to the understanding of bullying. Certainly the "do nothing" coping behaviour students reported using warrants further investigation. The development and administration of a faculty questionnaire regarding bullying would also be useful in comparing faculty and student perceptions regarding this phenomenon.

Convincing data presented from this study indicates the study of bullying in nursing education should be ongoing. While this study was descriptive, additional research on bullying in nursing education should provide a more in-depth exploration of the phenomena and test relationships. Also, qualitative studies are warranted. Expanding the study sample to include nursing students at all levels (i.e., first through final semester of nursing school) would provide an additional perspective to the presence of bullying in nursing education. A longitudinal follow-up with the participants in this study would be helpful in tracking long-term outcomes of bullying in nursing education.

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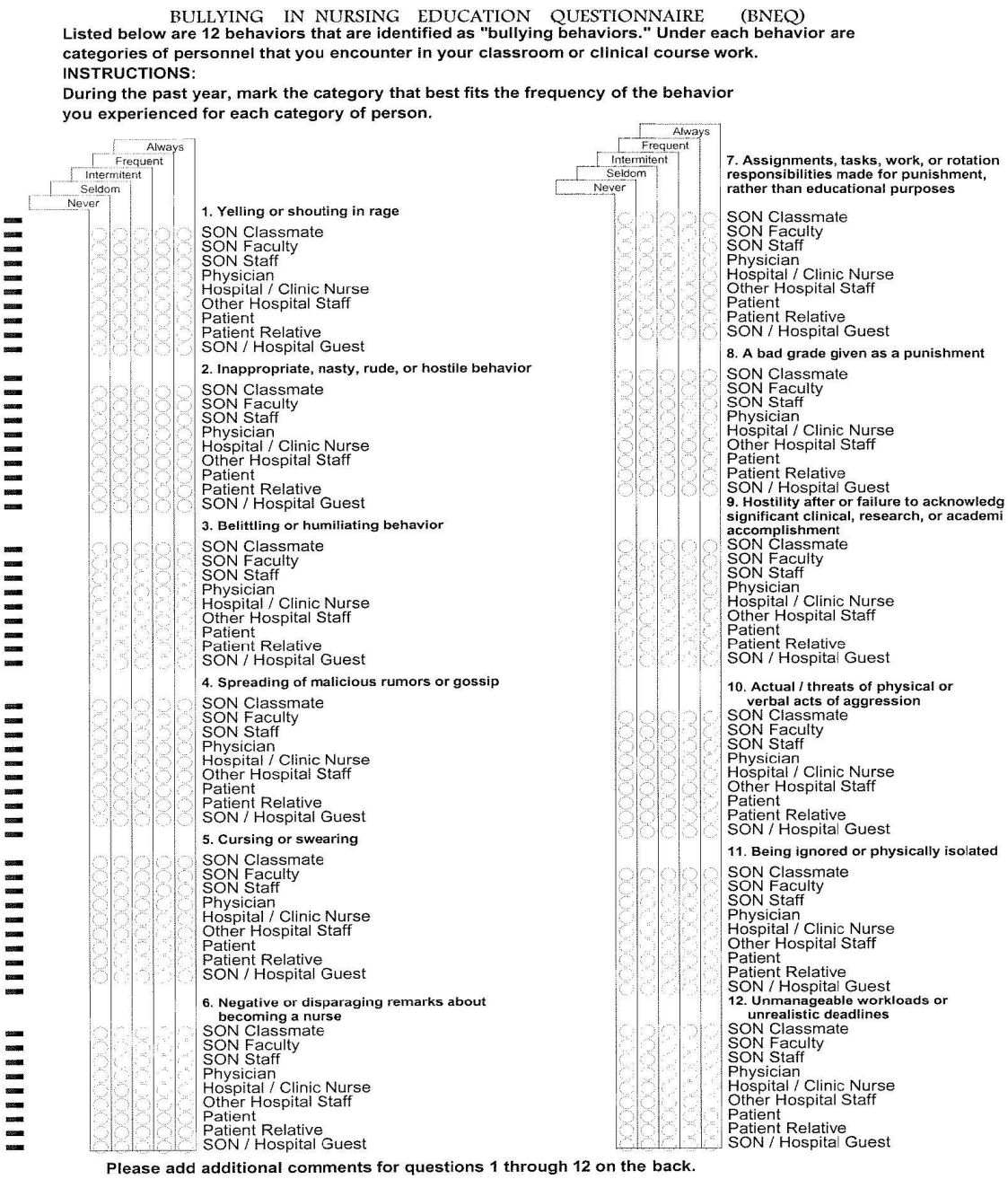
Appendix A


BULLYING IN NURSING EDUCATION QUESTIONNAIRE (BNEQ)
Listed below are 12 behaviors that are identified as "bullying behaviors." Under each behavior are categories of personnel that you encounter in your classroom or clinical course work.
INSTRUCTIONS:
During the past year, mark the category that best fits the frequency of the behavior you experienced for each category of person.
Always
Frequent
Intermitent
Seldom
Never
1. Yelling or shouting in rage
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
2. Inappropriate, nasty, rude, or hostile behavior
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
3. Belittling or humiliating behavior
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
4. Spreading of malicious rumors or gossip
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
5. Cursing or swearing
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
6. Negative or disparaging remarks about becoming a nurse
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
Always
Frequent
Intermitent
Seldom
Never
7. Assignments, tasks, work, or rotation responsibilities made for punishment, rather than educational purposes
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
8. A bad grade given as a punishment
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
9. Hostility after or failure to acknowledg significant clinical, research, or academi accomplishment
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
10. Actual / threats of physical or verbal acts of aggression
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
11. Being ignored or physically isolated
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
12. Unmanageable workloads or unrealistic deadlines
SON Classmate
SON Faculty
SON Staff
Physician
Hospital / Clinic Nurse
Other Hospital Staff
Patient
Patient Relative
SON / Hospital Guest
Please add additional comments for questions 1 through 12 on the back.

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