

Cognitive Rehearsal Training for Upskilling Undergraduate Nursing Students Against Bullying: A Qualitative Pilot Study

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Cover Page Footnote

Thank-you to Dr. Nicola Waters for her wise and thorough editing.

Introduction

Violence in many forms is accepted as a reality within the profession of nursing, the consequences of which include decreased job satisfaction, increased sick time, and attrition of nurses from the profession (Magnavita & Heponiemi, 2011; Roche, Diers, Duffield, & Catlin-Paull, 2009). Bullying is a form of violence in which inappropriate behaviours undermine the victim's dignity (Center for American Nurses, 2008). Some definitions of bullying stipulate that the offensive behaviour is repeated (Hodgins, 2008), while others suggest that the impact of the behaviour is more important than its frequency or duration (Thomas, 2010). Griffin and Clark (2014) describe the related terms of *incivility* as “rude or disruptive behaviors” (p. 536) and *workplace mobbing* as several employees committing “egregious acts to control, harm, and eliminate a targeted individual” (p. 536). Eighty percent of practicing nurses report being the target of bullying behaviour in the past year (Stagg, Sheridan, Jones, & Speroni, 2011), and nursing students are more vulnerable to being victimized due to lack of knowledge and experience, as well as lack of status and power (Pope, 2010; Seibel, 2014). However, students represent the future of the profession, and, as such, should be taught effective strategies to cope with workplace stressors such as bullying. Common organizational responses to the issue of bullying have been to develop zero tolerance policies, which “treat all cases in the same manner, regardless of who is involved” (Brown, 2015, para. 11). The purpose of this qualitative pilot study was to investigate the effectiveness of a specific anti-bullying intervention using Cognitive Rehearsal Training (CRT) (Griffin, 2004; Griffin & Clark, 2014) to increase nursing students' knowledge and confidence in addressing bullying behaviour. Cognitive rehearsal is a strategy for negotiating emotional or stressful situations that is based in cognitive behavioural therapy (CBT). The core elements of CRT include knowledge and best practices, personal perceptions and recognizing bullying behaviour, managing personal reactions, rehearsing responses in a safe and collaborative environment, and increasing skill and confidence. (Griffin, 2004; Griffin & Clark, 2014).

The dynamics of the bullying that nursing students experience is complex and multifaceted. The perpetrators of bullying present from various groups, including clients and family members, staff, faculty instructors, and even fellow students (Cooper, 2007). Risk factors for all forms of violence include inexperience and youth, which explains in part why nursing students—both within health care and in academic contexts—often perceive themselves to be on the receiving end of bullying behaviours (Clarke, 2009; Del Prato, 2010). Theories of why bullying is so prevalent in health care are many, and include those grounded in feminism, sociology, and psychology. Bullying behaviour is perpetuated by staff inexperience with conflict resolution, insecurity of leaders in their roles, poor communication and social skills, past experiences of being a victim of bullying, lack of self-awareness, and lack of role modelling of civil behaviour (Broome & Williams-Evans, 2011; Clark & Springer, 2007; King-Jones, 2011; Lux, Hutchenson, & Peden, 2014). Regardless of the causes, the effects of bullying are substantive, and strategies to decrease its occurrence and diminish its impact must be sought.

Background

The literature on workplace violence includes examples of bullying behaviour and its consequences across nursing academic and clinical contexts (Luparell, 2011; Lux et al., 2014; Kolanko et al., 2006). When bullying occurs in the clinical context, patient safety is compromised (Luparell, 2011). When bullying occurs in the academic context, it threatens student retention (Clark & Springer, 2007; Thomas, 2010). Lazarus and Folkman (as cited in Del

Prato, 2010) propose that cognitive appraisal of a potentially stressful situation, such as bullying, determines whether and to what degree an event will be perceived as a threat. Perception is a strong indicator of how people will interpret events and respond to them, thus encouraging the recipient to Stop! Reflect! Respond! (Griffin, 2004) before reacting is an important skill to develop (Adler, Rolls, & Proctor, 2015).

Stagg and Sheridan (2010) and Thomas (2009) highlight the effectiveness of CRT in studies with practicing nurses and identify it as the most effective anti-bullying intervention when provided in a collaborative and safe environment. Thomas (2010) recognizes that although CRT and similar bullying interventions have been studied among practicing nurses, few studies exist that involve students within their pre-licensure training program. Introducing skills such as CRT early in the development of a nurse will forecast consistent and positive habits of thinking and responding to bullying (Griffin & Clark, 2014).

Griffin (2004) conducted a study of newly licensed nurses in which participants attended a workshop comprised of three components: 1) theoretical presentation on bullying, 2) an interactive session of cognitive rehearsal (practicing responses to specific types of bullying), and 3) the receiving of laminated cards summarizing the information presented. The participants reported that the information and skills attained enabled them to confront nurses who bullied, and in turn decreased bullying behaviours. Ten years later, Griffin and Clark (2014) revisited the literature on cognitive rehearsal and found that this anti-bullying intervention resulted in increased confidence in working nurses to address conflict and incivility. Stagg et al. (2011) conducted a similar study with hospital nurses in which they employed pre- and post-tests around a 2-hour training program consisting of a theoretical presentation regarding the concept of bullying and rehearsed responses based on Griffin's (2004) work. These research findings support the benefits of CRT to address bullying behaviours in the workplace. In addition, participants reported that CRT increased their knowledge of bullying, its management, and how their responses might either escalate or diminish bullying behaviours. Griffin's research has informed the current pilot study.

Post-secondary education climates—including practice settings—directly affect student learning experiences. Failing to provide strategies to address bullying in clinical and classroom settings places nursing students in danger of perpetuating the behaviours by accepting a victim role or becoming a bully themselves (Beckmann, Cannella, & Wantland, 2013). Faculty and administrators of schools of nursing must not accept bullying as a status quo in the health care sector or in academia (Clark & Springer, 2007) and must take the lead in supporting students to overcome bullying experiences in a positive and constructive manner (Risling & Ferguson, 2013). Teaching the management of workplace relationships and communication is a responsibility of nursing schools to prepare nursing students for practice (Hodges et al., 2010; Lux et al., 2014).

In 2011, the Government of British Columbia enacted anti-bullying legislation under Bill 14 that enables claimants to cite psychological distress as a valid and compensable workplace injury (Clarke & Rennebohm, 2012). Once an employer has been made aware of a workplace dynamic leading to psychological distress (such as bullying) they are required to take specific and corrective action. As a result, employers now have a legal duty to their employees to provide psychologically safe workplaces, and consequently many have created mandatory anti-bullying or harassment and discrimination training in order to demonstrate their due diligence in

providing the necessary information to their employees. This trend towards increased training in all sectors could increase the scope and utility of techniques such as CRT.

The pilot study will contribute to knowledge related to anti-bullying interventions. The study is expected to benefit the student participants by giving them tools to address bullying and provide valuable data for curriculum development and to leaders within schools of nursing. Currently, a similar study is being conducted in the United States by Iheduru-Anderson (2014); preliminary findings include students feeling more confident and hopeful, and invested in the benefits of anti-bullying education.

Methods

Cognitive Rehearsal Training (CRT) has benefited practicing nurses in managing workplace violence (Stagg & Sheridan, 2010); and by extension the researchers for this pilot study propose that this same approach would be beneficial to nursing students. As students develop both personally and within their practice, they must be taught and modelled constructive ways to address relational practice issues which arise, such as bullying (Clarke, 2009; Iheduru-Anderson, 2014; Seibel, 2014). Identifying an effective way to do this is the primary aim of this study. Results will be used to ground larger studies and will have application for nursing school curricula and academic contexts in other disciplines, such as social work and education.

Design

The pilot study was conducted using a qualitative exploratory design to examine the effectiveness of an applied anti-bullying intervention using CRT within an undergraduate nursing program. The qualitative method was appropriate to elicit, analyze, and interpret in a research context where the variables influencing nursing students and their perceptions of bullying are not well understood. The study took place in a small university in British Columbia, Canada. The use of a senior-level nursing student as a research assistant for the preparation and facilitation of the CRT workshop was anticipated to be advantageous to increase the comfort of participants in connecting with the potentially sensitive topic, and also to provide the researchers with insight into the student experience and perspective. The research assistant benefited through taking part in the study by learning new skills such as preparing a workshop, collecting data, and assisting with its analysis and dissemination. The researchers conducted role plays with the research assistant and actors hired through the university's Fine Arts Department. Data collected from the participants in the discussion groups and individual questionnaires was transcribed and analyzed using Giorgi's (1997) method for descriptive qualitative analysis. Following Giorgi's method, we identified meaning units under each semi-structured question, reading and re-reading for patterns, and ultimately established categories and themes. Themes were then reviewed, and additional commentary and context were bracketed as a form of field notes in order to put aside any potential researcher biases or assumptions.

Themes were gathered under each question asked during the workshop. Themes (each of which consisted of three or more similar comments) were consistent among the participants, with few outliers, and saturation was reached after no new themes arose.

Sample and Ethical Considerations

Third-year nursing students (N=58) voluntarily participated in the workshop in a classroom setting, and were given the option not to attend or to refrain from answering questions. Before taking part in the study, the students were emailed a description of the study and the

consent form. There were no inclusion criteria other than being a member of the third-year Bachelor of Science in Nursing cohort. There were no exclusion criteria, although students were advised in the consent form that if they had been a victim of bullying or other forms of violence, that personal feelings may arise during the workshop due to the sensitive nature of the topic. The university counselling department was informed of the study, and any student wishing to discuss their personal experiences further was invited to use the service.

The participant consent procedure was approved by the university's Research Ethics Board. It should be noted that neither researcher, although members of the faculty, had the potential to instruct the students while they were participants, thereby avoiding conflict of interest and recognizing the potential influence of power between educators and students. Students participated without coercion, although door prizes were supplied as an incentive to attend. A small internal research grant was used to fund the study, which included remuneration for the research assistant.

Data Collection and Instruments

The researchers planned a 2-hour workshop for data collection. A workshop manual was provided to the participants and included the following: a workshop schedule, theoretical perspectives on bullying, research questions, the consent form, and the research proposal. Additionally, the workshop participants received a laminated lanyard card outlining the most common types of bullying and appropriate responses as adapted by Stagg and Sheridan (2011) from the work of Griffin (2004) (see Appendix). The workshop began with a brief introduction to the purpose of the study followed by small group discussions and written summaries on the following semi-structured questions: 1) What does bullying look like to you? Is that the same for you as a nursing student and a private individual?; 2) What do you know about the impacts of bullying? How has it affected you personally?; 3) How do you describe your confidence in addressing bullying behaviour?; and 4) What have your experiences been related to bullying while in nursing school?

After the group sessions, the facilitators presented a 15-minute interactive lecture including definitions of bullying, examples of bullying and how bullying impacts nursing practice as presented in current literature. The CRT intervention and lanyard were reviewed and demonstrated through role-playing using nursing student-based scenarios (Fleming & Sutherland, 2011). After the role-playing, each participant answered an individual questionnaire regarding the workshop outcomes which included the following questions: 1) Drawing on your nursing school experiences, how might you find CRT useful?; 2) What advice would you give to the facilitators to improve the workshop and implementation of a CRT program?; 3) Are there any other changes or strategies that you suggest to assist student nurses with bullying experiences?; 4) What new knowledge or perceptions do you have as a result of this workshop?; and 5) How confident would you be to deal with bullying in nursing practice now? Participants were reminded that their insight would be valuable toward making the utility of the CRT successful, and that the comments would remain anonymous.

Results and Findings

Data was collected both from small group work and individually. Under each question asked, one or two themes were identified, which are described below.

Group Data

The students self-selected into groups of four to five members and discussed and answered the group questions collectively in writing.

What does bullying look like to you? Themes in response to this question were that bullying was a) pervasive, b) came in different forms, and c) affected confidence in the practice setting. Bullying during nursing school was similar to past experiences with bullying, and included descriptions of power imbalances and victim uncertainty as to how to address the situation. Most participants described bullying as part of the health care system or a pre-existing dynamic waiting to be experienced by newcomers such as student nurses. Bullying experiences included overt and covert actions, with covert experiences being more prevalent. Covert bullying included exclusion and undermining tactics within the health care team. Bullying decreases confidence and reinforces pre-existing notions of helplessness or incompetence.

What do you know about the impact of bullying? The negative consequences of bullying on the individual and how these affected performance was a clear theme for this question. Bullying decreased confidence, hindered learner performance, and was likely to elicit negative emotional responses. The resulting emotional outcomes included decreased self-esteem and confidence, depression, suicidal thoughts, anxiety, and feelings of isolation. Participants also reported that their experiences with bullying influenced their performance as learners by making them feel negative toward others, decreased their motivation to learn, caused them to withdraw from their clinical studies, and to feel less able to participate in team work. Some questioned their abilities to cope in nursing school and wanted to quit altogether. Several participants stated they were more prone to making mistakes when they had been victims of bullying.

How do you describe your confidence in addressing bullying? Although there was a great deal of data in response to this question, the main theme was that confidence to address bullying depended on context and the perceived benefits or risks of standing up for oneself. A secondary theme was that confidence influenced the participants' assessment of the situation, and that those with high confidence were less likely to feel threatened in a situation than those with low confidence. Confidence levels were influenced by unpredictable degrees of support from leaders such as nursing faculty and registered nurses in clinical settings. Participants worried about the repercussions of attempting to resolve a perceived conflict, citing ruinous expectations such as being denied future work positions after graduation or escalating behaviour on the part of the bully. Students were anxious that a staff nurse in a clinical setting might give a negative report for a student sticking up for themselves, resulting in "burning bridges" or making the learning experience or future work dynamics "uncomfortable". For example, P6 stated,

Even though you are only standing up for yourself, as a student, you really have no pull when it comes to that situation, because when you come back, and get a job after... I mean either they are going to look at you and say "hey she stood up for herself, she'll stand up for her patients and stand up for what she believes in" or they are going to say, "don't hire her, she'll come after everything you say".

Thus, although participants could see potential benefits in standing up to bullying behaviour, they also believed that the action could backfire in some way. It is worth adding here that at the beginning of the workshop, the comments tended to be more focused on negative outcomes; however, by the end of the workshop the participants had shifted to seeing the potential in using the CRT tools. Several discussed becoming champions of an anti-bullying campaign within the

school of nursing or after graduation. Others noted the importance of not being passive bystanders of bullying and the need to mentor less experienced learners to develop their conflict resolution skills.

Confidence levels influence students' receptiveness to feedback. As a result of feedback, some students were negatively impacted, and questioned their reason for being in nursing school and their ability to perform as nurses. One student stated, "Before I felt like a confident nurse and after that I almost quit nursing." Others were sensitive to hearing only negative parts of the feedback, describing it as a personal attack. Participants who began the program with low confidence struggled to develop positive responses to bullying. One participant shared a story about herself and another student receiving the same feedback from a nurse. The participant (with higher confidence) responded to the feedback by asking the nurse for more information in order to understand and use the advice; the other student felt diminished by the feedback and avoided further contact with the nurse.

There was some indication in the participant data that absolving others of poor behaviour or not addressing the behaviour on the part of the recipient could be done for a variety of reasons, such as, "choosing your battles," that the behaviour was "their problem" or that "people don't always recognize what they are doing is bullying." The implication was that if a person does not intend to be a bully, the behaviour could be dismissed or reframed. Another theme that developed was related to gender, and that "females have a lot of emotions," that "estrogen could fuel and perpetuate negative interactions," and that therefore it may be better to avoid confronting the bully as the student did not trust their own reactions to the situation. However, one male participant stated that "when guys get bullied it is always under the impression that *oh they are just going to brush it off*, which minimizes the impact on male students as well."

When discussing participant confidence to address bullying, students responded that nurse educators and nurse leaders can greatly influence the situation, either positively or negatively. Students noted unpredictable responses and varying skill with giving feedback from nurse leaders and instructors, and that they should recognize dynamics of power in situations involving conflict. One participant said "nurse instructors need to know they can crush people."

What have your personal experiences been, related to bullying, while in nursing school? Two themes arose from this question: a) nursing students described their experiences of bullying from multiple sources, and b) many reported feeling too vulnerable to deal directly with the situation. Students reported examples of bullying by their peers, by staff nurses, by nurse educators, and by patients. Bullying by classmates arose during group projects, within the classroom, and online. Common examples of peer bullying included covert behaviours such as facial expressions (a non-verbal innuendo), undermining activities, and gossiping. Copper et al., (2009) observed similar types of bullying amongst student peers and identified this kind of bullying as most frequent, with faculty as the next most common source of bullying. Students described both direct and bystander experiences of bullying by faculty and staff nurses in the clinical setting. When bullied by nurse educators, students felt powerless and disrespected. When bullied by staff nurses, the student sometimes felt the nurse educator let them down by not acting to support them in a timely way. Additionally, when threatened or belittled by staff nurses, students hesitated to report the situation to their instructor for fear of being placed in a more vulnerable position for the rest of the clinical rotation.

Would you wear the lanyard? The main theme under this question was a significant shift in the group's perspective during discussion. While students initially and almost reflexively said they wouldn't wear the lanyard—potentially making them a greater target for bullying—there was a shift in group perspective (as evidenced by the discussion) to seeing the possibilities in doing so. Responses from students regarding the bullying intervention workshop included a spectrum of comments expressing hope for change within the culture of nursing, support for wearing the lanyard card, and making suggestions to improve bullying outcomes using the tool. As discussion within the group continued, students shared feelings of empowerment and collegiality when they envisioned wearing the lanyard. Many hoped to convince others to join them in a cultural shift and respond to bullying in order to improve workplace relations, as opposed to maintaining the status quo. Others felt that champions of wearing the lanyard card would develop and that the lanyard could also serve as a reminder to the wearer to keep their own behaviour in check. Students continued to acknowledge their feelings of vulnerability and lack of power within the context of academia and health care settings.

Similar to Iheduru-Anderson's (2014) project, students enjoyed the practice time of the role-playing and using the lanyard card as a guide for response. The card in this pilot study represented both a pragmatic tool to identify bullying types and link to possible responses, and as a symbol or message to others to take notice of the behaviours not being tolerated. The idea of using the lanyard card as a tool to stop bullying led to other discussions such as introducing the lanyard sooner in the curriculum and having all faculty members on board with the training. Several students expressed a need for faculty and staff to also wear and understand the meaning behind the lanyard with the hope of having other stakeholders on board to stop bullying in nursing.

Individual Data

At the end of the workshop, students were asked to provide individual written responses to the following questions. One or two themes emerged under each question.

How might CRT be useful? Simply stated, the theme under this question is that participants believed that the CRT methods could increase their confidence and competence to respond to bullying constructively. Participants overwhelmingly endorsed the CRT intervention; this tool increased their confidence by providing practical phrases to be used even after graduation. Additionally, students identified that the CRT tool increased their self-awareness and made them question whether their own actions could be considered bullying. One participant summarized, "It will allow individuals to recognize their attitudes and behaviours and be aware of how they may affect those around them. In some situations, some individuals may not even recognize their actions and how they are affecting others." Another participant responded, that the CRT tool "gives good insight on how to respond since many times we are lost for what to do." The CRT tool was also described as having the potential to attract alliances and anti-bullying champions to work together to deal with work place conflict in a healthy manner. Others recognized that confidence could be enhanced and that the lanyard could, "help us feel more confident when dealing with difficult situations." CRT was recommended for broader application, as evidenced by, "CRT would be useful in all nursing school experiences, not only with other health care workers but also communicating with instructors but as well as with patients."

How could CRT be improved? Participants gave no suggestions to improve on the content of the CRT tools themselves, rather, they provided pragmatic ideas on how to fine-tune the workshop to increase its impact. Participants found the workshop to be a positive learning experience, citing support for the lanyard cards and appreciation for being heard and taken seriously. Many had not had a chance to speak openly about previous experiences of direct or bystander bullying. Others wanted more discussion about increasing their confidence to respond to acts of bullying in academia and in health care. The overall workshop feedback included a request for earlier introduction of tools in the curriculum and ongoing check-ins to assess whether they felt supported as learners. One student wrote, “implement earlier in the program, confidence is lowest at the beginning of year one.” Students requested stronger language in the workshop regarding the need to stand up against bullying, such as “we have the right to a bullying-free workplace environment!”

The students requested more scenarios and longer practice time with the anti-bullying intervention and having participants “tag people out in the acting” if they understood how CRT could be used in the situation. Another suggested, “ask participants to complete a private online survey prior to class” to make scenarios more realistic and increase involvement of the more introverted students. Additionally, students requested role-playing to use nurses or student nurses rather than actors. Students requested a greater focus on victim and bully awareness: “add *how not to become a bully* training because people don’t usually start as bullies, but somewhere along the lines fall into that trap.”

Future CRT workshops for faculty and staff nurses were suggested in order to provide a standard approach to resolve bullying situations. Participants wanted their nursing program to be recognized as taking a position against bullying. For example,

I think if the lanyard card was given to all students in the program and the faculty it would begin to be recognized by everyone and it would create an awesome awareness around how the TRU nursing program won’t put up with bullying, and that we as students have been trained to be empowered and stand up for ourselves as well as our colleagues.

Are there any other changes or strategies that you might suggest? The participants answered this question in two ways: one directed to faculty members, and the other directed to their peers and future students; therefore, the themes were summarized as a) advice to faculty, and b) advice to their peers.

Advice to faculty. Students highlighted faculty responsibility to be role models of positive workplace and academic relationships. Participants wanted a clear process for resolving conflict, and for faculty to have a defined role when intervening with bullying in academic and clinical settings. Additionally, the students requested that faculty have ongoing training to recognize and intervene in serious relational situations. Several participants felt faculty were oblivious to bullying and insensitive to the vulnerability felt by students in new learning settings, as well as within their peer groups. Students reported that faculty either ignored or did not recognize bullying behaviour within the classroom or clinical setting. Additionally, participants wanted faculty to meet with nurses on the unit before clinical education began and clearly relay the role of the student and the expected role of the staff. One student requested their instructor to say, “you guys are the mentors, you have got to display a positive role model for them and bullying is not part of that.”

Advice to peers. Participants served as a voice of encouragement and empowerment for future student nurses who might be victimized by bullies. Many gave advice to assist student nurses with positive phrases such as, “you must take a stand,” “do something about it,” and “don’t just let it happen.” Students in the study wanted their peers to know that they were not alone and that their confidence would rise if they responded to bullying in a constructive manner.

What new knowledge or perceptions do you have as a result of this workshop? The main theme under this question is that the CRT workshop enhanced and refined student awareness of bullying types and gave clarity to the definition of bullying. Knowledge changes included, “I now have a tool to use to stick up for myself without being passive” and “half the battle with bullying is just knowing what to say and how to say it without making the situation worse.” Another participant noted that knowing and naming the type of bullying was helpful.

Most students found new ways to approach conflict with increased confidence. One student noted: “Rather than directly approaching a bullying situation to make it stop, even deterring [redirecting] the conversation with a statement can better the situation and most likely decrease the bullying.” Further personal insight included, “it was interesting to find out that my entire class has experienced bullying in the program,” and “I also realized that being a strong individual willing to stand up for what’s right shouldn’t be looked down upon,” and standing up for yourself “may result in a gain of respect from your coworkers.” Most students left with a perception that bullying was not to be tolerated, as implied by “don’t be afraid to say something.”

How would you rate your confidence in addressing bullying behaviour now? The main theme under this question is that participant confidence depended on the several contextual factors. Participants in the study rated their confidence with the caveats of “it depends on the situation” and “it depends on past experiences” and “it depends on who is the bully.” Twelve out of the 58 participants stated they already had a healthy confidence level, and 33 out of 58 confided in needing more practice with conflict resolution role-play. Additional responses included being negatively influenced by past memories of being bullied and unsupportive reactions when reporting a bullying situation, which further decreased their confidence levels. The rating of confidence overall seemed mildly higher after the workshop; participants left with a level of hope, some new ideas, and a tool to assist with conflict. Additionally, participants recognized bullying as involving a power imbalance with the learner having less and therefore being more vulnerable to being victimized.

Discussion

Students and new graduate nurses are at the highest risk for experiencing bullying within their profession (Copper et al., 2009). Participants in the study described most bullying behaviour as covert, such as exclusion, resulting in the victim feeling isolated and unwelcomed, and through overt behaviours such as gossiping and undermining. Students perceived the feedback given by preceptors and instructors variably, with some receiving and using the feedback constructively, and others being threatened by it and viewing it negatively. Pope (2010) suggests that all feedback should be given in a manner sensitive to learner receptiveness and with effort to minimize dynamics of power. All participants agreed that unresolved conflict in the clinical setting resulted in decreased confidence and competence, and may result in thoughts of quitting school. Additionally, the participants recognized that lowered self-esteem related to past victimization triggered more sensitive responses to conflict and resulted in a hesitation to

advocate for themselves or others. Hunt and Marini (2012) connected uncivil behaviour with negative performance and personal outcomes, such as disruption of professional relationships, headaches, and depression. Self-esteem has been shown to influence motivation and the “ability to ask questions [and] search for learning opportunities” (Hakojärvi, Salmien, & Suhonen, 2012, p. 138). This illustrates the relationship between emotional states and performance specific to the context of nursing students.

Emotions and learning

D’Mello and Graesser (2012) noted that all learning is socially situated and that “emotions are systematically affected by the knowledge and goals of the learner, as well as vice versa” (p. 145). Participants suggested that strategies for increasing individual student confidence should be included in the nursing curriculum. They also suggested that nurse educators and registered nurses should receive training on giving feedback in order to give clear and gentle feedback to support learning and increase student confidence. Bradbury-Jones et al. (as cited in Chesser-Smyth & Long, 2013) found that “supportive mentors who instill empowerment led to increased self-esteem and self-confidence” (p. 153), and so the idea of putting intentional effort into increasing the skill of mentors to provide effective feedback seems well founded.

Bandura (as cited in Chesser-Smyth & Long, 2013) developed a Social Learning Theory in 1977. In his theory, he cited desire, motivation, and confidence as important influences on the student learning. Confidence rises and falls with positive and negative experiences, respectively (Randle, 2003). Chesser-Smyth and Long (2013) added that self-confidence was the “catalyst that was required to develop competence and ultimately capability for effective practice” (p. 153). Mastery of tasks, along with positive interpersonal interactions increased confidence and students’ ability to tackle the challenges of nursing practice.

Educators have power

The phenomenon of abuse of power by educators towards students is discussed in the important work by Davey (2002), who proposed that students are vulnerable and faculty do not consistently recognize their roles and their duty to support them. Failing to respond to a student’s need for support creates increased feelings of vulnerability and decreases the student’s sense of power to impact the cycle of bullying. P8 stated, “when I am a student nurse in the hospital and I see horizontal violence or bullying, I am not that competent in standing up because of my power role in that situation.” The power hierarchy was viewed as doctor-nurse-nursing students, with doctors having the most power and nursing students having the least. When addressing student-to-student bullying situations, a participant stated, “I feel like I have the confidence because we are on equal power planes.”

Nursing students in the pilot study provided insight into the educational process and the potential for further developing an anti-bullying intervention using CRT and related tools. Stagg and Sheridan (2010) proposed that CRT was the most effective anti-bullying intervention with practicing nurses, as it provided them with information and a collaborative and safe environment in which to practice responses. Through the use of CRT the participants described hope in working through conflict by using the lanyard card phrases as a guide to address bullying while in school.

Examination of violence and conflict resolution content in nursing education indicates that most programs cover all aspects of the topic in only a few hours of instruction, and that while most nursing faculty members acknowledge the importance of it, there is a lack of knowledge on the topic (Clark & Ahten, 2012; Ross, 2002). The research reported here suggests that conflict resolution training should be ongoing throughout the program and include parallel training to faculty.

Improving the intervention

The participants gave various suggestions for improving the workshop and making it more effective. They also gave advice about how the teaching of the CRT intervention should be positioned within the nursing curriculum. One such suggestion was that the workshop, or elements of it, should be repeated throughout the curriculum. It was also thought to be important that workshop facilitators should address in any way possible aspects of power and negative group dynamics during the workshop.

Other suggestions included to incorporate actual student experiences into the scenarios. This could be done by having students complete a questionnaire online prior to class. It was also believed that this would equalize student input, allowing more introverted students to contribute in a non-threatening manner. Several students commented that more time was needed for the scenarios, and that the students themselves should do the acting (as opposed to theatre students) and that this would bring more authenticity to the scene. Finally, participants suggested allowing the observers to “tag into” a scene if they had an idea or approach to positively impact the situation. This last group of suggestions represents an approach that can be summarized through a theatrical approach called forum theatre.

The origins of forum theatre (aka “theatre of the oppressed”) are in the work of Augusto Boal (as cited in Middlewick, Kettle, & Wilson, 2012), who developed the technique to explore scenes involving power and injustice, stimulate discussion, and ultimately to steer the scene to a positive conclusion. Boal (as cited in D’Ardis, 2013) described the audience of forum theatre as “spect-actors” (p. 1136), which denotes their important and integral role in the drama and how it unfolds. Forum theatre has been used in nursing education to investigate topics and scenarios that raise student anxiety and stress, such as end-of-life care, bullying and violence, mental health crises, and other highly emotional or tense circumstances (Middlewick et al., 2012; Tuxbury, McCauley, & Lement, 2012; Love, 2012; Wasylko & Stickley, 2003). Pedagogically, forum theatre is believed to result in moving students beyond “declarative knowledge” (Middlewick et al., 2012, p. 139) to a more functional or applied version of knowing, where it can be used to solve a difficult problem. As a technique, forum theatre can include the aspects of “tapping out” a current actor, and having the participants themselves develop the scenarios, and, therefore, it seems to be a good fit to meet the suggestions of the participants in this study.

What this study adds to knowledge

This study has added to existing knowledge by showing that the CRT intervention is an effective tool for use with undergraduate nursing students, and that it plays a role in developing positive attitudes, habits, and competencies to address bullying. The study also highlights the critical role of faculty during conflict in general and bullying in particular, and that faculty hold power to impact situations for better or worse. One participant said,

...the difference in the situation was the instructor that I had did not back me at all. Like I had been publicly in a nursing station totally shamed. The teacher did not back me whatsoever, did not approach the nurse. Nothing happened, nothing took place. And then I had... in the future after that, an event where something went wrong, and the instructor backed me so well immediately and was like *please don't talk to my student that way*—and it was like the whole world changed. (P6)

This perspective on the faculty role during conflict has been supported by the data from other student-based research. Cooper (2007) states that “nurse educators play a vital role by nurturing students and novices in their professional development” (p. 122) and further recommended that faculty development initiatives could increase awareness, sensitivity, and provide strategies to support students. Other authors support an intentional approach to increase faculty knowledge and skills to diminish bullying in nursing classrooms and practice settings (Clarke, 2009; Del Prato, 2010; Pope, 2010).

Next steps

This pilot study has revealed several potential directions for future investigation, including ongoing examination on the relevance of CRT in bullying situations for student nurses, faculty, recent nurse graduates, and other health care worksites. Suggestions also included nursing school curriculum changes such as incorporating CRT earlier in the program and investigating the consequences of bullying on patient safety. The researchers suggest future larger studies investigating the relationship between the psychological impact of bullying on competence and consequences for patient care.

Students in the study supported sporting the lanyard in clinical practice, believing the tool would assist them to strategize during workplace conflict, including bullying situations. The researchers support ladder CRT concepts throughout the nursing school curriculum and exploring the use of CRT in other pre-licensure programs identified as being at risk for bullying. Ongoing discussion and training with faculty regarding recognition of bullying, review of faculty role with bullying situations, raised awareness of the power dynamics involved between faculty and learners, and training with CRT to decrease incidents of bullying are strongly supported through the findings of this research project. Additional research is needed to assess the usefulness of CRT over the course of the curriculum as well as after graduation to assess if the knowledge gained influences how bullying situations are handled, if nursing retention rates have increased, and if bullying in academia and in health care workplace settings has decreased. A separate study on the success of CRT training for stakeholders, such as faculty, and a longitudinal study with our CRT-vetted grads to enhance nursing practice are suggested future studies based on the findings of this pilot study. This study did not determine whether students will be able to resolve bullying-related conflict, but longitudinal studies building on CRT can investigate this question further.

The phenomenon of bullying could be better understood through the use of a research method called brokered dialogue (Parsons & Lavery, 2012), in which stories are told and responded to between participants through filmed interviews. In brokered dialogue, the researcher facilitates or *brokers* conversation between participants who have potentially opposing views on a difficult topic. The method reveals sensitive responses from individuals and encourages participants to reflect back and forth in layered filmed interviews without having to be in the same physical space. Ultimately this creates a virtual dialogue between participants that

is controlled through participant-led film editing. The researchers of this study hope to conduct future research using brokered dialogue as a research method to promote dialogue between diverse participant perspectives, creating mutual understanding of the power imbalances experienced in bullying situations.

Limitations

Several study limitations were identified in this qualitative project. First, the study sample was small and represented a specific third-year student nurse population from a specific Canadian university. With a small study size, generalization for the study is more difficult to make. Further research needs to include other cohorts in different nursing programs and possibly other health care programs across Canada to determine if CRT is a useful intervention. Second, the researchers recognize that the experiences of bullying and perspectives of practicing the CRT as an intervention may vary according to school year levels. For example, how would a first-year nursing student perceive and react to bullying behaviours differently from a third-year nursing student? Third, participant experiences are viewed as unique to the individuals, as each nursing student has different levels of life experience and coping strategies to address conflict.

Conclusion

Student nurse confidence levels highly influence how they address bullying. With adequate preparation through CRT, the increased confidence to address bullying will help this vulnerable population. Promotion of the CRT program to other stakeholders in health care education, such as nursing faculty, staff nurses, student preceptors, and higher education administration will strengthen the culture against bullying and other forms of violence. Schools of nursing need to identify appropriate steps and protocols to manage bullying at all levels of academia for students, including student-to-student situations.

The study findings identify significant implications to nursing practice and the need to continue conflict resolution training that includes specific identification of bullying and useful responses to the bullying situation in a timely manner within the nursing school curriculum. The pilot study reinforced the need to attend to learner needs through a relational perspective, addressing the negative dynamics of academia and workplaces. Increased bullying awareness through CRT acknowledges individual experiences and addresses the need to increase confidence, skill, and collegiality in the health care sector. Students graduating from a nursing program with skills of conflict resolution and a zero tolerance for bullying will feel more prepared to manage the power dynamics that exist in the workplace.

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Appendix

Lanyard Card



STOP, REFLECT AND RESPOND WHAT TO SAY

Verbal affront (covert or overt snide remarks)

What do you mean by that comment?

Non-verbal innuendo (raising of eyebrows, making faces)

I see from your facial expression that you might be confused. What else do you need to know?

Withholding information (related to one's practice or a patient)

I feel that you aren't telling me everything I need to know.

Sabotage (any underhand interference in production, work)

I feel this should not have happened. We need to talk about this privately.

Undermining activities (to weaken, injure, destroy by secret or insidious means)

I feel that you don't trust me. Will you tell me why?

Infighting (bickering with peers)

We need to stop this behaviour and learn to work together.

Backstabbing (betraying a friend or an associate)

I don't feel comfortable talking about (person's name) when they are not present.

Broken confidences

This is information that should remain confidential.

Scapegoating (assigning the blame to one person for the shortcomings of others)

We can't blame one person for everything that goes wrong.

Gossiping (idle talk, groundless rumor)

This is inappropriate conversation that should not be taking place.

Developed by M. Griffen (2004), modified by N. Fleming & L. Sutherland (2011).

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