UNIVERSITY OF KWAZULU- NATAL

# STUDENT NURSES' PERCEPTIONS ON BULLYING BEHAVIOUR DURING CLINICAL PLACEMENT IN A SELECTED PRIVATE NURSING INSTITUTE IN KWAZULU-NATAL

MORNICA THANDIWE MAZIBUKO

2017

# STUDENT NURSES' PERCEPTIONS ON BULLYING BEHAVIOUR DURING CLINICAL PLACEMENT IN A SELECTED PRIVATE NURSING INSTITUTE IN KWAZULU-NATAL

**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR A MASTERS IN NURSING EDUCATION AT THE SCHOOL OF NURSING AND PUBLIC HEALTH**

**UNIVERSITY OF KWAZULU- NATAL**

**DURBAN**


**MORNICA THANDIWE MAZIBUKO**

**Student Number: 201511080**

**SUPERVISOR: Mrs Makhosazane Dube**


**June 2017**

## DECLARATION

I, Mornica Thandiwe Mazibuko, hereby declare this research dissertation titled "Exploration of the student nurses' perceptions towards bullying behavior during clinical placement at a selected private nursing institute in KwaZulu –Natal" is my original work. It has never been submitted for any other purpose or to any other academic institution. Sources of information used in this work have been acknowledged in the reference list.

Student's name: Mornica Thandiwe Mazibuko

Signature: …………… Date: ......................

Supervisors' name:

Signature………………… Date: …………………..

# DEDICATION

I dedicate this study to my husband Mr Mbongeleni Michael Mazibuko, my children Noluthando and Sukoluhle who at times could not get my attention as I attended to my studies.

## ACKNOWLEDGEMENTS

My sincerest gratitude to:

Mrs Makhosazane Dube my supervisor of UKZN –Durban campus for her selfless endless encouragement, supervision and support throughout this study. Your caring and selfless contribution is highly appreciated. You have always created a positive conducive learning atmosphere that encouraged me to do more.

Many thanks to all the hands that have touched this work, and thank you to Kemist Shumba for editing my work.

Many thanks to Mrs Pulelitso Ruth Mlotshwa for her time, dedication, encouragement and input in my study. You are a sister and a friend indeed.

Many thanks to my colleagues especially Mrs Sizakele Ngcobo, Ms Bridget Makhanya, Sbonelo Mzimela, Ntuthuko Buthelezi for support and the students who participated in the study during data collection. This project would not have been possible without their participation.

Thank you to Ms Philisiwe 'Mancane' Malinga for your input and encouragement, to my late mom who passed on while I was in the middle of this study, Mrs Thokozile Grema Malinga, I will always love and remember you mother! Your prayers have not remained unnoticed.

## ABSTRACT

### Background

Workplace violence in health care is a worldwide phenomenon. In nursing, the nature of workplace violence is predominantly non-physical in nature. Literature reveals the devastating consequences for the individual nurse, both non-physically and/ or emotionally.

### Purpose

The purpose of this study was to investigate the perceptions of student nurses towards bullying behavior during clinical placement.

### Methodology

A quantitative research design, utilizing a survey, was chosen for the study. A non-probability convenience sampling method was selected. A sample of n=120 students was selected, all those who were found in that research period and met the inclusion criteria.

### Findings

The study revealed that the perpetration of non-physical violence against student nurses is widespread, particularly that perpetrated by co-workers, more specifically registered, staff- and assistant nurses including doctors, patients and patient's relatives.

### Recommendations

The recommendation arising from this study therefore focuses on the nursing practice, regarding the formulation of the policy addressing workplace violence. Nursing education regarding the inclusion of the policy addressing workplace violence in the curriculum. As well as further research that will include all nurse categories.

# TABLE OF CONTENTS

DECLARATION .......... i

DEDICATION .......... ii

ACKNOWLEDGEMENTS .......... iii

ABSTRACT .......... iv

TABLE OF CONTENTS .......... v

LIST OF FIGURES .......... x

LIST OF TABLES .......... xi

ANNEXURES .......... xiii

CHAPTER ONE .......... 1

INTRODUCTION .......... 1

1.1. Background to the study .......... 1

1.2 Problem statement .......... 5

1.3 Purpose of the study .......... 6

1.4 Research objectives .......... 6

1.5 Research question .......... 7

1.6 Significance of the study .......... 7

1.6.1 Nursing practice .......... 7

1.6.2 Nursing Education .......... 7

1.6.3. Policy makers .......... 8

1.7. Clarification of Key Terms .......... 8

1.7.1. Perceptions .......... 8

1.7.2. Student nurse .......... 8

1.7.3. Bullying behaviour .......... 9

1.7.4. Clinical placement ........................................................................................9
1.8 The conceptual framework guiding the study ..........................................................9
1.8.1 Negative behavior of perpetrator ......................................................................12
1.8.2 Power imbalance between bullying victim and perpetrator .............................12
1.8.3 Duration and frequency of persistent negative behaviours of perpetrator.........13
1.8.4 Negative impacts of bullying on victim ..........................................................13
CHAPTER TWO ..........................................................................................................15
LITERATURE REVIEW ............................................................................................15
2.1 Introduction ..........................................................................................................15
2.2 The history of workplace bullying .......................................................................15
2.3 Theoretical background to workplace violence or aggression ..............................18
2.4 Working towards a definition of workplace violence ...........................................19
2.4.1 Bullying versus sexual harassment and discrimination ........................................21
2.5 Types of workplace violence..................................................................................22
2.6 Nature of workplace violence against nurses .........................................................24
2.7 Prevalence of workplace violence in health care and nursing ...............................27
2.7.1 Incidence of workplace bullying.............................................................................29
2.7.2 Workplace bullying in higher education...............................................................30
2.8 Perpetrators of workplace violence against nurses ...............................................31
2.8.1 Sources of bullying at a workplace.....................................................................32
2.8.2 The victim............................................................................................................33
2.8.3 The bully..............................................................................................................33
2.9 Antecedents / predictors of workplace violence ....................................................34
2.10 Consequences of workplace violence for nurses..................................................35
2.10.1 Self-esteem ........................................................................................................37
2.10.2 Self-efficacy.......................................................................................................38
2.10.3 Adverse effects ..................................................................................................39

2.10.4 Effects of workplace bullying....................................................................40
2.11 Strategies to address workplace violence....................................................43
2.11.1 Retention.......................................................................................46
2.12 Barriers to the implementation of strategies to prevent workplace violence......46
2.13 Under-reporting of workplace bullying.......................................................47
2.14 Coping strategies with workplace bullying...................................................48
2.15 International legislation relating to workplace bullying ..............................48
2.16 Behaviors and tactics...............................................................................49
2.17 Conclusion.............................................................................................50
CHAPTER THREE ..........................................................................................51
RESEARCH METHODOLOGY...........................................................................51
3.1 Introduction ...........................................................................................51
3.2 Research paradigm and approach...............................................................51
3.3. Research Design.....................................................................................51
3.4. Study setting..........................................................................................52
3.5. Study population ...................................................................................52
3.6. Inclusion and Exclusion criteria................................................................52
3.6.1. The inclusion criteria.............................................................................53
3.6.2 The exclusion criteria .............................................................................53
3.7. Sampling and sample size .......................................................................53
3.8. Data collection instrument .......................................................................54
3.8.1. Data collection process..........................................................................55
3.9. Validity and Reliability ...........................................................................56
3.9.1 Validity ................................................................................................57
3.9.2 Reliability ............................................................................................57
3.10. Data analysis .......................................................................................58
3.11. Ethical considerations ............................................................................58

3.12. Data management .......... 60
3.13. Dissemination of findings .......... 60
3.14. Conclusion .......... 61
CHAPTER FOUR .......... 62
PRESENTATION OF FINDINGS .......... 62
4.1 Introduction .......... 62
4.2 Sample realization .......... 62
4.3 Social demographic data .......... 63
4.3.1 Gender of the respondents n=114) .......... 63
4.3.2 Age of the respondents (n=114) .......... 63
4.3.3 Year of study (n=114) .......... 64
4.4 Types of bullying .......... 64
4.4.1 Relationship between respondents' demographic variables and types of bullying .......... 69
4.5 Frequency of bullying .......... 71
4.5.1 Overall frequency scores .......... 75
4.5.2 Relationships between respondents' demographic variables and frequency of bullying .......... 75
4.6 Sources of bullying .......... 78
4.6.1 Clinical areas where the bullying occurred .......... 78
4.6.2 Perpetrators of bullying .......... 79
4.7 Influence of bullying on work performance .......... 82
4.7.1 Overall scores on influence of bullying on work performance .......... 83
4.7.2 Relationship between demographic variables and influence of bullying on work performance .......... 84
4.7.3 Individual items on influence of bullying on work performance and demographic variables .......... 85
4.8 Personal consequences of bullying .......... 86

4.8.1 Overall scores on personal consequences of bullying ........................................ 88

4.8.2 Relationships between demographic variables and personal consequences of bullying ........................................ 88

4.8.3 Interrelationships between demographic variables and personal consequences of bullying ........................................ 89

4.8.4 Relationships between respondents' demographic variables and the different personal consequences of bullying ........................................ 89

4.9 Coping with workplace violence ........................................ 90

4.9.1 Reporting of bullying (N=92) ........................................ 90

4.9.2 Coping mechanisms ........................................ 91

4.9.3 Awareness of policy on workplace violence (N=100) ........................................ 96

4.9.4 Reporting of bullying and awareness of policy availability ........................................ 97

4.10 Summary of the chapter ........................................ 97

CHAPTER FIVE ........................................ 99

DISCUSSION AND CONCLUSION ........................................ 99

5.1. Introduction ........................................ 99

5.2 Discussion of the findings ........................................ 100

5.2.1 Types of bullying behaviour ........................................ 100

5.2.2 The frequency of bullying behavior ........................................ 107

5.2.3 Sources of bullying ........................................ 110

5.3 Recommendations ........................................ 113

5.3.1 Nursing practice ........................................ 113

5.3 Recommendations for further research ........................................ 114

5.4 Limitations of the study ........................................ 114

5.6 Conclusion ........................................ 114

REFERENCES ........................................ 116

ANNEXURES ........................................ 124

## LIST OF FIGURES

Figure 1. 1:The conceptual framework of bullying in the nursing workplace, by Rayner and Keashly (2005) ........ 11

Figure 4. 1: Gender of the respondents ........ 63

Figure 4. 2: Age of the respondents ........ 64

Figure 4. 3: Respondents and their year of study ........ 64

Figure 4. 4: Hospital setting ........ 78

Figure 4. 5: Community settings ........ 79

Figure 4. 6: Reporting of episode ........ 91

Figure 4. 7: Awareness of clinical policies on workplace violence ........ 96

## LIST OF TABLES

Table 2.1: Summary of the four main types of the workplace violence ............................23

Table 2.2: Summary of non-physical violence directed at nurses ....................................26

Table 4.1:Types of bullying ..........................................................................................68

Table 4.2: Relationships between demographic variables and types of bullying ..............70

Table 4.3: Frequency of bullying ....................................................................................74

Table 4.4: Overall frequency scores (n=104) ..................................................................75

Table 4.5: Cross tabulation of gender and frequency of bullying .....................................76

Table 4.6: Cross tabulation of age and frequency of bullying ..........................................76

Table 4.7: Cross tabulation of year of study and frequency of bullying ............................77

Table 4.8: Interrelationships between frequency of bullying and demographics ..............77

Table 4.9: Perpetrators of bullying ..................................................................................81

Table 4.10: Correlation of demographic variables and perpetrators of bullying ...............81

Table 4.11: Influence of bulling on work performance ....................................................83

Table 4.12: Overall scores on influence of bullying on work performance ......................83

Table 4.13: Cross tabulation of influence of bullying on work performance and gender .84

Table 4.14: Relationship between influence of bulling on work performance and age and year of the study ..........................................................................................................85

Table 4.15: Cross tabulation of gender and influence of bullying on standard of patient care ..................................................................................................................................85

Table 4.16: Relationships between respondents' demographic variables and items on influence of bullying on work performance ....................................................................86

Table 4.17: Personal consequences of bullying ...............................................................87

Table 4.18: Overall scores on personal consequences of bulling ..................................... 88

Table 4.19: Influence of demographic variables on personal consequences of bullying .. 88

Table 4.20: Relationships between the respondents' demographic variables and personal consequences of bulling ........................................................................................ 89

Table 4.21: Cross tabulation of reporting of bullying and year of study ........................... 91

Table 4.22: Coping mechanisms ......................................................................... 92

Table 4.23: Relationships between copying mechanisms and demographic variables ..... 95

Table 4.24: Cross tabulation of gender and policy awareness .......................................... 97

Table 4.25: Policy awareness and reporting of bullying episodes .................................... 97

## ANNEXURES

Annexure A: Information document ........ 124

Annexure B: Informed consent form ........ 126

Annexure C: Research questionnaire ........ 127

Annexure D: Letter requesting permission ........ 132

Annexure E: Letter granting permission to conduct study ........ 133

Annexure F: Approval letter from UKZN ethics committee ........ 134

Annexure G: Letter from Editor ........ 135

# CHAPTER ONE

# INTRODUCTION

## 1.1. Background to the study

Bullying is not a new problem among student nurses. The problem has existed for decades and bullying in the nursing profession was first defined in the mid-1960s, there is very little research about the efficiency of specific interventions to address the problem (Anno, Nuechterlein, Dyette, and Bonie, 2013). Horizontal violence and oppression, as well as their effects are reported in nursing literature for more than 20 years (McCaffrey and Woelfle, 2007). Although the phenomenon of bullying dates back to decades, it is only in recent years that it has been at the forefront of research. This is a very disappointing fact because nursing is supposed to be a supportive, companionate and caring profession. The prevalence of bullying of student nurses by superiors/ matrons, clinical instructors, registered nurses, doctors, patients, patient's relatives and other nurses does not portray the spirit of nursing. Unfortunately bullying in organisations is a worldwide phenomenon. It is not unique to student nurses.

According to Hickling (2006), workplace bullying is increasingly being recognised as a serious problem confronting contemporary society. Acts of bullying have been referred to as horizontal violence, relational aggression, incivility, mobbing, harassment and interpersonal conflict (Clarke, Kane, Racich and Lafreniere, 2012). Although the topic of bullying has been researched before, limited studies have focussed on bullying in nursing education. Studies demonstrate the existence of bullying in clinical settings where students go for clinical placement (Clarke, et al.,2012; Longo, 2007; Randle, 2003). The main difference that exists between these studies is the incidence rate of the bullying

phenomenon. Students go for clinical placement for educational purposes, but inadvertently, they are exposed to an environment that is not conducive for learning due to bullying behaviour.

A Canadian study by Clarke et al. (2012) suggests that students who experience more bullying behaviors are more inclined to consider leaving the nursing programme. Curtis, Bowen and Reid (2006) emphasize, from a purely economic perspective that it is important to retain students who have completed a substantial part of their nursing training and it is vital that new graduates continue with the nursing profession.

International studies have noted the phenomenon of bullying student nurses during clinical placement. A longitudinal empirical study carried out in England by Randle (2003) illustrated that over a three-year educational period, In England student nurses experienced qualified nurses exercising power over them and bullying them, often with them being ridiculed or humiliated in front of others. Similarly, results of a Canadian study conducted by Clarke et al. (2012) suggests that student nurses experience and witness bullying behaviours at various frequencies, most notably by registered nurses, doctors, clinical instructors and staff nurses or other nurses. Sometimes this behaviour is subtler in nature but can still cause students to feel powerless and their self-esteem to diminish.

Disturbingly, new graduates also experience bullying even after completing their nursing education. A recent New Zealand study discovered that 34% of new graduates reported experiencing overt verbal statements made by other nurses that were rude, abusive, humiliating or involved unjust criticism (McKenna, Smith, Poole, and Coverdale, 2003).

Workplace bullying is defined as harassing, offending, socially excluding someone or negatively affecting someone's work (Lutgen-Sandvik, Tracey, and Alberts, 2007; Waschgler, Ruiz-Hernandez, Llor-Esteban, and Jimenez-Barbero, 2013). This kind of bullying, when carried out in the health care sector by a colleague is known as lateral or horizontal workplace bullying or violence, and when carried out by a superior, it is known as vertical workplace bullying or violence (Waschgler et al., 2013). Many other terms exist to describe this behavior, including that nurses eating their young, verbal abuse, disruptive behaviour, and incivility (Sauer, 2012).

In Canada, participants in a study by Baker (2012) reported their first exposure to bullying which occurred while they were students in nursing school that in turn had devastating effects on self-confidence and self-image. It seems odd that a profession based on the principles of providing care, compassion and empathy often ignores nurse-to-nurse bullying and the victimization of its members (Baker, 2012).

A study conducted by Laschinger, Grau, Finegan and Wilk (2010) which looked at the link between bullying and burn out among newly graduated nurses in Canada, found that one third (33%) of their sample were bullied. Another study that looked at the rate of bullying experienced by student nurses in Canada found that 88.7% of respondents had experienced bullying at least once in a clinical setting, with 77% of student nurses reporting that they experienced bullying behavior in their first year of study (Clarke, Kane, Raciuch, and Lafrenier, 2012).

The most frequently reported bullying behavior experienced by students was feeling that their efforts were undervalued (60% of respondents), followed by being told negative remarks about becoming a nurse (40% of respondents) (Clark et al., 2012).

Thomas and Burk (2009), stated that the suppressed anger of bullied nursing students has also been shown to be a significant concern because it can be argued that this is how the cycle of bullying is instilled and perpetuated, even before nursing students graduate and begin to practice. Other study found that many student nurses accept horizontal violence as a rite of passage and repeat these behaviors in their future careers (Hinchberger, 2009).

Study conducted in nursing schools in the United Kingdom by Randle (2003), revealed that nearly half of the students (50%) indicated that they had experienced bullying in the past year while on clinical placement. One third (30.4%) had witnessed bullying of other students and 19.6% of incidents involved qualified nurses. The unwanted behaviors resulted to some students leaving nursing (19.8%). Some respondents indicated that the standard of patient care (12.3%) and their work with others (25.9%) was negatively affected.

The term horizontal violence describes bullying and aggression involving intergroup conflict (Curtis et al., 2006). Research has noted both physical and psychological consequences of horizontal violence on individual nursing students. A study done in Australia revealed that students often felt unable to deal with specific incidents of horizontal violence and one way of responding was by removing themselves from the situation when possible. Meanwhile an American study by McCaffrey and Woefle (2007) discovered that nurses themselves have been diagnosed with illnesses such as depression, acute anxiety, and post-traumatic stress disorder due to bullying behaviour.

The topic of bullying is inadequately researched in Africa. There is no empirical evidence available about the bullying phenomenon in most African countries. The World Health Organisation (WHO) recognises bullying as a form of violence. WHO, 2002 stated that violence is the intentional use of physical force or power, threatened or actual, against

force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has high like hood of resulting in injury, death, psychological harm, and deprivation. Bullying is one experienced through qualified nurses exercising power over them and bullying them, often with them being ridiculed or humiliated in front of others. Similarly, results of a Canadian study done by Clarke et al. (2012) revealed that nursing students experience and witness bullying behaviors at various frequencies, most notably by clinical instructors and staff nurses. Sometimes this behaviour is more subtle in nature but it still causes student to feel powerless and self-esteem to diminish.

In South Africa, the topic of bullying of student nurses is inadequately researched although its existence cannot be denied. Researchers have opted to focus on work place violence. In a study conducted in Cape Town revealed that from 471 respondents 54% agreed that there is violence in nursing work environments (Khalil, 2009). The types of violence included, psychological violence 15%, vertical violence 13%, 20% covert violence, 19% horizontal violence, 16% overt violence and 17% physical violence across all participating hospitals in Cape Town.

### 1.2 Problem statement

Despite the fact that international studies have demonstrated that nursing students experience bullying during their nursing education, generalisations cannot be made about the rate of incidence in South Africa. As such, it is vital to use a South African sample to determine the extent and nature of bullying in a South African context. Considering that bullying is a negative behaviour, South Africa is likely to loose nursing students to other professions due to the negative impact of bullying. In a study conducted in England by Randle (2003) it revealed that becoming a nurse and subsequent feelings associated with

the trajectory from students to nurse were greatly influenced by how students were treated by nurses in allocated clinical areas. Similarly, a Canadian descriptive study conducted by Clark et al. (2012), it revealed that nursing students who experience more bullying behaviors are more inclined to consider leaving the nursing program. Looking at the current state of affairs, nursing schools cannot afford to lose students nurses due to bullying.

According to a study done by Longo (2007), student nurses identified experiences of horizontal violence that included verbal or emotional abuse, with one student reporting physical abuse. However in a study done by Clark et al. (2012), results suggest that 88.7% (n-598) of nursing students reported experiencing at least one act of bullying and the most frequently reported form of bullying behaviour was undervaluing of their efforts (60%). These findings are consistent with other international studies. Considering the rate at which bullying occurs and the devastating negative impact bullying has on nursing students, it raises the possibility that student nurses may be socialised into an acceptance of such negative behaviour regarding modes of interaction.

### 1.3 Purpose of the study

The aim of this study is to investigate and describe student nurses' perceptions on bullying behaviour during clinical placement in a selected private nursing institute.

### 1.4 Research objectives

1. To describe the types of bullying behaviour on student nurses during clinical placement in a selected private nursing institute.

2. To measure the frequency of bullying behaviour on student nurses during clinical placement in a selected private nursing institute.

3. To describe the sources of bullying behaviour on student nurses during clinical placement in a selected private nursing institute.

4. To describe coping mechanisms adopted by student nurses during bullying behavior in a clinical placement selected private nursing institute.

### 1.5 Research questions

1. What are the types of bullying behaviour on student nurses during clinical placement?

2. What is the frequency of bullying behaviour, on student nurses during clinical placement?

3. What are the sources of bullying behaviour on student nurses during clinical placement?

5. What coping mechanisms do student nurses adopt in response to bullying behaviour during clinical placement?

### 1.6 Significance of the study

The study is hoped to be of significance to the nursing practice, nursing education and further research for policy development.

#### 1.6.1 Nursing practice

This study might raise awareness and enable nurse managers to give priority to reforming the context in which bullies operate, so that this behaviour is not perpetuated and become even more wide spread in the health care environment. The findings of this study may rather add the body of knowledge for purposes of professional and academic development and understanding of the phenomenon in a South Africa context.

#### 1.6.2 Nursing Education

Considering that student nurses spend a significant portion of their nursing education in a clinical environment, it is crucial to ensure that their experiences are positive. The

findings of this study can raise awareness among nurse educators and they may develop strategies that might assist student nurses to cope with bullying behaviour encountered during clinical placement.

### 1.6.3. Policy makers

This study might influence policy makers to develop and enforce new policies that will specifically address the issue of bullying within nursing programmes and within health care facilities where student nurses undertake their clinical nursing education.

## 1.7. Clarification of Key Terms

Below is a list of important terms operationalised in this dissertation; namely perceptions, student nurse, bullying behavior and clinical placement.

### 1.7.1. Perceptions

According to Burns and Grove (2012) perception refers to seeing things from a specific frame of reference, worldview or theory. This becomes our reality that will give us a sense of certainty, security and control (Burns and Grove, 2009:68). In this study, perceptions are used to define the student nurses' self-reported views of bullying behaviour at a clinical placement.

### 1.7.2. Student nurse

According to Nursing Act, 1978 Act No. 50 of 1978 a student nurse is an individual who is undergoing a two-year programme at an approved nursing school, who has complied with the prescribed conditions of training in an institution recognised by the council, and whose name appears on the register or roll of nursing. In this study, student nurse refers to a person registered with any of the nursing departments in a higher education institution studying full time towards attainment of a nursing qualification offered by that institution.

### 1.7.3. Bullying behaviour

Bullying behaviour in a workplace can be described as verbal, physical, social or psychological abuse by your employer (or manager), another person or group of people at work (Australian Human Rights Commission, 2013). Therefore, in this study bullying behaviour defines the activity of repeated behaviour intended to hurt another individual physically, emotionally or mentally.

### 1.7.4. Clinical placement

Clinical placement is defined as an authorised block of time (hours) in which students attend a clinical setting for a structured clinical experience as part of a specific unit in a hospital setting or clinic setting (Student Resource Manual, 2013).Therefore, in this study clinical placement defines the period of hours that student nurses are placed with the working force as to cover the period required.in the hospital or clinics.

### 1.7.5 Private Nursing School

According to Nursing Act, 1978 Act No. 50 of 1978, a Private Nursing School is an institution that renders either a one-year programme or a two-year programme training for student nurses to be competent in the field of nursing leading to registration with South African Nursing Council. In this study a private nursing school is an institution that train student nurses for a two-year programme.

## 1.8 The conceptual framework guiding the study

The negative behaviour of perpetrator is the concept from the conceptual framework by Rayner and Keashly (2005) which identified five core domains of the bullying interaction as being negative behaviours of a bully, persistent and repeated bullying interaction, person targeted experiences damage, person targeted labels the interaction as being bullied and imbalance of power. The negative behaviours of a bully are perceived as demeaning and down-grading through vicious words and cruel acts (Adams, Beasley and Rayner,1997); offensive, abusive, intimidating, malicious, or insulting behaviour

(McAvoy and Murtagh, 2003), and unreasonable behaviours (Rosenstein and O'Daniel, 2005).

Persistent behaviours were reported as repeated occurrence of bullying behaviours over at least once a week for at least a 6-month period (Adams et al., 1997; McAvoy and Murtagh, 2003). Damages experienced by the targeted person are described as gradual negative impact on the confidence and self-esteem of the bullied person (Adams et al., 1997) and health and safety risks (Robenstein and O'Daniel, 2005). Imbalance of power was addressed as abuse of power and unfair penal sanctions (McAvoy and Murtagh, 2003).

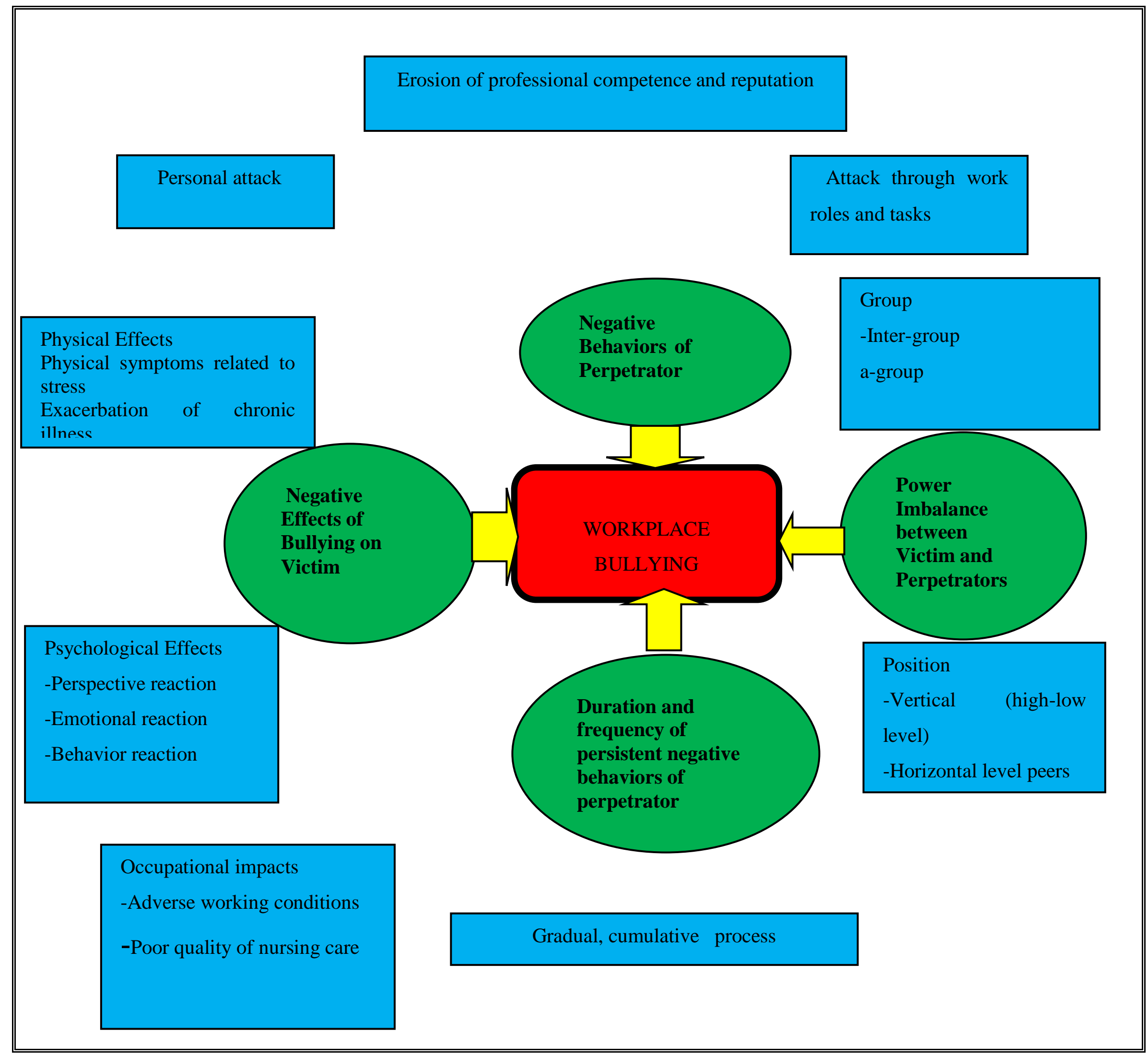

**Figure 1.1**:**The conceptual framework of bullying in the nursing workplace, by Rayner and Keashly (2005)**

Rayner and Keashly's (2005) model is similar to that of Zapf and Einarsen (2005) except that they propose the additional domain that the person being targeted labels the experience as bullying. The consequences or damages as a result of bullying in the nursing workplace not only affect interpersonal relationships but also, on an organisational level, quality of patient care, financial loss, and negative image of workplace (Rayner and Keashly, 2005). In this study, four core domains of bullying were adopted as the organising framework: negative behaviour of perpetrator, power imbalances between bullying victim and perpetrator, duration and frequency of persistent negative behaviours of perpetrator and negative effects of bullying on victim. The term "bully" and "target" were changed to "perpetrator" and "victim", respectively, in order to be consistent with current terminologies.

This conceptual framework may assist nurse leaders at clinical settings to have a better understanding of bullying dynamics and the inherent consequences while developing strategies to change the health care environment to a safer workplace for nurses. Nursing administrators and clinical supervisors may be able to detect early signs of bullying in the nursing workplace and intervene effectively. Such intervention may not only be for individual nurse victims but can also be at an organizational level in order to educate all employees and increase the knowledge of bullying and its secondary impacts on the quality of patient care, financial loss, and negative image of workplace. Additionally, nurse educators can incorporate this framework of bullying in the workplace as part of their curriculum to teach prelicensure nursing students before they enter the workplace.

### 1.8.1 Negative behavior of perpetrator

Hutchinson, Vickers, Wilkens, and Jackson (2010a) proposed that negative bullying behaviors of a perpetrator consisted of personal attack, erosion of professional competence and reputation, and attack through work roles and tasks. Personal attacks included verbalizing harsh innuendos and criticism, isolation, intimidation, degradation, belittling, sneering, rolling eyes in disgust, using hand gestures to ward off conversation, and threats of violence or actual physical abuse, which are reported as the least common episodes. The victim could lose self-confidence, causing stress and leading to physical illness and mental distress such as anxiety (Saunders et al., 2007).

Negative behaviour of perpetrator that make victims' work life difficult include giving an unmanageable workload (the most common behaviour), generating perceived unfair and punitive actions such as withholding information, posting documentation errors on bulletin boards for all disciplines to view and others to critique, and writing critical and abusive letters or notes to co-workers.

### 1.8.2 Power imbalance between bullying victim and perpetrator

Within the health care organizational structure, there are inter (outside of nursing) and intra (within nursing) groups and vertical structures with higher and lower levels, and horizontal structure between the same vertical levels within nursing (Randle, 2003). Workplace bullying could reflect an actual or perceived power imbalance (Dellasega, 2009). The power imbalance between victim and perpetrator in the nursing workplace was more common in inter-group structures at both vertical as well as horizontal levels compared to intra-group occurrences (Randle, 2003). The most common form of bullying involves the abuse of power by superiors against subordinates; some people hold information power over others as opposed to legitimate power (Neuman, 2000).

### 1.8.3 Duration and frequency of persistent negative behaviours of perpetrator

Persistent negative behaviors of a perpetrator indicate repeated negative behaviors of at least once or twice weekly by the perpetrator targeting a victim over a period of time of at least 6 months and as long as 12 months. Two studies measured one or more bullying experience within a 12-month period (Quine, 2001; Yildirim, 2009). Another study measured at least two bullying experiences weekly within a 6-month period (Laschinger, Grau, Finegan and Wilk, 2010). Two studies measured no frequency but only duration of 6 months (Johnson and Rea, 2009) and 12-month period (Yildirim and Timucin, 2007). The frequency of bullying at the workplace varied between daily to a minimum of once a week (Pearson and Porath,2002).

### 1.8.4 Negative impacts of bullying on victim

Bullying had a range of impacts on the victim's physical, psychological and occupational lives (Laschinger et al., 2010; Rocker, 2008). Physical effects of bullying included cardiovascular problems such as hypertension, chest pain, and /or heart palpitations as the most common symptoms, followed by headaches and weight loss/gain, sleep disturbance, gastro-intestinal distress, and fatigue, loss of libido and exacerbation of chronic illness. Psychological impact was mostly associated with fear, anxiety, depression, and posttraumatic stress disorder (PTSD) (Rocker, 2008; R;Yildirim, 2009).

Fear was the most reported symptom, which could be considered as a key symptom category of PTSD. In addition to fear, other reported symptoms of PTSD were anger, irritability, powerlessness, distrust of others, frustration, rumination over the situation at work, and low self-confidence. Some of these symptoms were also related to anxiety and experiencing panic attacks. Symptoms related to depression, low self-esteem, and lack of motivation, loneliness, sadness, suicidal ideation, hopelessness, and helplessness.

Occupational impacts included low job satisfaction (decreased sense of pride in their work) (Quine,2001), work absence (increased sick days, absenteeism from work, repeated sick calls (Laschinger et al., 2010; McKenna et al., 2003). Poor productivity (reduced productivity, difficult carrying out normal work, reluctant to attend work, lack of commitment to work, decrease in quality of care with poor relationships with patients, managers, and colleagues (MacIntosh et al., 2010; Yildirim, 2009). The victim's potential to leave job (considering or looking for alternative employment, changing work practices, claiming to leave (and work absenteeism were the most common phenomena followed by poor productivity, low job satisfaction, leaving for another job or leaving nursing profession all together, and leading to high turnover of staffing for the organization. In addition, the institution's reputation for absenteeism, attrition, and decreased productivity could be costly to the organization (Johnson and Rea, 2009; Nam, 2010).

The next chapter will present the literature review related to this study. The literature will indicate whether bullying seems to harm with result to physical or psychological consequences of workplace violence. The researcher will support the literature by quoting the relevant sources.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

This chapter provides an analysis of the literature regarding workplace violence in health care in general, and the nursing context in particular. This includes a review of recent relevant research. While there is a growing body of literature describing various aspects of workplace violence in the health care setting, not many studies are specifically focusing on the experiences of student nurses. Hinchberger (2009) points out that student nurses have rarely been included in the sampled population of previous research in workplace violence.

According to Nau, J., Dassen, T.,and Needham, I. (2009), a literature review conducted in 2007, using multiple search terms, only located 10 articles for the previous 15 years, dealing with this topic. The purpose of the literature review was to explore and understand the issues regarding workplace violence that threaten nurses, so as to inform the exploratory research of the degree and nature of workplace violence experienced by student nurses. The search terms utilized in several combinations were workplace violence, aggression, incivility, disruptive behavior, intimidation, bullying, and student nurse or, because of the paucity of research directed at student nurses, the literature search was conducted on the CINAHL, PUBMED, SABINET and GOOGLE SCHOLAR databases.

## 2.2 The history of workplace bullying

Although the phenomenon of bullying dates back decades, it is only in recent years that it has been at the forefront of research (Clarke, C.M.,Pontecorvo, M.J., and Beach,T.G.,2012). Bullying has been commonly associated with schoolyard settings and

more recently places of work. However, bullying in the health care settings appear to be a growing concern that encompasses negative and unwanted acts towards others (Clarke et al., 2012). In nursing education, students are beginning to identify uncivil faculty behaviours, suggesting that, at times, faculty has contributed to dehumanizing conditions that negatively affect students; leading to student anger, discontent, disrupted student-faculty relationships, problematic, learning environments, and increased stress levels among students and faculty (Hall, 2004).

Moreover, when students experience negative relationships with staff, they report feeling inhibited and undervalued, intrusive, uncomfortable, and unwelcome (Vallant and Neville, 2006; Jackson and Mannix, 2001). Students report feelings of anxiety during clinical rotation, which subsequently affects performance (Moscaritolo, 2009). Nursing students struggle with the stress of conflict in the classroom and clinical setting, creating an environment in which they witness and experience bullying first-hand (Lewis, 2004). Because nursing students are socialised into nursing while learning how to prioritize personal needs, nursing class assignments, and patient care needs, most students have little time to address or worry about bullying from others or directed toward others (Cooper, J., Walker, J., and Askew, 2011).

Nursing students have the highest risk of experiencing aggression because of inexperience, frequent ward changes and the challenge of meeting new environments (Ferns and Meerabeau, 2007). In a study of nursing students in New Zealand, Foster, B.,Mackie, B., and Barnett, N. (2004) suggested that 90% of them had experienced some form of bullying while in clinical placement. Similarly, Randle (2003) reported that nursing students often find present continuous their experience to be distressing and psychologically damaging. Moreover, in this case, 'all students provided examples where

they felt that some of the nurses with whom they worked would have used their position to bully ‘subordinates’, with some participants going as far as comparing their experiences to bullying in schools. In a British study, around 35% of students reported having been bullied; and around one in four of 1,000 students questioned indicated that a doctor had bullied them, while one in six had been bullied by a nurse (Andrews, G.J., Brodie, D.A.,and Andrews, J.P. (2005). In another study, 57% of student nurses either witnessed or experienced horizontal violence, in the form of humiliation and lack of respect; powerless and becoming invisible; the hierarchical nature of horizontal violence and impacted coping strategies and future employment choices (Curtis, J., Bowen, I., and Reid, A. (2017).

Similarly, Stevenson et al. (2006) reported that 53% of student nurses surveyed indicated that they had experienced negative interactions during their clinical placements. 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, and seventy-four percent had vicious rumours spread about them (Celik and Bayraktar, 2004). In this same study, 83.1% of student nurses reported experiencing academic abuse as being assigned responsibilities as punishment rather than educational purposes, and being punished with poor grades (Celik and Bayraktar, 2004). Supporting these results, a United States study revealed that 95% of fourth year nursing students surveyed, reported experiences of bullying behaviours, in which the most frequently reported bullying behaviours perceived included cursing or swearing, inappropriate, nasty, rude or hostile behaviours and belittling or humiliating behaviour (Cooper et al., 2011).

The study of types, sources and frequency of bullying or violence behaviours encountered by Egyptian nurses in the workplace attracted noticeable attention recently (Abbas, M.A.,Fiala, L.A.,and Abdel Rahman, A.G.(2010); Samir, 2012). All of them demonstrated the existence of bullying in the workplace, where nursing students undertake a significant amount of their nursing education. Since nursing students share that same ambiguous nursing environment with professional nurses, it is imperative to discover if they too are victims of bullying. It is a professional and ethical responsibility to be aware and facilitate change to stop the cycle of bullying. This is important particularly in order to improve the students' educational experience prior to entering a workforce in which bullying has been paid a little attention to the investigation of bullying against nursing students in Egypt. This present study attempts to contribute to redressing this gap by investigating perceived bullying behaviours experienced by nursing students and coping strategies used. Therefore, this study's main purpose was to investigate the perceptions of student nurses on bullying behaviour during their clinical placement, types, frequency, and the sources of bullying. The study also sought to coping mechanisms used to cope with these bullying behaviours.

## 2.3 Theoretical background to workplace violence or aggression

Neuman and Baron (2005) propose that the General Affective Aggression Model (GAAM) summarizes the current state of thinking in this area. According to this model, aggression is triggered by situational variables, for example stressors, frustration and provocation, and by individual variables such as type A behavior pattern, pro-aggression values and low self-esteem. All of this impact on the psychological processes of arousal, affective states and cognitions and, depending on a person's appraisal, may result in an aggressive, or non-aggressive response (Neuman and Baron, 2005).

A popular theoretical framework used to explain lateral violence (nurse to nurse), is that of oppressed group behavior (Matheson and Bobay, 2007). The domination of powerful groups, such as physicians and hospital administrators, are seen to have caused an identity crisis in nursing, manifesting in reluctance to confront the reigning group, with resultant passive-aggressive behavior and self-dislike (Roberts, 1983, cited in Matheson and Bobay, 2007). Hutchinson, Jackson, Vickers and Wilkes (2006), suggest that the use of an 'oppressed group' theory is too simplistic and fails to recognize other important organizational attributes of lateral violence, or bullying at the workplace. In addition, changes in the nursing profession over the past twenty years have resulted in modern, contemporary, registered nurses who may not agree that they fit into an 'oppressed group' category (Thomas and Burk, 2009).

According to Luck, Jackson and Usher (2006), these various perspectives are useful in that they increase understanding regarding the etiology and complexity of aggression, but fail in the sense that they do not provide predictive models to understand aggression towards nurses. In the researcher's opinion, though, this may be a somewhat limited point of view. This is so becausee uunderstanding of the etiology of aggression and of individual and situational variables, associated with aggression or violence, has some predictive value when designing intervention strategies.

## 2.4 Working towards a definition of workplace violence

Waddington, Badger and Bull (2005), indicate that some of the definitions of workplace violence are so broad and inclusive that any kind of behavior experienced by an employee, ranging on a continuum from disagreeable to frightening, is labeled as violent. They do acknowledge that people experience violence differently and that such experiences should be respected form an analytical and practical point of view. However,

they point out that broad, inclusive definitions of workplace violence are problematic, in the sense that the same conceptual tools are used to describe distinctly different circumstances and events (Waddington, Badger and Bull, 2005).

Alternatively, definitions restricting workplace violence to, for example, intended or physical assault, excludes the harmful effects of non-physical actions or threats, such as verbal and emotional abuse. To demonstrate this, the World Health Organization's definition of violence is the intentional use of physical force or power, threatened or actual against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, deprivation. Although helpful in recognizing that violence occurs at individual, group and community level and in acknowledging the psychosocial consequences of violence, this definition, by limiting violence to actual or threatened physical assault, it is not comprehensive enough to be suitable for research on workplace violence targeting student nurses. Instead, violence in the nursing context should be viewed as an overarching term comprising a wide range of behaviors (Luck, Jackson and Usher, 2006).

Fox and Spector (2005) express preference for the more global term, that is counterproductive workplace behavior, which they regard as an umbrella term for a domain that deals with any kind of behavior that is detrimental to an organisation. In defining workplace aggression as any form of behavior directed to one or more persons in a workplace towards the goal of harming one or more others in that workplace, in ways the intended targets are motivated to avoid, Neuman and Baron (2005). According to Neuman and Baron, (2005), the isolate intention is regarded as a critical factor that differentiates workplace aggression from other forms of counterproductive work behavior.

Workplace violence in the nursing workplace as inclusive of aggression, harassment, bullying, intimidation and assault (Hegney,D.,Eley, R.,and Plank, A. (2006). Other researchers have used terms like disruptive behavior and bullying (Hutchinson, M., Vickers, M.,and Wilkes,.L. (2006). Violence would exhale definition once the comparability of data attained in research, and would enable nurses to recognize and confront episodes of violence and aggression more effectively. However, it could be argued that a universally shared definition may have an opposite, simplistic effect and would exclude some of the finer cultural distinctions of workplace violence, as experienced in different context.

There also seem to be consensus that workplace violence encompasses at least two subcategories of workplace violence, namely physical and non-physical violence (Luck, Jackson and Usher, 2006). The formulation of a functional definition of workplace violence for the purpose of this study was further reliant on typologies or classification of workplace violence and an analysis of the nature of workplace violence experienced by nurses.

### 2.4.1 Bullying versus sexual harassment and discrimination

Simpson and Cohen (2004) explain sexual harassment versus bullying grounded in tendencies. Bullying behavior tends to be located in organizational power while sexual harassment tends to be in gendered power. Bullies choose targets based on individual characteristics such as competence, while sexual harassers choose targets based on group characteristics such as gender. Discrimination and workplace bullying also have some conceptual and legal overlap.

## 2.5 Types of workplace violence

Workplace violence may be classified as being one of four types, based on the perpetrator's relationship to the workplace (LeBlanc and Barling, 2005; National Institute for Occupational Safety and Health, 2006).

**Table 2.1: Summary of the four main types of the workplace violence**

| | |
|---|---|
| Type 1 | Refers to violent acts committed by criminals who enter the workplace to commit a crime. These individuals do have a legitimate reason to enter the workplace |
| Type 2 | Refers to violent acts committed by those who are the recipients of the services provided in the workplace. These individuals have a legitimate relationship with the workplace. |
| Type 3 | Refers to violent acts by worker to worker, where current or past employees are the agents of violence. |
| Type 4 | Refers to violence committed in the workplace by a non-employee who has a relationship with a worker |

According to Kgosimore (2004), type 3 which refers to employer to employer at a workplace. He claims that this type of violence, though under researched, is prevalent, particularly in the relatively secluded farming and domestic sectors in South Africa. According to Kgosimore (2004) this type of violence can be ascribed in part to the legacy of the oppressive socio-political system and colonialism. Although this does not appear to have direct bearing on workplace aggression and violence in nursing, it is conceivable that this legacy may also be included in the authority structure of other areas of social functioning in South Africa, including the health care system.

A widely recognised and foundational typology for many studies on workplace aggression is that proposed by Buss (cited in Neuman and Baron, 2005) who classifies workplace aggression using three dichotomies namely physical-verbal, active-passive, and direct-indirect. Physical aggression involves physical actions (e.g. pushing, assault) inflicts harm through words, rather than deeds. Active aggression implies that the perpetrator does something to harm the target, either directly, for example through theft or by spreading rumors, while passive aggression involves withholding something the

target needs or values, for example, ignoring the target, or failing to provide important feedback (Neuman and Baron, 2005).

## 2.6 Nature of workplace violence against nurses

Relevant literature revealed that in nursing, non-physical forms of violence, for example, verbal aggression, incivility, bullying and intimidation, are far more common that actual physical assault, and that in the few instances where weapons are involved, weapon use is opportunistic, rather than premeditated (Ferns, 2005). A similar pattern was reported by Khalil (2009) when she asked nurse respondents in eight public hospitals in Cape Town to respond to questions regarding six levels of violence. From most to least frequent, these levels were psychological violence, vertical violence, covert violence, horizontal violence, overt violence and physical violence.

Violence committed by fellow colleagues (type 3) is usually, but not exclusively, emotional and non-physical (Longo and Sherman, 2007). Typically called horizontal or lateral violence, it relates to inter group conflict and is expressed as bullying and aggression (Curtis, Bowen and Reid, 2007).

Common examples of lateral violence include being undervalued, blocking of learning opportunities, emotional neglect, nonverbal manifestations, such as rolling eyes, verbal manifestations, such as rude or demeaning comments, actions, such as not being available to help with difficult care related issues, sabotage, such as withholding important information, disinterest, excessive criticism, scapegoating, gossiping, forming cliques, exclusion, intimidation and humiliation. These behavioral manifestations can be classified as overt or covert (Griffin, 2004).

The lack of definitional clarity is also apparent in the description of lateral violence. Most researchers refer to lateral violence as workplace violence committed by nurse against nurse, irrespective of the status of the perpetrator. On the contrary, Thomas and Burk (2009) suggest a refinement of terminology that restricts lateral violence to violence among equals, and propose vertical violence as the term describing abusive behavior by a colleague in a superior position to a subordinate. Johnson (2009) is of the opinion that the terms, lateral or horizontal violence and bullying, are synonymous. Griffon (2004) holds the view that the concept, bullying, is replacing that of lateral or horizontal violence. In bullying, a definite power differential exists between the victim and the perpetrator(s), suggesting that the victim is unable to defend him / her (2009). The vulnerability associated with power inequality, would be particularly relevant to student nurses.

According to Rayner and Keashly (2005), bullying has been broadly defined as persistent, negative, interpersonal behavior, experienced by people at work. It refers too many, rather than isolated instances of behavior, which undermines, or humiliates. It further refers to what is done, for example personal attacks on credibility and what is not done, and for example not receiving needed information. The three factors forming the construct of bullying in the nursing contexts are (1) attack upon competence and reputation, (2) personal attack and (3) attack through work tasks.

Although most attempts to describe workplace violence emphasize the harmful intention of the perpetrator, an interesting development in recent years has been the tendency to utilize the concept, incivility, when studying aggression and violence towards nurses (Felblinger, 2008; Hutton and Gates, 2008) stated that workplace incivility is as low-intensity, deviant behavior, with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. They emphasize that incivility differs from other

types of workplace aggression or violence, in its ambiguous intent to cause harm. According to Cortina et al. (cited in Pearson, Anderson and Porath 2005), qualitative research has identified the content of uncivil behavior as disrespect, dishonesty, ignoring, exclusion, professional discrediting, silencing, gender belittling, threats, intimidation, unprofessional address and comments about appearance.

It is evident that conceptually, there is no clear distinction between incivility, lateral violence and bullying. However, the undisputed fact that these behaviors occur is more important than being able to place them in neat, mutually exclusive categories. The researcher attempted to summarize the general nature of non-physical violence directed at nurses in table 2.2 on the hand it illustrates the lack of conceptual clarity, but on the other hand, perhaps more significantly, it reflects the high degree of consensus, irrespective of terminology, regarding the nature of non-physical workplace violence in nursing.

**Table 2.2: Summary of non-physical violence directed at nurses**

| Non-physical violence | Manifestation / General nature |
|---|---|
| Lateral violence | Rude of demeaning comments; anger; judging; excessive criticism; condescension; rolling eyes; disinterest; withholding information; exclusion / clique formation; undervaluing; blocking of learning opportunities; emotional neglect; scapegoating; gossiping; intimidation; humiliation; withholding help in difficult care related issues |
| Bullying | Persistent, negative, interpersonal behavior; undermining or humiliating behavior; attacks on credibility, competence and reputation; personal attack; attack through work tasks |
| Incivility | Disrespect; dishonesty; ignoring; exclusion; professional discrediting; gender belittling; threats; intimidation; unprofessional address; comments about appearance. |

In this study among student nurses, workplace violence was defined as, 'aggressive behavior towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence, such as verbal abuse, incivility, bullying and intimidation'.

### 2.7 Prevalence of workplace violence in health care and nursing

A high prevalence of aggression and violence against health care workers, throughout the world, is revealed in the literature. In the United State of America, the likelihood of non-fatal assaults was found to be almost four times higher in health care that in all other private sector industries combined (Clements, P. DeRaniere, J., and Clark, K. 2005). A local study on workplace violence in three provincial health services in the Western Cape revealed that 61.1% of the sampled health workers had reported that they frequently had to contend with violence, or crime in the workplace.

A study, the largest of its kind to date, carried out by the Health Services Advisory committee in five Area Health Authorities (AHA) in England and yielding a 60% response rate, found that nurses were the group of health service workers with the greatest risk of being assaulted. Similarly, between 40-60% of nurse respondents in a study, targeting public, private and aged care services in Queensland Australia, had experienced workplace violence it the previous three months (Hegney et al., 2006). In another study in a hospital in South Eastern United States of America, results revealed that 28% of the nurses had experienced physical violence in the past year and 39% of them had experienced injury as a result of this violence (Spector and Matz, 2007).

A total of 58% had experienced verbal aggression. Hader (2008) also undertook a survey in the USA and in seventeen other countries and found that almost 80% of nurse's leaders had experienced a form of workplace violence. In Turkey, a prevalence rate of 80.3% for

verbal abuse against nurses was reported by (Oztunc, 2006). In a study conducted by Khalil (2009), he discovered that nurses, sampled from eight public hospitals in Cape Town, agreed that violence existed among nurses. However, the latter research only focused on lateral violence and did not address the issue of violence from other professional groups, patients, visitors and others.

Nurses working in emergency care departments and psychiatric units are particularly vulnerable (McPhaul and Lipscomb, 2004; Ferns, 2005; Chapman and Styles, 2006; Wand and Coulson, 2006). Some of the reasons for the increased prevalence of aggression and violence in emergency department settings are thought to be a combination of emotional factors such as fear, anger, disorientation and frustration due to excessive pain, long waiting periods and lack of privacy, in addition to other situational factors, such as easy access to emergency departments (Wand and Coulson, 2006). The restriction of personal freedom and geographical isolation in residential psychiatric units also seem to contribute to a higher level of violence.

Although the prevalence of workplace violence in health care is already consistently and disconcertingly high, this may only be the tip of the iceberg, due to the under reporting of violence, especially non-physical violence. Marais, Van der Spuy and Rontsch (2002) found for example that 50% of respondents had not reported verbal abuse. Similarly, in a large New Zealand study, investigating horizontal violence among registered nurses in their first year of practice discovered that less than half of lateral violence episodes had been reported (McKenna et al. 2003).

Potentially rampant under reporting was also reported by other researchers (Ferns, 2005). Nurses may tend to under report episodes of aggression and violence for many reasons, for example lack of confidence that management will do anything, a perception that, due

to emotional or physical reasons, patients are not really responsible for their actions, fear of reprisal and cumbersome reporting procedures (Luck, Jackson and Usher, 2006).

### 2.7.1 Incidence of workplace bullying

Incident is difficult to assess from the multidisciplinary body of literature, as researchers use different definitions, criteria and methods to arrive at these statistics. How one measure the problem depends largely on how one defines the problem. This point makes current estimates of incidence non-comparable. Leymann (1990) includes the criterion of at least one incident per week for at least six months. Other researchers, measure whether a person has ever experienced bullying in the workplace (Rayner, 1997). In answer to the question of how many people experience workplace bullying, the answer must be; it depends.

Zapf, D and Eirnarsen, S. (2005) provides a useful table comparing studies in terms of populations; number of participants, definition used and reported prevalence of workplace bullying. A review of this table shows a range of 0.3% prevalence in a Norwegian psychologists' union (Einarsen and Skogstad, 1996). A total of 53% prevalence in a study of United Kingdom part-time students (Ryner, 1997). The respondent groups on both ends of this statistical spectrum are obviously somewhat homogenous, but the vastly different statistics reflect the problem of definition and measurement of workplace bullying.

A study of Baltimore workers in four industries reported that 88% of the respondents were bullied at least once in the previous six months (Forni et al., 2003). Salin (2001) studies prevalence and subjective experiences of Finnish business professionals; 8.85% labeled their experiences as bullying, but 24% identified experiencing negative acts meeting the bullying criteria. In a United States of America higher education workforce

study, 23% of respondents employed by the University of Washington reported experiencing workplace mistreatment, while 40% had witnessed bullying. A random sampling of university ombudsman records at the same university revealed that 35% of the documented cases described workplace-bullying incidents (Price Spratlen, 1995).

Keashly and Neuman (2004), conducted a study which revealed that 18.4% of the 689 respondents reported experiencing workplace bullying at least weekly for a year, and 47% reported experiencing aggressive. A follow up study in 2004 showed a decrease in bullying (to 14%) and an increase in aggressive (to 56%); the authors acknowledge that the decrease in bullying may have been due to a more stringent definition in the follow-up survey.

A National Veterans Affairs study of 8.596 respondents reports that 36% experienced at least one bullying incident per week in the previous year (Keashly and Neuman, 2004). In studies including statistics of those witnessing bullying, rates increase (Keashly and Neuman, 2004).

The definition problem associated with workplace bullying directly affects measurement of the phenomena. While most studies follow sound research methods, the incident results are not comparable because of the definition used for measurement problem. However, all studies conclude that workplace bullying is a real problem in the need of attention.

### 2.7.2 Workplace bullying in higher education

Workplace bullying in higher education settings has received little attention in scholarly journals. A review of workplace-bullying literature produces a handful of studies specific to higher education workplaces with only one study in the United States of America, speculates that the limited number of studies on workplace bullying in the United States

of America generally indicates that the issue is still not accepted in America, just as school bullying was not accepted a few decades ago.

One Canadian scholar has produced a series of books about faculty mobbing in higher education, primarily based on case studies of faculty from around the world (Westhues, 2005a, 2010b, 2011). According to Salin (2014), bullying is a widespread problem among professionals and that a high education does not provide a shield against negative behaviors. The indication that education does not protect employees from being targeted is relevant in higher education workplaces where highly educated faculty members may believe they are too competed to become victims (Lewis, 2004). The first workplace-bullying study to focus on a university setting was conducted in Finland and included surveys and interviews across all job categories at a private university.

According to Swain, H. (2008), the problem with being bullied at work is that often subtle is isolation, many of the events can be trivial and the important thing about bullying is its persistence. He further stated that many students who are bullied do not realise it until their health suffers or they have gone through disciplinary procedures.

## 2.8 Perpetrators of workplace violence against nurses

As was discussed, nurses are most often the targets of type 2 (committed by the recipient of the service provided by the health care institution) and type 3 (committed by an employee or former employee of the workplace) workplace violence (LeBlanc and Barling, 2005). Specifically, the most common source of workplace violence was found to be patients, visitors or relatives, other nurses, nursing management and doctors (Sherlock, 2005 and Hegney et al., 2006). Heder (2008) reported that patients (53.2%) were most often the perpetrators of violence, followed by nursing colleagues (51.9%), physicians (49%), visitors (47%) and other health care workers (37.7%). These

percentages indicate that most few studies targeting student nurses, found that the perpetrators were most commonly staff members, with patients coming a close second (Hinchberger (2009).

In a study conducted in a single hospital in South Eastern United States of America, Spector, P., Coulter, M.,and Stokwell, H. (2007) discovered that 28% of nurses had been the target of physical violence in the previous year. Most of the physical violence had been caused by patients (100%) by colleagues or supervisors. They found that 38% of nurses had experienced verbal aggression in the previous year, 45% from patients and 17% from colleagues or supervisors. Interestingly, Rowe and Sherlock (2005) found that 19% of registered and licensed practical nurse respondents had reported verbal abuse from sources other than the above, for example housekeeping, radiology, volunteers and pharmacy.

**2.8.1 Sources of bullying at a workplace**

In a study involving Turkish nursing students (Celik and Bayraktar, 2004), 100% of the participants reported they had experienced verbal abuse at the hands of classmates. Celik and Bayraktar also found that students were the primary source of academic abuse, with nurses (38.6%) cited as the second most frequent offenders of academic abuse, followed by nursing school faculty (19.%), patients (25.%), and physicians (17.4%) Similarly, in a study investigating nursing students' perceptions of bullying behaviors, other nursing students (classmates or peers) were identified as the most frequent source of 8 of the 12 bullying behaviors identified by the researcher (Mc Adam Cooper, 2007).

Conversely, Foster et al. (2004) reported that nursing students 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 nursing students in a

United Kingdom study, followed by health care workers (19.6%) and visitors or their relatives (15.7%). In recent Italian study, teachers, doctors and supervisors accounted for 76% of the non-physical violence reported by nursing students (Magnavita and Heponiemi, 2011). Although there may not be consistency regarding the perpetrators of bullying behaviors, there appears to be no doubt that nursing students are experiencing bullying behavior.

### 2.8.2 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, and Bayraktar, 2004). Conversely, a New Zealand sample (N=40) of student nurses revealed that the majority of student nurse who were bullied, were in their first year and second year (Foster, B.,Mackie, B., and Barnett, N. 2004). In a United States of America study exploring student nurses' perceptions of bullying behaviors, nearly all categories of bullying behaviors as identified on the research survey were most frequently experienced by student nurses whose ages ranged from 18 to 24 years. Conversely, Stevenson et al. (2006) reported that students over the age of 35 years were frequently exposed to negative interactions.

### 2.8.3 The bully

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, patients, nurses and physicians (Celik and Bayraktar, 2009). Similarly, in a study investigating student nurses' perceptions of bullying behaviors, students of nursing were identified as the most frequent source of 8 of 12 bullying behaviors identified by the researcher (McAdam Cooper, 2011). In Celik and

Bayraktar's research, nurses (68.45%) were cited as the most frequent offenders of academic abuse, followed by nursing school faculty, patients and physicians. Although a small sample was used, Foster et al. (2004) similarly reported that student nurses identified nurses as being the largest source of bullying (88%). Ferns and Meerabeau (2008) reported patients followed by the health care workers, and visitors or relatives.

**2.9 Antecedents / predictors of workplace violence**

There is a fairly general consensus about job related risk factors for workplace violence. Of the 28 job characteristics identified may increase the risk for workplace violence (LeBlanc and Kelloway, 2002). A total of 4 are directly applicable to nursing, namely: physical care of others; emotional care of others; decisions that influence other people's lives; denying the public a service or request. Working alone during the evening / night. Dispensing drugs; exercising physical control over others; supervising others; interacting with frustrated individuals; disciplining others; working evenings / nights; working in contact with individuals under the influence of alcohol, working in contact with individuals under the influence of illegal drugs; and contact with individuals under the influence of medication.

Marais, Van der Spuy and Rontsch (2002), found that at the three health services being studied in the Western Cape, frustration, as a result of lengthy waiting periods, and substance abuse were primary reasons for aggressive behavior. Rayner and Keashly (2005) suggest that antecedents of workplace violence should be examined at the individual and organizational level. Some established precipitators of type 2 workplace violence in healthcare contexts, at individual level, are emotional stressors, such as depression, grief and death, mental health illnesses, confusion and disorientation related

to age or medication, and psychosocial or socio-economic factors, such as financial burdens and anxiety (Luck, Jackson and Usher 2006).

## 2.10 Consequences of workplace violence for nurses

Workplace violence obviously has consequences for the individual and the workplace or organisation (Camerino , D.,Estryn-Behar,M.,and Conway, P.M. 2008). Victims of violence experience immediate, short, or long term trauma, which is exacerbated by an increased frequency and severity of incidents. Clearly, the individual may experience actual physical injury, following physical assault. As has been noted, non-physical abuse is the most common type of workplace violence experienced by nurses and may result in physical and emotional distress. The results of a survey yielding 303 registered nurse respondents across the United States of America showed that bullying resulted in significant emotional and physical distress. In this particular study, 95% of respondents had experienced anxiety, whilst 72% had experienced headaches, or gastrointestinal symptoms because of bullying (Vessey, and Budin, 2009).

Emotional responses to verbal abuse from most to least common were found to be anger, sadness or hurt, shock or surprise, embarrassment or humiliation, powerlessness, fear, shame, hostility and intimidation (Kisa, 2008). The disruptive behavior, any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment at a workplace is also regarded as bullying behavior (Rosenstein and O'Daniel, 2005).

Felblinger (2008) found that nurses often respond to intimidation and incivility with self-directed feelings of shame and anger, leading to negative self-evaluation and an increased potential for re-victimization. Students experiencing, or witnessing lateral violence, reported feelings of humiliation, dissonance, powerlessness and a firm resolve not to

accept future employment is an area, institution, or unit, where they had been abused in this fashion (Curtis, Bowen and Reid, 2008).

Rosenstein and O'Daniel (2005) conducted a large survey on the perceptions of nurses and physicians regarding clinicians' disruptive behavior in 50 hospitals along the west coast of America. Most nurse respondents indicated that disruptive behavior by clinicians had significantly negative effects on selected behavioral and psychological variables, namely, workplace relationships (92% of respondents), information transfer (89%), team collaboration (91%), communication (94%), concentration (85%), frustration and stress (95%). Although the results of this study may have been biased by the fact that a convenience sample was used it does reflect an almost unanimous perception by the nurse respondents of the destructive consequences of workplace aggression (Rosentstein and O'Daniel, 2005).

Organisations have been facing increased absenteeism and staff turnover, increased sick leave, increased security and litigation costs and decreased productivity (Ramos, 2006 and Vessey, J.A.,Demarco, R.F., and Gaffney, D.A. 2009). Intent to leave the profession because of workplace violence was demonstrated in a study on the experiences of registered nurses regarding lateral violence in their first year of practice. In this study, one in three respondents considered leaving the profession because of an abusive incident. It was also reported that 33.4% of respondents had considered resigning, following verbal abuse. These findings have serious implications for a profession already crippled by a shortage of staff.

Organizations suffer from losses in productivity, due to strained professional relationships and below standard patient care (Kisa, 2008). A survey of 1,565 nurses by the Institute of Safe Medication Practices (2004) revealed that 49% had acknowledged that intimidation

had affected the way that they had clarified medication orders. In their survey, Rosenstin and O'Daniel (2005) asked respondents to indicate any link between disruptive behavior and negative clinical outcomes.

Many nurse respondents indicated a strong link between disruptive behavior and adverse events (25% of respondents), medical errors (23%), compromised patient safety (14%), diminished quality of care (22%) and reduced patient satisfaction (16%). Rowe and Sherlock (2005) reported that 13% of the respondents admitted that verbal abuse had resulted in them making a care giving error. Vassey et al. (2009) also reported and increased potential for below standard care as a result of bullying. Thus, workplace violence has serious implications for patient safety. A distressing consequence of exposure to workplace violence is the normalization of the experience. Students are socialized into the antisocial behavior, whilst those who have been victims, subject new nurses to the same treatment (Ramos, 2006), possible in an attempt to protect their self-esteem (Rowe and Sherlock, 2005). In a training program, students were exhibiting the same bullying behavior that had caused them stress and anxiety at the start of their course.

### 2.10.1 Self-esteem

Self-esteem is concerned with evaluation of one's self and refers to an individual's like or dislike of them. Self-esteem is understood to be a predictor of behavior and is of unique concern in nursing, as the behavior of registered nurses and student nurses may directly impact on the well-being of patients while in their care. Social interactions may either positively or negatively impact on one's self-esteem (Randle, 2003). Social interactions for student nurses frequently include dyadic interactions with nursing educator, staff nurse, other hospital staff, classmate, physician or patient and or patient families.

In view of the fact that student nurses are frequently being judged on their skill of performance, feedback has the potential to either damage or support self-esteem. Because student nurses straddle the education-workplace divide, it was suggested that self-esteem relates to occupational performance and is important in influencing attitudes and behaviors. It 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 because of experiences of horizontal violence (McKenna, B.G.,Smith, N.A,.and Poole, S.J. 2003). They described being devalued and felt that nurses used 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 percussion and admitted to eventually participating in the intimidating behavior themselves. Shockingly, quantitative findings demonstrated that 95% of students had below average self-esteem by the end of their nursing education, in contact 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 because of bullying behaviors (Stevenson et al., 2006; Foster et al., 2004).

### 2.10.2 Self-efficacy

Self-efficacy is the belief in one's capabilities. Although one would theoretically postulate that a relationship would exist between bullying and self-efficacy, a study of 4323 Danish manufacturing employees found no association between exposures to

bullying behavior and self-efficacy (Mikkelsen and Einsarsen, 2002). 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 with personal accomplishments.

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 known to the researcher 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 behaviors (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.

### 2.10.3 Adverse effects

The consequences to bullying are numerous in the healthcare setting and these include frustration, anger, fear and emotional hurt feelings of powerlessness, decreased morale and productivity, an increase in errors (Sofield and Salmond, 2003) and symptoms associated with Post Traumatic Stress Disorder. As a result of the distressing nature of bullying, nurses have reported having to take days off of work (McKenna, et al., 2002).

Nurses have compared the clinical settings to that that of a battlefield and described their environment as hostile and across studies, nursing students have reported both psychological and physical reactions such as, feelings of helplessness, feeling depressed, fear and guilt , sleeplessness, anger, anxiety, worrying, stress, self-hatred, a decrease in confidence, and an increase in absence or sickness (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 because of intimidating behavior (Medication Safety Alert, 2004).

### 2.10.4 Effects of workplace bullying

A great deal of workplace-bullying research focuses on the effects experienced by individuals, organizations or both. Scholars agree that workplace bullying has negative effects for an organisation and its employees. Workplace bullying can result to all other kinds of work related stress to the employee (Zapf et al., 2003).

a) **Individual effect**

The individual effect of bullying persists long beyond the bullying itself. Not only is the target affected perhaps for life, but those who witness bullying of others also experience negative effects. The negative effects could include health problems, relationship problems and career problems.

b) **Health effect**

Negative health effect of workplace bullying is well documented in the literature. Damage to mental health includes depression, post-traumatic stress disorder, psychological stress, anxiety, sleep disorders, low self-esteem and suicidal thoughts. Physical health effects include nausea, vomiting, migraines, cardiovascular problems, musculoskeletal pain, high blood pressure, substance abuse, ulcers and more.

In Vickers'(2004) introduction to a journal's special issue dedicated to the traumatized worker, she likens workplace bullying to torture, comparing characteristics of the two phenomena and concluding that they are the same process. From this perspective, it is

easy to understand the resulting physical and emotional trauma suffered by workplace bullying targets.

Post-traumatic stress disorder (PTSD) symptoms are higher in targets of workplace bullying than in the general population. Matthiesen and Einarsen (2004) find a strong correlation between PTSD symptoms and negative affectivity in workplace-bullying targets, suggesting that personality characteristics may make some employees more vulnerable to bullying. Their findings of increased PTSD symptoms in bullying targets are consistent.

a) **Relationship effects**

As a bullied employee's stress increases and physical and mental health deteriorates, it is understandable that personal relationships begin to suffer. As anger, irritability or depression set in, it is difficult for those around the target to remain understanding and sympathetic. MacIntosh (2005) notes some interesting personal-relationship problems in her study of rural workplaces. Bully targets reported having no social support and stated that they could not talk to their life partners because they feared further misunderstanding and further isolation. Three of MacIntosh's (2005) study participants reported becoming aggressive at home after being bullied at work.

**b) Career and financial effects**

Workplace-bullying targets are often set up to have job, career and financial problems. As discussed earlier, bullies may sabotage an employee by preventing him or her from obtaining the resources or information needed to do the job. The targets are then blamed

for poor performance, while stress mounts, and performance deteriorates further. A bullying environment negatively affects creativity, which in turn negatively affects the target's performance. While the bullies are busy making sure the target is not able to perform up to par, the target's physical and psychological health are affected, and job performance is again negatively affected (Barling et al., 2001and Einarsen, 2000).

Studies show an increase in sick-leave usage among bullies' targets (Kevenki et al., 2003 and Tepper, 2000). This puts some employees at risk in terms of job security or promotion. Some targets seek counseling to deal with the effects of bullying, either while they are still in the job or after they leave (MacIntosh, 2005). Targets who feel forced to leave a job fear being unable to find another job in their discipline or geographic area because of ruined reputation or the appearance of changing jobs too often (MacIntosh, 2005).

### c) Organisational effects

If people think about the consequences of bullying, they most likely think about the consequences for the target, or perhaps for the bully who was caught. The literature on workplace bullying exposes another category of consequences: the organizational effects. These consequences are the negative effects experienced by an organization in which workplace bullying occurs. Rayner and Cooper (1997) describe the effects of workplace bullying as too costly to ignore. The authors cite the high cost of litigation, employee turnover, poor performance resulting from stress and difficulty recruiting new employees as reasons why organizations should stand up and take notice of the issue.

Johnson and Indvik (2001) discuss the organisational costs of workplace incivility, including a decrease in employee loyalty, litigation costs, legally awarded damages,

turnover, absenteeism and the potential of escalation into violence. Glendinning (2001) discusses the cost of decreased productivity as a result off workplace bullying in American workplaces.

In order for targets of workplace harassment to seek legal resolution of their bulling experiences, they must have some legal framework within which to make a claim. Workplace bulling is not against the law in the United States of America, unless it is based on membership in a protected group, but advocacy groups have tried to pass legislation (Yamada, 2000) for status-blind protection of employees since 2003. Anti-bullying laws have been established in several other countries. In places where there is no protection from workplace bullies, some abused employees are winning lawsuits pursued through related legislation.

## 2.11 Strategies to address workplace violence

Strong support is found in the literature that managerial intent, buy-in and commitment to addressing workplace violence are fundamental to the success of any violence prevention / management program (National Institute for Occupational Safety and Health, 2006 and Gallant-Roman, 2008). General strategies formulated at the conference on workplace violence prevention in Baltimore (National Institute for Occupational Safety and Health, 2006), included a multidisciplinary approach to workplace violence prevention, a written workplace violence policy, tailored to an organization's particular profile, training in the implementation of policies regarding the reporting of lateral violence, and continuous evaluation of programs and strategies adopted to address workplace violence.

There is strong support for the application of a zero tolerance policy for all forms of workplace violence (Gallant-Roman, 2008). In contrast, Duxbury and Whittington (2005) are of the opinion that different kinds of workplace violence necessitate different

management strategies. They feel that zero tolerance policies, aimed at managing patient aggression, would result in patient blaming and intolerance on the part of health workers and that it may have the regrettable consequence that the training of nurses in more proactive, de-escalation strategies of violence prevention, would be neglected (Wand and Coulson,2006). It thus seems as if policies that do not accept violence may be very effective against lateral violence and bullying (type 3 workplace violence), but less effective against violence committed by patients (type 2 violence). Training in de-escalation techniques, early recognition of potentially volatile situations and sound interpersonal skills is therefore the preferred way of managing most expressions of patient aggression (Wand and Coulson, 2006). In this regard, Beech (2008) noted a definite trend in the recent past towards interventions emphasizing prevention and de-escalation strategies.

Generally, the training and education of nurses to recognize and defuse potential episodes of workplace violence and to report incidences of workplace violence are widely recommended (Beech, 2008 and Gallant-Roman, 2008). Nau et al. (2009), as far as nursing students are concerned, reported that training in violence and aggression management is very rare. In view of this, they implemented a three days training course to increase student nurses' confidence to cope with patient aggression. They found that because of this intervention, confidence levels were significantly increased. However, a limitation to this study was that the students' self-reported capacities to deal with patient aggression were measured only two weeks after the training course. The proximity to the received training may thus have produced false positive results. The actual efficacy of workplace violence prevention programs, however, is still a relatively under researched area.

A specific strategy identified to address type 2, workplace violence, is to ensure an adequate staffing and skills mix (National Institute for Occupational Safety and Health, 2006). It has been noted earlier, for example, that working alone, or working with clients under the influence of alcohol, increases the risk for workplace violence. Student nurses, by virtue of their inexperience, can be expected to be even more vulnerable to inadequate staffing and skills mix.

Hutchinson (2009) provides an insightful typology regarding approaches to combat bullying in the nursing workplace, by distinguishing between an individual focus and an organizational focus. Strategies with an individual focus include a remedial approach, centered on counseling and mediation, while a corrective approach applies discipline and ensures aggression de-escalation training. Strategies with an organizational focus comprise regulatory measures, such as policy and legislation, and value group restorative measures, centering on shared responsibility and shared concern.

According to Hutchinson (2009), an institutionally supported group approach to bullying actualized through the intervention of restorative circles and conferencing, where group members are encouraged to expose and discuss the problem.

With reference to student nurses, Hutchinson (2009) strongly advocates the use of restorative interventions in pre-registration training programs, to create awareness of and commence moral discourse about bullying behavior. It is well documented that horizontal and hierarchal aggression exists in the health care workplace internationally (McKenna, et al., 2003 and Mannix, 2002). It is duly noted that nurses are at great risk of experiencing aggressive behavior by colleagues and physicians (Rowe and 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 setting

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 they are more concerned about aggression between colleagues (May and Grubbs, 2002), More recently, studies have been undertaken to investigate the phenomenon of bullying in nursing education. (Farrell, 2001).

### 2.11.1 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 and Bayraktar, 2004). Randle (2001) supports these findings as student nurses ‘psychological reactions to bullying included the intention to leave the profession. 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).

## 2.12 Barriers to the implementation of strategies to prevent workplace violence

At a conference held in Baltimore in 2004, under the auspices of the National Institute for Occupational Safety and Health, and incorporating a diverse group of representatives from various disciplines and organizations, common barriers to the implementation of workplace violence prevention were identified. Some of these were related to the particular organisation itself, whilst others were related to the type of workplace violence. The barriers identified by participants, were corporate denial of workplace violence. A

culture of violence that permeates society, lack of worker empowerment. A lack of incentives to implement strategies. It is also seen as lack of awareness of the extent of the problem. A lack of evidence based information to formulate prevention strategies. A lack of training regarding management of workplace violence. A lack of resources (particularly where prevention strategies are seen as costly and unjustified), lack of effective follow-up to reported incidents, under reporting of incidents of workplace violence. A lack of written prevention of workplace violence policies, and lack of teamwork to sustain such programs. (National institute for Occupational Safety and Health, 2006).

Under reporting of workplace violence is a major barrier to successful management of the problem in nursing (McKenna et al., 2003 and Ferns, 2005). Understandably, student nurses are reluctant to report incidents of lateral violence, because of the relative powerlessness they experience when having to confront the behavior of, for example, registered nurses / superiors (Thomas and Burk, 2009). Student nurses do not report incidents of assault, because of breaches in confidentiality and because they feel unsupported by senior staff.

### 2.13 Under-reporting of workplace bullying

It appears that retribution and lack of support by management 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 was reported. Little is known about why nursing students fail to report bullying behavior. 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 United States of America study of nursing students'

perceptions of bullying behaviors, 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 behavior 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 behaviors are sharing their experiences with classmates, as the majority (65.5%) of students in a United Kingdom study indicated that they were aware of other students' experiences of verbal abuse (Ferns and Meerabeau, 2008).

### 2.14 Coping strategies with workplace bullying

Various coping strategies have been identified in the relevant literature. Registered nurses who have experienced bullying behaviors in the workplace have reported taking days off of work, changing areas of practice, leaving nursing, dealing directly with the nurse, calling in sick, and attempting to clear the misunderstanding (Rowe and Sherlock, 2005).

### 2.15 International legislation relating to workplace bullying

The concept of workplace bullying was first identified outside of the United States of America, so it is not surprising that legislation addressing the workplace-bullying issue first emerged abroad. Sweden was first in 1993, when its National Board of Occupational Safety and Health enacted the Victimization at Work Ordinance, which covers several types of victimization including bullying and sexual harassment (Yamada, 2003).

Australia protects workplace-bullying targets in Queensland (Workplace Health and Safety Act, 1995), and South Australia (index of South Australian Legislation, 2005).

New proposed legislation from Safe Work Australia would apply across all of Australia (Work Health and Safety Codes of Practice, 2011). Colombia's anti-bullying law went into effect in 2006 (Davenport, n.d.).

In North America, Canada leads the charge on making workplace bullying illegal. Quebec passed the first North American law against bullying in 2004 (Labor Standards Law, 2004). Quebec's Office of Labor Standards (2006), focuses on the prevention of bullying and offers free handbooks and other resources as downloads from their website. Saskatchewan (Occupational Health and Safety Act, 2007), Ontario (Occupational Health and Safety Act, 2010) and Manitoba (Workplace Safety and Health Act, 2010) amended earlier legislation to make psychological abuse and bullying illegal.

### 2.16 Behaviors and tactics

The behaviors and tactics used in the workplace are more sophisticated than the ones used on the playground. More subtle and persistent tactics that can do more harm and have longer-lasting effects than physical aggression replace hitting and kicking behaviors. Simmons' (2002) work on hidden aggression in girls seems to indicate that girls master these subtle tactics earlier than boys. Societal rules excuse physical aggression in young boys (boys will be boys), but girls are denied access to such expression. Without the physical option, girls learn more sophisticated, underground behaviors to torment the objects of their aggression. Simmons states that girls use backbiting, exclusion, rumors, name-calling, and manipulation to inflict psychological pain of targeted victims.

Like the girls in Simmons' (2002) study, the workplace bully uses manipulative behaviors that preserve or elevate the bully's status while aiming to destroy the chosen target (Davenport et al., 1999). Keashly and Jagatic (2003) report that the most hostile behavior in the workplace is verbal, indirect and passive, and they provide a chart of example

behaviors cited in other literature. These behaviors include but are not limited to name calling, belittling, false accusations, rumor spreading, ignoring memos or messages, deliberate exclusion, assigning work overload or taking away meaningful work, turning others against the target, public criticism, interrupting, silent treatment, withholding information or resources and imposing unreasonable deadlines (Keashly and Jagatic, 2003).

Leymann (1993) developed a list of 45 behaviors in five categories that may be exhibited by workplace bullies. Davenport (2002) provides an English translation and summary of Leymann's (1993) work, originally published in German (Leymann, 1993 in Davenport et al., 2002). Any one of the behaviors on the list seems minor if considered as a single incident, but when they occur repeatedly over time they have significant negative effects (Davenport et al., 2002; Einarsen et al., 2003).

## 2.17 Conclusion

The literature reveals a great deal of crossover in the identified behaviors of workplace bullies, but again, definition is linked to manifestation, and there is no agreement on definition. Many of the items in more current literature are similar to those in Leymann's original typology. The following chapter will present the research methodology that the researcher will use in this study.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1 Introduction

In this chapter the researcher presents research paradigm and approach, research design, study setting, research setting, population, sampling and sample size, data collection instrument, data collection process, reliability and validity of the instrument, data collection process and data analysis, ethical considerations relating to this study, data management as well as dissemination.

## 3.2 Research paradigm and approach

The positivist paradigm, sometimes known as logical positivism, serves as a guide in this study. The positivist's scientific approach involves the use of orderly disciplined procedures with the tight control over the research situation (Polit and Beck, 2008). A quantitative approach, which is closely allied with the positivist tradition, was used in this study. A quantitative approach is a formal, objective, rigorous, systematic process for generating new information about the world, and the phenomenon of interest can be precisely measured and quantified in a rigorous and controlled manner as stated by Polit and Beck (2008). A quantitative approach was therefore found appropriate in this study which intends to investigate the nursing students' perceptions on bullying behaviour during clinical placement without any interference from the researcher and for objectivity.

## 3.3. Research Design

A quantitative, non-probability, convenience method was deployed in this inquiry. According to Burns and Grove (2009), the purpose of descriptive research is to provide an illustration of a situation as it naturally occurs. This design is used to examine the characteristics of the sample, and is essentially useful in acquiring knowledge in an area where little research has been conducted in relation to student nurses 'perception on bullying behaviour during clinical placement. Since the descriptive design simply

observes and describes the phenomenon, research investigates the full nature of the phenomenon, the manner in which it is presented and other factors related to it (Polit and Beck, 2008). Furthermore, research design is used to obtain information on the current status of the phenomenon in order to describe what actually exist with respect to variables or conditions (Burns and Grove, 2009).

In this study an exploratory and descriptive design is found to be appropriate as the study explores and describes the perceptions' of student nurses concerning bullying behaviour during clinical placement in a selected private nursing institution.

### 3.4. Study setting

Data was collected at a selected private nursing Institute in KwaZulu- Natal Province near Durban situated in Hammarsdale. The school offers a two-year programme which enables students to register with the South African Nursing Council (SANC) on completion of the course. The school offers one year for enrolled nursing, two year programme for enrolled nurses and a bridging course. The study respondents were student nurses registered for the 2016 academic year.

### 3.5. Study population

The population of the study consisted of student nurses who are registered for a first and second year programme n =120. The researcher took all student nurses who met the inclusion criteria.

### 3.6. Inclusion and Exclusion criteria

According to Polit and Beck (2008), eligibility criteria determine who may participate in the study and who may be excluded.

### 3.6.1. The inclusion criteria

All student nurses enrolled in the programme as full time students in the programme for 2016 academic year in a selected private nursing institute. The student nurses willing to participate and those who met the inclusion criteria.

### 3.6.2 The exclusion criteria

The exclusion criteria specify characteristics that eliminate a subject from being eligible to participate in the study (Polit and Beck, 2009). In this study, the exclusion criteria will consists of those student nurses not willing to participate in the study and not meeting the criteria.

### 3.7. Sampling and sample size

According to Polit and Beck (2008), sampling is the process whereby portions of the population who are representative of the entire population are selected. On the other hand sample is defined as subset of a population selected to participate in the study. The purpose of selecting a sample is to obtain descriptions that would accurately portray the characteristics of the total population. In this particular study non-probability, convenience sampling method was used. The whole population was requested to participate in this study because of the limited number, thus making the total size of 120 student nurses that is all student nurses who were registered in a first and second year programme in 2016.

According to Van der Walt and Van Rensburg, (2012 ) there is no recommended simple way of calculating the sample size for a descriptive quantitative approach but the number of student nurses must be large enough to represent the entire population hence this research had targeted 120 student nurses but only 114 questionnaires came back. The technique will be suitable for current study because of the time available to the

researcher. The researcher managed to distribute the questionnaires during lecture sessions as per permission received from the principal of the school in two conservatives lecture sessions.

### 3.8. Data collection instrument

A 90 itemed research questionnaire was used to collect data in this study. Kumar, R. (1999, 2005, and 2011) describes questionnaires as a list of questions that are studied and decoded by the respondents. A questionnaire was considered the most appropriate data collection instrument as it was quantitative in nature adopted a positivist paradigm. Questionnaires are also a quick way of obtaining data from a large group of population simultaneously and less expensive in terms of time and money.

The rationale for using a structured questionnaire in this study was that through systematized questions the researcher is able to obtain similar answers from the respondents, as stated in Saunders, Lewis and Thornhill (2003). The use of a questionnaire as a data collection instrument enabled the researcher to obtain information from the selected sample of student nurses in a consistent manner.

Data collection was conducted through the use of questionnaires and document analysis. The researcher adapted questionnaires from the work of Hewett (2010), who developed and tested the tool with 218 undergraduate nursing students in South Africa, see Annexure C. The choice of the questionnaire being guided by the research objectives, conceptual framework and the literature. The instrument was in simple and clear English, which was easier for respondents to complete (Burns and Grove, 2003), and was tested by experts from the School of Nursing. The questionnaire used mainly closed-ended questions that is only one word answer was required and that were rated using four-point response scale. The questionnaire was divided into four sections. Section A entails

demographic data which includes the student nurse's age, gender, program and level of study, whether student nurses has been trained as nursing assistants before. Section B sought the perceptions of student nurses concerning bullying behaviour during clinical placement, in terms of the state to which bullying had gone to, types and frequency. Section C entails data related to source of workplace violence and Section D entails coping strategies adopted.

### 3.8.1. Data collection process

According to Polit and Beck (2008), quantitative researchers collect empirical evidence according to the formulated plan, using a structured instrument to gather the required information. Data collection was conducted after obtaining ethical clearance from the University of KwaZulu-Natal (UKZN), Faculty of Health Sciences Research and the Ethics Committee. Permission to collect data was granted by the principal of the Nursing School of a selected private nursing institution in KwaZulu Natal Province. The researcher was allowed to collect data at lecture rooms during lecture sessions since they usually come on the same day or week. A questionnaire that took about 30 minutes to fill was distributed to student nurses and collected after 30 minutes that was permitted to the researcher by the principal of the school. The researcher started by introducing herself, explaining the purpose of the study and responding to the potential student nurse's questions and clarification regarding the study. The researcher explained that participation is voluntarily, they are not forced to participate. The researcher distributed the instructions for the student nurses which were in a form of a letter and the consent form for reading and signing. These were attached to the questionnaire. The researcher spent some time explaining how to complete the questionnaire to the student nurses because spoiled questionnaires are a waste and it is unethical to dispose questionnaires with errors which could have been avoided by the researcher. The researcher assured the

student nurses that confidentiality will be maintained throughout the study and during the process of disseminating findings from this study. The information letter to the student nurses included the names and the telephone numbers of the researcher and supervisor in case there is a need. The information letter included the name of the university endorsing the research. The researcher was available to explain and clarify questions and to answer student nurses queries as suggested by Polit and Hungler (2001). Student nurses were informed that it was anonymous and that no identifiable information should be entered on the questionnaire. These as well as to ascertain their rights to participate.

The principal of the school and lecturers assisted the researcher with the distribution of the questionnaires to student nurses, because the researcher was given 30 minutes without disrupting classes or practical sessions. The completed questionnaires were collected by the researcher and placed in a box for security reasons. Numbers were used instead of nursing students' names to ensure confidentiality (Burns and Grove, 2003). Out of 120 questionnaires distributed, 114 were collected after completion. At the end of the data collection process, the researcher thanked the participants and the school authorities and promised to come back to submit the final report.

### 3.9. Validity and Reliability

According to Polit and Beck (2008) an ideal measuring instrument is one that results in measures that are relevant, accurate, unbiased, sensitive, uni-dimensional and efficient. Validity and reliability are major criteria for assessing the instruments quality and adequacy. Polit and Beck (2008) describe reliability as a degree of consistency or accuracy with which an instrument measures an attribute. It refers to the likelihood that a given measurement or procedure will yield the same description of a given phenomenon, if that measurement or procedure is repeated. A reliable item is one that consistently

conveys the same meaning every time it is read by respondents and it is interpreted in the same way.

### 3.9.1 Validity

According to Polit and Beck (2008), the validity of the research instrument determines the degree to which it measures what it is intended to measure. Burns and Grove (2009) concur that instrument validity determines the extent to which the instrument actually reflects the abstract construct being investigated. Construct and content validity were ensured by checking items in the data collection tool against the study objectives and the concepts in the conceptual framework, to establish if all elements to be investigated were covered. The research supervisors, as well as a panel of experts in the research and Nursing Education Department of the University Of KwaZulu-Natal School Of Nursing helped review the instrument.

### 3.9.2 Reliability

According to Polit and Beck (2004), reliability is the consistency in which an instrument measures the target attribute. Defines reliability as the degree to which an instrument can depend upon to yield consistent results if used repeatedly over time on the same population, can yield same results or if used by two researchers. Reliability of the instrument was ensured by undertaking the test-retest activity.

**Test-retest reliability:** The research instruments were administered twice in two weeks' time to ten student nurses before the actual data collection. The ten student nurses who took part in the test-retest did not participate in the main study. The first answers were compared to the second set by calculating the correlation coefficient, which according to Burns and Grove (2009) must be at least 0.8.

**Internal consistency:** refers to the homogeneity of an instrument (Polit and Beck, 2008) or a measure of reliability by determining the degree to which each item in the instrument correlates with each other. Reliability testing was carried out by measuring the Cronbach alpha coefficient which is expected to be 0.7. According to Burns and Grove (2009), a newly developed psychosocial instrument with 0.7 is considered acceptable as a researcher refines the instrument to attain > 0.8 reliability.

### 3.10. Data analysis

Data in this study was analysed using quantitative data analysis methods (statistically). The Statistical Package for Social Sciences (SPSS) version 24 was used to analyse all variables. Descriptive statistics were used to describe and synthesize data where the frequencies, percentages, standard deviations and mean, median and mode. The standard deviation as stated in Polit and Beck (2008) was also established. Reflected tables and graphs were used to illustrate interpretation. All the scores were computed for the main concepts of the questionnaires.

### 3.11. Ethical considerations

According to Burns and Grove (2009), nursing research requires not only expertise and diligence but honestly and integrity as well, therefore ethical research is essential to generate a sound evidence-based practice for nursing.

*Permission:* The researcher prior to data collection, the permission was sought and granted by the Principal of the Nursing Institute where the study was going to be conducted. The research proposal was then submitted to the University of KwaZulu-Natal, Ethics Committee who granted ethical clearance. The researcher has a duty treat all respondents with dignity and to reduce anxiety or discomfort. Student nurses were

provided with a written explanation of the purpose of the study, the nature and the procedure of the study and their expected roles as participants of this study.

*Informed consent:* Involves voluntary participation of the participants. A two page participation letter was provided to each student nurse explaining the purpose of the research and the nature of the questionnaire. They were also provided with a consent form to participate in the study which they signed before answering any question. Every student was issued with a copy of the consent form. Student nurses approval to take part in the study was obtained through written and signed informed consent.

*The principle of justice*: was adhered to by ensuring the student nurse's confidentiality. During the data collection processes, the researcher informed the participants not to write their names on the questionnaires. It was explained to them that the completion of the questionnaire required signing a consent form. Student nurses were assured that no sensitive information would be divulged during the publication of the study results.

*Confidentiality:* Burns and Grove (2012) state that confidentiality means that the researcher keeps, in confidence, issues that the respondent does not want to disclose to others. Confidentiality was observed in that the student nurses who were asked to participate in this research were given assurance of confidentiality.

*Anonymity:* The researcher ensured that the questionnaire did not require that the name of the selected nursing institute or that of the student nurses be stated. The signed consent forms were separated from the completed data collection tools to ensure that there is no link between the two. The names of the student nurses were not used on the questionnaire but the numbers were assigned to each questionnaire.

*Benefits:* There were no potential, physical, psychological, social and legal risks to the participants. The researcher explained to the participants that there were no direct benefits to them, and that they would not receive course credits for participation in the research. However, the information which they contributed would enhance the improvement of Nursing Institute and health care provision.

*Psychological Effects*: The researcher further explained that the study does not have any physical, psychological, social or legal risks for respondents. The researcher explained that as answering a questionnaire might have trigger emotional or psychological responses in some participants therefore a psychologist with be available during data collection to provide support and minimise psychological harm.

### 3.12. Data management

The researcher kept the collected data safely. The data was kept confidentially on a computer which has a code of access known by the researcher only. Completed questionnaires were kept in box in a safe lockable cupboard in the university by the supervisor and will be kept for a period of five years thereafter destroyed by means of shredding. Data stored on the computer was erased from both programme files and the recycle bin.

### 3.13. Dissemination of findings

The findings of this study will be presented to the University of KwaZulu Natal in a hard copy and another copy will also be made available to the School of Nursing where this study was conducted. The researcher and the supervisor will publish the findings in accredited scientific nursing journal. The names of the respondents and the institution that is used as a research setting in this study will be kept confidential as per policy.

### 3.14. Conclusion

This chapter focused on the research paradigm and approaches, the research design, the research tool and the validity and reliability of the research tool. This chapter explains the research setting and the study population, the sampling and the sample size. This chapter describes how data were collected, the methods used for data analysis and the ethical considerations involved in this study. The data management and the dissemination of the results were also explained. The next chapter will present research findings of this study.

# CHAPTER FOUR

# PRESENTATION OF FINDINGS

## 4.1 Introduction

This chapter presents the findings of the study whose aim was to explore student nurses' perception on bullying behavior during clinical placement in a selected nursing institution in KwaZulu-Natal province. The respondents were full-time student nurses at the selected institution. A self-administered questionnaire was used to collect the data, which were entered and subsequently analyzed using Statistical Package for the Social Sciences (SPSS) version 24. The results are presented in frequency tables and figures. Statistical tests such as Fisher's exact test, Pearson's chi-squared test, Kruskal-Wallis test and the Mann-Whitney U test were performed to test for associations between the respondents' social demographic variables and bullying behavior during clinical placement.

The results have been presented in line with the objectives of the study as follows:

a) Demographic data
b) Types of bullying experienced by student nurses during clinical placement
c) Frequency of bullying behavior on student nurses during clinical placement
d) Sources of bullying behavior on student nurses during clinical placement and
e) Coping mechanisms used by student nurses experiencing bullying behavior during clinical placement

## 4.2 Sample realization

All respondents who met the inclusion in the study that is all student nurses registered in a selected higher education institution. The non-probability, convenience sampling

method was used to recruit the respondents. This technique was suitable for current study because of the time available to the researcher.

### 4.3 Social demographic data

The respondents' demographic data that were collected included gender, age and year of study.

#### 4.3.1 Gender of the respondents n=114)

The results displayed in Figure 4.1 shows that the majority of the respondents (90%: n=102) were females, while males comprised only 10% (n=12) of the sample.

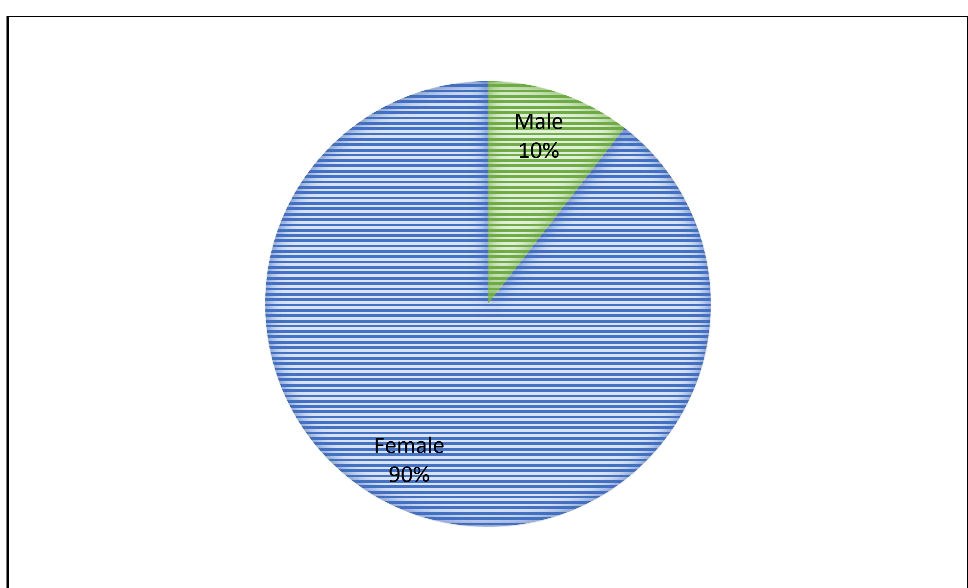


**Figure 4.1: Gender of the respondents**

#### 4.3.2 Age of the respondents (n=114)

Analysis of age indicated that the respondents mean age was 30.70 with a standard deviation of 8.25. The youngest age was 19 and the oldest was 53. When the data were grouped, most of the respondents (40.9%: n=45) fell within the age range of 25-34 years followed by 30% (n=33) who fell within the age range of 15-24 years. The 35-44 years age group comprised 21.8% (n=24) and only 7.3% (n=8) were aged above 45 years (Figure 4.2).

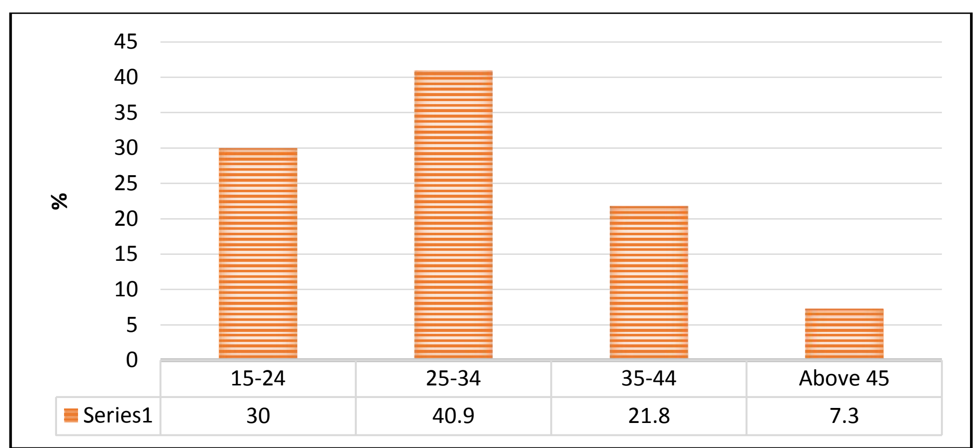


**Figure 4.2: Age of the respondents**

### 4.3.3 Year of study (n=114)

Analysis of year of study revealed that the majority of the respondents (64.4%: n=73) were in their second year. First year students comprised 35.6% (n=41) of the respondents. (Figure 4.3).

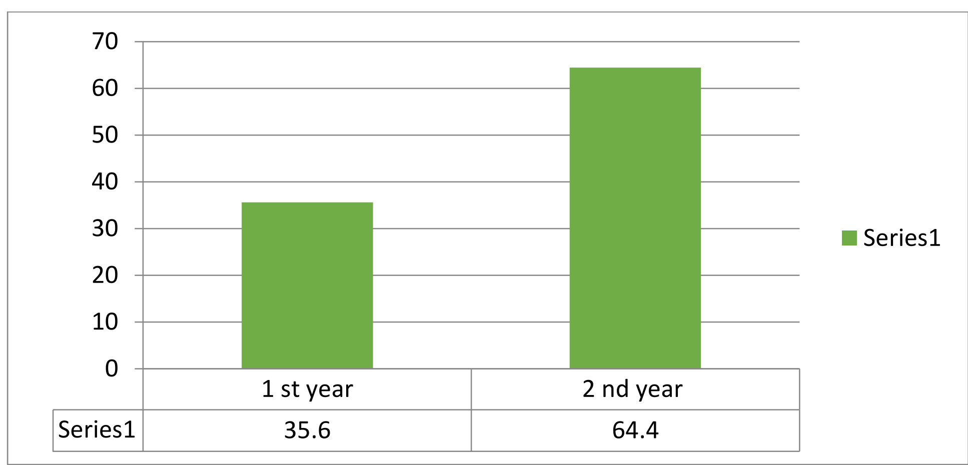


**Figure 4.3: Respondents and their year of study**

## 4.4 Types of bullying

The respondents were requested to indicate the types of bullying they experience in the clinical area on a four point Likert scale ranging from strongly disagree to strongly agree. The results are displayed in Table 4.1.

The majority of the respondents never experienced non-verbal bullying, with 47% (n=55) disagreeing and 6.8 % (n=8) strongly disagreeing. A total of 23.1% (n=27) strongly

agreed and an equal number agreed. The mean was 2.62 with a standard deviation (SD) of 0.92. Most of the respondents also denied being sworn or shouted at with 45.8% (n=54) disagreeing and an additional 9.3% (n=11) strongly disagreeing. Only 22.9% (n=27) agreed and 22% (n=26) strongly agreed with a mean of 2.58 and SD of 0.94. When asked if they were harshly judged or criticized, the majority (53%: n=62) disagreed and a further 6.8% (n=8) strongly disagreed. The remaining 21.4% (n=25) and 18.8% (n=22) strongly agreed and agreed respectively. The mean was 2.55 with an SD of 0.91.

The respondents were further asked if they experienced neglect and the majority denied with 52.5% (n=62) disagreeing and 10.2% (12) strongly disagreeing. Only 21.2% (n=25) strongly agreed and 16.1% (n=19) agreed with a mean of 2.48 and SD of 0.94. The majority of the respondents (58.1%: n=68) also disagreed to being ridiculed, and a further 10.3% (n=12) strongly disagreed. Of the remaining 37 respondents, 21.4% (n=25) strongly agreed and 10.3% (n=12) agreed. The mean was 2.43 with an SD of 0.94. When asked if they were unfairly treated in terms of on/off duty schedules, the majority (62.9%: n=73) disagreed and an additional 9.5% (n=11) strongly disagreed. Only 19.8% (n=23) strongly agreed and 7.8% (n=9) agreed. The mean was 2.38 and SD 0.91. Similarly, when asked if they were given unfair work allocation, most of the participants (47.9 %: n=57) disagreed and a further 5.9% (n=7) strongly disagreed. A total of 23.5% (n=28) and 22.7% (n=27) agreed and strongly agreed respectively with a mean of 2.63 and SD 0.90.

In terms of not being acknowledged for good work, the majority of the respondents (54.6%: n=65) disagreed and 8.4% (n=10) strongly disagreed. A total of 18.5% (n=22) strongly agreed and a similar number agreed. The mean was 2.47 and SD of 0.89. Similarly, the majority of the respondents (62.2%: n=74) disagreed and 11.8% (n=14) strongly disagreed that they were denied learning opportunities. Of the remaining 31

respondents, 15.1% (n=18) strongly agreed and the other 10.9% (n=13) agreed with a mean of 2.29 and SD of 0.87. When asked if they ever had racist remarks directed at them, the majority denied with 65.8% (n=75) disagreeing and 13.3(n=16) strongly disagreeing. Only 12.5% (n=15) and 8.3% (n=10) strongly agreed and agreed respectively with a mean of 2.20 and SD of 0.83.

The majority of the respondents also denied not being treated as part of the multidisciplinary team with 55.5% (n=66) disagreeing and another 10.1% (n=12) strongly disagreeing. The remaining 18.5% (n=22) and 16% (n=19) strongly agreed and agreed respectively. The mean was 2.43 and SD of 0.91. When asked if they have ever been pushed or shoved, 68.6% (n=81) disagreed and a further 16.1% (n=19) strongly disagreed. Only 10.2% (n=12) strongly agreed and 5.1% (n=6) agreed with a mean of 2.09 and SD of 0.78.

Most of the respondents (69.5 %: n=82) and 21.2% (n=25) disagreed and strongly disagreed ever been kicked. Of the remaining 11 respondents, 7.6 % (n=9) strongly agreed and 1.7 % (n=2) agreed with a mean of 1.92 and SD of 0.74. When asked if they had ever been slapped/punched, the majority denied, with 68.1% (n=81) disagreeing and a further 23.5% (n=28) strongly disagreeing. Only 7.6% (n=9) and 0.8% (n=1) strongly disagreed and disagreed respectively. The mean was 1.92 and SD of 0.74, 82 respondents (68.9%) disagreed that they had ever been hit with something and a further 23.5% (n=28) strongly disagreed. The remaining respondents, 5.9% (n=7) and 0.8% (n=1) strongly agreed and agreed respectively with a mean of 1.90 and SD of 0.69. The majority of the respondents (65.5%: n=78) also disagreed to ever had a gun or knife being pulled on them and a further 27.7% (n=33) disagreed. Of the remaining 8 respondents, 5.9 % (n=7) strongly agreed and 0.8% (n=1) agreed with a mean of 1.85 and SD of 0.71. In terms of

being threatened with physical violence, 67.2% (n=80) disagreed and 24.4% (n=29) strongly disagreed. Only 4.2 % (n=5) agreed, and a similar number strongly agreed. The mean was 1.88 with an SD of 0.66. The majority of the respondents also denied having their things deliberately damaged with 68.9% (n=82) disagreeing and an additional 18.5% (n=22) strongly disagreeing. The remaining respondents, 6.7% (n=8) and 5.9% (n=7) strongly agreed and agreed respectively. The mean was 2.01 and the SD was 0.72.

When asked if they had ever been inappropriately touched, the majority of the respondents (70%: n=84) disagreed and 20% (n=24) strongly disagreed. Only 5.8% (n=7) agreed and 4.2% (n=5) strongly agreed with a mean of 1.95 and SD of 0.65. The majority of the respondents also denied being threatened with sexual assault with 71.7% (n=86) disagreeing and 23.3% (n= 28) strongly disagreeing. A total of six respondents agreed with 3.3% (n=4) and 1.7 (n=2) strongly agreeing and agreeing respectively. The mean was 1.85 and SD was 0.60. Most of the respondents also denied having had sexist remarks directed at them with 69.2% (n=83) disagreeing and a further 20% (n=24) strongly disagreeing. Only 5.8% (n=7) agreed and another 5 % (n=6) strongly agreed with a mean of 1.96 and SD of 0.68. Pertaining to suggestive sexual gestures being directed at them, the majority of the respondents (75.4 %: n=89) disagreed and a further 18.6 % (n=22) strongly disagreed. Of the remaining 7 participants, 4.2 % (n=5) agreed and only 1.7% (n=2) strongly agreed with a mean of 1.89 and SD of 0.54.

**Table 4.1: Types of bullying**

| Item | Strongly disagree | | Disagree | | Agree | | Strongly agree | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | | |
| Non-verbal e.g. raised eye brows, rolling eyes | 8 | 6.8 | 55 | 47.0 | 27 | 23.1 | 27 | 23.1 | 2.62 | 0.92 |
| Sworn, shouted or yelled at | 11 | 9.3 | 54 | 45.8 | 27 | 22.9 | 26 | 22.0 | 2.58 | 0.94 |
| Harshly judged/criticized | 8 | 6.8 | 62 | 53.0 | 22 | 18.8 | 25 | 21.4 | 2.55 | 0.91 |
| Ignored or neglected | 12 | 10.2 | 62 | 52.5 | 19 | 16.1 | 25 | 21.2 | 2.48 | 0.94 |
| Ridiculed or humiliated | 12 | 10.3 | 68 | 58.1 | 12 | 10.3 | 25 | 21.4 | 2.43 | 0.94 |
| Been unfairly treated regarding on/off duty schedules | 11 | 9.5 | 73 | 62.9 | 9 | 7.8 | 23 | 19.8 | 2.38 | 0.91 |
| Given unfair work allocation | 7 | 5.9 | 57 | 47.9 | 28 | 23.5 | 27 | 22.7 | 2.63 | 0.90 |
| Not receiving acknowledgment for good work | 10 | 8.4 | 65 | 54.6 | 22 | 18.5 | 22 | 18.5 | 2.47 | 0.89 |
| Denied learning opportunities | 14 | 11.8 | 74 | 62.2 | 13 | 10.9 | 18 | 15.1 | 2.29 | 0.87 |
| Had a racist remark directed at me | 16 | 13.3 | 79 | 65.8 | 10 | 8.3 | 15 | 12.5 | 2.20 | 0.83 |
| Not been treated as part of the multidisciplinary team | 12 | 10.1 | 66 | 55.5 | 19 | 16.0 | 22 | 18.5 | 2.43 | 0.91 |
| Pushed or shoved | 19 | 16.1 | 81 | 68.6 | 6 | 5.1 | 12 | 10.2 | 2.09 | 0.78 |
| Kicked | 25 | 21.2 | 82 | 69.5 | 2 | 1.7 | 9 | 7.6 | 1.96 | 0.73 |
| Slapped or punched | 28 | 23.5 | 81 | 68.1 | 1 | 0.8 | 9 | 7.6 | 1.92 | 0.74 |
| Hit with something | 28 | 23.5 | 82 | 68.9 | 2 | 1.7 | 7 | 5.9 | 1.90 | 0.69 |
| Had a gun or knife pulled on me | 33 | 27.7 | 78 | 65.5 | 1 | 0.8 | 7 | 5.9 | 1.85 | 0.71 |
| Been threatened with physical violence | 29 | 24.4 | 80 | 67.2 | 5 | 4.2 | 5 | 4.2 | 1.88 | 0.66 |
| Had something of mine deliberately damaged | 22 | 18.5 | 82 | 68.9 | 7 | 5.9 | 8 | 6.7 | 2.01 | 0.72 |
| Been inappropriately touched | 24 | 20.0 | 84 | 70.0 | 7 | 5.8 | 5 | 4.2 | 1.94 | 0.65 |
| Been threatened with sexual assault | 28 | 23.3 | 86 | 71.7 | 2 | 1.7 | 4 | 3.3 | 1.85 | 0.60 |
| Had sexist remarks directed at me | 24 | 20.0 | 83 | 69.2 | 7 | 5.8 | 6 | 5.0 | 1.96 | 0.68 |
| Had suggestive sexual gestures directed at me | 22 | 18.6 | 89 | 75.4 | 5 | 4.2 | 2 | 1.7 | 1.89 | 0.54 |
| Had a request for intimate physical contact | 21 | 17.6 | 87 | 73.1 | 5 | 4.2 | 6 | 5.0 | 1.97 | 0.65 |

The majority of the respondents' (73.1%: n=87) also disagreed to having had a request for intimate physical contact and a further 17.6 % (n=21) strongly disagreed. Only 5 % (n=6) and 4.2% (n=5) strongly agreed and agreed respectively with a mean was 1.97 and SD of 0.65.

### 4.4.1 Relationship between respondents' demographic variables and types of bullying

Cross tabulations were performed to assess for relationships between the respondents' demographic variables and the different types of bullying. Fishers exact and Pearson Chi-square tests results have been displayed in Table 4.2. In terms of gender, most females agreed to have experienced the different forms of bullying compared to males with the exception of being ignored or neglected where the majority of males than females agreed. The results were significant with the following forms of bullying: non-verbal bullying with Pearson Chi-squared ($X^2$) value of 16.35 and P-value of 0.001; sworn, shouted or yelled at : $X^2$ value =15.75, P-value= 0.001; highly judged /criticized: $X^2$ value= 14.91, P-value = 0.002; ignored/ neglected: $X^2$ value =7.78, P-value = 0.047; ridiculed/ humiliated: $X^2$ value = 9.44, P-value= 0.022; not acknowledging good work: $X^2$ value =14.67, P-value = 0.003 and denied learning opportunities with $X^2$ value of 7.61 and P-value 0.053.

In terms of age, the majority of younger respondents agreed to experiencing the different forms of bullying compared to the older respondents with significant relationships established with the following forms of bullying: sworn, shouted or yelled: $X^2$ = 21.01, P-value = 0.012; given unfair work allocation: $X^2$ = 24.28, P-value = 0.004; denied learning opportunities: Fishers exact value =17.68, P-value = 0.020 and not treated as part of multi-disciplinary team with $X^2$ value of 29.44 and P-value of 0.001. For year of study, the lower the year of study, the higher the experience of different forms of bullying. Significant relationships were found with the following forms of bullying: non-verbal: $X^2$ value =13.27, P-value= 0.037; sworn, shouted /yelled at: $X^2$ = 20.29, P-value = 0.002; highly judged/criticized: $X^2$ value =15.24, P-value = 0.019; Ignored/neglected: $X^2$ value=

18.99, P-value = 0.004; ridiculed/ humiliated: $X^2$ value= 12.53, P-value = 0.049; been unfairly treated regarding on/off duty: $X^2$ = 16.46, P-value = 0.012; given unfair work allocation: $X^2$=16.69, P-value = 0.011; not acknowledged: $X^2$ value =14.96, P-value = 0.020; denied learning opportunities: $X^2$ value = 13.63, P-value =0.034; racist remarks directed at me: Fishers exact value = 14.38, P-value = 0.014 and not being treated as part of multidisciplinary team with $X^2$ value of 12.45, P-value of 0.050.

**Table 4.2: Relationships between demographic variables and types of bullying**

| Types of bullying | Gender | | Age | | Year of study | |
|---|---|---|---|---|---|---|
| Non-verbally e.g. raised eyebrows, rolling eyes | $X^2$ value | 16.35 | $X^2$ value | 15.41 | $X^2$ value | 13.27 |
| | P-value | 0.001 | P-value | 0.075 | P-value | 0.037 |
| Sworn, shouted or yelled at | $X^2$ Value | 15.75 | $X^2$ value | 21.01 | $X^2$ value | 20.29 |
| | P-value | 0.001 | P-value | 0.012 | P-value | 0.002 |
| Harshly judged or criticized | $X^2$ value | 14.91 | Fishers exact | 14.11 | $X^2$ value | 15.24 |
| | P-value | 0.002 | P-value | 0.081 | P-value | 0.019 |
| Ignored or neglected | $X^2$ value | 7.78 | Fishers exact | 14.50 | $X^2$ value | 18.99 |
| | P-value | 0.047 | P-value | 0.072 | P-value | 0.004 |
| Ridiculed or humiliated | $X^2$ value | 9.44 | Fishers exact | 16.37 | $X^2$ value | 12.53 |
| | P-value | 0.022 | P-value | 0.102 | P-value | 0.049 |
| Been unfairly treated regarding on/off duty | $X^2$ value | 4.56 | Fishers exact | 9.29 | $X^2$ value | 16.46 |
| | P-value | 0.207 | P-value | 0.348 | P-value | 0.012 |
| Given unfair work allocation | $X^2$ value | 5.94 | $X^2$ value | 24.28 | $X^2$ value | 16.69 |
| | P-value | 0.115 | P-value | 0.004 | P-value | 0.011 |
| Not received acknowledgement | $X^2$ value | 14.67 | Fishers exact | 15.11 | $X^2$ value | 14.96 |
| | P-value | 0.003 | P-value | 0.058 | P-value | 0.020 |
| Denied learning opportunities | $X^2$ value | 7.61 | Fishers exact | 17.68 | $X^2$ value | 13.63 |
| | P-value | 0.053 | P-value | 0.020 | P-value | 0.034 |
| Had racist remarks directed at me | $X^2$ value | 4.94 | Fishers exact | 11.93 | Fishers exact | 14.38 |
| | P-value | 0.163 | P-value | 0.154 | P-value | 0.014 |
| Not been treated as part of multidisciplinary team | $X^2$ value | 5.50 | $X^2$ value | 29.44 | $X^2$ value | 12.45 |
| | P-value | 0.129 | P-value | 0.001 | P-value | 0.050 |
| Pushed or shoved | $X^2$ value | 1.30 | Fishers exact | 6.24 | Fishers exact | 3.70 |
| | P-value | 0.722 | P-value | 0.702 | P-value | 0.719 |
| Kicked | $X^2$ value | 0.40 | Fishers exact | 10.06 | Fishers exact | 4.23 |
| | P-value | 0.940 | P-value | 0.261 | P-value | 0.642 |
| Slapped or punched | Fishers exact | 1.40 | Fishers exact | 11.97 | Fishers exact | 5.03 |
| | P-value | 0.813 | P-value | 0.158 | P-value | 0.567 |
| Hit with something | $X^2$ value | 1.47 | Fishers exact | 8.74 | Fishers exact | 3.84 |
| | P-value | 0.678 | P-value | 0.393 | P-value | 0.708 |
| Had a gun or knife pointed on me | $X^2$ value | 1.05 | Fishers exact | 13.70 | Fishers exact | 6.43 |
| | P-value | 0.822 | P-value | 0.072 | P-value | 0.356 |
| Been threatened with physical violence | $X^2$ value | 1.50 | Fishers exact | 8.72 | Fishers exact | 8.68 |
| | P-value | 0.656 | P-value | 0.385 | P-value | 0.135 |

| Types of bullying | Gender | | Age | | Year of study | |
|---|---|---|---|---|---|---|
| Had something of mine deliberately damaged | $X^2$ value | 3.11 | Fishers exact | 8.81 | Fishers exact | 5.27 |
| | P-value | 0.359 | P-value | 0.385 | P-value | 0.473 |
| Been inappropriately touched | Fishers exact | 1.42 | Fishers exact | 10.77 | Fishers exact | 4.29 |
| | P-value | 0.701 | P-value | 0.206 | P-value | 0.609 |
| Been threatened with sexual assault | Fishers exact | 0.98 | Fishers exact | 9.03 | $X^2$ value | 3.99 |
| | P-value | 0.750 | P-value | 0.410 | P-value | 0.687 |
| Had sexist remarks directed at me | $X^2$ value | 2.49 | Fishers exact | 9.68 | Fishers exact | 4.10 |
| | P-value | 0.498 | P-value | 0.294 | P-value | 0.650 |
| Had suggestive sexual gestures directed at me | Fishers exact | 1.89 | Fishers exact | 6.36 | Fishers exact | 3.20 |
| | P-value | 0.523 | P-value | 0.732 | P-value | 0.778 |
| Had a request for intimate physical contact | Fishers exact | 2.33 | Fishers exact | 7.17 | Fishers exact | 3.12 |
| | P-value | 0.408 | P-value | 0.574 | P-value | 0.788 |

### 4.5 Frequency of bullying

The frequency of bullying was measured on a four point Likert scale ranging from never as score 0, to often times as score 3. The findings have been presented in Table 4.3.

Most of the respondents (53%: n=61) indicated that they never experienced non-verbal bullying. Of the remaining 54 respondents who experienced non-verbal bullying, 20.9 (n=24) experienced it occasionally, while 20% (n=23) indicated that they sometimes experience bullying. Only 6.1% (n=7) experienced it often times with a mean of 0.79 and SD of 0.97. In terms of being sworn/shouted at, 45.7% (n=53) never experienced it. Those that experienced, 32.8% (n=38) indicated occasionally, 15.5% (n=18) sometimes and only 6% (n=7) often times with a mean was 0.82 and SD of 0.91. The majority of the respondents 53% (n=62) also indicated they were never harshly judged/criticized. For those that agreed, 24.8 % (n=29) experienced it occasionally, 17.9% (n=21) sometimes, and 4.3% (n=5) often times with a mean of 0.74 and SD of 0.94.

A total of 57.6% (n=68) indicated that they never experienced neglect. Of the remaining 50 that experienced it, 22% (n=26) experienced it occasionally, 16.1% (n=19) sometimes and 4.2% (n=5) often with a mean of 0.67 and SD of 0.90. Similarly, the majority 55.1% (n=65) had never been ridiculed or humiliated. Those that did, 22.9% (n=27) experienced

it occasionally, 16.1% (n=19) sometimes and 5.9% (n=7) oftentimes with a mean of 0.73 and SD of 0.94.

Pertaining to unfair treatment regarding on/off duty schedules, 67.5% (n=79) never experienced it while 23.1% (n=27) indicated sometimes, 6.8% (n=8) occasionally and 2.6% (n=3) oftentimes. The mean was 0.61 with SD of 0.92. Most of the respondents (55.1%: n=65) were never given unfair work location. For those that did, 23.7% (n=28) experienced it sometimes, 17.8 % (n=21) occasionally and 3.4% (n=4) often times with a mean of 0.75 and SD of 0.93.

A total of 51 (44.3%) never experienced lack of acknowledgement for good work. Those that experienced it, in 27.8% (n=32) it occurred occasionally, 22.6% (n=26) sometimes and 4.3% (n=5) often times with a mean of 0.90 and SD of 0.96. Similarly, 55.2% (n=64) were never denied learning opportunities, while 34.5% (n=40) indicated sometimes, and 10.3% (n=12) occasionally with a mean of 1.79 and SD of 0.93.

A total of 28% (n=33) had racist remarks directed at them with 17.8 % (n=21) indicating this had occurred sometimes, 9.3 % (n=11) occasionally and 0.8% (n=1) often times with a mean of 0.47 and SD of 0.81. A majority number of respondents, 52.1 % (n=61) indicated they were not treated as part of the multidisciplinary team. Of these, in 33.3% (n=39) it occurred sometimes, 15.4 % (n=18) occasionally and 3.4% (n=4) often times with a mean of 0.92 and SD of 0.98.

Only 26.3 % (n=31) were ever pushed or shoved with 16.1 % (n=19) experiencing it sometimes, 5.1 % (n=6) often times and a similar number occasionally with a mean of 0.53 and SD of 0.94. The majority of the respondents (78.8 %: n=93) indicated that they had never been kicked. Those that experienced this, in 12.7 % (n=15) it occurred

sometimes, 5.1% (n=6) often times and 3.4% (n=4) occasionally with a mean of 0.44 and SD of 0.90.

A total of 92 respondents (78%) indicated they had never been slapped/punched but this occurred sometimes in 12.7% (n=15), oftentimes in 5.1% (n=6) and occasionally in 3.4 % (n=4) with a mean of 0.46 and SD of 0.92. Similarly, the majority of respondents (76.1%: n=89) had never been hit with something. In those that experienced this, it occurred sometimes in 14.5% (n=17), occasionally in 5.1% (n=6), and often times in 4.3% (n=5) with a mean of 0.47 and SD of 0.90.

A total of 91 respondent's (77.1%) never had a gun or knife pulled on them while 12.7 % (n=15) experienced this sometimes, 5.1 % (n=6) often times and a similar number occasionally. The mean was 0.46 and SD 0.92. Most respondents' 68.6 % (n=81) had never been threatened with physical violence. Of those that experienced this, in 14.4% (n=17) it occurred sometimes, 11.9% (n=14) occasionally and 5.1% (n=6) often times with a mean of 0.56 and SD 0.92.

A total of 31.6 % (n=37) had one of the belongings being deliberately damaged, with 13.7 % (n=16) experiencing this sometimes, 12.8% (n=15) occasionally and 5.1% (n=6) oftentimes with a mean of 0.56 and SD of 0.91. Similarly, 26.3% (n=31) had been inappropriately touched with 13.6 % (n=16) experiencing it sometimes, 6.8% (n=8) occasionally and 5.9% (n=7) oftentimes with a mean of 0.52 and SD of 0.94.

The majority of the respondents' 77.6% (n=90) had never been threatened with sexual assault, while 13.8% (n=16) experienced this sometimes, 5.2% (n=6) often times and 3.4% (n=4) occasionally with a mean of 0.47 and SD of 0.92. Similarly, most respondents' (71.4 %: n=85) never had sexual remarks directed at them. Those that did,

15.1% (n=18) it occurred sometimes, 6.7% (n=8) oftentimes and a similar number occasionally with a mean of 0.57 and SD of 0.98, 88 respondents (74.6%) never had suggestive sexual gestures directed at them.

**Table 4.3: Frequency of bullying**

| Item | Never | | Occasionally | | Sometimes | | Often times | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | N | % | n | % | n | % | | |
| Non-verbally e.g. raised eye brows, rolling eyes | 61 | 53.0 | 24 | 20.9 | 23 | 20.0 | 7 | 6.1 | 0.79 | 0.97 |
| Sworn, shouted or yelled at | 53 | 45.7 | 38 | 32.8 | 18 | 15.5 | 7 | 6.0 | 0.82 | 0.91 |
| Harshly judged/criticized | 62 | 53.0 | 29 | 24.8 | 21 | 17.9 | 5 | 4.3 | 0.74 | 0.94 |
| Ignored or neglected | 68 | 57.6 | 26 | 22.0 | 19 | 16.1 | 5 | 4.2 | 0.67 | 0.90 |
| ridiculed or humiliated | 65 | 55.1 | 27 | 22.9 | 19 | 16.1 | 7 | 5.9 | 0.73 | 0.94 |
| been unfairly treated regarding on/off duty schedules | 79 | 67.5 | 8 | 6.8 | 27 | 23.1 | 3 | 2.6 | 0.61 | 0.92 |
| given unfair work allocation | 65 | 55.1 | 21 | 17.8 | 28 | 23.7 | 4 | 3.4 | 0.75 | 0.93 |
| not receiving acknowledgement for good work | 51 | 44.3 | 32 | 27.8 | 26 | 22.6 | 5 | 4.3 | 0.90 | 0.96 |
| Denied learning opportunities | 64 | 55.2 | 12 | 10.3 | 40 | 34.5 | 0 | 0 | 0.79 | 0.93 |
| Had a racist remark directed at me | 85 | 72.0 | 11 | 9.3 | 21 | 17.8 | 1 | 0.8 | 0.47 | 0.81 |
| Not been treated as part of the multidisciplinary team | 56 | 47.9 | 18 | 15.4 | 39 | 33.3 | 4 | 3.4 | 0.92 | 0.98 |
| Pushed or shoved | 87 | 73.7 | 6 | 5.1 | 19 | 16.1 | 6 | 5.1 | 0.53 | 0.94 |
| Kicked | 93 | 78.8 | 4 | 3.4 | 15 | 12.7 | 6 | 5.1 | 0.44 | 0.90 |
| Slapped or punched | 92 | 78.0 | 5 | 4.2 | 14 | 11.9 | 7 | 5.9 | 0.46 | 0.92 |
| Hit with something | 89 | 76.1 | 6 | 5.1 | 17 | 14.5 | 5 | 4.3 | 0.47 | 0.90 |
| Had a gun or knife pulled on me | 91 | 77.1 | 6 | 5.1 | 15 | 12.7 | 6 | 5.1 | 0.46 | 0.90 |
| Been threatened with physical violence | 81 | 68.6 | 14 | 11.9 | 17 | 14.4 | 6 | 5.1 | 0.56 | 0.92 |
| Had something of mine deliberately damaged | 80 | 68.4 | 15 | 12.8 | 16 | 13.7 | 6 | 5.1 | 0.56 | 0.91 |
| Been inappropriately touched | 87 | 73.7 | 8 | 6.8 | 16 | 13.6 | 7 | 5.9 | 0.52 | 0.94 |
| Been threatened with sexual assault | 90 | 77.6 | 4 | 3.4 | 16 | 13.8 | 6 | 5.2 | 0.47 | 0.92 |
| Had sexist remarks directed at me | 85 | 71.4 | 8 | 6.7 | 18 | 15.1 | 8 | 6.7 | 0.57 | 0.98 |
| Had suggestive sexual gestures directed at me | 88 | 74.6 | 5 | 4.2 | 17 | 14.4 | 8 | 6.8 | 0.53 | 0.98 |
| Had a request for intimate physical contact | 90 | 76.3 | 2 | 1.7 | 14 | 11.9 | 11 | 9.3 | 0.57 | 1.07 |

Of the remaining 30 respondents that experienced this, it occurred sometimes in 14.4% (n=17), oftentimes in 6.8% (n=8) and occasionally in 4.2% (n=5) with a mean of 0.53 and SD 0.98. Most respondents (76.3%: n=90) also never had a request for intimate contact. Those that did, in 11.9% (n=14) it occurred sometimes, 9.3% (n=11) often times and 1.7% (n=2) occasionally with a mean of 0.57 and SD of 1.07.

### 4.5.1 Overall frequency scores

As already discussed, the frequency of bullying was measured on a four-point Likert scale with response options ranging from never as score 0, occasionally as score 1, sometimes as score 2 and often times as score 3. The frequency scale had 23 items, thus the possible minimum score was 0 and maximum was 69. The analysis showed that the median score was 8 with an inter-quartile range of 67. The respondents' minimum score was 0 and maximum score was 67. The scores were grouped in two categories with score 0-35 as less frequent and 36-69 as more frequent. The results displayed in Table 4.4 show that the majority of the respondents (82.7%: n=86) experienced bullying less frequently and only 17.3% (n=18) experienced it more frequently.

**Table 4.4: Overall frequency scores (n=104)**

| Frequency of bullying | Score | n | % |
|---|---|---|---|
| Less frequent | 0-35 | 86 | 82.7 |
| More frequent | 36-69 | 18 | 17.3 |
| Total | 69 | 104 | 100.0 |

### 4.5.2 Relationships between respondents' demographic variables and frequency of bullying

Cross-tabulations were done to determine if the respondents' gender, age and year of study had an influence the frequency of bullying.

#### 4.5.2.1 Gender and frequency of bullying

Though not statistically significant, the results displayed in Table 4.5 show that females experienced bullying more frequently than males as 18.6% (n=18) of females experienced bullying more frequently compared to males 16.7% (n=2). Pearson chi-square value 0.26, df: 1and p-value: 0.871.

**Table 4.5: Cross tabulation of gender and frequency of bullying**

| Gender | | Frequency of bullying | | Total |
|---|---|---|---|---|
| | | Less frequent | More frequent | |
| Male | n | 10 | 2 | 12 |
| | % | 83.3% | 16.7% | 100.0% |
| Female | n | 70 | 16 | 86 |
| | % | 81.4% | 18.6% | 100.0% |
| Total | n | 80 | 18 | 98 |
| | % | 81.6% | 18.4% | 100.0% |

#### 4.5.2.2 Age and frequency of bullying

The results of the cross tabulation of age and frequency of bullying (Table 4.6) show that older respondents experienced bullying less frequently than younger respondents with all respondents aged above 45 years falling within the less frequent group, and 90.9% (n=20) of those aged 35-44 falling within the low-frequency group compared to 75.7% (n=28) and 83.3 % (n=25) for those aged 25-34 years and 15-24 years respectively. The results however were not statistically significant; Pearson chi-squared value = 4.103, df = 3 and p-value = 0.251.

**Table 4.6: Cross tabulation of age and frequency of bullying**

| Age | | Frequency of bullying | | Total |
|---|---|---|---|---|
| | | Less frequent | More frequent | |
| 15-24 | n | 25 | 5 | 30 |
| | % | 83.3% | 16.7% | 100.0% |
| 25-34 | n | 28 | 9 | 37 |
| | % | 75.7% | 24.3% | 100.0% |
| 35-44 | n | 20 | 2 | 22 |
| | % | 90.9% | 9.1% | 100.0% |
| Above 45 | n | 8 | 0 | 8 |

|  | % | 100.0% | 0.0% | 100.0% |
|---|---|---|---|---|
| Total | n | 81 | 16 | 97 |
|  | % | 83.5% | 16.5% | 100.0% |

#### 4.5.2.3 Year of study and frequency of bullying

The results of the analysis of year of study and frequency of bullying indicate that the lower the year of study, the more frequent the bullying with 24.5% (n=8) of first years experiencing bullying more frequently compared to 18.2% (n=20) for second years (Table 4.7). The results however were insignificant with a Pearson chi-squared value of 3.507, df =2, and P-value of 0.173.

**Table 4.7: Cross tabulation of year of study and frequency of bullying**

| Year of study | | Frequency of bullying | | Total |
|---|---|---|---|---|
| | | Less frequent | More frequent | |
| 1st year | n | 25 | 8 | 33 |
| | % | 75.8% | 24.2% | 100.0% |
| 2nd year | n | 45 | 10 | 55 |
| | % | 81.8% | 18.2% | 100.0% |
| Total | n | 82 | 18 | 100 |
| | % | 82.0% | 18.0% | 100.0% |

#### 4.5.2.4 Interrelationships between frequency of bullying and demographic variables

Non-parametric tests were also performed to test the association between respondents' demographic variables and frequency of bullying. Mann-Whitney U-test was performed for gender and the results were insignificant with p-value of 0.343. Kruskal-Wallis tests were performed for age and year of study and the results were significant with p-values of 0.013 in both (Table 4.8).

**Table 4.8: Interrelationships between frequency of bullying and demographics**

| Variable | Test | P-value |
|---|---|---|
| Gender | Mann- Whitney U-test | 0.343 |
| Age | Kruskal-Wallis test | 0.013 |
| Year of study | Kruskal-Wallis test | 0.013 |

### 4.6 Sources of bullying

Sources of bullying that were examined were in two categories namely: clinical areas where the bullying occurred and the perpetrators of bullying.

#### 4.6.1 Clinical areas where the bullying occurred

The respondents were asked about the clinical areas where the bullying occurred on a four-point Likert scale with dis/agree options. The clinical settings were in two categories: hospital and community settings.

##### 4.6.1.1 Hospital setting

The results displayed in Figure 4.4 indicate that the majority of the respondents (39.8%: n=45) agreed that the bullying occurred at the hospital setting and a further 31.9 % (n=36) strongly agreed. Only 25.7% (n=29) disagreed and 2.7% (n=3) strongly disagreed. The mean was 3.01 with an SD of 0.83.

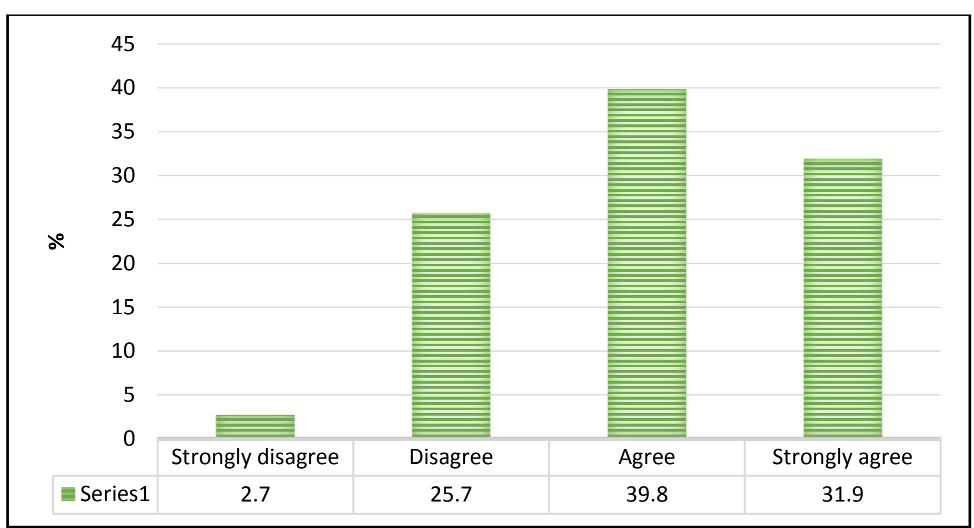


**Figure 4.4: Hospital setting**

##### 4.6.1.2 Community settings

Most respondents (39.8 %: n=45) also agreed that the bullying occurred in community settings, and an additional 19.5 % (n=22) strongly agreed. Of the remaining 46

respondents, 37.2% (n=42) disagreed and 3.5 % (n=4) strongly disagreed (Figure 4.5). The mean was 2.75 with an SD of 0.81.

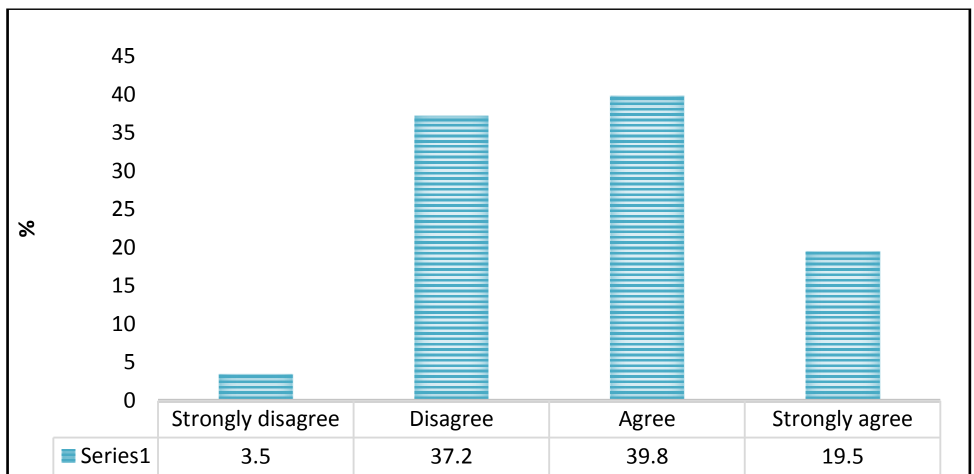


**Figure 4.5: Community settings**

### 4.6.2 Perpetrators of bullying

In order to identify the perpetrators of bullying, the participants responded to a four point Likert scale with options ranging from strongly disagree to strongly agree.

Patients were identified as a major perpetrators' of bullying with 50.8% (n=60) agreeing and a further 19.5 % (n=23) strongly agreeing. Only 28 % (n=33) and 1.7 % (n=2) disagreed and strongly disagreed respectively with a mean of 2.88 and SD of 0.73. When asked if they experienced bullying by doctors, the majority 52.1 % (n=61) agreed and 16.2 % (n=19) strongly agreed. The remaining 30.8 % (n=36) disagreed and 0.9% (n=1) strongly disagreed with a mean of 2.84 and SD of 0.69. Most respondents 44.4 % (n=52) and 26.5 % (n=31) also agreed and strongly agreed respectively that they experience bullying by patient's relatives and friends. Only 24.8 % (n=29) disagreed and 4.3 % (n=5) strongly disagreed with a mean of 2.93 and SD of 0.83. Matrons/nurse managers were also identified as major perpetrators of bullying with 50.4 % (n=59) agreeing and 21.4 %

(n=25) strongly agreeing. Of the remaining 33 respondents, 24.8% (n=9) disagreed and 3.4 % (n=4) strongly disagreed with a mean of 2.90 and SD of 0.77.

A total of 80 respondents also indicated that they experienced bullying by registered nurses with 47% (n=54) agreeing and 22.6 % (n=26) strongly agreeing. Only 27.8 % (n=32) and 2.6 % (n=3) disagreed and strongly disagreed respectively. The mean was 2.90 with an SD of 0.78. Similarly, the majority of respondents 44.3% (n=51) agreed that they were bullied by staff nurses and a further 20.9% (n=24) strongly agreed. Of the remaining 40 respondents, 32.2 % (n=37) disagreed and 2.6% (n=3) strongly disagreed with a mean of 2.83 and SD of 0.83. Most respondents 47.5 % (n=56) also agreed that they were bullied by assistant nurses and an additional 22.9 % (n=27) also strongly agreed. Only 26.3 % (n=31) and 3.4% (n=4) disagreed and strongly disagreed respectively with a mean of 2.90 and SD of 0.79.

When asked if they had experienced bullying by other student nurses, the majority 47 % (n=54) agreed and a further 21.7 % (n=25) strongly agreed. The remaining 27.8 % (n=32) and 3.5 % (n=4) disagreed and strongly disagreed respectively with a mean of 2.87 and SD of 0.79. The respondents also identified clinical educators as a major source of bullying with 56.8% (n=67) agreeing and 10.2 % (n=12) strongly agreeing. Only 28% (n=33) disagreed and 5.1 % (n=6) strongly disagreed with a mean of 2.72 and SD of 0.72. Similarly, the majority of respondents (54.7 %: n=64) and (10.3 %: n= 12) agreed and strongly agreed respectively to being bullied by lectures. Of the remaining 41 respondents, 30.8% (n=36) disagreed and 4.3 % (n=5) strongly disagreed with a mean of 2.71 and SD of 0.71. Administrative staff were also identified as a source of bullying with 54.4% (n=62) agreeing and 2.3% (n=14) strongly agreeing. The remaining 27.2 % (n=31)

disagreed and 6.1 % (n=7) strongly disagreed with a mean of 2.73 and SD of 0.76 (Table 4.9).

**Table 4.9: Perpetrators of bullying**

| Item | Strongly disagree | | Disagree | | Agree | | Strongly agree | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | | |
| Patients | 2 | 1.7 | 33 | 28.0 | 60 | 50.8 | 23 | 19.5 | 2.88 | 0.73 |
| Doctors | 1 | 0.9 | 36 | 30.8 | 61 | 52.1 | 19 | 16.2 | 2.84 | 0.69 |
| Patients relatives or friends | 5 | 4.3 | 29 | 24.8 | 52 | 44.4 | 31 | 26.5 | 2.93 | 0.83 |
| Matrons/nurse managers | 4 | 3.4 | 29 | 24.8 | 59 | 50.4 | 25 | 21.4 | 2.90 | 0.77 |
| Registered nurses | 3 | 2.6 | 32 | 27.8 | 54 | 47.0 | 26 | 22.6 | 2.90 | 0.78 |
| Staff nurses | 3 | 2.6 | 37 | 32.2 | 51 | 44.3 | 24 | 20.9 | 2.83 | 0.83 |
| Assistant nurses | 4 | 3.4 | 31 | 26.3 | 56 | 47.5 | 27 | 22.9 | 2.90 | 0.79 |
| Other student nurses | 4 | 3.5 | 32 | 27.8 | 54 | 47.0 | 25 | 21.7 | 2.87 | 0.79 |
| Clinical educators | 6 | 5.1 | 33 | 28.0 | 67 | 56.8 | 12 | 10.2 | 2.72 | 0.72 |
| Lectures | 5 | 4.3 | 36 | 30.8 | 64 | 54.7 | 12 | 10.3 | 2.71 | 0.71 |
| Administrative staff | 7 | 6.1 | 31 | 27.2 | 62 | 54.4 | 14 | 12.3 | 2.73 | 0.76 |

#### 4.6.2.1 Relationship between demographic variables and perpetrators of bullying

Correlations were done to determine if there was any relationship between the respondents' demographic variables and perpetrators of bullying.

**Table 4.10: Correlation of demographic variables and perpetrators of bullying**

| | | Gender | Age | Year of study |
|---|---|---|---|---|
| Patients | Pearson Correlation | .184 | .089 | -.342** |
| | Sig. (2-tailed) | .052 | .378 | .000 |
| | N | 112 | 100 | 113 |
| Doctors | Pearson Correlation | .090 | .193 | -.418** |
| | Sig. (2-tailed) | .347 | .056 | .000 |
| | N | 111 | 99 | 112 |
| Patients relatives or friends | Pearson Correlation | .210* | .231* | -.309** |
| | Sig. (2-tailed) | .027 | .021 | .001 |
| | N | 111 | 99 | 112 |
| Matrons/nurse managers | Pearson Correlation | .171 | .195 | -.253** |
| | Sig. (2-tailed) | .072 | .053 | .007 |
| | N | 111 | 99 | 112 |
| Registered nurses | Pearson Correlation | .163 | -.128 | -.356** |
| | Sig. (2-tailed) | .090 | .211 | .000 |
| | N | 110 | 97 | 112 |
| Staff nurses | Pearson Correlation | .216* | -.049 | -.398** |
| | Sig. (2-tailed) | .024 | .633 | .000 |
| | N | 109 | 97 | 110 |

| | | | | |
|---|---|---|---|---|
| Assistant nurses | Pearson Correlation | .217* | .045 | -.320** |
| | Sig. (2-tailed) | .022 | .659 | .001 |
| | N | 112 | 100 | 113 |
| Other student nurses | Pearson Correlation | .281** | .068 | -.287** |
| | Sig. (2-tailed) | .003 | .506 | .002 |
| | N | 109 | 98 | 110 |
| Clinical educators | Pearson Correlation | .155 | .135 | .004 |
| | Sig. (2-tailed) | .103 | .180 | .965 |
| | N | 112 | 100 | 113 |
| Lectures | Pearson Correlation | .236* | .093 | .019 |
| | Sig. (2-tailed) | .013 | .361 | .841 |
| | N | 111 | 99 | 112 |
| administrative staff | Pearson Correlation | .232* | .127 | -.041 |
| | Sig. (2-tailed) | .016 | .218 | .673 |
| | N | 108 | 96 | 109 |

*.Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

The results as displayed in Table 4.10 demonstrate that there is no linear relationship between any of the demographic variables and perpetrators of bullying as all the correlation coefficient values were closer to zero.

### 4.7 Influence of bullying on work performance

The influence of bullying on work performance was measured on a four-point Likert scale with agree options ranging from strongly disagree as score 1 and strongly agree as score 4. The findings have been displayed on Table 4.11.

The majority of the respondents 61.7 % (n=58) disagreed that bullying made them to consider leaving nursing and an additional 7.4 % (n=7) strongly disagreed. Only 16% (n=5) and 14.9 % (n=14) agreed and strongly agreed respectively with a mean of 2.38 and SD of 0.83. Most respondents, however, acknowledged that bullying made them to call in absent with 39.1 % (n=45) and 13% (n= 15) agreeing and strongly agreeing respectively. A total of 40% (n=46) disagreed and 7.8 % (n=9) strongly disagreed with a mean of 2.57 and SD of 0.82.

Most of the respondents (42.6% (n=49) disagreed and an additional 12.2% (n=14) strongly disagreed that bullying made them scared to check patients orders. Of the remaining 52 respondents, 29.6 % (n=34) agreed and 15.7 % (n=18) strongly agreed respectively with a mean of 2.49 and SD of 0.90. When asked if bullying negatively affected standard of care, the majority 44.7 % (n=51) disagreed and a further 8.8% (n=10) strongly disagreed. A total of 30.7% (n=35) agreed and 15.8% (n=18) strongly agreed with a mean of 2.54 and SD of 0.86.

**Table 4.11: Influence of bulling on work performance**

| Item | Strongly disagree | | Disagree | | Agree | | Strongly agree | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | | |
| Made me consider leaving nursing | 7 | 7.4 | 58 | 61.7 | 15 | 16.0 | 14 | 14.9 | 2.38 | 0.83 |
| Caused me to call in absent | 9 | 7.8 | 46 | 40.0 | 45 | 39.1 | 15 | 13.0 | 2.57 | 0.82 |
| Made me scared to check orders for patients | 14 | 12.2 | 49 | 42.6 | 34 | 29.6 | 18 | 15.7 | 2.49 | 0.90 |
| Negatively affected my standard of patients care | 10 | 8.8 | 51 | 44.7 | 35 | 30.7 | 18 | 15.8 | 2.54 | 0.86 |

### 4.7.1 Overall scores on influence of bullying on work performance

The influence of bullying on work performance was measured on a four point Likert scale with strongly disagree as score one and strongly agree as score four. There were four items in total giving a possible score ranging from 4-16. The respondents' minimum score was 4 and maximum 14.

**Table 4. 12: Overall scores on influence of bullying on work performance**

| | Score | n | % |
|---|---|---|---|
| Less influence | Less than 8 | 42 | 46.2 |
| More influence | 9-16 | 49 | 53.8 |
| Total | 16 | 91 | 100.0 |

The mean score was 9.91 with SD of 2.84. The scores were grouped in two categories with scores less than 8 as less influence and 9-16 as more influence. The majority of respondents (53.8%: n=49) fell within the more influence group and the remaining 46.2 % (n=42) within the less influence group (Table 4.12).

### 4.7.2 Relationship between demographic variables and influence of bullying on work performance

Cross-tabulations were performed to examine the influence of demographics on the impact of bullying on work performance

#### 4.7.2.1 Gender and influence of bullying on work performance

The results shown in Table 4.12 demonstrate that females were more influenced by bullying in their work performance compared to males as 56.3% (n=45) fell within the high influence group compared to 22.2% (n=2) for males (Table 4.13). The results however were not statistically significant with Pearson chi-squired value of 3.759, df =1, and p-value of 0.078.

**Table 4.13: Cross tabulation of influence of bullying on work performance and gender**

| Gender | | Influence of bullying on work performance | | Total |
|---|---|---|---|---|
| | | Less influence | More influence | |
| Males | n | 7 | 2 | 9 |
| | % | 77.8% | 22.2% | 100.0% |
| Females | n | 35 | 45 | 80 |
| | % | 43.8% | 56.3% | 100.0% |
| Total | n | 42 | 47 | 89 |
| | % | 47.2% | 52.8% | 100.0% |

#### 4.7.2.2 Relationships between age, year of study and influence of bullying on work performance

The results for age and year of study were insignificant with P-values of 0.743 and 0.367 respectively as demonstrated in Table 4.14.

**Table 4.14: Relationship between influence of bulling on work performance and age and year of the study**

| | Test | Value | df | p-value |
|---|---|---|---|---|
| Age | Pearson chi-squared | 1.355 | 3 | 0.743 |
| Year of study | Pearson chi-squared | 2.249 | 2 | 0.367 |

#### 4.7.2.3 Interrelationships between demographic variables and influence of bullying on work performance

Non-parametric tests were also performed to test for interrelationships between respondents' demographic variables and influence of bullying on work performance; Mann-Whitney U-test for gender and Kruskal-Wallis tests for age and year of study. The results were insignificant for gender, age and year of study with P-values of 0.097, 0.837 and 0.606 respectively.

### 4.7.3 Individual items on influence of bullying on work performance and demographic variables

A significant relationship was found between bullying negatively affecting the standard of patient care and gender.

**Table 4.15: Cross tabulation of gender and influence of bullying on standard of patient care**

| Gender | | Negatively affected standard of patient care | | | | Total |
|---|---|---|---|---|---|---|
| | | Strongly disagree | Disagree | Agree | Strongly agree | |
| Male | n | 3 | 6 | 0 | 2 | 11 |
| | % | 27.3% | 54.5% | 0.0% | 18.2% | 100.0% |
| Female | n | 7 | 45 | 29 | 16 | 97 |
| | % | 7.2% | 46.4% | 29.9% | 16.5% | 100.0% |
| Total | n | 10 | 51 | 29 | 18 | 108 |
| | % | 9.3% | 47.2% | 26.9% | 16.7% | 100.0% |

As demonstrated in Table 4.15 most male respondents 81.8% (9) disagreed compared to only 53.6 % (n=52) of females. Pearson chi-squired value was 7.74, df =3 and P-value = 0.049.

No relationships were found between the respondents' demographic variables and the other items on influence of bullying on work performance (Table 4.16).

**Table 4.16: Relationships between respondents' demographic variables and items on influence of bullying on work performance**

| | Gender | | Age | | Year of study | |
|---|---|---|---|---|---|---|
| Made me consider leaving nursing | $X^2$ | 4.87 | Fishers exact | 5.65 | Fishers exact | 2.43 |
| | P-value | 0.135 | P-value | 0.778 | P-value | 0.907 |
| Caused me to call in absent | Fishers exact | 5.23 | Fishers exact | 10.94 | Fishers exact | 7.35 |
| | P-value | 0.106 | P-value | 0.231 | P-value | 0.253 |
| Made me scared to check patients orders | Fishers exact | 5.17 | Fishers exact | 12.34 | Fishers exact | 9.17 |
| | P-value | 0.133 | P-value | 0.160 | P-value | 0.138 |
| Negatively affected standard of patient care | $X^2$ | 7.74 | Fishers exact | 14.56 | $X^2$ | 6.64 |
| | P-value | 0.049 | P-value | 0.070 | P-value | 0.359 |

## 4.8 Personal consequences of bullying

Personal consequences of bullying were also measured on a four-point Likert scale with agree options ranging from strongly disagree and strongly agree.

Most respondents acknowledged that bullying resulted in Anger with 39.1 % (n=45) and 20% (n=23) agreeing and strongly agreeing respectively. Only 35.7 % (n=41) disagreed and 5.2% (n=6) strongly disagreed with a mean was 2.74 with SD of 0.84. When asked if they experienced depression as a result of bullying, 34.5% (n=40) agreed and an additional 23.3% (n=27) strongly agreed. The remaining 42.2 % (n=49) denied with 37.9% (n=44) disagreeing and 4.3% (n=5) strongly disagreeing. The mean was 2.77 with an SD of 0.86.

The majority of the respondents 56.5 % (n=65) also acknowledged that bullying caused humiliation/embarrassment with 33% (n=38) strongly agreeing and 23.5% (n=27) agreeing. Of the remaining 50 respondents, 37.4 % (n=43) and 6.1 (n=7) disagreed and

strongly disagreed respectively with a mean of 2.83 and SD of 0.96. In terms of bullying causing anxiety on the respondents, the majority agreed with 31 % (n=36) strongly agreeing and 23.3% (n=27) agreeing. A good number, 40.5 % (n=47) disagreed and a further 5.2 % (n=6) strongly disagreed with a mean of 2.80 and SD of 0.94.

**Table 4.17: Personal consequences of bullying**

| Item | Strongly disagree | | Disagree | | Agree | | Strongly agree | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | | |
| Anger | 6 | 5.2 | 41 | 35.7 | 45 | 39.1 | 23 | 20.0 | 2.74 | 0.84 |
| Depression | 5 | 4.3 | 44 | 37.9 | 40 | 34.5 | 27 | 23.3 | 2.77 | 0.86 |
| Humiliation/ embarrassment | 7 | 6.1 | 43 | 37.4 | 27 | 23.5 | 38 | 33.0 | 2.83 | 0.96 |
| Anxiety | 6 | 5.2 | 47 | 40.5 | 27 | 23.3 | 36 | 31.0 | 2.80 | 0.94 |
| Confusion | 6 | 5.2 | 43 | 37.4 | 31 | 27.0 | 35 | 30.4 | 2.83 | 0.93 |
| Feeling of inadequacy | 6 | 5.2 | 44 | 38.3 | 29 | 25.2 | 36 | 31.3 | 2.83 | 0.94 |
| Negative effect on personal relationships | 5 | 4.3 | 47 | 40.9 | 28 | 24.3 | 35 | 30.4 | 2.81 | 0.93 |

The majority of the respondents also acknowledged that bullying caused confusion with 30.4 % (n=35) strongly agreeing and 27% (n=31) agreeing. The remaining 37.4% (n=43) and 5.2 % (n=6) disagreed and strongly disagreed respectively. The mean was 2.83 with an SD of 0.93.

When asked if bullying caused feelings of inadequacy, 31.3% (n=36) strongly agreed and an additional 25.2% (n=29) agreed. The remaining 38.3 % (n=44) disagreed and 5.2 % (n=6) strongly disagreed with a mean of 2.83 and SD of 0.93. The majority also acknowledged that bullying negatively affected their personal relationships with 30.4 % (n=35) strongly agreeing and 24.3% (n= 28) agreeing. Of the remaining 52 respondents, 40.9% (n=47) disagreed and 4.3% (n=5) strongly disagreed with a mean of 2.81 and SD of 0.93 (Table 4.17).

### 4.8.1 Overall scores on personal consequences of bullying

Personal consequences of bullying were also measured on a four point Likert scale with strongly disagree as score one and strongly agree as score four. There were 7 items in total giving a possible minimum score of 7 and a maximum score of 28. The respondents' minimum score was 7 and maximum was 28 with a median score of 21 and interquartile range of 21.

**Table 4.18: Overall scores on personal consequences of bulling**

| | Score | n | % |
|---|---|---|---|
| Less personal consequences | Less than 14 | 38 | 33.6 |
| More personal consequences | 15-28 | 75 | 66.4 |
| Total | 28 | 113 | 100.0 |

When the scores were grouped with a score of less than 14 as less personal consequences and 15-28 as more personal consequences, most respondents (66.4 % : n=75) fell within the more personal consequences group and only 33.6% (n=38) within the less personal consequences (Table 4.18).

### 4.8.2 Relationships between demographic variables and personal consequences of bullying

The results of the analysis showed no significant results regarding demographic variables and personal consequences of bullying as follows: gender: $X^2$ value= 0.53 and P-value =0.515, Age: $X^2$ value =6.72 and P-value = 0.085, Year of study: $X^2$ value = 4.95 and P-value 0.098 (Table 4.19).

**Table 4.19: Influence of demographic variables on personal consequences of bullying**

| | Test | Value | df | p-value |
|---|---|---|---|---|
| Gender | Pearson chi-Square | 0.53 | 1 | 0.515 |
| Age | Pearson Chi-Square | 6.72 | 3 | 0.085 |
| Year of study | Pearson Chi-Square | 4.95 | 2 | 0.098 |

### 4.8.3 Interrelationships between demographic variables and personal consequences of bullying

Non-parametric tests were also performed, Mann-Whitney U test for gender and Kruskal-Wallis test for age and year of study. In terms of gender, the results were insignificant with P-value of 0.440. The results were also insignificant for age and year of study with P-values of 0.272 and 0.136 respectively.

### 4.8.4 Relationships between respondents' demographic variables and the different personal consequences of bullying

Cross tabulations were performed to test for relationships between the different personal consequences of bullying and the respondents' demographic variables.

In terms of gender, the majority of females agreed to have experienced the different personal consequences of bullying compared to males. Significant results were found with the following personal consequences: Anger with Fishers exact value of 8.72 and P-value of 0.022; depression: Fishers exact value = 9.49, P-value = 0.014; humiliation/embarrassment: $X^2$ = 0.16, P-value = 0.020; Anxiety : Fishers exact = 7.73, P-value = 0.036; feeling of inadequacy: Fishers exact = 8.21, P-value = 0.028 and negative effect on personal relationships with $X^2$ value of 14.71 and P-value of 0.007. For age, a significant relationship was only found with confusion; Fishers exact value: 15.86 and P-value: 0.043. No significant relationships were found between year of study and any of the personal consequences (Table 4. 20).

**Table 4.20: Relationships between the respondents' demographic variables and personal consequences of bulling**

| | Gender | | Age | | Year of study | |
|---|---|---|---|---|---|---|
| Anger | Fishers exact | 8.72 | Fishers exact | 8.04 | Fishers exact | 7.49 |
| | P-value | 0.022 | P-value | 0.499 | P-value | 0.242 |

| Depression | Fishers exact | 9.49 | Fishers exact | 8.89 | Fishers exact | 9.33 |
|---|---|---|---|---|---|---|
| | P-value | 0.014 | P-value | 0.409 | P-value | 0.124 |
| Humiliation/ embarrassment | $X^2$ | 10.16 | Fishers exact | 10.74 | Fishers exact | 9.23 |
| | P-value | 0.020 | P-value | 0.250 | P-value | 0.132 |
| Anxiety | Fishers exact | 7.73 | $X^2$ | 11.25 | Fishers exact | 5.99 |
| | P-value | 0.036 | P-value | 0.213 | P-value | 0.395 |
| Confusion | $X^2$ | 4.92 | Fishers exact | 15.86 | Fishers exact | 3.80 |
| | P-value | 0.190 | P-value | 0.043 | P-value | 0.707 |
| Feeling of inadequacy | Fishers exact | 8.21 | Fishers exact | 13.74 | Fishers exact | 6.85 |
| | P-value | 0.028 | P-value | 0.093 | P-value | 0.305 |
| Negative effect on personal relationships | $X^2$ | 14.71 | Fishers exact | 14.59 | Fishers exact | 7.31 |
| | P-value | 0.007 | P-value | 0.067 | P-value | 0.257 |

### 4.9 Coping with workplace violence

#### 4.9.1 Reporting of bullying (N=92)

The respondents were further asked if they reported the bullying and as shown in Figure 4.6 the majority of the respondents, (83 %: n=77) indicated that they never did, and only 17% (n=15) reported the episodes.

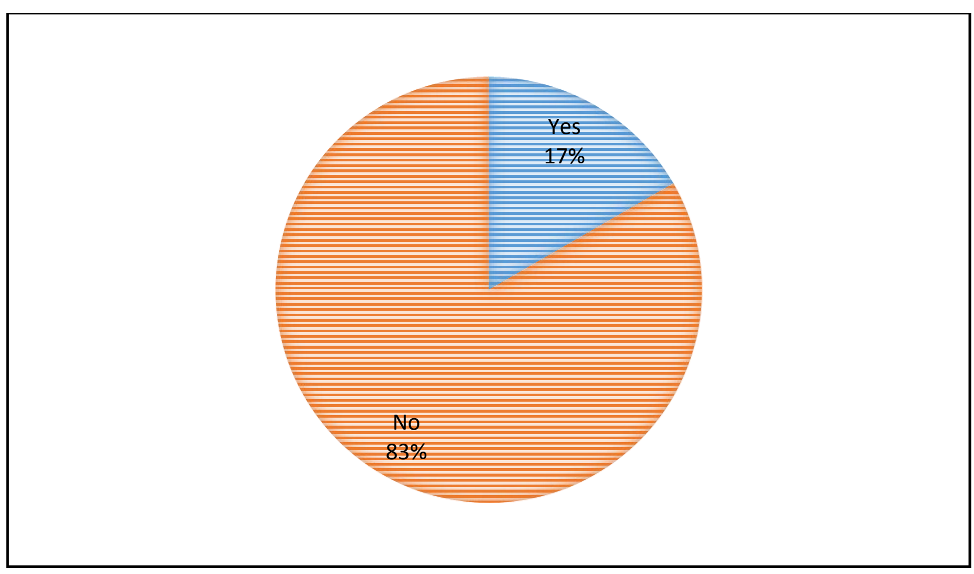

**Figure 4.6: Reporting of episode**

#### 4.9.1.1 Respondents demographic variables reporting of bullying

Cross tabulations were performed to test the relationship between respondents' demographic variables and reporting of bullying.

**Table 4.21: Cross tabulation of reporting of bullying and year of study**

| Year of study | | Reporting of episodes | | Total |
|---|---|---|---|---|
| | | Yes | No | |
| 1st year | n | 1 | 24 | 25 |
| | % | 4.0% | 96.0% | 100.0% |
| 2nd year | n | 14 | 39 | 53 |
| | % | 26.4% | 73.6% | 100.0% |
| Total | n | 15 | 73 | 88 |
| | % | 17.0% | 83.0% | 100.0% |

A significant relationship was found between reporting of bullying and year of study. A good number of second year students (26.4%: n=14) reported the episodes compared to 4 % (n-1) for first years with Pearson chi-squared value of 8.354, df =2 and P-value of 0.015 (Table 4.21).

No relationship was found between gender and reporting of episodes with Pearson chi-squired value of 0.47, df = 1, and P-value of 0.829. Similarly, no relationship was found with age with Pearson chi-squared test value of 6.948, df = 3 and P-value of 0.740.

### 4.9.2 Coping mechanisms

In order to identify coping mechanisms that respondents' used to deal with bullying, they were asked to respond to various statement on a four point Likert scale ranging from strongly disagree to strongly agree.

The results displayed in Table 4.22 illustrate that 54% (n=60) did nothing with 36.9 % (n=42) agreeing and 17.1 % (n=19) strongly agreeing. The remaining 39.6 % (n=44) and 6.3 %(n=7) disagreed and strongly disagreed respectively with a mean of 2.65 and SD of

0.84. When asked if they did put up barriers, the majority denied with 47.3% (n=52) disagreeing and 10% (n=11) strongly disagreeing. Only 25.5% (n=28) and 17.3% (n=19) agreed and strongly agreed respectively with a mean of 2.50 and SD of 0.90.

The majority of the respondents (61.3 %: n=68) disagreed that they confronted the bully and an additional 9% (n=10) strongly disagreed. Only 18.9% (n= 21) and 10.8% (n=12) agreed and strongly agreed respectively with a mean of 2.32 and SD of 0.79. Most of the respondents 41.4% (n=46) and 9.9% (n=11) also disagreed and strongly disagreed respectively that they pretended not to see the behavior. The remaining 32.4% (n=36) agreed and 16.2% (n=18) strongly agreed with a mean of 2.55 and SD of 0.88.

When asked if they reported the behavior to authorities, the majority (59.5 %: n=66) disagreed and an additional 9.9% (n=11) strongly disagreed. Only 15.3% (n=17) strongly agreed and a similar number agreed. The mean was 2.36 with SD of 0.86. The majority of the respondents also denied to have increased use of unhealthy coping behavior with 63.1% (n=70) disagreeing and 10.8% (n=12) strongly disagreeing. Only 16.2% (n=18) and 9.9% (n=11) strongly agreed and agreed respectively with a mean of 2.32 and SD of 0.87.

**Table 4.22: Coping mechanisms**

| Item | Strongly disagree | | Disagree | | Agree | | Strongly agree | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | | |
| Did nothing | 7 | 6.3 | 44 | 39.6 | 41 | 36.9 | 19 | 17.1 | 2.65 | 0.84 |
| Put up barriers | 11 | 10.0 | 52 | 47.3 | 28 | 25.5 | 19 | 17.3 | 2.50 | 0.90 |
| Spoke directly to the bully | 10 | 9.0 | 68 | 61.3 | 21 | 18.9 | 12 | 10.8 | 2.32 | 0.79 |
| Pretended not to see the behavior | 11 | 9.9 | 46 | 41.4 | 36 | 32.4 | 18 | 16.2 | 2.55 | 0.88 |
| Reported the behavior to superior/ authority | 11 | 9.9 | 66 | 59.5 | 17 | 15.3 | 17 | 15.3 | 2.36 | 0.86 |
| Increased the use of unhealthy coping behavior | 12 | 10.8 | 70 | 63.1 | 11 | 9.9 | 18 | 16.2 | 2.32 | 0.87 |
| Warned the bully not to do it | 17 | 15.2 | 57 | 50.9 | 30 | 26.8 | 8 | 7.1 | 2.26 | 0.80 |

| again | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Shouted or snapped at the bully | 28 | 25.0 | 68 | 60.7 | 9 | 8.0 | 7 | 6.3 | 1.96 | 0.76 |
| Demonstrated similar behavior | 25 | 22.5 | 67 | 60.4 | 11 | 9.9 | 8 | 7.2 | 2.02 | 0.79 |
| Went to a doctor | 28 | 25.2 | 69 | 62.2 | 7 | 6.3 | 7 | 6.3 | 1.94 | 0.75 |
| Perceived the behavior as a joke | 15 | 13.5 | 68 | 61.3 | 18 | 16.2 | 10 | 9.0 | 2.21 | 0.79 |

Pertaining to giving a warning the bully, the majority 50.9% (n=57) disagreed and an additional 15.2% (n=17) strongly disagreed. Of the remaining 38 respondents’, 26.8% (n=30) agreed and 7.1% (n=8) strongly agreed with a mean of 2.26 and SD of 0.80. The majority of the respondents also denied shouting at the bully with 60.7% (n=68) disagreeing and 25% (n=28) strongly disagreeing. Only 8 % (n=9) agreed and 6.3% (n=7) strongly agreed with a mean of 1.96 and SD of 0.76. Similarly, the majority of the respondents’ 60.4 % (n=67) disagreed and 22.5 % (n=25) strongly disagreed respectively that they demonstrated similar behaviors. Only 9.9% (n=11) agreed and 7.2% (n=8) strongly agreed with a mean of 2.02 and SD of 0.79.

A total of 62.2% (n=69) disagreed that they went to a doctor and a further 25.2 % (n=28) strongly disagreed. Only 6.3 % (n=7) strongly agreed and a similar number agreed with a mean of 1.94 and SD of 0.75. When asked if they perceived the behavior as a joke, the majority, (61.3%: n=68) disagreed and an additional 13.5% (n=15) strongly disagreed. The remaining 16.2 % (n=18) and 9% (n=10) agreed and strongly agreed respectively with a mean of 2.21 and SD of 0.79.

#### 4.9.2.1 Relationships between respondents’ demographic variables and the different coping mechanisms

Cross tabulations were performed to assess for relationships between the respondents’ demographic variables and the different coping mechanisms. The results have been presented in Table 4.23. No significant relationships were found between the different

coping mechanisms and gender. In terms of age, a significant relationship was found with putting up barriers as a coping mechanism with the majority of younger respondents agreeing to this mechanism compared to older respondents.

Fishers exact test value was 19.64 with a P-value of 0.010. With regard to year of study relationships were found with the following coping mechanisms: did nothing with Fishers exact test value of 13.03 and P-value of 0.027; putting up barriers: Fishers exact value = 14.70, P-value = 0.013; reporting behavior to authorities: Fishers exact value = 22.12, P-value = 0.000, increased use of unhealthy coping behavior: Fishers exact value = 11.42, P-value = 0.050 and perceiving the behavior as a joke with Fishers exact value of 17.39 and P-value of 0.004.

**Table 4.23: Relationships between copying mechanisms and demographic variables**

| | Gender | | Age | | Year of study | |
|---|---|---|---|---|---|---|
| Did nothing | Fishers exact | 6.52 | Fishers exact | 9.84 | Fishers exact | 13.03 |
| | P-value | 0.062 | P-value | 0.320 | P-value | 0.027 |
| Put up barriers | $X^2$ | 0.96 | Fishers exact | 19.64 | Fishers exact | 14.70 |
| | P-value | 0.811 | P-value | 0.010 | P-value | 0.013 |
| Spoke directly to the bully | $X^2$ | 5.07 | Fishers exact | 8.32 | Fishers exact | 11.16 |
| | P-value | 0.154 | P-value | 0.461 | P-value | 0.055 |
| Pretended not to see the behavior | $X^2$ | 2.823 | Fishers exact | 15.33 | Fishers exact | 9.50 |
| | P-value | 0.408 | P-value | 0.056 | P-value | 0.119 |
| Reported the behavior to superior/ authority | Fishers exact | 0.15 | Fishers exact | 8.91 | Fishers exact | 22.12 |
| | P-value | 1.000 | P-value | 0.401 | P-value | 0.000 |
| Increased the use of unhealthy coping behavior | $X^2$ | 1.81 | Fishers exact | 5.77 | Fishers exact | 11.42 |
| | P-value | 0.646 | P-value | 0.762 | P-value | 0.050 |
| Warned the bully not to do it again | $X^2$ | 2.00 | Fishers exact | 14.80 | Fishers exact | 4.15 |
| | P-value | 0.650 | P-value | 0.064 | P-value | 0.648 |
| Shouted or snapped at the bully | $X^2$ | 0.99 | Fishers exact | 9.88 | Fishers exact | 9.47 |
| | P-value | 0.910 | P-value | 0.294 | P-value | 0.106 |
| Demonstrated similar behavior | $X^2$ | 1.40 | Fishers exact | 10.52 | Fishers exact | 9.14 |
| | P-value | 0.764 | P-value | 0.251 | P-value | 0.124 |
| Went to a doctor | $X^2$ | 1.13 | Fishers exact | 10.17 | Fishers exact | 7.86 |
| | P-value | 0.817 | P-value | 0.266 | P-value | 0.194 |
| Perceived the behavior as a joke | $X^2$ | 1.98 | Fishers exact | 6.45 | Fishers exact | 17.39 |
| | P-value | 0.659 | P-value | 0.684 | P-value | 0.004 |

### 4.9.3 Awareness of policy on workplace violence (N=100)

The respondents were asked if they were aware of any policy in the clinical area that addresses workplace violence. The results displayed in Figure 4.7 Shows that the majority 58% (n=58) were not aware and only 42% (n=42) were aware of the availability of such policies.

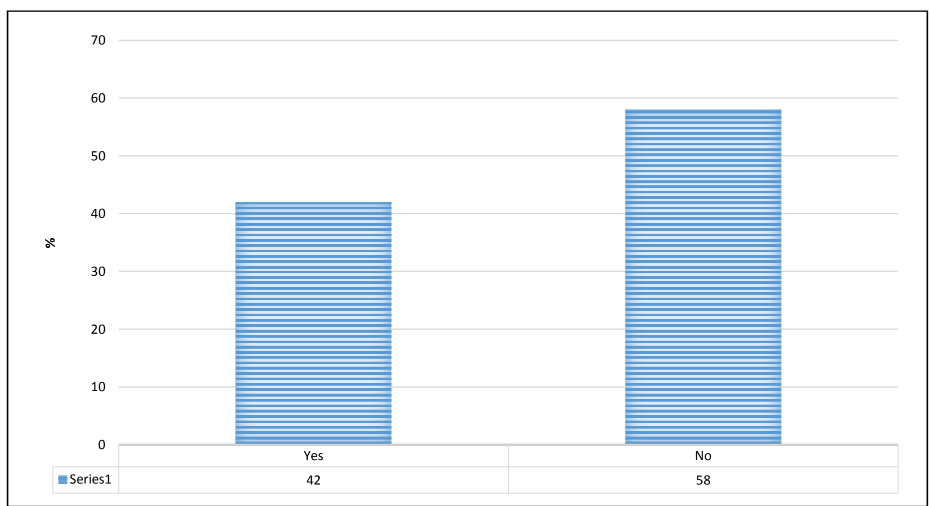


**Figure 4.7: Awareness of clinical policies on workplace violence**

#### 4.9.3.1 Relationships between respondents' demographic variables and awareness of policy availability

Cross tabulations were performed to test the relationship between the respondents' demographic variables and awareness of work place violence policy availability in the clinical area. The results showed a significant relationship between gender and awareness of policy with the majority of males 78.8% (n=7) being aware compared to only 41.2% (n35) of females. Pearson chi-squared test value was 4.411, df =1, and P-value was 0.036 (Table 4.24).

**Table 4.24: Cross tabulation of gender and policy awareness**

| Gender | | Awareness of policies | | Total |
|---|---|---|---|---|
| | | Yes | No | |
| Male | n | 7 | 2 | 9 |
| | % | 77.8% | 22.2% | 100.0% |
| Female | n | 35 | 50 | 85 |
| | % | 41.2% | 58.8% | 100.0% |
| Total | n | 42 | 52 | 94 |
| | % | 44.7% | 55.3% | 100.0% |

No relationship was found between awareness of policy availability and age with Pearson chi-squared test value of 4.950, df = 3 and p-value = 0.175. Similarly, no significant relationship was found between awareness of availability of policy and year of study with Pearson chi-squared test value of 4.932, df = 2, and p-value of 0.085.

### 4.9.4 Reporting of bullying and awareness of policy availability

The results showed no significant relationship even though 60% (n=9) of those that reported the episode were aware of the policy compared to only 36.1% (n=22) of those that did not report. Pearson chi-squared value was 2.856, df = 1, P-value = 0.091 (Table 4.25).

**Table 4.25: Policy awareness and reporting of bullying episodes**

| Episode reporting | | Awareness of policy availability | | Total |
|---|---|---|---|---|
| | | Yes | No | |
| Yes | n | 9 | 6 | 15 |
| | % | 60.0% | 40.0% | 100.0% |
| No | n | 22 | 39 | 61 |
| | % | 36.1% | 63.9% | 100.0% |
| Total | n | 31 | 45 | 76 |
| | % | 40.8% | 59.2% | 100.0% |

### 4.10 Summary of the chapter

This chapter has presented the findings of a study aimed at exploring student nurses' perception on bullying behavior during clinical placement in a selected nursing institution in KwaZulu-Natal province. The findings revealed that the majority of the respondents were young adult females, in their second year of study.

Non-physical bullying was the most common form of bullying experienced by the respondents. Although experienced by less than half of the respondents, the most common forms of non-physical bullying included unfair work allocation, non-verbal e.g. raised eye brows, sworn, shouted or yelled at and being harshly judged or criticized. Physical and sexual bullying was less prevalent among the respondents. Most of the bullying occurred in a hospital setting compared to the community setting even though most respondents also experienced bullying in the community setting. The respondents experienced bullying from all the hospital staff as well as their course lecturers.

The results further established that the bullying affected the students work performance with most students acknowledging to ever been absent because of bullying. Additionally, the students also experienced a number of personal consequences because of bullying such as anger, depression, and humiliation. However, most respondents did not report the bullying incidents presumably because of lack of knowledge of existence of work place violence policies. Most of the respondents did nothing, or pretended not to see the behavior and a good number also had to put up several barriers to protect themselves.

The respondents' gender, age and year of study were found to have an influence on the forms of non-physical violence, frequency of violence, influence on work performance, personal consequences and coping with work place violence. However, no relationship was found with the perpetrators of bullying. The next chapter will present a discussion of the study findings, recommendations, limitations of the study and the conclusions drawn from the study.

# CHAPTER FIVE

# DISCUSSION AND CONCLUSION

## 5.1. Introduction

This chapter presents the discussion of the recommendations, and conclusion findings of this research study. The purpose of this study was to investigate and describe student nurse's perceptions on bullying behavior during clinical placement at a selected private nursing institute. The research objectives were to: (a) describe the types of bullying on student nurses during clinical placement; (b) measure the frequency of bullying behavior on student nurses during clinical placement; (c) describe sources of bullying behavior on student nurses during clinical placement (d) describe coping mechanisms about behavior on student nurses during clinical placement.

The findings are discussed in relation to the research objectives and the conceptual framework used in this study as well as the relevant literature reviewed. A quantitative investigative and descriptive design was used to conduct the research. A questionnaire was used as a data collection tool. Utilizing the survey for its investigative purpose allowed the researcher to obtain information relating to the perceptions of student nurses on bullying behavior during clinical placement. A non-probability convenient sampling technique was used to obtain a sample of one hundred and twenty student nurses studying in one selected private school. Only 114 out of 120 in the sample returned with completed questionnaires. The majority of the respondents 90% were females, while males comprised only 10 % of the sample.

## 5.2 Discussion of the findings

The major themes that are discussed in this chapter are the types of bullying behavior, frequency of bullying behavior, sources of bullying behavior and coping mechanism adopted by the victims of bullying.

### 5.2.1 Types of bullying behaviour

The findings indicated that respondents are not protected from bullying behavior during clinical placement, by virtue of their novice status. It emerged that during clinical placement students often encounter active and passive manifestations of bullying behavior. When asked about non-verbal bullying for example raised eyebrows, rolling eyes, 53.8% who strongly disagreed and disagreed. This is in line with Griffin (2004) who stated that in nursing, common examples of lateral violence include being undervalued, blocking of learning opportunities, emotional neglect, non-verbal manifestations, such as rolling eyes, actions such as not being available to help with difficult care related issues, sabotage, such as withholding important information, disinterest, excessive criticism, scapegoating, gossiping, forming cliques, exclusion, intimidation and humiliation. These behavioral manifestations can be classified as either overt or covert. This corresponds with the four types, based on the perpetrator's relationship to the workplace, especially type 2 and type 3 (Le Blanc and Barling, 2005; National Institute for Occupational Safety and Health, 2006). This is in line with the study conducted by (LeBlanc and Kelloway, 2002; McPhaul and Lipscomb, 2004) which states that health care workers, including student nurses, are particularly at risk of violence from recipients or clients of the services provided in the workplace, especially type 2 and type 3 of violence. However, findings from a study conducted by LeBlanc and Barling, (2005) revealed that worker to worker violence type 3, targeting student nurses, had been distressingly prevalent.

Most respondents also denied being sworn or shouted at with 55. 1% who strongly disagreeing and disagreeing. This is similar to a study conducted by Buss (2005), who classified workplace aggression using three dichotomies, namely physical-verbal, active-passive, and direct-indirect. Physical aggression involves physical actions that inflict harm through words, rather than deeds. This is in line with the study conducted by Fern (2005), which revealed that in nursing, non-physical form of violence, for example, verbal aggression, incivility, bullying and intimidation, are far more common than physical assault, and that in the few instances where weapons are involved, weapon use is opportunistic, rather than premeditated. This was asserted by a similar pattern that was reported by Khalil (2009), when she asked nurse respondents in eight public hospitals in Cape Town to respond to questions regarding six levels of violence. The levels were psychological violence, covert violence, horizontal violence, overt violence and physical violence. This is in line with the study conducted by Celik and Bayraktar (2004) in Turkey, which stated that being yelled at or shouted at, were behaved towards in an inappropriate manner which included, nasty, rude or hostile way, or were belittled or humiliated, and 74% had vicious rumors spread about them.

The findings further indicated that the majority of respondents 59. 8% strongly disagreed and disagreed when asked if they were harshly judged criticized. Findings of the study revealed that the majority of respondents indicated that 68.3% strongly disagreed and disagreed that they were ignored or neglected during clinical placement. Similarly, Felblinger (2008) discovered that nurses often respond to intimidation and incivility with self-directed feelings of shame and anger, leading to negative self-evaluation and increased potential for re-victimisation. A study by Bowen and Reid (2007) indicates that students experiencing, or witnessing lateral violence, reported feelings of humiliation,

dissonance, powerless and a firm resolve not to accept future employment in an area, institution or unit, where they had been abused in this fashion.

Regarding the view that respondents were ridiculed or humiliated, the majority, 68.4% strongly disagree and disagree to this view. These findings are similar to those of a study conducted in the United States which revealed that respondents reported bullying behaviors perceived included cursing or swearing, inappropriate, nasty, rude or hostile behaviors and belittling or humiliating behavior (Cooper et al., 2011). This was echoed by a study conducted by Celik and Bayraktar (2004) where 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, and 74% had vicious rumors spread about them.

Findings of the study also indicated that the majority 72. 4% of the respondents strongly disagree and disagree that they have been unfairly treated regarding on or off duty schedules. This is in line with a study conducted by Luck, Jackson and Usher (2006) which argued (about the definition) with the definition of workplace violence from WHO (2002). They stated that the violence in nursing context should be viewed as an overarching term comprising a wide range of behaviors, such as non-physical actions or threats, such as verbal and emotional abuse. WHO,( 2002) defined workplace violence as the intentional use of physical force or power, threatened or actual against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. This is echoed by the studies conducted by Ramos (2006) and Vessey et al., (2009), which discovered that organisations have been facing increased absenteeism and

staff turnover, increased sick leave, increased security and litigation costs and decreased productivity. Kisa (2008), agrees that organizations suffer from losses in productivity, due to strained professional relationships and below standard patient care.

The findings in this study further indicated that the majority 53.8% of the respondents strongly disagreed and disagreed to the view that unfair work was allocated to them. Rayner and Keashly (2005) state that negative behavior makes the victims' work life through allocating unmanageable workloads (the most common behavior), generating perceived unfair and punitive actions such as withholding information.

Regarding the view on not receiving acknowledgement for good work, the majority 63% of the respondents, strongly disagreed and disagreed to this view. Similarly, a study conducted by Rayner and Keashly (2005) indicates that persistent, negative, interpersonal behavior, experienced by people at work refers to many, rather than isolated instances of behavior, which undermines and humiliates. It further refers to what is done for example personal attacks on credibility and what is not done for example not receiving needed information

The findings of this study showed that the majority 74% of the respondents strongly disagreed and disagreed to the view that they were denied learning opportunities. This is similar to a study Bowen and Reid (2007) which states that typically called horizontal or lateral violence, relates to inter group conflict and is expressed as bullying and aggression, common examples include being undervalued, blocking of learning opportunities, emotional neglect, non-verbal manifestation such as rolling eyes. This study also links to Dellasen (2009) who explains that workplace bullying can reflect an actual or perceived power imbalance. The power imbalance between victim and perpetrator in the nursing clinical area was more common in inter-group structures at both

vertical as well as horizontal levels compared to intra-group occurrences Randle (2003). Neuman (2000) concurs with this idea by stating that the most common form of bullying involves the abuse of power by superiors against subordinates, some people hold information power over others as opposed to legitimate power.

About 79.1% of the respondents were of the view that they did not have a racist remark directed to them. Zapf and Einarsen (2003) reveal that discrimination and workplace bullying also have some conceptual and legal overlap. One difference worth noting is that discrimination involves mistreatment based on membership to a group, while workplace bullying can happen to anyone (Namie and Namie, 2000). This is also echoed by the United States legislation which gained momentum largely through the work of activists Gary and Ruth Namie, who founded the Workplace Bullying and Trauma Institute in 2002 (Namie and Namie, 2002). The Namies maintain a website for grassroots organisers lobbying for state legislation in the United States of America (Namie and Namie, 2011).

The findings further indicated that the majority of the respondents 65.6% strongly disagreed and disagreed to the statement that they were not treated as part of the multi-disciplinary team. Similarly, Cooper et al., (2011) state that nursing students are socialized into nursing while learning how to prioritize personal needs. Therefore, most students have little time to worry about bullying from others or directed towards others. However, Moscaritolo (2009) revealed that students report feelings of anxiety during clinical rotation, which affects performance. Lewis (2004) affirms that nursing students struggle with the stress of conflict in the classroom and clinical setting, creating an environment in which they witness and experience bullying firsthand.

Findings in this study indicated that the majority of the respondents 84.7% strongly disagreed and disagreed that they were pushed or shoved. This is echoed by the study

conducted by Wilkens and Jackson (2010) which stated that negative bullying behaviors of a perpetrator consisted of personal attack. With regards to whether respondents experience being kicked, findings in this study revealed that the majority 90.7% of the respondents strongly disagreed and disagreed with the statement. Hutchinson et al., (2010a) state that threats of violence or actual physical abuse were reported as the least common episodes. Furthermore, the findings in this study indicated that the majority 91.6 % of the respondents strongly disagreed and disagreed to the statement that they were slapped or punched. The findings of this study are supported by Hutchinson et al., (2010b) report that the least common form of abuse that has been reported which is actual physical abuse that results in injuries.

Findings in this study indicated that the majority of the respondents 92.4% strongly disagreed and disagreed to the statement that they were hit with something. This is supported by a study conducted by Rayner and Keashly (2005) which states that they are three factors forming the construct of bullying in nursing context those are attack upon competences and reputation, personal attack and attack through work tasks.

About 93% of the respondents strongly disagreed and disagreed to the view that they had a gun or knife pulled on them. About 91.6% of the respondents strongly disagree and disagree that they have been threatened with physical violence. Similarly, study conducted by Spector et al.,(2007) found that most of the physical violence had been caused by patients followed by registered nurses and supervisors.

About 87% of the respondents strongly disagreed and disagreed to having their things deliberately damaged. This finding is similar to the study conducted by Adams et al., (1997) stating that damages experienced by the targeted person are described as gradual negative impact on the confidence and self-esteem of the bullied person. Robenstein and

O'Daniel (2005), raise the issue of health and safe risks and they define workplace violence as disruptive behavior which results in an inappropriate behavior, confrontation or conflict, ranging from verbal abuse to physical and sexual harassment. This is also in line with the conceptual framework of a study by Rayner and Keashly (2005) which states that five core domains of the bullying interaction as being negative behaviors of a bully, persistent and repeated bullying interaction person targeted experiences damage, person targeted labels the interaction as being bullied and imbalance of power. Rayner and Keashly (2005) indicate that damage as a result of bullying in nursing does not only affect interpersonal relationships but also have an impact on the organizational level through, quality of patient care, financial loss, and negative image of the workplace.

Findings of this study further indicate that the majority 90% of the respondents strongly disagreed and disagreed to the statement that they have been inappropriately touched. According to Simpson and Cohen (2004), bullying behavior tends to be located in organisational power while sexual harassment tends to be in gendered power. Furthermore, they stated that bullies choose targets based on individual characteristics such as competence, while sexual harassers choose targets based on a group characteristic, which is gender.

The findings of this study indicate that the majority of the respondents 95% strongly disagreed and disagreed to the view that they have been threatened with sexual assault. Similarly, Zapf and Einarsen (2003) state that those who are in minority or protected groups are more likely to be bullied. This is also in line with the findings of a study conducted by Rippon (2000) which state that student nurses do not report incidents of assault, because of the breaches in confidentiality and because they feel unsupported by senior staff. Findings from this study also indicate that the majority of respondents 89.2%

strongly disagreed and disagreed to the view that had sexist remarks directed at them. Furthermore, 94% of the respondents strongly disagreed and disagreed to the statement that had suggestive sexual gestures directed to them. Findings in this study also indicate that majority of the respondents 90.7% strongly disagreed and disagreed that they had a request for intimate physical contact. This is in line with Simpson and Cohen's (2004) study which offers an explanation of sexual harassment versus bullying grounded on tendencies.

### 5.2.2 The frequency of bullying behavior

The findings from this study indicate that the majority 53% of the respondents indicated that they never experienced non-verbally bullying, for example raised eyebrows, rolling eyes during clinical placement. This finding is similar to that of a study conducted by (Abbas, 2010; Samir, 2012) which states that in most circumstances, frequency of bullying or violence behavior encountered by Egyptian nurses in the workplace recently attracted noticeable attention Abbas (2010) and Samir (2012) demonstrated the existence of bullying in workplace, where nursing students undertake a significant amount of their nursing education. Since nursing students share that same ambiguous nursing environment with professional nurses, it is imperative to discover if they too are victims of bullying.

About 45.7% of the respondents indicated that they never experienced being sworn or shouted or yelled at. The majority of respondents 53% indicated that they were never harshly judged or criticised. Findings in this study indicated that the majority of the respondents 57.6% never experienced neglect. The finding is similar to that of a study conducted by (Ferns, 2005) which states that in most circumstances violence is verbal aggression, incivility, bullying and intimidation are more common that actual physical

assault, and in few instances where weapons are involved, and weapon use is opportunistic rather than premeditated.

Furthermore, the findings in this study showed that the majority of the respondents 55.1% had never been ridiculed or humiliated. About 67% of the respondents never experienced the unfair treatment regarding on/off duty schedules during their clinical placement. The finding is similar to that of a study conducted by Longo and Sherman (2007) which states that violence committed by fellow colleagues (type 3) is usually but not exclusively, emotional and non-physical. This is supported by the study conducted by Curtis et al. (2007) which states that typically called horizontal or lateral violence, relates to inter group conflict and is expressed as bullying and aggression. Common examples of lateral violence include being undervalued, ridiculed, blocking of learning opportunities, emotional neglect, demeaning comments, actions such as not being available to help with difficult care related issues, sabotage, such as withholding important information.

The findings in this study indicate that the majority of the respondents, 55.1% were never given unfair work allocation. Regarding not receiving acknowledgement for good work, the majority, and 44.3% of the respondents never experienced it. The findings in this study indicated that the majority 55.2% were never denied learning opportunities. Findings in this study showed that the majority 72% never had racist remarks directed at them. This is supported by the study conducted by Hutchison et al.,(2010a) which states that negative bullying behavors of a perpetrator consisted of personal attach, erosion of professional competence and reputation, and attach through work roles and tasks. This is in line with the study conducted by (Saunders et al., 2007) which states that the victim could lose self-confidence, causing stress and leading to physical illness and mental distress such as anxiety. Negative behavor of the perpetrator that make victim's life

difficult include giving an unmanageable workload (the common behavor), generating perceived unfair and punitive actions such as withholding information, posting documentation errors on bulletin boards for all disciplines to view and others to critique, and writing critical and abusive letters or notes to co-workers.

The findings in this study showed that majority 47.9% of the respondents indicated that they never experienced not being treated as part of the multi-disciplinary team. The results of this study also indicate that the majority, 73.7% of the respondents, had never be pushed or shoved.

The findings in this study indicated that majority of the respondents 78.8% had never been kicked. Findings further indicate that the majority of respondents 78% indicated that they had never been slapped or punched. Findings also revealed that 76.1% of the respondents had never been hit with something.

Furthermore, the findings indicated that 77.1% of the respondents never had a gun or knife pulled on them. Most respondents 68.4% had never been threatened with physical violence. Findings indicate that 68.4% of the respondents had never had one of their belongings deliberately damaged. Similarly, 73.7% had never been inappropriately touched.

The findings in this study indicate that the majority, 77.6% of the respondents had never been threatened with sexual assault. Again, the majority of the respondents 71.4% never had had sexist remarks directed at them. The findings in this study further revealed that the majority 74.6%of the respondents never had suggestive sexual gestures directed at them. Most respondents, 76.3% also indicated that they never had a request for intimate contact.

### 5.2.3 Sources of bullying

The findings of the current study indicate that sources of bullying occurred in two categories which are, clinical area where bullying occurred and the perpetrators of bullying. The clinical settings were in two categories: hospital and the community settings for example clinics and day hospitals. The majority of the respondents 71.7% agreed and strongly agreed to that the bullying occurred at the hospital setting. Most respondents 59.3% agreed and strongly agreed that the bullying occurred in community settings.

Findings in this study also identified several perpetrators of bullying. Majority of respondents 70.3% had strongly agreed and agreed that patients were major perpetrators of bullying. Furthermore, this study indicates that the majority, 68.3% strongly agreed and agreed that doctors as well are perpetrators of bullying. The findings also revealed that patients' relatives and friends are perpetrators, majority 70.9% of the respondents agreed and strongly agreed to this statement. Results of this study also showed that the majority 71.8% agreed and strongly agreed to the view that matron's/nurse managers are also perpetrators of bullying. Respondents when asked about registered nurses, the majority 73% agreed and strongly agreed. Similarly, Rowe and Sherlock (2005) and Hegney et al. (2006) discovered that the most common source of workplace bullying was found to be the patients, visitors or relatives, registered nurses, nursing management and doctors. Spector et al. (2007) found that most of the physical violence had been caused by patients followed by registered nurses and supervisors.

### 5.2.4 Coping mechanisms adopted by the victims of bullying

The respondents in this study were asked to identify coping mechanisms that were used to deal with bullying behavior during clinical placement. The majority of the respondents

54% did nothing with agree and strongly agreed. Findings in this study also indicated that the majority of respondents denied that they put up barriers. 57.3 % strongly disagreed and disagreed to putting up barriers. Findings further showed that the majority 70.3% strongly disagreed and disagreed that they had confronted the bully. This is similar to the discussions and results of a conference held in Baltimore in 2004, where various disciplines and organisations were represented. The conference was held under the auspices of the National Institute for Occupational Safety and Health Common barriers to the implementation of workplace violence prevention were identified. Some of the barriers are in line with the findings of the study such as lack of worker or student empowerment, lack of incentives to implement strategies, lack of awareness of the extent of the problem and lack of written prevention of workplace violence policies and lack of team work to sustain such programs. This is also echoed by the study conducted by Thomas and Burk (2009) which states that student nurses are loath to report incidents of lateral violence, because of the relative powerlessness they experience when having to confront the behavior of, for example registered nurses / superiors. Furthermore, Rippon (2000) and Ferns (2005), affirmed that under-reporting of workplace violence is a major barrier to successful management of the problem in nursing.

About 57% of the respondents denied responding to bullying by way of pretending not to see the behavior, with strongly disagreed and disagreed. Majority of the respondents 69.50% strongly disagreed and disagreed denied that they reported the behavior to a superior or an authority. This is also echoed by Gallant-Roman (2008) who states that there is lack of awareness of a zero tolerance policy for all forms of workplace violence. Similarly, relevant literature states that the managerial intent, buy-in and commitment to addressing workplace violence are fundamental to success of any violence prevention/management program (National Institute for Occupational Safety and Health,

2006; Gallant-Roman, 2008). The majority of the respondents 73.9% strongly disagreed and disagreed to increase used of unhealthy coping behaviors. The findings also showed that the majority 87% strongly disagreed and disagreed that they went to see the doctor. McKenna et al. (2002) stated that nurses who had experience bullying behavior at a workplace have reported days off, changing areas of practice, leaving nursing. This is echoed by the study conducted by Rowe and Sherlock (2005) which stated that other dealing directly with the bully, calling sick and attempting to clear the misunderstanding.

Findings also revealed under-reporting of workplace violence is a major barrier to successful management of the problem in nursing (McKenna et al., 2003; Ferns, 2005). This is in line with a study conducted by Thomas and Burk (2009) which revealed that student nurses are scared to report incidents of lateral violence because of the powerlessness they experience when having to confront the behavior of, for example, registered nurses or superiors. This is also supported by the framework which asserts that power imbalances between the victim and the perpetrator contributes to under-reporting. These results are similar to those of a study conducted in the United States which stated that most student nurses reported doing nothing following the event, others reported putting barriers, and others reported ignoring the behavior. In New Zealand a study conducted by Foster, et al. (2004) results showed that even those who reported an incident of bullying, actions to rectify the problem was taken in only 3.8% of cases, which may result in hesitancy to report. even in this study findings revealed that student for some reasons were scared to report workplace violent. Similarly, student nurses tend to under report episodes of aggression and violence for many reasons seeing that management will do nothing about it. Findings from this study revealed that student nurses did not report the workplace violence because they were not aware of the policy that protects them. Similar findings were yielded by studies conducted by Rippon (2000) and Ferns (2005)

which indicate that less than half of lateral violence episodes had been reported due to many reasons, including fear.

## 5.3 Recommendations

The recommendations ensuing from this study mainly focused on preparing and equipping the student nurse to confront, create awareness of the policy, empower student nurses to report incidences of workplace violence withstand and break the cycle of workplace violence or bullying behavior towards student nurses during clinical placement. Findings from this study indicate that the process of becoming a nurse is profoundly dependent upon how trained nursing staff treats students in clinical areas. However, cessation of lateral violence perpetrated by nurses, after teaching newly qualified nurses' confrontation techniques, indicates that the cycle of workplace violence can be interrupted by equipping the potential victim. Most of the recommendations are located within the nursing practice and nursing education and or training provider environment. Furthermore, in line with the findings, the recommendations are heavily weighted towards the management and prevention of non-physical workplace violence predominantly perpetrated by fellow workers in hospitals, but also by patients, doctors, patient's relatives or friends, registered nurses. Based on the conclusions and the literature review, the recommendations are structured around the following sub-headings:

### 5.3.1 Nursing practice

- The policy makers should consider the formulation of a policy addressing workplace violence, a policy that will guide clinical practice. The policy should be in place and communicated to workers or students.

### 5.3.2 Nursing education

- Nursing education managers to formulate a curriculum that will address the workplace violence create awareness to student nurses and communicated during training to students.
- In nursing colleges or educational facilities, the internal policies addressing workplace violence, in the multi-setting clinical placements required to meet the objectives of the training program, that is, the curriculum.
- The curriculum should emphasize the importance of communication skills, particularly assertiveness and debriefing skills.

## 5.3 Recommendations for further research

- Further research is needed to include qualified staff such as registered nurses, enrolled nurses and all staff categories including educators because the current study only focused on student nurses.

## 5.4 Limitations of the study

The limitation of this study was that it focused on student nurses only and not the qualified staff such as registered nurses, staff nurses and other staff categories. Furthermore, the researcher had no control over unanswered questions. Furthermore, the study was only quantitative, focusing on the views provided by the respondents and they had to choose only those responses that the researcher thought of. However, other nurse training institutions in the KwaZulu-Natal province utilize the same clinical placement areas for their training.

## 5.6 Conclusion

The findings in this research study indicated that workplace violence, targeting student nurses in clinical areas remains a challenge. The setting for this study was a selected

private nursing institute in Kwazulu-Natal and the population was all the first and second year students because the number was limited and those who were willing to participate after informed about the study. The overall conclusion arising from the study is that student nurses, in accordance with a worldwide trend amongst all categories of nurses, are the targets of workplace violence during clinical placement. The most common violence being encountered by student nurses is of a non-physical nature, for example verbal abuse, intimidation and bullying. The most common perpetrators are fellow nurses, particularly the professionals and sub-professional categories of trained nursing staff, followed by patients. Student nurses are negatively affected by workplace violence and the standard of patient care is jeopardized, because of intimidation and emotional responses, such as anger. Generally, student nurse fails to report episodes of workplace violence.

The overall recommendation is that education and training provider management should assume responsibility for the comprehensive management of the problem of workplace violence targeting student nurses, and not solely rely on policy, existent to a lesser or greater degree, in the clinical facilities. Apart from equipping the student nurse with skills to confront and manage workplace violence, the recommendations also aim at interrupting the socialization process that perpetuates workplace violence in profession.

## REFERENCES


Abbas, M.A., Fiala, L.A., and Abdel Rahman, A.G. (2010). Epidemiology of workplace violence against nursing staff in Ismailia Governorate, Egypt. J Egypt Public Health Assoc., 85 (1-2), 29-43. PMID: 21073846. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21073846, accessed 15 August 2012.

Adams, A., Beasley, J., and Rayner, C. (1997). Bullying at work. *Journal of Communication and Applied Social Psychology,*7(3), 177-180. doi: 1002/ (SICI) 1099-1298 (199706)

Anno, L., Nuechterlein, A., and Bonie, J. (2015). Eating Their Youth: *A Prevention of Horizontal Violence in Acute Care Nursing.* Nevada RNformation 16

Anderson, L., and Pearson, C. (1999). Tit for tat? The spiralling effect of incivility in the workplace. *Academy of Management Review*: 24 (3): 452-471.

Andrews, G.J., Brodie, D.A., Andrews, J.P., Wong, J., and Thomas, B.G. (2005). Placement matters: Students'clinical experiences and their preferences for first employers. *International Nursing Review*, 52, 142-153.

Australian Human Rights Commission. (2016). *Workplace bullying: Violence, harassment and bullying fact sheet* (online), Available from: https://www.humanrights.gov.au/workplace-bullying-violence-harassment-and-bullyinh fact-sheet [Accessed 20th December 2016].

Baker, C. (2012). *Nurses Eating their Youth: Are We Teaching Students More Than Nursing Skills? The Oklahoma Nurse* 57 (1):9.

Baltimore, J.J. (2006). *Nurse Collegiality*: Fact or Fiction. Nursing Management, 37 (5):28-36

Bandura, A. (1997). *Self- Efficacy: The Exercise of Control.* New York: W.H. Freeman and Company.

Barling, J. Rogers, A.D., and Kelloway, E.K. (2001). Behind closed doors: in-home workers 'experiences of sexual harassment and workplace violence. *Journal of Occupational Health Psychology*, 6, 225-269.

Bjorkqvist, K., Osterman, K., and Hjelt-Back, (1994). Aggression among university employees. *Aggression Behavior*, 20(3), 173-184.

Brockner, J. (1998). *Self-Esteem at Work Research. Theory and Practice.* Lexington, Massachusetts/Toronto: Lexington Books.

Budden, L.M., Birks, M., Cant, R., Bagley, T., and Park,T. (2017). *Australian nursing students' experience of bullying and/ or harassment during clinical placement*. Collegian (2015), http://dx.dol.org/10.1016/j.colegn.2015.11.004

Burns, N. and Grove, S. (2009). *Understanding Nursing Research.* Philadelphia: Saunders.

Burns, N and Grove, S. (2012).*Understanding Nursing Research.* Philadelphia: Saunders.

Burns, N., Gray, J., and Grove, S.(2017). *Practice of Nursing Research*.8th *Edition* Sutherland: Saunders.

Camerino, D., Estryn-Behar, M., Conway, P.M., van Der Heijeden, B.I.J. and Hassehorn, H. 2008. Work –related factors and violence among nursing staff in the European NEXT study: a longitudinal cohort study. *International Journal of Nursing Studies,* 45(1): 35-50.

Celik, S.S, and Bayraktar, N. (2004). A study of nursing student abuse in Turkey. *Journal of Nursing Education*, 43 (7) : 330-336.

Cooper, J.,Walker, J., Askew, R., Robinson, J., and McNair, M. (2011). *Students' perceptions of bullying behaviors by nurse faculty*. Issues in Educational Research, 21 (1), 1-21.

Chapman, R. and Styles, L. (2006). *An epidemic of abuse and violence: nurse on the frontline.* Accident and Emergency Nursing, 14(4) : 245-249.

Clements, P., DeRaniere, J. Clark, K., Manno, M. and Douglas, W.(2005). *Workplace violence and corporate policy for health care settings*. Nursing Economics, 23(3): 119-124.

Clarke, P.A.,Drain, M., Gesell , S.B, Mylod, D.M.,( 2007). State nursing shortages and patient satisfaction: more RNs-better patient's experiences. *Journal of nursing care quality 22* (2) 119-127.

Clarke, C.M.,Pontecorvo, M.J.,Beach, T.G.,Bedell, B.J., (2012). Bullying in Undergraduate Clinical Nursing Education. *Journal of Nursing Education* 51 (5), 269-276.

Collins South African Dictionary, 2017. Glasgow: Harper Collins Publishers.

Curtis, J., Bowen, I., and Reid, A. (2007). *You have no credibility: Nursing student's experiences of horizontal violence.* Nurse education in practice 7, 156-163.

Curtis, J., Bowen, I., and Reid, A. (2006). *You have no credibility: Nursing student's experiences of horizontal violence.* Nurse education in practice, 7, 156-163.

Dellasega, C.A. (2008). Bullying among nurses. *The American Journal of Nursing, 109 (1),*52-58.

Farrel, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35, 26-33.

Felblinger, D. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic and Neonatal Nursing* , 37(2): 234-242.

Ferns, T. and Meerabeau, L. (2008). Verbal abuse experienced by nursing students. *Journal of Advanced Nursing*, 61,436-444.

Foster, B., Mackie, B., and Barnett, N. (2004). Bullying in the health sector: A study of bullying of nursing students. *New Zealand Journal of Employment Relations, 29 (2), 67-74.*

Fox, S. and Spector, P.(2005). Introduction. In S.Fox and P. Spector (eds). *Counterproductive work behaviour. Investigations of actors and targets.* Washington: American Psychological Association. 3-10.

Gallant-Roman, M.A. (2008). Strategies and tools to reduce workplace violence: *AAOHN Journal,* 56(11): 449-454.

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: an intervention for newly licensed nurses. *Journal of Continuing Education in Nursing,* 35(6):257-263.

Hader, R. (2008). Workplace violence survey (2008): unsetting findings: employees safety isn't the norm in our healthcare settings. *Nursing Management*, 39(7): 13-19.

Hall, J. (2004). *Dispelling desperation in nursing education*. Nursing Outlook, 52, 147-154.

Hegney, D. Eley, R. Plank, A ., Buikstra, E. and Parker, V. (2006). Workplace violence in Queensland, Australia: the results of comparative study. *International Journal of Nursing Practice*, 12 (4): 220-231.

Hesketh, K. Duncan, S.M., Estabrooks, A.A., Reimer, M.A., Giovannetti, P., Hyndman, & Acorn, S. (2003). *Workplace violence in Alberta and British Columbia hospitals.* Health Policy, 63, 311-321.

Hickling, K. (2006). *Workplace Bullying*. In Randle, J. (ed.), Work Place Bullying in the NHS. Oxford: Radcliffe Publishing.

Hinchberger, P. (2009). Violence against female student nurses in the Workplace. *Nursing Forum*, 44 (1): 37-46.

Hutchison, M., Vickers,M., Wilkes,L., and Jackson, D. (2010a). A typology of bullying behaviours: The experiences of Australian nurses. *Journal of Clinical Nursing*,19, 2319-2328.

Hutchison, M., Vickers,M., Wilkes,L., and Jackson, D. (2010b). Integrating individual, work group and organizational factors testing a multidimensional model of bullying in the nursing workplace. *Journal of Nursing Management, 18*, 173-181.

Hutton, S. and Gates, D.(2008). Workplace incivility and productivity losses among direct care staff. *AAOHN Journal,* 56(4): 168-175.

Jackson, D., and Mannix, J. (2001). Clinical nurses as teachers: Insights from students of nursing in their first semester of study. *Journal of Clinical Nursing* . 10, 270-277.

Johnson, S.L., and Rea, R.E. (2009). Workplace bullying: Concerns for nurse leaders. *The Journal of Nursing Administration,* 39 (2), 84-90

Kgosimore, D. (2004). Employer–on-employee violence: type V workplace violence . *Acta Criminologica*, 17 (2): 60-70.

International Labour Organisation. (1998). *Violence on the job: A global problem.* Available: *htt://ilo.org/public/english/burea/inf/pr/1998/30.htm*

Kisa, S. (2008). Turkish nurses 'experiences of verbal abuse at work. *Archives of Psychiatric Nursing*, 22 (4): 200-207.

Khalil, D. (2009). *Level of violence among Nurses in Cape Town Public Hospitals*. Nursing Forum 44(3), 207-217.

Kumar, R., (1999, 2005 and 2011). Research Methodology. *A step by step guide for beginners 3rd Edition,*London.

Kyriacos, U., Jelsma, J., James,.M., (2014). Newly Qualified South African Nurse's Lived Experiences of the Transition from Student to Community Service Nurse: A Phenomenological Study. *The Journal of Continuing Education in Nursing*, 45(2), 91-100.

Laschinger, H.K., Grau, A.L., Finegan, J., and Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing,* 66(12).

Lee, D. (2001), Bully for the Men. *Trouble and Strife: the radical feminist magazine,* 42, 48-50.

LeBlanc. M.M. and Barling, J. (2005). Understanding the any faces of workplace violence. In S. Fox and P. Spector (eds*). Counterproductive behaviour: investigations of actors and targets*. Washington: American Psychological Association.

LeBlanc, M.M.,and Kelloway, E.K.,(2002). Predictors and outcomes of workplace violence and aggression. *Journal of Applied Psychology*, 87 (3), 444-453.

Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violences and Victims,* 5, 119-126.

Lewis, M.A. (2004), Will the real bully please stand up? *Occupational Health*, 56 (5), 22-26.

Longo, J. (2007). *Horizontal Violence among Nursing Students. Archives of Psychiatric Nursing* 21(3), 177-178.

Longo, J. and Sherman, R. (2007). Levelling horizontal violence. *Nursing Management,* 38(3): 34-51.

Luck, L., Jackson, D., and Usher, K. (2002). Survival of the fittest, or socially constructed phenomena?: theoretical understandings of aggression and violence towards nurse. *Contemporary Nurse*, 21 (2): 251-264.

Marias, S., Van Der Spuy, E. and Rontsch, R. (2002). Crime and violence in the workplace: effects on health workers, Part II. Injury and Safety Monitor, 1(1):8-12.

Mason, T. and Chandley, M. 1999. Managing violence and aggression: a manual for nurses and health care workers, Part II . Injury and Safety Monitor, 1(1): 8-12.

Matheson, L.K. and Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing*, 23 (4): 226-234.

Magnavita, N., and Heponiemi, T. (2011). Workplace violence against nursing students and nurses: An Italian experience. *Journal of Nursing Scholarship*, 43, 203-210.

Management of workplace in hospital: A review of the use of cognitive rehearsal as an alternative management strategy. *International Journal of Nursing Sciences*, (2016): 213-222.

Mayhew, C. (2004). Occupational violence/ bullying in the health industry. In P. McCarthy and C. Mayhew. *Safeguarding the organization against violence and bullying.* Houndmills: Palgrave. 110-128.

McAdam Cooper, J.R. (2007). *A survey of students 'perceptions of bullying behaviours in nursing education in Mississippi,* (Unpublished doctoral dissertation). The University of Southern Mississippi, Hattiesburg, Mississippi.

McCaffrey, R. and Woelfe, (2007). *Nurse -on -Nurse. Nursing Forum* 42 (3), 123-131.

MacIntosh, J., Wuest, J., Gray, M. M., and Cronkhite, M. (2010), *Workplace bullying in health care affects the meaning of work. Qualitative Health Research*, 20 (8): 1128-1141.

McAvoy, B.R., and Murtagh, J. (2003). Workplace bullying: The silent epidemic. *British Medical Journal,* 326 (7393).

McKenna, B.G., Smith, N.A., Poole, S.J., and Coverdale, J.H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1):90-96.

McPhaul, K. and Lipscomb, J.(2004). Workplace violence in health care: recognized but not regulated. *Online Journal of Issues in Nursing*. 9(3): 168-185.

Mikkelsen, E.G. and Einarsen, S. (2002). Basic assumptions and symptoms of post-traumatic stress among victims of bullying at work. *European Journal of work and Organizational Psychology,* 10:393-414.

Moscaritolo, L.M. (2009). Interventional strategies to decrease nursing student anxiety in the clinical learning environment. *Journal of Nursing Education*, 48(1), 17-23.

National Institute for Occupational Safety and Health (NIOSH) conference on partnering in workplace violence prevention: translating research to practice, 2004, Baltimore, 2006. *Workplace violence prevention strategies and research needs,* J Weber (ed). Cincinnati: NIOSH Publications.

Nam, Y. (2010). *The relationship between workplace bullying and intention to leave among nurses in one university hospital. Unpublished master's thesis,* Catholic University, Seoul.

Namie, G., and Namie, R. (2000). *The bullying at work: What you can do to stop the hurt and reclaim your dignity on the job*. Naperville, IL: Sourcebooks.

Nau. J., Dassen, T., Needham, I. and Halfens, R. (2009). The development and testing of a training course in aggression for nursing students: a pre- and post-test study. *Nurse Education Today*, 29(2): 196-207.

Neuman, J.H. (2000, January). *Injustice, stress and bullying can be expensive,* Paper presented at Workplace Bullying Conference, Oakland, CA.

Neuma,J. and Baron, R. (2005). Aggression in the workplace: A social-psychological perspective. In S. Fox and P.Spector (eds). *Counterproductive work behaviour investigations of actors and targets*. Washington: American Psychological Association. 13-40

Oztunc, G. (2006). Examination of incidents of workplace verbal abuse against nurses. Journal of Nursing Care Quality, 21 (4): 360-365.

Pearson, C.M., and Porath, C.L.(2002). *Rude awakening: Detecting and curtailing workplace incivility.* London, Ontario, Canada: Richard Ivey School of Business, University of Western Ontario.

Polit, F.D. and Beck, C.T. (2017). *Nursing Research: Generating and assessing evidence for nursing practice.10th ed.* Philadephia: Wolters Kluwer Health.

Polit, F.D. and Beck, C.T. (2008). *Nursing Research: Generating and assessing evidence for nursing practice.8th ed.* Philadephia: Lippincott Williams.

Polit, F.D. and Beck, C.T. (2004). *Nursing Research: Principles and Methods.*Philadephia, Lippincott Williams and Wilkins.

Pons, M.B. (1995). The relationship between stress, self-efficacy and burnout among nurses. *Unpublished Doctoral Dissertation*. The Saybrook Institute, San Fransisco, U.S.A.

Price Spratlen, L. (1995). Interpersonal conflict which includes mistreatment in a university workplace. *Violence and Victims*, 10(4), 285-296.

Quine, L. (2001). Workplace bullying in nurses. *Journal of Health psychology,* 6 (1): 73-84

Randle, J. (2001). The effects of a three year pre-registration training course on students' self-esteem. *Journal of clinical nursing,* 10, 293-300.

Randle, J. (2002). Bullying in nursing profession. *Journal of Advanced Nursing,* 43(4): 395-401

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing* 43(4): 395-401.

Rayner, C., and Keashly, L. (2005). Bullying at work: A perspective from Britain and North America. In S. Fox. and P.E. Spector (Eds.),). *Counterproductive work behaviour: Investigations of actors and targets.* Washington, DC; American Psychological Association.

Rayner, C., (1997). The incidence of workplace bullying. *Journal of Community & Applied Psychology,* 7(3), 199-208.

Rippon, T.J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31 452-460.

Roberts, W. (2000). The bully as victim. *Professional School Counselling*, 4, 148-156.

Rosenstein, A,H.,and O' Daniel, M. (2005). Original research: Disruptive behaviour and clinical Outcomes: perceptions of nurses and physicians: nurses, physicians, and administrators say that clinicians' disruptive behaviour has negative effects on clinical outcomes. *American Journal of Nursing*, 105 (1): 54-64.

Rowe, M.M., and Sherlock, H. (2005). Stress and verbal abuse in nursing: Do burn out nurses eat their young? *Journal of Nursing Management,* 13, 242-248.

Samir, N. Mohamed, R..,Moustafa, E., and Saif, H.A. (2012). Nurses' attitudes and reactions to workplace violence in obstetrics and gynaecology departments in Cairo hospitals. *Eastern Mediterranean Health Journal*, 18 (3), 198-204.

Sauer, P. (2012). So Nurses Eating Their Young? Truth and Consequences. *Journal of Emergency Nursing.* 38 (1), 43-46.

Simpson, R., and Cohen, C.(2004). Dangerous work: the gendered nature of bullying in the context of higher education. *Gender, Work and Organization.* 11 (2): 163-186.

Simons, S.R., and Mawn, B. (2010). Bullying in the workplace- A qualitative study of newly licensed registered nurses. *Journal of the American Association of Occupational Health Nurses*, 58(7): 305-311.

Simons, S.R., Stark, R. B., and DeMarco, R. F. (2011). A new, four-item instrument to measure workplace bullying. *Research in Nursing and Health,* 34 (2): 132-140.

Sofield , S. AND Salmond, S. (2003). Workplace violence: a focus on verbal abuse and intent to leave the organisation. *Orthopaedic Nursing,* 22 (4): 274-283.

Shelton, E.N. (2003). Faculty support and student retention. *Journal of Nursing Education,* 42 (2): 68-76.

Spector, P., Coulter, M., Stockwell, H. and Matz, M. (2007). Perceived violence climate: a new construct and its relationship to workplace violence and verbal aggression, and their potential consequences. *Work and Stress*, 21 (2):117 -130.

Clinical Placement Resources Manual Students. (2013). *Charles Darwin University*

Thomas, S.P. and Burki, R. (2009). *Junior nursing students' experiences of vertical violence during clinical rotations. Nurse Outlook,* 57: 226-231.

Turnbull, J. (1999). Violence to staff: who is at risk? In Turnbull and B. Paterson (eds.). *Aggression and violence: approaches to effective management.* Macmillan: London.

Stevenson, K., Randle, J., and Grayling, I. (2006). Inter-group conflict in health care: UK students 'experiences of bullying and the need for organizational solutions. *The Online Journal of issues in Nursing,* 11 (2), Manuscript 5. DOI: 10.3912/OJIN.*Vol11No02Man*05

Vallant, S., and Neville, S. (2006). The relationship between student nurse and nurse clinician: Impact on student learning. *Nursing Praxis New Zealand,* 22, 23-33.

Vessey, J.A., Demarco, R.F., Gaffney, D.A. and Budin, W.C. (2009). Bullying of staff registered nurses in the workplace: a preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25 (5): 299-306.

Vickers, M. (2004). The traumatized worker: a concern for employers and employees. *Employee Responsibilities and Rights,* 16 (3): 113-116.

Waddington, P., Badger, D. and Bull, R. (2005). Appraising the inclusive definition of workplace violence. *British Journal of Criminology*, 45(2):141-164.

Wand, T.C. and Coulson, K. (2006). Zero tolerance: a policy in conflict with current opinion on aggression and violence management in health care. *Australian Emergency Nursing Journal*, 9(4):163-170.

Waschgler, K., Ruiz-Hernandez, J., Llor-Esteban,.B., and Jimenez-Barbero, J. (2013). Vertical and Lateral Workplace Bullying in Nursing: Development of the Hospital Aggressive Behaviour Scale. *Journal of Interpersonal Violence*, 28 (12), 2389-2412.

Westhues, K. (1998). *Eliminating professors: a guide to the dismissal process.* United Kingdom: Edwin Mellen Press.

World Health Organisation. (2002). World report on violence and health: summary, (Online). Available at: http://www.who.int/violence injury prevention/violence/world report/en/summaryen.pdf (Accessed 22 March 2009).

Yadama, D. (2003). Workplace bullying and law: Towards a transnational consensus. In S. Einarsen, H. Hoel, D. Zapf and C.L. Cooper, *Bullying and emotional abuse in the workplace. International perspective in research and practice* (pp. 165-184). London: Taylor and Francis.

Yildirim, D.,Yildirim, A., and Timucin, A (2007). Mobbing behaviors encountered by nurse teaching staff. *Nursing Ethics,* 14 (4).1444-1453.

Yildirim, D. (2009). Bullying among nurses and its effects. *International Nursing Review,* 56 (4): 504-511.

Zapf, D. and Einarsen, S. (2005). Mobbing at work: Escalated conflicts in organizations. In S. Fox and Spector, P.E.(Eds), (2005). *Counterproductive work behaviour: Investigations of actors and targets.* Washington, DC; American Psychological Association.

# ANNEXURES

## Annexure A: Information document

Study Title: **EXPLORATION OF STUDENT NURSES PERCEPTIONS ON BULLYING BEHAVIOUR DURING CLINICAL PLACEMENT IN A SELECTED SCHOOL OF NURSING**

Dear Nursing Students

### INTRODUCTION

I, Mrs M.T. Mazibuko, am a student at University of KwaZulu- Natal doing Masters in Nursing Education. As part of my student at the University I am required to conduct a study in an area of my interest. My study is **Exploration of Nursing Student's Perceptions on Bullying Behaviour During Clinical Placement**.

I am requesting your participation in the study because you meet the criteria of the people who are eligible to participate in the study. The purpose of the study is to explore nursing student's perceptions on bullying behaviour during clinical placement. The study findings may assist improve nursing body of knowledge, help in policy making in matters related to bullying behaviour, it may create basement for making policies. The findings of the study may also help in the development of nursing curriculum for the better performance of nursing practice. Please note that there is no incentive for the participation.

If you agree to participate, you will be provided with a structured questionnaire and requested to complete it upon your voluntary agreement to participate in the study. The researcher will liaise with your principal to complete the questionnaire during lunch time. Completing the questionnaire will take 30 minutes of your lunch time. Your information you give will be treated utmost confidentiality. Any personal information will not be disclosed unless required by law. Your names will not appear anywhere in the questionnaires provided. There are no expenses involved because the study will be conducted during usual school days at lunch time.

Please feel free to ask questions you may have so that you are clear about what is expected of you. You are free to participate or not to participate in this study. You are free to withdraw from the study at any stage without repercussions. There will be no risk attached to your participation. The results of the study will be made available to you on

completion of this study. Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Thank you for your time and cooperation

Yours sincerely

Signature..................

Mrs M.T. Mazibuko Date:..........................

Contact details of the researcher –for further information/ reporting of study related matters:

Mrs M.T.Mazibuko
Cell: +2735 787 6309/ 72 632 9013
Email: mornica69.mazibuko@gmail.com

Supervisor contact details:
Mrs Makhosazane Dube
Howard College
School of Nursing and Public Health
4th floor, Desmond Clarence Building
4041,Durban, South Africa
Email: dube@ukzn.ac.za
Contact number: +27 31 260 2497

HSSREC Research Office: Mariette Snyman
Contact number: 031-260 8350
Email: snymanm@ukzn.ac.za

**Annexure B: Informed consent form**

**<u>Consent to participate in research</u>**

Dear Nursing Students

I, Mrs M.T. Mazibuko, a student at the University of KwaZulu Natal, as one of the requirements to complete my studies, I am conducting a study through the college of Health Sciences, School of Nursing and Public Health, University of KwaZulu Natal.

The title of the study is: **Exploration of Nursing Student's Perceptions on Bullying Behaviour During Clinical Placement.**

You have been asked to participate in a research study on: exploration of nursing student's perceptions on bullying behaviour during clinical placement. The purpose of the study is to explore the nursing student's perceptions on bullying behaviour during clinical placement.

You have been informed about the study by: Mrs M.T.Mazibuko-contact number +27 35 787 6309/ 72 632 9013, Email:mornica69.mazibuko@gmail.com

You may contact me at any time if you have any question about the research.

You may contact the researcher's supervisor- XXX- contact number +27 31 260 2497, Email: dubeb@ukzn.ac.za

You may contact HSSREC Research Office – Mariette Snyman contact number 031 260 8350, Email: snymanm@ukzn.ac.za

Your participation in this research is voluntary and you will not be penalised if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is written summary of the research.

A psychologist will be available to refer students who will need psychological interventions.

The research study including the above information has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given opportunity to ask questions that I might have for my participation in the study.

Signature of participants................................ Date.............................

**Annexure C: Research questionnaire**

**Title of the research project**

Exploration of student nurses concerning bullying behaviour during clinical placement

**Definition of workplace violence**

Workplace violence is aggressive behaviour towards another person or object of that person, finding expression in physical assault, sexual harassment and non-physical violence such as verbal abuse, incivility, bullying and intimidation.

**Instructions**

Please complete the questionnaire. Select your response by placing a cross (x) at the appropriate spot next to each question.

The principles of confidentiality and anonymity will be maintained.

**SECTION A: DEMOGRAPHIC DATA**

1. **Gender**

| Male | |
|---|---|
| Female | |

2. **Age: Please fill in:**

| |
|---|

3. **Year of study**

| **1st year** | |
|---|---|
| **2nd year** | |

**SECTION B: DATA RELATED TO WORKPLACE VIOLENCE**

Please read each question / statement carefully.

Make a cross (x) in the appropriate box next to the question.

**Cross (x) only one (1) box for each question/ statement.**

**Types of bullying**

| | | | | |
|---|---|---|---|---|
| **In the <u>past year</u> in the *clinical areas*, I have been intimidated, bullied or verbally abused in the following ways:** | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 4. Non-verbally, e.g. raised eyebrows, rolling eyes | | | | |
| 5. sworn, shouted or yelled at | | | | |
| 6. harshly judged/ criticized | | | | |
| 7. ignored or neglected | | | | |
| 8. ridiculed or humiliated | | | | |
| 9. been unfairly treated regarding on /off duty schedules | | | | |
| 10. given unfair work allocation | | | | |
| 11. not received acknowledgement for good work | | | | |
| 12. denied learning opportunities | | | | |
| 13. had a racist remark directed at me | | | | |
| 14. not been treated as part of the multidisciplinary team | | | | |
| 15. pushed or shoved | | | | |
| 16. kicked | | | | |
| 17. slapped or punched | | | | |
| 18. hit with something | | | | |
| 19. had a gun or knife pulled on me | | | | |
| 20. been threatened with physical violence | | | | |
| 21. had something of mine deliberately damaged | | | | |
| 22. been inappropriately touched | | | | |
| 25. been threatened with sexual assault | | | | |

| | | | | |
|---|---|---|---|---|
| 26.had sexist remarks directed at me | | | | |
| 27. had suggestive sexual gestures directed at me | | | | |
| 28. had a request for intimate physical contact | | | | |

**Frequency of bullying occurrence**

**Cross (x) only one (1) box for each question/ statement.**

| | Never (0) | Occasionally (1-2 times) | Sometimes (3-5 times) | Often (>5times) |
|---|---|---|---|---|
| 29.non-verbally, e.g. raised eyebrows, rolling eyes | | | | |
| 30.sworn, shouted or yelled at | | | | |
| 31.harshly judged/ criticized | | | | |
| 32.ignored or neglected | | | | |
| 33.ridiculed or humiliated | | | | |
| 34.been unfairly treated regarding on /off duty schedules | | | | |
| 35. given unfair work allocation | | | | |
| 36. not received acknowledgement for good work | | | | |
| 37.denied learning opportunities | | | | |
| 38.had a racist remark directed at me | | | | |
| 39.not been treated as part of the multidisciplinary team | | | | |
| 40. pushed or shoved | | | | |
| 41. kicked | | | | |
| 42. slapped or punched | | | | |
| 43. hit with something | | | | |
| 44.had a gun or knife pulled on me | | | | |
| 45.been threatened with physical violence | | | | |
| 48.had something of mine deliberately damaged | | | | |
| 49.been inappropriately touched | | | | |
| 50.been threatened with sexual assault | | | | |
| 51. had sexist remarks directed at me | | | | |
| 52. had suggestive sexual gestures directed at me | | | | |

| 53. had a request for intimate physical contact | | | | |
|---|---|---|---|---|

**SECTION C: SOURCES OF BULLYING**

**Cross (x) only one (1) box for each question/ statement.**

| | Strongly Disagree | Disagree | Agree | Strongly Agree |
|---|---|---|---|---|
| **In the past year I experienced intimidation, bullying or verbal abuse, in the following *clinical areas:*** | | | | |
| 54.hospital | | | | |
| 55.community settings, e.g. day hospitals, clinics | | | | |
| **In the past year I experienced intimidation, bullying or verbal abuse, in the following sources:** | | | | |
| 56.patients | | | | |
| 57.doctors | | | | |
| 58.patients' relatives or friends | | | | |
| 59.matrons/ nurse managers | | | | |
| 60.registered nurses | | | | |
| 61.staff nurses | | | | |
| 62. assistant nurses | | | | |
| 63.other student nurses | | | | |
| 64.clinical educators | | | | |
| 65. lecturers | | | | |
| 66.administrative staff | | | | |
| **Intimidation, bullying or verbal abuse in the *clinical areas* has influenced my work performance in the following ways:** | | | | |
| 67.made me consider leaving nursing | | | | |
| 68.caused me to call in absent | | | | |
| 69.made me scared to check orders for patients | | | | |
| 70.negatively affected my standard of patients care | | | | |
| **Intimidation, bullying or verbal abuse in the *clinical areas* has resulted in the me experiencing the following personal consequences:** | | | | |
| 71. anger | | | | |
| 72.depression | | | | |
| 73.humiliation/ embarrassment | | | | |
| 74.anxiety | | | | |
| 75.confusion | | | | |
| 76.feelings of inadequacy | | | | |
| 77. negative effect on personal relationships | | | | |

## SECTION D: COPING MECHANISM TO WORKPLACE VIOLENCE

78. Have you ever **reported** an episode of any kind of workplace violence to the authorities?

| Yes | |
|---|---|
| No | |

If yes, proceed to question 90

If No, continue with question 79 by crossing the appropriate box

Cross (x) only one (1) box for each question/ statement.

| | Strongly Disagree | Disagree | Agree | Strongly Agree |
|---|---|---|---|---|
| **I have used the following strategies to cope with bullying** | | | | |
| 79.I did nothing | | | | |
| 80.I put up barriers | | | | |
| 81. I spoke directly to the bully | | | | |
| 82. I pretending not to see the behaviour | | | | |
| 83.I reported the behaviour to a superior/ authority | | | | |
| 84.I increased my use of unhealthy coping behaviour | | | | |
| 85 I warned the bully not to do it again | | | | |
| 86.I shouted or snapped at the bully | | | | |
| 87.I demonstrated similar behaviour | | | | |
| 88. I went to a doctor | | | | |
| 89. I. perceived the behaviour as a joke | | | | |

**90. Are you aware of any policy in the clinical areas addressing workplace violence?**

| Yes | |
|---|---|
| No | |

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE**

## Annexure D: Letter requesting permission

**Re: Requesting permission to conduct a study**

23 September 2016

64 Jesmond Road

Pelham

Pietermaritzburg

04 October 2016

Head of the Department

School of Nursing

Mpumalanga Institute of Nursing

Hammarsdale

Dear Madam

**Re: Request for the permission to conduct a study**

**TITLE: Exploring Nursing Students Perceptions on Bullying Behaviour During Clinical Placement in a Selected Private institution of Nursing in Kwa Zulu Natal.**

Reference is made with regards to the above-mentioned subject matter. I am currently pursuing a Master's Degree in Nursing Education at University of KwaZulu Natal in partial fulfilment of the aforementioned degree. The study attempts to Explore Student Nurses Perceptions on Bullying Behaviour during Clinical Placement for students enrolled in the year 2016.

The study might benefit the institution in identifying students that are faced with bullying at their clinical placement. The study does not have any risk or discomfort and is conducted as a requirement for Master's Degree in Nursing Education purpose only. If permission granted, I intend to collect data on the 25$^{th}$ and 26$^{th}$ October 2016. The questionnaire will take about 30 minutes.

Thanking you in advance.

Yours Sincerely

Mrs M.T. Mazibuko Signature:

Cell: 072 632 9013

Email: monica69.mazibuko@gmail.com

Supervisor: Mrs M. Dube

Tel: 031 260 2497

Email: dubeb@ukzn.ac.za

## Annexure E: Letter granting permission to conduct study

MPUMALANGA INSTITUTE OF NURSING

**(Pty) Ltd 2006/31377/07**
**SANC REF NO: S1684**
25 Green Road
Coveway Industrial Park
Hammarsdale
3700
Tel: (031) 7363820/821/822
Fax: (031) 7363973
E-mail: mpumalanganursing@telkomsa.net
ENQUIRIES: Mrs P.R. Mlotshwa PRIVATE BAG X03, CATO RIDGE, 3680


05/10/2016

Mrs M. T. Mazibuko
64 Jesmond Road
PELHAM
**PIETERMARITZBURG**
3201

Dear Madam

**REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY FOR PRACTICAL FULFILMENT OF A MASTER'S DEGREE IN NURSING EDUCATION.**

Thank you for your letter dated 04/10/2016 about the above mentioned matter. Permission is granted to you for the collection of data on the 26 October from 10h00- 12 h00 hrs.

We wish you good luck with your studies.

Thanking you in anticipation.

Yours faithfully

MPUMALANGA INSTITUTE OF NURSING
25 GREEN ROAD
COVEWAY
INDUSTRIAL PARK
HAMMARSDALE
3700
Tel: 031 736 3820/21/22
Fax: 031 736 3973
Email: mpumalanganursing@telkomsa.net
www.mpumalangainstituteofnursing.co.za

Mrs. P R Mlotshwa
**PRINCIPAL**


BOARD OF DIRECTORS: MANAGING DIRECTOR MRS P.R. MLOTSHWA – DIPLOMA GENERAL NURSING, MIDWIFERY, PSYCHIATRIC NURSING, BA (Cur) NURSING EDUCATION, COMMUNITY HEALTH NURSING & BA Soc SCIENCE (Hons) MAJORING NURSING MANAGEMENT, MR M.M. MAHASE - BA COMMUNICATION SCIENCE & MS N.N. MAHASE DIPLOMA GENERAL NURSING.

## Annexure F: Approval letter from UKZN ethics committee

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

21 October 2016

Mrs Mornica Thandiwe Mazibuko 201511060
School of Nursing and Public Health
Howard College Campus

Dear Mrs Mazibuko

Protocol reference number: HSS/1716/016M
Project title: Exploring student nurses perceptions on bullying behavior during clinical placement in a selected School of Nursing in KwaZulu-Natal

**Full Approval – Expedited Application**

In response to your application received 11 October 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

..........................................................

Dr Shamila Naidoo (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Mrs M Dube
cc. Academic Leader Research: Professor B Sartorius
cc. School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 [illegible] Facsimile: +27 (0) 31 260 4609 Email: [illegible]
Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: Edgewood, Howard College, Medical School, Pietermaritzburg, Westville

## Annexure G: Letter from Editor

08 February 2017

To Whom It May Concern

**Re: Editing of Masters Dissertation for Ms Mornica Thandiwe Mazibuko**

I am writing this letter at the request of Ms Mornica Thandiwe Mazibuko whose masters' dissertation I edited. The dissertation was titled:

*Exploring student nurses' perceptions on bullying behaviour during clinical placement in a selected private nursing institute in KwaZulu-Natal.*

In the event that you may need additional information, please feel free to contact me.

Yours sincerely

**Mr Kemist Shumba**

Doctoral Research Fellow,

Senior Tutor, Language Editor & Post-graduate Research Adviser

Discipline of Psychology

**School of Applied Human Sciences**

University of KwaZulu-Natal

**Private Email**: kemishumba@gmail.com |**C:** +27 778 315 6186

**Work Email:** shumbak@ukzn.ac.za |**W:** www.sahs.ukzn.ac.za

Office IV05, MTB | Howard College Campus | Mazisi Kunene Avenue | Durban, 4041 | South Africa