

Old Dominion University

ODU Digital Commons

Educational Foundations & Leadership Theses
& Dissertations

Educational Foundations & Leadership

Summer 2012

The Socialization of Bullying Through Community College Nursing Education: A Multiple Case Study

Margaret M. O'Conner Machon
Old Dominion University

Follow this and additional works at: https://digitalcommons.odu.edu/efl_etds



Part of the [Community College Leadership Commons](#), [Higher Education Commons](#), [Medical Education Commons](#), and the [Nursing Commons](#)

Recommended Citation

Machon, Margaret M.. "The Socialization of Bullying Through Community College Nursing Education: A Multiple Case Study" (2012). Doctor of Philosophy (PhD), Dissertation, Educational Foundations & Leadership, Old Dominion University, DOI: 10.25777/9vjj-bs83
https://digitalcommons.odu.edu/efl_etds/144

This Dissertation is brought to you for free and open access by the Educational Foundations & Leadership at ODU Digital Commons. It has been accepted for inclusion in Educational Foundations & Leadership Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact digitalcommons@odu.edu.

THE SOCIALIZATION OF BULLYING
THROUGH COMMUNITY COLLEGE NURSING EDUCATION:
A MULTIPLE CASE STUDY

by

Margaret M. O'Connor Machon
B.S.N. 1968, D'Youville College, New York
M.S. May 1980, Aurora-George Williams University, Illinois

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY
COMMUNITY COLLEGE LEADERSHIP

OLD DOMINION UNIVERSITY
August 2012

Approved by:

Mitchell R. Williams (Director)

Dennis E. Gregory (Member)

Jaime R. Lester (Member)

ABSTRACT

THE SOCIALIZATION OF BULLYING THROUGH COMMUNITY COLLEGE NURSING EDUCATION: A MULTIPLE CASE STUDY

Margaret M. O'Connor Machon
Old Dominion University, 2012
Director: Mitchell R. Williams

Many recent studies propose that bullying in the workplace is prevalent and is a phenomenon which occurs in the nursing workplace as well as in nursing education. This qualitative study examined the effects of vertical bullying upon community college nursing students and graduates, and the effect of this behavior upon the socialization of those learning the nursing profession. The study is based on a theoretical framework based on the findings of Salin (2003) and Twale and De Luca (2008) adapting their theory of bullying in academia which incorporated enabling, motivating and precipitating factors leading to intensified bullying. The study investigated the effects vertical bullying has on nursing student and graduate behavior, the socialization of vertical bullying through education, and its possible connection to nursing hierarchy and the academic structure supporting bullying through nursing education.

This dissertation is dedicated three-fold:

To my husband Steve Machon, for your endless support, encouragement and understanding, and to our devoted and patient family, sons Kevin and Michael, daughter-in-laws Mary and Jana, four grandsons- Teddy, Marty, Connor and Braden, and baby granddaughter Margaret. You have all been wonderful.

To my mother, Olive O'Connor, R.N., now in heaven—the best nurse I have or will ever know; who endured bullying as a new nurse but never allowed it to touch the nurses she worked with and later supervised as a head nurse. Thanks Mom.

Finally, this dissertation is dedicated to the millions of faithful nurses and nursing students who are exposed to bullying regularly while they are devoted to their patients and committed to their profession. Thank you all for what you are and what you do.

ACKNOWLEDGMENTS

It has taken more than a village for me to reach my goal of a PhD in Community College Leadership. I have been lucky enough to have had not a village but a world of wonderful professors, mentors, colleagues, friends and family to help me in this venture.

My first *Thank You* is to my dissertation committee: Dr. Mitchell R. Williams, my committee Chair--for “taking me on” mid-stream, and providing kindness, unwavering support and guidance; Dr. Jaime Lester, for the skill, direction and patience over these many years; and Dr. Dennis E. Gregory, for generosity with time, talent and examples of real educational leadership. Please accept my profound gratitude.

Thank you also to the leaders at Moraine Valley Community College who model true servant leadership, especially Dr. Vernon O. Crawley, out-going President of the college and distinguished leader and initiator of the partnership between Moraine Valley and Old Dominion University, and role model for all. There are other Moraine Valley leaders who have always been so supportive. I am privileged to call these my colleagues and friends, including Dr. Sylvia Jenkins, in-coming President of the college, and past Vice-Presidents Dr. Terry Ludwig, and Dr. Mary Kay Kickels, all gentle, persistent educational cheer-leaders. Special thanks to retired administrators, Dr. Pat Bauhs, friend, mentor and “administrator extraordinaire”, and Dr. Dick Fritz, the best math teacher ever! Thank you all for your support and encouragement.

Additionally, I have been lucky to have experienced special mentors and friends who never stopped “being there” for me. First, Dr. Susan Phelan, my dear friend and “colleague-in-crime” and a natural leader, the “Lucy” to my “Ethel”, who has shared years of laughter and tears and pickles-in-bags as we waded through everything together. You are the best. Next, thank you to Dr. Suzanne Hammersberg-Herman, national

healthcare education leader and my treasured friend, the “dean of all deans” in my eyes. Thanks also to Dr. Judith Marwick, Provost of Harper College and a true friend and leader in community college-land. Thank you to my panel of nurse experts for this dissertation: Dr. Rita Amerio, Dr. Paula Hodkowski, and Dr. Anne Morgan- all exemplary nurse leaders and exemplary friends as well. Thank you all for everything.

I have also been lucky enough to work with outstanding leaders and colleagues at Moraine Valley who have supported and cheered-me-on in a hundred different ways: my fellow deans and friends, Jane Anne Long, Joann Wright, Dr. Pam Haney and Wally Fronczek; my wonderful faculty Department Chairs: Bill Barz, Steve Brasel, Barbara Martin, and again Susan Phelan, and my great Career Program faculty. There were other Moraine Valley friends and colleagues with never ending support: my own personal advisor and good friend Debbie Sievers; nurses Mary Therese Galka, Kim Kocur, and Diane Kovacevic, and retirees Mary Hughes and Marianne Krajacic. Finally, I am grateful for the support of the MVCC Chief of Police, my cousin and friend, Patrick O’Connor, now the provider of Segueways. Special thanks to my assistant Nancy Spaulding, my right arm and sometimes both arms, and Chris Kuropas and Lisa Lezon, word processing gurus.

My world of support these last seven years also included steadfast and encouraging friends away from MVCC who forgave some of my many absences and always gave me encouraging words: Dr. and Mrs. Tom McKiernan; the Sullivans and Thomas’; my Elmhurst bridge group of thirty years plus; my dear St. Xavier friends, especially Carol Stefan; my loyal College of Du Page friends; my D’Youville “dollie”

friends of forty plus years; our wonderful in-laws-now family, Jim and Carol Wynne and Rick and April Richardson. Thank you all for your love and support.

Last but certainly not least, acknowledgement goes to my family, some here and some already in heaven: my Papa James Collins and aunt Cathy, for teaching us “education can never be taken away from you”; my mom and dad, Olive and Jim O’Connor, for their examples and sacrificing so that we could be educated women; my sisters Ellen, Mary Pat, Terry and Anne and their families for excusing me from drying the dishes and other things for these last seven years; my kids and grandkids for letting me “go” for awhile and still being there for me; my husband Steve for years of “All-But-Dinner”(ABD), his technical assistance, calm listening and then finding a way. And finally, I thank God for my world with all of the people mentioned above and others not mentioned. This “diss” would not have happened without all of you. I thank God for all of you and all of this. pm

TABLE OF CONTENTS

	Page
LIST OF FIGURES	x
INTRODUCTION	1
BACKGROUND	4
PROBLEM STATEMENT	11
PURPOSE OF STUDY	12
RESEARCH QUESTIONS	13
SIGNIFICANCE	15
DELIMITATIONS	18
DEFINITION OF TERMS	18.
LITERATURE REVIEW	21
DEFINITIONS OF BULLYING	24
SOCIALIZATION IN NURSING AND NURSING EDUCATION	29
CONCEPTUAL FRAMEWORK	40
FACTORS CONTRIBUTING TO NURSING BULLYING	44
SUMMARY	58
METHODOLOGY	61
RESEARCH DESIGN	63
PARTICIPANTS	68
INSTRUMENTATION	70
DATA COLLECTION	72
DATA ANALYSIS	76
VALIDATION	82
LIMITATIONS	84
SUMMARY	85
ANALYZED DATA AND REPORTED FINDINGS	87
PURPOSE OF STUDY	87
CHRONICLES	88
FINDING ONE: NURSES DO EAT THEIR YOUNG	98
FINDING TWO: BULLYING IS LEARNED THROUGH SOCIALIZATION	122
FINDING THREE: IMPORTANCE OF THE CLINICAL	140
SUMMARY	151
DISCUSSION AND CONCLUSIONS	153
STATEMENT OF THE PROBLEM	153
PURPOSE OF STUDY	155
RESEARCH QUESTIONS	156
REVIEW OF METHODOLOGY	156
DISCUSSION OF RESULTS	157
RESPONSE TO RESEARCH QUESTION ONE	157

RESPONSE TO RESEARCH QUESTION TWO	164
RESPONSE TO RESEARCH QUESTION THREE	168
RESPONSE TO RESEARCH QUESTION FOUR.....	173
COMPARISON OF FINDINGS WITH TWALE AND DE LUCA.....	176
 IMPLICATIONS FOR PRACTICE	 182
IMPLICATIONS FOR RESEARCH.....	192
CONCLUSION.....	196
 REFERENCES.....	 200
 APPENDICES.....	
APPENDIX A: BULLYING BEHAVIOR	214
APPENDIX B: BANDURA’S COGNITIVE MECHANISMS	215
APPENDIX C: PROTOCOL QUESTIONS ASKED	217
APPENDIX D: RESEARCH CONSENT FORM	225
APPENDIX E: RESPONSES TO BULLYING	228
 VITA.....	 229

LIST OF FIGURES

Figure	Page
1. Enabling, Precipitating, and Motivating Processes which Contribute to Nurse Bullying.....	44
2. Factors and Processes Contributing to the End Result of Bullying in Nursing...	45
3. Organization of Finding One Themes	101

CHAPTER ONE

INTRODUCTION

Dear Nursing Administration:

Your instructors are unfair...many teachers show favoritism and if they don't like you, they scare you so much and try to make you fail. Like Ms. X, she does not treat everyone equally. And some of the nurses on the floor treat the students so poorly. I had an absolutely terrible clinical experience. You can't learn if you're nervous and I mean extreme nervousness. Not all of them are like that, but you don't realize how many students have been so frustrated and discouraged. Even the "A" students are made to feel like they could fail at any moment. Can't you make sure nursing instructors are respectful of your students? I was often subjected to verbal and psychological abuse and I'm a good student. I lost eight pounds during that last rotation. Each week a different student was picked on in clinical and the stress leading up to clinical each day was unbearable. Students are afraid to complain while they are in the program and just so happy to make it out of the program alive that they don't want to be reminded how bad it was. Not all of them are bad; but why don't the good ones tell the bad ones to stop? Can't you do something?

Nurse-to-nurse aggression or bullying in nursing is a known phenomenon that occurs within the practice of nursing, especially in clinical settings as well as within the discipline of nursing education. It causes some nursing students to leave their nursing

profession before finishing their studies and is a cause for high turnovers of graduate nurses within the workplace. One recent study found that more than 60% of new graduates leave their first clinical position within the first six months because of the non-professional behavior and bullying that they experience on the job (Embree & White, 2010). Bullying in nursing is devastating, both professionally and personally, resulting in “social, psychological and physical consequences, negative patient outcomes and damaged relationships” (Embree & White, p.167).

Provision One of the American Nurses Association’s (ANA) Code of Ethics, states “the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (ANA, Code of Ethics for Nurses, 2001). The code also requires that the nurse treat her or his colleagues with the same respect and ethical, professional behavior shown to all patients. Unfortunately, despite the growing interest concerning ethical and professional behavior in nursing, horizontal or lateral violence is increasingly being identified as a severe problem by some nurses and students in nursing education.

Especially in the workplace, bullying is usually labeled as horizontal bullying or vertical bullying. In the nursing workplace, horizontal violence or bullying occurs when there is interpersonal conflict among nurses who may be colleagues or on the same level of employment, and is indeed a serious problem in the nursing profession (McKenna, Smith, Poole & Coverdale, 2003). Horizontal bullying is also labeled lateral violence by some researchers, or nurse-to-nurse aggression that can occur through non-verbal innuendo, withholding information, sabotage, verbal affront, undermining, failure to

respect privacy and scape-goating (Griffin, 2004). The terms “verbal abuse”, “horizontal hostility” and “lateral violence” are also labeled bullying, mobbing, incivility and psychological abuse (Kolanko, Clark, Heinrich, Olive, Serenbus, & Sifford, 2006; Olson, 2007).

The workplace pressures experienced by nurses and other healthcare workers, including pressure to deliver care on time, uncontrolled patient workloads, and high pressured work environments are identified as contributing factors in the phenomena of increased nurse-to-nurse bullying (Spiers, 2007). Horizontal and vertical violence and bullying in nursing leads to individuals with low self-esteem, low morale, depression, hypertension, other physical symptoms, and could also lead to impaired relationships, post-traumatic stress and eventually suicide (Thobaben, 2007). This kind of unethical, non-professional behavior is a serious, insidious problem in the nursing profession and it cannot and should not be tolerated. Hastie (2002) offers that bullying is endemic in the nurses’ professional workplace and culture and is definitely unacceptable, destructive activity.

Vertical bullying occurs when abuse is conducted towards a student or new nurse from another person who is in a superior position in an organization (Thomas & Burk, 2009). It is this vertical bullying which is examined in the current study of the effects of vertical bullying upon community college nursing students and graduates, and the effect of this behavior upon the socialization of those learning the nursing profession. This study concentrated on responses from new graduates reporting their experiences in community college nursing education; therefore references to bullying in this paper

predominately indicate vertical bullying rather than horizontal bullying from a colleague or peer.

For the purpose of a frame of reference for this study on the socialization of bullying through nursing education, an operational definition is submitted for the frequently used terms of bullying and socialization. As noted in the Definition of Terms section of this paper, bullying is defined as “a form of interpersonal aggression or hostile, anti-social behavior” (Salin, 2003, p. 1215). In this paper, most reference regarding bullying will refer to vertical bullying, which is defined as “abusive behavior from a co-worker in a superior position towards a subordinate” (Thomas & Burk, 2009, p. 227). Socialization is defined as the complex process by which a person acquires the knowledge, skills and sense of occupational identity characteristic of a member of that profession (Du Toit, 1995). In most cases in this paper, socialization will refer to the process associated with nursing students acquiring the knowledge, skills and other identifying characteristics in the nursing profession.

Background

While widely accepted as one of the most ethical and respected professions today, even in recent Gallup polls (Jones, 2006), the nursing profession has a history of its members frequently having to prove their worth to other professions, especially medicine, while delivering patient care in a stressful, demanding environment. Spiers (2007) describes how “Nursing historically has had a self-sacrificing definition of responsibility in which ‘good’ is equated with caring for others” (p.15). According to Randle (2003), a good nurse is represented by female stereotypical attributes like compassion and caring, “contributing to nursing’s relatively powerless position in

comparison with male dominated professions such as medicine” (Randle, 2003).

Additionally, nursing is seen as an altruistic profession in which the needs of others have routinely been met, while the needs of the nurse providing for others may not have been met. Some theorists have connected bullying to these mentioned historical attributes in nursing, theorizing that nurses’ “frustration-turned inward” (McKenna et al., 2003) and that the feelings of powerlessness significantly contribute to the nursing bullying culture (Roberts, 1983; Stevenson, Randle & Grayling, 2006).

It is clear that non-professional behavior in nursing or in nursing education is contrary to the ANA’s Code of Ethics (2001). However, incidents of non-professional behavior, vertical bullying and “lateral violence” in nursing and in nursing education in community colleges have undoubtedly increased. A recent three year study of the connection between nurses’ self-esteem and bullying confirmed that bullying was found to be “common-place” in the transition from nursing education to nursing (Randle, 2003). Despite this fact, some studies insist that bullying does not happen exclusively to students and new nurses but occurs among experienced and highly educated nurses in a diverse range of nursing specialties (Dellasega, 2009; Johnson, 2009).

Current Research. It is apparent that research into this phenomenon in the nursing profession in this country is in its infancy, but the interest in this topic in the United States is growing (Johnson & Rea, 2009; Stanley et al.; 2007; Simons & Mawn, 2010; Thomas & Burk, 2009; Vessey et al., 2009; Woelfle & McCaffrey, 2007). In particular, Johnson and Rea’s study of 249 nurses from the Washington State Emergency Nurses Association is representative of other recent US studies, as it reports that 27% of Washington’s ER nurses responding had experienced workplace bullying in the last six

months. These findings are similar to the reported 33% of workers from various other occupations who also report bullying in the workplace (Salin, 2003).

Another recent on-line study done in the US reports an alarming 75% of almost 2,000 online nursing respondents from this country agree that nurses do indeed “eat their young,” a commonly heard response from both nurses and nursing administrators (Baltimore, 2006). Unfortunately, many nurses agree that nurses, while attacking the “young” or the newest in their profession also attack one another despite age or experience.

Along with the problem being perpetuated by individual role models in nursing, academic centers are sometimes participants in making nursing education more difficult for students. The academic philosophy or institutional attitude of some institutions that “students need to suffer in order to learn” (Baltimore, 2006) is a common approach at some schools of nursing. There are sometimes unrealistic expectations for students in nursing programs, as well as for some new enthusiastic nursing instructors. Principles of adult learning may be replaced with punitive, demeaning nursing program “Rules and Regs.” thus devaluing some students and some faculty. Finally, some new student-friendly faculty who treat students professionally and support treating students with respect are admonished and brow-beaten by experienced faculty so that the newer faculty members “don’t make us look bad” (Twale & De Luca, 2008).

Until recently, bullying and non-professional behavior in nursing had not been studied from a United States perspective as much as it had been studied in Europe, the Middle East, Australia, and New Zealand. In a study in the United Kingdom sponsored by the Royal College of Nursing (RCN) Randle (2003) found that one in six nurses in the

study reported being subjected to bullying within a year's period, but only six percent of these nurses formally reported the incidents. Another RCN (2002) study discovered that 33% of nurses who were on long term sick leave who experienced bullying left their profession as compared to 16% of nurses on leave who had not experienced bullying (Randle, 2003). Bullying as a reason for new nurses leaving nursing is a common theme in the literature and a contributing factor in the world-wide shortage of nurses (Celik & Bayraktar, 2004; Jackson, Clare, & Mannix, 2002; Ramsey, 2001).

Another UK study reported that 44% of graduate nurses and 35% of other healthcare staff experienced "peer bullying" (Dellasega, 2009). In Ireland, a 2007 study of the Irish Nurse Organization (INO) reported that 80% of nurses surveyed by the INO reported witnessing bullying in their profession, and 50% of these nurses were recipients of bullying from other nurses. A New Zealand survey of 500 new nursing graduates reported that covert horizontal violence was common in their workplaces (McKenna et al., 2003). Student-bullying specifically studied in one UK research project reported that 34% of students experienced bullying during their educational programs, but none took action. Examples of student responses were reported, such as: "It was not worth the hassle," "You just put up with it," "The staff was just having a bad day," and "We just needed to 'fit in'" (Stevenson et al., 2006).

Limited Research. While there has been limited research reported on vertical bullying and violence in nursing education in the United States, there is even less research concerning this problem connected to community college nursing education. The community colleges in the United States provide more than 60% of the registered nurses practicing in healthcare in this country today (American Association of

Community Colleges, AACC, 2012). If the data regarding the problem of vertical bullying of nursing students and graduates of nursing programs in other countries and at four year institutions is generalized to fit students and graduates of community colleges, it is assumed that a significant number of nurses, community colleges nursing students and graduates also experience bullying behavior in their learning environment. Coping strategies, internalization of norms and values of oppressive role models and the eventual community college students' gradual resignation to the continuance of this non-professional behavior may readily contribute to perpetuating this behavior in the nursing profession.

What is known about this problem is that vertical bullying in the nursing profession is recognized as prevalent by members of the profession as well as those outside the profession (American Organization of Nurse Executives , AONE), 2008; Gallent-Roman, 2008; Hutchinson et al., 2006; Leymann, 1996; Twale & De Luca, 2008). What is not known is how bullying is perpetuated in a profession that is also known to be centered on "caring," and how the members of the profession are socialized into accepting the behavior in the profession. The current study addresses this identified gap in the research concerning the problem of non-professional behavior and vertical bullying in community college nursing education and its effect on the socialization on nursing students and graduates from community colleges. This information will assist educators in all levels of nursing education and nursing leaders as they strive to deal with this non-professional behavior problem.

It is also recognized that the phenomena of bullying in nursing is known and accepted in the "white wall of silence" surrounding bullying in nursing (Murray, 2007). However, educators and administrators in nursing also need to know how and why some

nurses and nurse educators disconnect unprofessional behavior and treatment of coworkers from unprofessional treatment of patients. More importantly, what role does nursing education play in non-professional behavior and the eventual assimilation of this behavior into the socialization process of nurses? If nurses have been perceived as the healthcare providers being the most honest and with the highest ethics surpassing even physicians in recent Gallup polls (Jones, 2006), why is it accepted by so many in the profession that in the nursing culture “nurses eat their young” (Baltimore, 2006)? Data on non-professional behavior of nurses leads to the following questions: (1) “what is it that often makes nurses compassionate and endlessly kind with patients while at the same time inconsiderate and sometimes cruel with fellow nurses?” (Tschuudin, 2007, p. 442) and (2) “how is this non-professional behavior learned, accepted and perpetuated through the current system of nursing education in community colleges?” The findings from the current study lead to discovery of answers to some of these questions.

Connection to Community Colleges. Because approximately 60% of the nurses practicing in the United States today begin their education at community colleges (AACC, 2012), community college nursing education may strongly impact the culture and professional socialization of nursing in the United States, as well as the individual behavior learned and perpetuated through nursing education. With the growing interest and awareness of vertical violence in nursing education (Kolenko et al., 2006; Woefel & McCaffrey, 2007; Yildirim, 2007), this study should allow a greater opportunity to address and alleviate vertical bullying and non-professional nursing behavior through enlightenment and acceptance of the fact that this negative behavior exists in this culture,

leading to revisions in community college nursing curriculum and administrative policies and procedures.

The current study particularly focused on the socialization and culture surrounding non-professional behavior and vertical bullying experienced by graduates from community college nursing education. Although there is a predominance of literature concerning non-professional behavior in four year schools of nursing, (Gaul, 1987; Munhall, 1980) there are few studies of this nature linked to vertical bullying and socialization through community college nursing education.

Connection to Nursing Culture. The study examined if vertical bullying and non-professional behavior has been engrained in and has become part of the fabric of nursing education, supporting and participating in the socialization of vertical bullying through education (Hampshire, 2000). Nursing students, learning the culture of their profession before becoming graduates, may “acquire the values, attitudes and practices that make a profession distinct” (Gray & Smith, 1999) while frequently experiencing verbal abuse and covert bullying from their teachers, clinical nurses, and other role models as they learn their profession.

The culture of the nursing profession is also supported with nursing leadership which may find non-professional behavior within nursing education to be so ingrained into the traditions that ignoring this fatal flaw in the profession is easier than dealing with the behavior (Hampshire, 2000; Lewis, 2006; Quine, 2001; Randle, 2003). Twale and De Luca (2008) regarded nursing education leadership and bullying as the “conspiracy of silence” or the “dry rot in academe” and used the following words:

Perhaps leaders have no idea what to do about such problems when they encounter them as no repertoire of proven solutions exists...a 'conspiracy of silence' avoids the hard truths that surround reality. (Twale & De Luca, p. 46)

This gap in information surrounding the socialization of vertical bullying within this "conspiracy of silence" in the nursing profession which is supported by community college education and leadership has been investigated in the current study.

Problem Statement

Bullying, defined by Dellasega (2009) as the "repeated effort to cause another person physical or emotional harm or injury" (p. 52) is seen increasing in the nursing workplace as it becomes part of the fabric of the nursing culture (Almost, 2005; Center for American Nurses (CAN), 2009; Hutchinson et al., 2006; Murray, 2009). There are many reasons that are given for this kind of negative behavior in clinical nursing environments, with high stress and nurse shortages in the workplace frequently proposed as contributing factors. Vertical bullying and non-professional behavior is experienced through-out the education of the nurses in undergraduate experiences, and may be more fully experienced as the new graduates from a community college program begin to practice as registered nurses on their own (Beecraft et al., 2008; Bellinger et al., 1985; Duchscher, 2008; Griffin, 2004).

Because of the effect bullying and non-professional behavior has on the retention of nurses in their profession, the current phenomenon of bullying in nursing in the United States has made it imperative that national healthcare organizations must address this problem in the nursing profession. "As of January 1 (2008), the Joint Commission on Accreditation in Healthcare (JCAH), concerned with behavior that undermines a culture

of safety, is requiring institutions to have a process in place for addressing ‘intimidating and disruptive’ behavior in the workplace” (Dellasega, 2009). AONE (2009) highlights the need for nursing management to encourage positive and supportive behavior among nursing staff to insure a healthy working environment.

The study of vertical bullying and the potential socialization through nursing education, specifically community college nursing education, is the topic of the current study. While there have been many studies on the subject of bullying in nursing, particularly outside the United States, there is a dearth of information concerning how vertical bullying is socialized into the essence of nursing, particularly its connection to community college nursing education.

Nursing students and new graduates, the majority coming from the nation’s community college programs, should be able to learn and function in environments which are safe and free of non-professional behaviors. Nursing students and new graduates should also be able to learn how to contribute to optimal patient care for those who look to them for safekeeping. Vertical bullying hampers continued learning in nursing and should not be included as new nurses are socialized into their new profession.

The Purpose of the Study

The purpose of this study was to examine the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education, and ultimately to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. Professional socialization is known as the manner by which an individual discovers the characteristics and the culture of a profession (Gray &

Smith, 1999). This study examined nursing behavior and practices from the perspectives of new graduates of community college nursing programs, as new community college nursing graduates were the major participant group interviewed in the study.

This study also investigated the effect of role modeling in bullying and the influence of “power” (Dunn, 2003) in the non-professional bullying behaviors identified and experienced by community college nursing graduates. Some graduates as students of community college nursing programs may have experienced behavioral responses, aggression and use of power experientially as they learned nursing. These graduates have been selected by nurse educators and interviewed to determine if and how this behavior has affected them as they practice in their profession. A focus group interview was also held with community college nursing educators willing to share their experiences concerning bullying and its possible connection to community college nursing education. Triangulation of findings were completed with a review of documents related to nursing and nursing education and student and graduate nurse experiences associated with learning, socialization and behavior.

Research Questions

Because the proposed study is centered on student experiences in community college education, the research questions for this study are in reference to vertical bullying which is defined as “abusive behavior from a co-worker in a superior position towards a subordinate” (Thomas & Burk, 2009, p. 227) and not bullying from a colleague also known as horizontal bullying, a consistent pattern of behavior that controls or diminishes a peer (Farrell, 2001).

The following research questions will be addressed in the proposed study:

1. What is the effect of vertical bullying on students in a community college nursing program?
2. Are community college nursing students socialized into a bullying culture?
3. How does this socialization into a vertical bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
4. Do components of the academic structure (e.g. hierarchy, student discipline, faculty reward systems, etc.) support vertical bullying at the community college?

Methodology of Study

The qualitative method chosen for this study, a multiple-case case study approach, was utilized to look at the connection between community college nursing education and the non-professional behavior of vertical bullying (Patton, 2002). Participants were representatives from three different community college programs, leading to ultimate comparisons between the three different “cases” or the three programs’ connections to bullying in community college nursing education. The researcher examined if community college nursing education is (1) a contributor to the larger culture and professional socialization in nursing, and (2) its connection to the predominant nursing culture and practice of non-professional or bullying behavior in nursing. The researcher attempted to methodologically and thoroughly capture and describe how new graduate nurses remember, describe, make sense of, feel about, and judge non-professional or bullying behavior in nursing.

Utilizing criterion sampling (Creswell, 1998), the researcher interviewed a targeted group of community college graduate nurses. The volunteer participants were recruited by three members of a panel of nursing education experts deemed to have experience and insight into behaviors in nursing. From Chicago-area University RN to BSN completion programs, the researcher conducted formal and informal interviews, interviewing 21 individuals who are graduate nurse participants, most recent graduates from community colleges. Triangulation research methods included interviewing a nursing faculty focus group, as well as an extensive document review, all accompanied with researcher journaling.

The major source of data collection was from oral, comprehensive interviews with 21 student or nurse participants in the study. Before the interviewing of the graduates began, carefully planned focus group discussions with six to ten educators were conducted discussing the subject of non-professional behavior in nursing education. The third method of data collection was extensive documentation review. All interviewing focus group activity and documentation review was accompanied by researcher journaling. This journaling assisted with the triangulation of the data collection through self-appraisal of the issue from the perspective of a nurse educator/ administrator who has known and lived the nursing education experience for many years.

Significance of the Study

Research in workplace bullying suggests that bullying in healthcare organizations is escalating, while morale and job satisfaction in nursing is decreasing (Murray, 2009). Nursing leaders and educators must be aware of the consequences of continued socialization of non-professional behavior and bullying in the nursing profession. Denial

of the negative behavior in the profession is common. Some studies have found that nurses and nursing leaders have identified some non-professional behavior as “bullying”; however, these same individuals did not identify the bullying as problematic (Baltimore, 2006; Farrell, 1999). Because of the potential to discover why and how non-professional behavior and bullying may occur in some healthcare organizations, the current study is of great value organizationally. With information from this study, healthcare leaders and educators can work to eradicate this behavior in nursing while positively impacting patient care.

Other Benefits of the Study. The current study may also help individuals and new graduates dealing with non-professional behavior understand the past uncivil behaviors or with existing behavior as a new graduate. Historically, students and new graduates have sometimes identified negative treatment from superiors or colleagues as threatening and undesirable. However, they also sometimes choose to “take” the treatment handed to them, especially from instructors, staff and co-workers in order to complete their program of study or be assimilated into the work environment (Baltimore, 2006; Simons & Mawn, 2010). Through the current study, identification of non-professional, intimidating and hostile treatment of student nurses and others in the profession may lead to administrative steps to correct this negative activity in community college nursing education.

A significant reason for this current study is the opportunity to address the attrition of nursing students and graduates from their chosen profession. Attrition of community college nursing students and graduates as contributing factors to the looming shortage of registered nurses is a serious societal concern. This attrition of nurses and students may be due to the treatment they may receive from others in their profession. According to the

Metropolitan Chicago Healthcare Council (MCHC) (2006) the loss of even one student from a community college program of nursing represents thousands of dollars already invested in another potential nurse. MCHC stressed that “by 2020, Illinois will face a shortage of 21,000 registered nurses, about 19% of the projected demand. Two-thirds of these vacancies will be in the Chicago area” (2006, p.3) emphasizing an even greater need to retain rather than lose nurses for any reason. In illuminating the perpetuation of non-professional behavior, especially in the education of new nurses, this study may contribute to alleviating the unprecedented current and predicted shortage of nurses by pointing to positive approaches and supportive policies in keeping present and future nurses in their profession.

Reasons to Investigate. There is obviously more than one reason for this attrition of nurses; however, vertical bullying and its effect upon the socialization of non-professional behavior in schools of nursing is a major contributor of dissatisfaction of new nurses in the healthcare workplace. (Jackson et al., 2002; McKenna et al., 2003; Woefel & McCaffrey, 2007). Being the “low man on the totem pole” while assuming the role of student or new graduate nurse, as studied by many researchers looking at predominantly four year programs (Longo, 2007; Mozingo et al., 1995) has brought to light that “many nursing students felt embarrassed, intimidated and humiliated . . . in the clinical setting as well as in the classroom” (Thomas & Burk, 2009, p. 226). It is expected that the current study will promote dialog among nursing educators and leaders concerning nursing education’s appropriate responses in protecting new nurses while fostering the learning of the nursing profession. Finally, through the proposed study there

may be a chance to change the acceptance of the philosophy that “nurses eat their young” and any other age group that gets in their way.

Delimitations

The proposed study will be conducted within the Midwest region of the country, utilizing a qualitative multiple-case case study method and purposeful interviewing techniques, and a relatively small number of participants. The time frame for the study was limited to the last few months of the year 2011 and first few months of 2012. The participants in the study were students who are were graduates from community college nursing programs, registered nurses most of whom were currently students in bachelor-completion (BSN) programs at Chicago-area universities.

Definition of Terms

For the purpose of this study, the following terms will be defined as follows:

1. *Associate Degree in Nursing (ADN)*: usually a two year degree or entry level degree in nursing frequently offered by community colleges.
2. *Bachelors of Science in Nursing (BSN)*: a four year degree in the concentration of nursing/ science, usually offered at the university level in higher education.
3. *Bullying*: “a form of interpersonal aggression or hostile, anti-social behavior in the workplace” (Salin, 2003, p. 1215). This term of “bullying” is frequently used in the United Kingdom, Ireland, Australia and Northern Europe, while in Germany “mobbing” is used; however, in North America, the bullying phenomena may be labeled employee abuse, workplace aggression or incivility. All are “forms of interpersonal aggression and hostile workplace behaviours... (which) overlap with the term ‘bullying’ ” (Salin, p. 1215).

4. *Culture of Nursing*: the acquiescence of the values, attitudes and practices that make nursing distinct (Gray & Smith, 1999).
5. *Clinical*: This experience is a situated learning component of nursing programs which includes a specified number of hours of clinical practice supervised by an instructor or clinical preceptor at one of the program's healthcare sites. It is one part of the learning experience in the nursing program, accompanying the didactic (or theory learning) and learning (practice) in the nursing lab.
6. *Clinical preceptor*: A preceptor is a nursing professional employed and compensated by the clinical site, who supervises nursing students during their clinical placements as nursing students work directly with patients.
7. *Horizontal Violence or bullying*: a consistent pattern of behavior that controls or diminishes a peer (Farrell, 2001). Also called lateral violence and is a "term used to depict abusive behaviors between co-workers of similar status" (Thomas & Burk, 2009, p. 226).
8. *Non-professional behavior or lateral violence*: nurses overtly or covertly directing their dissatisfaction inward toward (a) those less powerful than themselves (b) themselves, and (c) each other (Griffin, 2004).
9. *Nurse-to-nurse horizontal violence or bullying*: deliberate, unwarranted or unwanted behavior shown by one nurse towards another nurse displaying the intent to isolate, degrade or sabotage (Hutchinson, Jackson, Vickers, & Wilkes, 2006; Jackson et al., 2002; Thomas & Burk, 2009).
10. *Professionalization*: may occur with the development of a professional subculture with an explicit or implicit code of conduct, or esprit de corps among members of

the same profession on the grounds of lengthy study and with training in a particular field (Du Toit, 1995)

11. *Professional socialization*: The complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristics of a member of that profession (Du Toit, 1995).
12. *Socialization*: the process by which a human being beginning at infancy acquires the habits, beliefs and accumulated knowledge of society through education and training for adult status (Merriam-Webster, 2012). Bandura (1977b) proposes in his social learning theory that socialization is the result of modeling behavior to the expectation of others, a response to encouragement and reinforcement from others.
13. *Two-plus-two agreements*: formal and signed agreements between colleges and universities which stipulate conditions of acceptance of courses and programs by the university so that students are able to transfer seamlessly into BSN programs.
14. *Verbal abuse*: a type of communication that is considered harsh, an attack on professional capabilities, or an attack that is considered of a personal nature (Sheridan-Leos, 2008).
15. *Vertical violence or bullying*: describes “abusive behavior from a co-worker in a superior position towards a subordinate” (Thomas & Burk, 2009, p. 227). Recipients of this kind of violence are frequently students or new nurses, supporting the frequent reference to “nurses eat their young.”

CHAPTER TWO

LITERATURE REVIEW

From nursing administrators to new students in nursing programs, a commonly accepted phenomenon in nursing is the belief that negative behavior towards the newest in the profession is an expected and accepted practice as these new nurses are socialized into their profession (Quine, 2001).

The concept of nurses eating their young was noted by nurse (beginning) in the formative years of the respondents' education as a nurse. One commented, 'When I was in nursing school, I found so much negativity in this environment that I considered quitting nursing school'. Another wrote, 'Nursing school was a very difficult experience. I witnessed many registered nurses treat my classmates horribly, and that almost prevented me from practicing' (Simons & Mawn, 2010, p. 308).

With worker dissatisfaction playing a major role in the loss of nurses and other healthcare workers from the healthcare workplace, current research indicates that non-professional behavior and bullying are major contributors to worker dissatisfaction and ultimate abandonment of nurses from their professions. Supported in literature, (Beecraft, Dorey, & Wenton, 2008; Farrell, 2001; Hoel, Giga, & Davidson, 2007; Lewis, 2006; McKenna, Smith, Poole, & Coverdale, 2003; Randel, 2003; Sheridan-Leos, 2008) non-professional behavior and vertical bullying are increasingly identified as severe problems by students in nursing education and graduates from nursing programs. Because of non-professional behavior and the bullying effects on the retention of students and nurses, the

possibility of the perpetuation of this phenomenon through socialization in higher education must be addressed.

The purpose of this study is to examine the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education, and ultimately to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. This study examined nursing behavior and practices from the perspectives of new graduates of community college nursing programs, many aware of and supporting the current nursing culture. Since the community college associate degree nursing programs are the entry levels of more than 60% of practicing nurses in the country (AACC, 2012), investigation of this bullying phenomenon from the perspective of community college nursing education involvement provides the greatest chance to understand and generalize this bullying phenomenon with possible application to all nursing education programs.

Bullying is Learned

Students and new graduates of community college programs may be both unwilling victims and learners of bullying techniques in the clinical nursing environment. It has been proposed frequently that bullying is indeed learned and socialized within the workplace or the clinical experience of the student nurse and graduates of nursing programs (CAN, 2009; Johnson & Rea, 2009; Thomas, 2010; Thomas & Burk, 2009; Simons & Mawn, 2010). Lewis (2006) was a noted member of an army of researchers from the UK who examined bullying, its origins and how it was perpetuated in nursing and nursing education. Addressing how it was problematic for nursing, Lewis believed

that bullying was compiled of “complex dynamics . . . [and] nursing managers have also been targets of bullying themselves, not infrequently accused of it” (p. 52). Lewis’ research (2006) concluded that bullying was learned behavior within the workplace rather than any predominantly psychological defect within the individual perpetrators.

By witnessing nonprofessional behavior and vertical bullying in their clinical rotations as they learn how to be professional nurses, the students and new graduates of community college programs may appear to be first-hand unwilling victims and learners of bullying techniques in their clinical learning experiences (Thomas, 2010). Additionally, as they are socialized into their profession during clinical experiences in nursing education, students and later new graduates may come to accept vertical bullying behavior as part of being a nurse, adapting and protecting themselves in a variety of ways (Dellasega, 2009).

International bullying. Professional behavior and vertical bullying in nursing education is indeed an international phenomenon. While it is increasing, there is less research concerning nurse-to-nurse or student bullying in the United States than research conducted on this topic internationally. Relevant research concerning nursing bullying originates predominantly from European countries, the United Kingdom and Australia (Dellasega, 2009). In Turkey, Celik and Bayrakta’s study (2004) of 225 nursing students concerning four types of student abuse (verbal, physical, sexual and academic) determined that all nurse participants stated they had at least experienced verbal abuse...and 83.1% claimed they had experienced (or witnessed) academic abuse...most often from instructors. Similar studies corroborated these results concerning nursing students, bullying and lack of empowerment by a broad range of researchers from

England (Freshwater, 2000), Canada (Sinclair, 2000), Ireland (Begeley & White, 2003), and New Zealand (Pearson, 1998), as well as the United States (Roberts et al., 2004).

Organization of chapter. This literature review is organized as follows: first a definition and discussion of the non-professional behavior known as bullying and bullying in the workplace; second, a discussion of student socialization and the socialization of nursing students and new graduates; third, a discussion of the theoretical framework of this study; and finally, a new conceptual framework incorporating two models of theories utilizing a conceptual framework emphasizing enabling, motivating and precipitating factors.

The Definition of Bullying

Workplace violence and bullying is a growing concern in a majority of workplaces across nations, not just in nursing and not just in the United States (Begley & White, 2003; Farrell, 1997, 1999, 2001; Hinchberger, 2009; Hutchinson, Jackson, Wilkes & Vickers, 2008; Lewis, 2006; Randel, 2003). Workplace bullying was first identified by Swedish psychologist Leymann (1996) in the 1980s, and defined as “an on-going conflict in which the victim is subjected to two or more negative incidents on at least a weekly basis over at least a six month period” (Johnson & Rea, 2009, p. 85).

Bullying is further distinguished from the current higher education issues of academic dishonesty and incivility which are concerns in nursing education worldwide today. Incivility is considered as rude behavior demonstrating a lack of respect for others (Rau-Foster, 2004). Academic dishonesty is commonly considered to be deceptive practices surrounding one’s academic endeavors or the endeavors of another person (Gaberson, 1997). In nursing, both are considered to be lesser aggressive behaviors than

nursing bullying; however, both may lead to more destructive behavior and bullying if not abated.

The commonly accepted interpretation of nursing bullying has evolved in recent years. It has been identified to run the gamut from physical-open assault to more understated, masked covert behaviors which may include exclusion, blaming, or backbiting (Hutchinson et al., 2006; Randle, 2003). Bullying has been labeled horizontal when it originates from peers or equals: “abusive behaviors between coworkers of similar status, such as staff nurses, in the workplace” (Thomas & Burk, 2009, p. 226). Bullying is considered vertical when its perpetrators are supervisors or perceived superiors of any sort. In nursing education, horizontal bullying, or bullying from a peer or colleague is distinguished from vertical bullying or psychological abuse from a superior or instructor, frequently cited as the abuse experienced by many students or new graduates (Farrell, 2001).

In their New Zealand study, McKenna et al., (2003) labeled most workplace nursing bullying as horizontal violence, better known as bullying from a colleague. In the McKenna et al. study which investigates the prevalence and perpetuation of horizontal violence reported by new graduates in their first year of professional nursing, the research reported that horizontal violence is experienced by many new graduates across a variety of clinical settings. New graduates report high absenteeism from work as one way to cope with bullying in their workplace (Kelly, 1993; Tradewell, 1996). Moreover, many new nurse-respondents in these studies and other studies considered leaving nursing entirely because of experiencing abuse from their peers.

Vertical violence or bullying is the kind of bullying being examined in this study. Vertical bullying frequently includes psychological harassment and is said to be learned and accepted by many nurses and students, encompassing verbal attacks, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunities, disinterest, discouragement, and the withholding of information (Farrell, 1999; McKenna et al., 2003; Quine, 2001). The perpetuation of psychological bullying is considered commonplace for students and new graduates as they are socialized into their profession; however, it is not always considered psychological bullying by the senior nurse members of the profession involved in the behavior. To some senior nurses, bullying behavior is considered to be an orientation to the profession and may be considered by senior nurses to be necessary for new nurses to be acclimated to the nursing profession as they are introduced to the accepted “chain of command” concept in nursing.

These references to the struggles to establish power in nursing are also discussed in some research, as many researchers into nursing bullying believe that the issues concerned with real or perceived imbalance of power are necessary for the behavior to be considered legitimately as bullying (Duchscher & Myrick, 2008; Fulton, 1997; Kuokkanen & Leino-Kilpi, 2000).

An important distinction which will be held about behavior concerning bullying within the context of this current study on the socialization of bullying through nursing education is that bullying is not a random, one-time act but intentional and experienced over a period of time, targeting one or more individuals who may be unable to defend themselves (Olender-Russo, 2009). It is the witnessing of these repeated, intentional acts

by students and new graduates which leads to the gradual acceptance of this kind of behavior and the socialization of bullying into nursing through nursing education. Appendix A in this study gives examples of common bullying behaviors in nursing milieus, and some selected overt and covert actions exhibited and associated with the behavior.

Nursing Workplace Bullying

Before beginning the discussion of vertical bullying of community college students and new graduates, a discussion of bullying in the nursing workplace is imperative. One of the distinguishing factors in nursing and allied health education is that part of the learning must be performed in the clinical environment. In the case of nursing, this aspect of practical hands-on learning takes place in the healthcare workplace, usually the hospital clinical setting. Research in healthcare workplace bullying and its effect on students and graduates utilizing the clinical sites to learn their profession indicates that “there has been a growing recognition that workplace bullying is one of the most serious forms of aggression experienced by nurses . . . and to date, there has been little progress in developing explanatory models” (Hutchinson et al., 2008, p. 60).

Nursing workplace bullying was first identified in literature in the 1950s (Dellasega, 2009) although its effects on nursing students and graduates have recently been determined to be serious and persistent problems among nurses (Gallant-Roman, 2008; Holmes, 2006; Hutchinson et al., 2008; Palmer, 2003; Stanley et al., 2007). Bullying is a contributor in reported low self esteem and increased attrition, leading to many nurses abandoning their professions at a time when the shortage in nursing is at

crisis levels. These negative outcomes are also more thoroughly addressed in a subsequent section later in this paper addressing the precipitating factors of bullying.

Workplace bullying is part of the daily experience in the healthcare workplace, and some researchers propose that it is even more prevalent in the healthcare settings than some other settings (Diener, Dineen, Endresen, Beaman, & Fraser, 1975; Gallent-Roman, 2008; Jackson, Clare & Mannix, 2002). The predominance of studies concerning workplace bullying in nursing have been done outside of the United States. Johnson and Rea (2009) are two researchers who comment on the lack of research done on nurses' workplace bullying in the U.S. (Lutgen-Sandvik, Tracy, & Alberts, 2007; Roberts et al., 2004; Zapf, Einarsen, Hoel, & Vartia, 2003). According to Lutgen-Sandvik, "Workplace bullying occurs in all occupations and work settings; however, in studies done in Europe, healthcare occupations have been identified as having higher rates of workplace bullying . . . it is not possible to determine if this is definitely the case in the United States...as fewer empirical studies have been done" (p. 86).

In one U.S. study concerning nursing workplace violence, Gallent-Roman (2008) reports that "fewer than 20% of the respondents felt safe at work, and almost 60% reported they were threatened or verbally abused during the past year" (p. 450). Another U.S. study of workplace lateral violence at a southeastern medical center designed to "measure the perceived incidence and severity of lateral violence in the nursing workplace" (Stanley, Martin, Michel, Welton, & Nemeth, 2007, p. 1251) mirror the results from Gallent-Roman (2008). Results of the Stanley et al., study reveal that 56% of the nurses report lateral violence as "a very serious or somewhat serious problem" (p.

1251) while “65% report frequently observing lateral violence among co-workers” (p. 1247).

Causes and Responses

Some research is done to determine causes that increase the phenomena of workplace bullying in nursing, however, there appears to be no single accepted explanation when it comes to addressing responses for this unprofessional behavior in nursing. (Holmes, 2006; Hutchinson et al., 2008; Quine, 2001; Yarnada, 2000). There is little agreement concerning causes of bullying among nurses in the workplace, or the factors that may reduce or exacerbate the problem. Hutchinson et al. (2008) noted, “Of critical concern is evidence that in place of strategies to address [workplace] bullying, the evidence of reported exposure among nurses continues to escalate” (p. 61).

Finally, in a study done in the United States to determine the prevalence and causes of workplace violence among nursing personnel, a modified tool derived from a survey previously distributed in 1995 by the MCHC, Hinchberger’s study (2009) reported that “one hundred percent of those surveyed had experienced some type of workplace violence, and the perpetrators were most often other staff members” (p.37). One additional conclusion from this study was that “many students and new graduates accept vertical violence [and bullying] as ‘rites of passage,’ only to mimic and repeat this behavior later in their careers (p. 43). The study concludes that “Yes, it does seem that nurses learn to ‘eat their young’ AND each other as part of their profession” (p. 43).

Socialization in Nursing and Nursing Education

Current literature concerning the connection between nursing education and vertical bullying suggests that the nursing educational system may actually contribute to

oppression and bullying in nursing by reinforcing the “dominant groups” concept in nursing. By nursing education subscribing to the “submissive-aggressive syndrome” (Freshwater, 2000, p. 482), nursing education is controlled by those in power, dictating the curricula and practice that supports oppressive values. Freshwater proposes that nursing education supports covert conflict within the profession, manifested as “internalized self-depreciation, self harm, and horizontal violence” (p. 482).

General Professional Socialization

There are several definitions of professional socialization in the literature.

Cohen (1981) defined professional socialization as:

the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession

It involves the internalization of the values and norms of the group into the person’s own behavior and self-conception In this process, a person gives up the societal and media stereotype prevalent in our culture and adopts those held by members of that profession. (p. 168)

Gartner’s (2007) definition of professional socialization was similar: “It is the process through which an individual learns to adopt the values, skills, attitude, norms, and knowledge needed for membership in a given society, group or organization” (p. 371).

Van Maanen and Schein (1979) further defined professional socialization from an organizational perspective as “the process by which an individual acquires the social knowledge and skills necessary to assume an organizational role” (p. 211), also necessary to enter and be successful in the chosen profession.

No matter which organization or occupation, professional socialization is routinely acknowledged to be made up of essential processes such as skills, attitudes and behaviors needed for professional roles. Utilizing social learning theory, professional socialization is considered to be “the subconscious process of internalizing the values, traditions, obligations and responsibilities of a profession, thereby achieving an occupational identity” (Tradewell, 1996, p. 183). Professional behavior in any profession is demonstrated as a neophyte in the profession develops a “realistic perception of the role of the professional and the self as part of that profession” (Tradewell, p. 183).

Socialization into a profession has also been described as the process of moving from one social role to another by gaining knowledge, skill, and behavioral characteristics in order that the individual may authentically participate in new group activities. This has been called “mediated individual-societal relationship building” (Tradewell, 1996) and is common as newcomers in the profession become socialized into professional institutions or organizations.

One of the defining attributes of professional socialization is the socialized individual’s adoption of a profession’s values and norms by the individual being socialized into the profession. As a noted social scientist, Hinshaw (1977) presented a general model of professional socialization and re-socialization based on the work of Sampson (1967) which consisted of three phases. During the first phase of professional socialization, there was a shift in the perception of a role from pre-conceived notions or expectations to typically defined and real-world expectations. In learning the new expectations of the new role in this first phase, individuals assume the responsibility of learning the new roles in their socialization process. In the ensuing second phase, there

was a strong identification and attachment of individuals to significant mentors or persons identified by socializing individuals. The occurrence of inconsistencies between anticipated versus actual values and professional standards may also produce strong emotions in those being socialized into their professions.

During the third phase in Hinshaw's (1977) model, internalization of standards and values connected to new roles was seen. The degree of internalization may be exhibited in one of three responses: 1) compliance, which allows the individual being socialized to "act the part," thus receiving positive feed-back; 2) identification, which produces accepted behavior in the profession but not value adoption; and 3) true internalization, which occurs when the socializing individual endorses and believes in the values and standards of the new role. The possible connection of Hinshaw's model to the currently proposed study will be proposed later in this chapter when stages of socialization in nursing education are discussed.

Professional Socialization in Nursing

The issue of professional socialization of nurses has been discussed in nursing for many years as evidenced in the literature. Professional socialization of students in nursing has been presented since 1958 when the socialization process was described as "the period when students' lay culture and the nursing professional roles interact" (Tradewell, 1996, p. 183). Socialization in nursing, which occurs through professional education, insures that the attitudes, values, behaviors, knowledge, and skills are taught and learned in apprenticeship and further developed as a graduate nurse. Nursing socialization "refers to the process through which novice practitioners in nursing are merged into the profession to become professional practitioners" (DuToit, 1995, p. 164).

Professional socialization in nursing has also been described as “more than just acquiring skills and knowledge necessary to perform a role” (Price, 2008, p. 12) but must also include the individual’s understanding of fundamental norms and values in the profession. While learning the values and norms of their new profession, individuals may forgo and downplay their own values and norms while assuming new ones. In nursing, the individual proceeds from “acting like a nurse” to becoming a professional nurse. In doing so, the individual adopts the characteristics of the nursing professional while beginning to make their commitment to the profession.

The concept of the previously discussed Hinshaw’s (1977) model concerning internalization during the socialization process may be easily applied to this aspect of nursing socialization, as individuals may have varying degrees of adopting nursing values and norms during their socialization process. Wilson and Startup’s (1991) land-mark study in the United Kingdom concerned student nurse socialization, and found that student nurses felt that they were treated as workers rather than learners during socialization, while feeling conflicted in clinical experiences concerning their application of learned theory in actual nursing practice.

More than one study concerning the socialization process in nursing highlighted the frequently reported effort of nurses, especially students and new graduates, to “fit in” with the organizational norms and values of the clinical nursing experiences (Kramer, 1974; Olsson & Gullberg, 1987; Wilson & Startup, 1991). Individuals in the socialization process who find conflict in what they have learned in the theory of clinical practices versus the expected practice in a bullying, clinical environment may “feel guilty but also powerless to do anything but conform and fit-in” (Wilson & Startup, p. 1482). The

frequently cited effort to fit in which echoes in responses from students and new graduates and feelings of guilt and powerlessness were reported in the findings of this study as students perceived the need to conform in their socialization into nursing. These concepts of fitting in and guilt support the connection of socialization and bullying in nursing, the topic of the proposed study. Applying Hinshaw's (1977) socialization model to the fitting-in phenomenon, conflicted students and new graduates may feel pressure to conform, identify or internalize the values and norms of the clinical area, furthering the practice, culture, and socialization of bullying.

Various studies of nursing socialization. Many approaches in studying nursing socialization are recorded in the literature. One of these studies done by Reutter et al. (1997) utilized the combined framework of the functionalist socialization approach and the interactionist socialization approach in explaining the socialization of 4 year baccalaureate students. The first approach known as the functionalist approach proposed by Linton (1936) and Parsons (1952) views role expectations as grounded in "shared values and norms that are internalized through a process of socialization" (Reutter et al., 1997, p. 149). With this approach, roles are seen as expectations, not subject to interactions or negotiation, and developed through social interaction only. Individuals passively accept the traditions, norms, and values of the profession with little questioning. Faculty members, professionals in the work environment, and peers are considered the socializing agents of the individuals being socialized.

The second approach or the interactionist approach in socialization theory is based on interaction which is symbolic; in other words "a person acquires meaning through interaction with others and the environment as well as through a reflective

process” (Reutter et al., 1997, p. 149). Conforming to pre existing social norms is not expected with this approach in professional socialization, but individuals experiencing interactionary socialization are more active and creative in their socialization into their profession. This approach considers role behavior to be a process rather than a conformation to norms and values which are preexistent. Situational adjustment through role-taking, then modifying expectations leading to the creation of new roles and behaviors is the predominant process in interactionary socialization. This approach does not “assume a consensual value system among the professional school, practitioners, and students” (Reutter et al., p. 150).

The researchers in Reutter’s et al. (1997) study suggest that both approaches are utilized in nursing socialization, with the functionalist approach utilized in the initial socialization process gradually evolving to the interactionary approach in the final period of the education program incorporating the socialization process. The crucial finding from this study was that “nursing students’ socialization involves two interrelated but different processes: socialization to the student role (interactionalist approach) and socialization to the nursing role (functionalist approach)” (Reutter et al., 1997, p. 154).

In applying this approach concept to the current study regarding the socialization of bullying through nursing education, the finding that socialization of the nursing student to the nursing role continues to rely on fundamentalist approaches of passivity of students may be an important consideration concerning the significance of socialization of bullying in nursing. It may also support the concept that nursing socialization begins early in the process of nursing education and continues to strongly influence the

socialized professional regarding the esteemed values and norms of the profession, where the socialized professionals are passive recipients in the socialization process.

In another frequently cited study concerning nurse socialization, Kelly (1993) investigated perceptions of ethical dimensions of nursing versus what the nurses found in the “real world.” Kelly’s study determined that student nurses believed that ethical practices such as information giving, self-determination, and caring for patients were important principles in their actions as nurses. Kelly also found that another common practice for students or new graduates occurring in nursing socialization was connected to compromising the integrity of individuals being socialized, frequently reported as “not making waves” for the sake of keeping the environment pleasant, while cited as a source of mental stress in their socialization process. New nurses compromising their integrity ensure that the socialized individual is supported in their learning of the profession.

In another nurse socialization study, Brady (1990) discussed the phenomenon that students, during their socialization process, feel overwhelmed by the great responsibility they assume during their socialization process in their role as a nurse. Students report that they are expected by nursing staff to perform as a nurse while not having the knowledge and experience needed to perform at that level. Brady’s study also determined that students and new graduates began to value feeling part of the team over quality patient care. Another resounding finding of this socialization study is that during socialization students were increasingly concerned with the notion of “getting along with” staff and supervisors at any cost, and whether or not the staff nurse would like them.

Socialization Through Nursing Education

While nursing education in the United States is attempting to empower students-then-new-graduates to deliver the highest standard of patient care, Duchscher and Myrick (2008) stated “the socialization of new nursing graduates into the dynamic (though oppressive) culture of today’s hospitals creates significant challenges not only for nurses themselves, but also for institutions of higher education, healthcare administrators and policy makers across this country” (p. 191). Through nursing education, new graduates may be traumatically socialized into a healthcare workforce which is aging, exhausted, experiencing high turnover and high job stress. If this is true, the question remains: How does the student-then graduate nurse accept being socialized into a work culture and hierarchy from fatigued, dissatisfied colleagues?

The tendency to overlook oppression in the nursing socialization process is noted in the findings from Mooney’s study (2006) which found that the ability and the willingness of the new graduate nurses to become socialized professionally “determines their ease of survival at clinical levels” (p. 75). In determining the significance that professional socialization has for new nurses, Mooney (2006) found new nurses were frustrated in their new professions, with “resentment towards the hierarchy . . . [and] avoid challenging those issues and philosophies with which they disagree and instead conform to the accepted ward culture through the process of professional socialization” (p. 79-80). The frequent reference to chain-of-command, a concept learned early in students’ formal nursing education, is frequently noted to indicate that respect for the profession requires obeying the chain of command at all costs.

Chain of command link. The link between the nursing profession’s chain of command, socialization, and the hierarchy in nursing and nursing education is

strengthened within many persistent references in studies. The link gives further evidence that students are socialized into a culture of obeying and subordination (Freire, 1972; Freshwater, 2000; Randle, 2003). Nursing education theorists continue to debate about the concept of hierarchy, power, and control in nursing (Fulton, 1997; Heslop et al, 2001; Kuokkanen & Leino-Kilpi, 2000) and the abuse of power which is frequently displaced through nurse-to-nurse violence. Duchscher and Myrick (2008) proposed that nurses “while advocating for the disenfranchised . . . have tended to overlook the role of oppression in their own experiences within the system . . . [and] have traditionally aimed their efforts at assisting the oppressed to adapt, rather than change, the circumstances responsible for their social conditions . . . [an] insidious nature of an oppressive culture in nursing” (p. 193).

Related Dissertation Studies

There are recent investigations through dissertations concerning non-professional behavior and bullying, some investigating the accompanying nursing socialization aspect. Szutenbach (2008) identified bullying of staff nurses as possible reasons for poor nurse recruitment and retention, but did not investigate the connection to nursing education. Simons (2006) also studied bullied newly licensed staff nurses who also identify workplace bullying contributing to increased workplace dissatisfaction. Simons concludes with a recommendation for education to develop interventions to reduce high turnover rates.

Two recent studies involving student perceptions of bullying in nursing education are also noted. Cooper et al (2009) described types and sources of bullying in nursing education, coping strategies of individuals and programs, and different student

characteristics. Dunn (2007) also examined bullying in nursing education, but concentrates on studying students of color and their interaction with instructors.

Other researchers are investigated professional socialization, with one in particular also dealing with worker satisfaction. Jackson (2007) finds that new staff nurses who lack mentoring struggle to socialize into their roles in nursing. There is no connection to nursing education mentioned in this study. However, the findings that there are difficult transitions in the socialization from student to new nurse are found in Hamel's (1990) study. While mention is made concerning preceptors lack of support for new nurses, bullying is not cited as such in this study. Messersmith (2008) found that nursing faculty are the primary agents of socialization of baccalaureate nursing students, however, non-professional behavior also is not mentioned in the socialization of the students into nursing.

Socialization and students and graduates from associate degree nursing programs are studied by some other researchers. Fetzer (1998) in a study concerning "profession hood," proposed six variables identified to impact the socialization process of Associate Degree Nursing (ADN) graduates. While bullying was not included in the discussion, recommendations to education and industry include strategies to better psychological acculturation. Woodman (1994) presented findings of how community colleges affect the nursing socialization of ADN students, but no mention of non-professional behavior is included. Hershey (2007) investigated the ADN's process of acquiring professional identity, determining that structural functionalism or reproducing group norms is an important component of their socialization process. While not directly addressing

bullying in this study, the application of socializing concepts from this study support the concept of bullying socialization in the current study.

Investigation into the current dissertation literature provides additional evidence that while non-professional behavior and bullying are indeed serious and growing problems, there are multiple gaps in the literature. The study of and connection to socialization through nursing education, particularly community college nursing education, has not been investigated fully. It was the intent of this current study to provide additional thorough and dedicated research and didactic, scholarly exploration of this topic in the study of non-professional and bullying behavior in the socialization of community college nursing students and graduates.

The ensuing discussion concerning nursing education and bullying is built on a conceptual framework of Twale and De Luca (2008), discussed in the following section, which singles out only a handful of the most discussed factors in current literature connecting the phenomena of bullying in nursing and nursing education. Concepts of nursing culture and organizational power—to name just a few factors—are common reference points in this literature review. Even though education “usually results in knowledge that helps to confer power . . . it is not easy to shift power (in nursing) or change organizational culture” (Molzahn, p. 279). Conversely, nursing education may (or may not) be a negative socialization force “that contributes to the perpetuation of this bullying culture” (p. 279).

Conceptual Framework

To better understand vertical bullying in nursing and in nursing education, a conceptual framework based on the findings of the model of academic bullying from

Twale and De Luca (2008) is employed, adapted from Salin's model (2003) of three groups of bullying factors associated with organizational bullying behavior. In Salin's model, "explanations for and factors associated with bullying are classified into three groups" (p. 1213). These three groups are labeled as follows: 1) enabling structures or necessary antecedents; 2) motivating structures or incentives; and 3) precipitating processes or triggering circumstances. Salin proposed that "bullying is often an interaction between structures and processes from all three groupings" (p. 1213). Salin agrees with Zapf (1999) that bullying is "seldom explained by one factor alone but is rather a multi-causal phenomenon" (Salin, 2003, p. 1217). Hence, according to these and other theorists (O'Leary-Kelly et al., 1996; Zapf, 1999) bullying may be the result of many interacting factors or processes.

Salin (2003) studied workplace bullying in general and developed a model to explain the interaction of the three structures or processes which contribute to the bullying. This same model was employed by Twale and De Luca (2008) in their study and discussion of faculty bullying and incivility in higher education. Concentrating on incivility and bullying which the authors believe is increasing in the halls of academe, their study cites 370 years of higher education supporting incivility in their higher education profession with examples of elitism, power and politics, paternalism and other aggressive behaviors experienced by new and experienced higher education professionals. Twale and De Luca also utilized Salin's organizational model as a framework to explain and try to determine possible causes and effects of incivility and bullying in faculty ranks.

In utilizing Salin's (2003) and ultimately Twale and De Luca's (2008) frameworks in the current study of bullying in community college nursing education, three groups bullying factors are presented and tend to fall under one of the following process categories concerned with : (1) enabling (2) motivating and (3) precipitating of bullying. Enabling processes support and "provide fertile soil for bullying" (p. 1219). Motivating processes are circumstances which "make it rewarding to harass others" (p. 1222). Lastly, precipitating processes are factors which "often act as the actual triggers of bullying" (p. 1224). According to Salin's model, "bullying can be understood as the result of an interaction between these three groupings of explanators, or at least two of them" (p. 1217).

In the current application of the Salin (2003) model to this nursing education bullying study, the first enabling factors in nursing bullying may be associated with issues of power misuse, exhibited frustration, and nursing culture influences. One nursing example supporting the enabling factor present in bullying can be seen when student nurses or new graduates decide to adapt and fit in when faced with bullying in the clinical environment even when they know bullying may be occurring and they should "speak up" for one being bullied by a senior nurse or instructor. The second or precipitating circumstances are linked to organizational stressors and the shortages associated with the nursing profession. Examples of stressors or shortages affecting behavior and causing bullying in the clinical site occur when students or new graduates are asked to care for a disproportionate number of critically ill patients when a clinical unit is short staffed. Finally, motivation factors contributing to nursing bullying may be connected to perceived benefits and rewards for bullying, and the motivation to be or produce the

“good nurse.” An example of a motivating factor causing bullying occurs when students or new graduates conform to good nurse or amicable non-confrontational behavior which is demanded by nurses-in-charge versus behavior which may be unprofessional or bullying in nature.

Figure 1 presents a proposed model for the study, an adaptation of both Salin’s model (2003) and Twale and De Luca’s (2008) model, depicting the interaction of enabling, motivating, and precipitating processes which may occur in bullying in nursing and in nursing education. This model demonstrates agreement with the theories of Salin and Twale and De Luca that bullying is frequently the result of many interacting factors occurring simultaneously.

Borrowing from both of these two models, the model presented with this nursing bullying model also designates that any interaction between two of the three factor groupings could result in nursing bullying. However, the Salin (2003) and Twale & De Luca (2008) models seem to indicate that bullying occurs in an inter-related but sequential manner rather than occurring reciprocally and synergistically. This study and model propose that bullying in nursing is more likely to deepen and be amplified with the interaction of processes from all three factor groupings, with bullying being intensified with the accumulation of two or more factors as shown in Figure 1.

To emphasize that vertical bullying in nursing education is intensified with a number of contributing factors, a Venn diagram is used in Figure 3 to demonstrate the amalgamation of those factors which may contribute to the end result of bullying. The figure depicts the incorporation of the Salin model and the Twale and De Luca (2008) model into a new model, also with three factors made up of processes combined to

produce the intensified core of bullying. Bullying is produced by the combination of factors in each of the circles, and is represented by the very center of the diagram, indicated with “B” and shown intensified with contributing factors from the three enabling, motivating, and precipitating groupings.

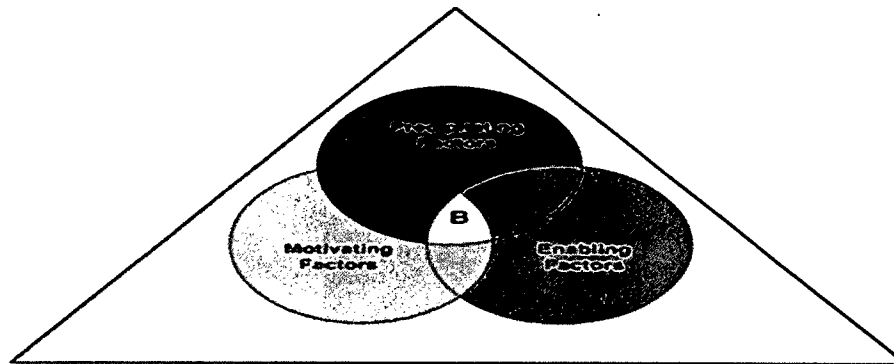


Figure 1. Enabling, precipitating, and motivating processes which contribute to nurse bullying.

Factors Contributing to Nursing Bullying

In an attempt to further explain the framework proposed for this study, the enabling factors, the precipitating factors and the motivating factors which may contribute to the socialization of vertical bullying in community college nursing graduates is presented as follows, along with a review of literature associated with these factors and examples of possible nursing bullying behavior associated with that factor. Figure 2 organizes the factors and the selected processes which will be discussed in the proposed study.

FACTOR	PROCESSES
Enabling	<ul style="list-style-type: none"> • Lack of Power or Control • Frustration • Culture
Precipitating	<ul style="list-style-type: none"> • Stressors • Shortages
Motivating	<ul style="list-style-type: none"> • Rewards and Benefits • The Good Nurse Syndrome

Figure 2. Chart of factors and processes which may contribute to the end result of bullying in nursing.

Enabling factors: power, frustration, and culture. In this study of nursing education bullying, the three enabling processes frequently referenced in nursing bullying literature are identified as lack of power and control, the occurrence of frustration in nursing, and the influence of culture contributing to bullying in nursing (Daiski, 2004; Farrell, 1997; Heslop et al., 2001; Lewis, 2006; Magnussen & Amundson, 2003). Each of these three groups is cited as a determining enabling factor of bullying in providing support and nurturing for bullying practices, and each is discussed in more detail in the next section.

Power and its misuse. Power is a concept which is frequently associated with the phenomena of bullying in nursing and its perpetuation of vertical bullying through nursing education. Molzahn (2008) noted, “Power and knowledge attained through

education and learning are inseparable” (p. 279). Molzahn additionally wrote of power and nursing:

Power is manifested in established structures, cultured belief systems practices, and sources of knowledge. It extends beyond the capacity of individuals into social structures and institutions. Power is everywhere we look...power and oppression go hand in hand...(and) even the nurses’ rationalizations of the surgeons abuse of power is typical of gross misuse of power. (p. 279)

Molzahn further suggested that contributing forces such as high stress in the delivery of patient care, along with the continuing struggle to destroy the myth of nurses “are the hand-maidens to physicians”(p. 279) syndrome are additional reasons for the perpetuation of bullying in nursing.

In research describing the origins of vertical bullying in nursing and in nursing education, fear of retaliation and oppression connected to bullying was also cited by Roberts (1983). Again, in applying Freire’s (1972) theory to the phenomena of bullying in nursing, Roberts (1983) proposed that nurses as the oppressed group display common behavioral characteristics as their perceived oppressors. Another theorist, Bartholomew (2006), agreed with Roberts, stating “submissive-aggressive syndrome is a term that describes an occurrence when nurses feel they have lost their power (submissiveness) and react by overpowering others by aggression” (p. 399). While being bullied in the clinical setting, students and new graduates perceive they are powerless, feel alienated, and feel little control over what and how they are learning. Sheridan-Leos (2008) asserted, “This leads to a cycle of low self-esteem and [increased] feelings of powerlessness” (p. 399).

Nevertheless, some disagreement exists regarding the response of nurses and students to bullying and oppression. Farrell (2001), a noted nursing theorist concerning oppression as a cause for bullying in nursing, contended that “it is the nurses themselves who in their everyday work and interpersonal interactions, act as insidious gate-keepers to an iniquitous status-quo” (p. 26). In Farrell’s landmark study concerning loss of power and disenfranchising in nursing, Farrell proposed three levels of explanation leading to poor nursing staff interaction. In the discussion of his theory, he urged nurses to acknowledge but get past the obsession with the oppression theories while taking part in the redesigning of their nursing workplaces.

Contradictorily, Duchscher and Myrick (2008) argued “nurses have tended to overlook the role of oppression in their own experiences within the system” (p. 193). These researchers suggested that nurses and students in nursing education acknowledge and resist oppression overtly, and concluded with the following in their study:

Most oppressed situations remain so until they are forced to yield to the demands of opposition...Once a critical level of awareness has been attained through guided reflection, freedom from perceived constraints requires that the disenfranchised unify and organize for the purpose of dialoging with the oppressors, demanding libratory action, and participating in transformative change. Emancipatory actions increase the potential for oppressed groups to take power from those who oppress them. (p. 201)

Moreover, Moccia (1988), cited in Duchscher and Myrick (2008), stated “nurses have traditionally aimed their efforts at assisting the oppressed to ‘adapt to’ rather than change the circumstances responsible for their social conditions [offering] insight into the

insidious nature of oppressive culture in nursing” (p. 158). It is this response which is most traditionally observed in nursing and nursing education.

Misuse of power, especially by senior nurses over students and new graduates, is also a recurring theme in the researched literature (Daiki, 2004; Farrell, 1997; Lewis, 2006; Magnussen & Amundson, 2003). Students and new graduates with less perceived knowledge and skills are particularly vulnerable to bullying due to their perceived lack of expertise that accompanies novice status (Hoel et al., 2007).

A frequently reported reason for the continued misuse of power and the perpetuation of nursing bullying is because this phenomenon is grossly unreported, possibly due to students and graduates feeling powerless and having fear of retaliation from superiors (Farrell, 1999; McKenna et al., 2003; Sheridan-Leos, 2008). The student nurse may choose to “take it” or ignore psychological bullying for the duration of their program, while new graduates may attempt to fit in as they begin their new job. Both of these enabling responses to bullying contribute to its perpetuation in the fertile enabling “soil” (Salin, 2003). This enabling response to misuse of power as students and graduates take it and fit in are taught in nursing education as students are socialized and indoctrinated to following the chain of command which are referenced in every school of nursing’s Rules and Regulations, and re-enforced in every hospital’s Department of Nursing.

Frustration. A frequent complaint from students learning in any discipline is the lack of control over the how and why of their learning situations. Community college nursing students and new graduates may experience even more frustration in their lack of control over their environment as their learning experiences are compounded and layered

with elements of nurse-on-nurse psychological abuse sprinkled into legitimate clinical nursing assignments and experiences. As new nurses learning their profession, the students and new graduates may experience feelings of being overwhelmed with educational program requirements and the expectations of instructors or other nursing preceptors, as well as anticipations of staff nurses in clinical settings (Garrett et al., 1976; McKenna et al., 2003).

Role conflict, a frustration experienced by students and new graduates, is a frequent reference in the literature as student and new graduates' perceptions of nursing evolve and change during and after new nurses' learning experiences are sustained (Jackson & Mannix, 2001; Manninen, 1998). According to some nursing theorists, bullying of other nurses may occur as the result of unmet expectations of nurses and high frustration levels that accompany high patient acuity and overwhelming patient and clinical assignments (Kleehammer et al., 1990; McKenna et al., 2003).

The frustration of nurses and nursing students lacking autonomy and control while experiencing hierarchical and generational abuse is also a frequent reference in research surrounding learner bullying (Freshwater, 2000; Gray and Smith, 1999; Roberts et al., 2004). The literature shows that, according to Farrell (1997, 2001) and Freshwater (2000), nurses are dominated "by a patriarchal system headed by doctors, administrators and marginalized nurse managers" (Freshwater, p. 482) so that nurses in lesser positions in the hierarchy of power turn to nurse-on-nurse aggression (Farrell, 1997) in perpetuation of bullying.

Culture. The concept of a nursing culture enabling unprofessional behavior was introduced over 25 years ago. Kohnke (1981) addresses the concept of generational

reasons for bullying and unprofessional behavior in nursing, suggesting that some nurse leaders and educators “believe that they have earned the right to be served . . . and because they were treated badly as beginning level nurses, they see it as their right to do the same to juniors” (Farrell, 2001). Kohnke (1981) believed that students in nursing are socialized into a culture of nurse-to-nurse abuse. Further discussion of the connection of culture in nurse socialization follows later in this chapter.

Culture also contributes to bullying in nursing education according to Marks (1988) who proposed that nurses are frequently masochistic, and have feelings that they have been abused. According to Marks (1988), this leads to increased hostility towards others, and eventually leads to nurses acting-out with aggression now labeled horizontal bullying. Bullying of students and new graduates may be reinforced in organizational cultures which treat bullying as “normal and acceptable ways of getting things done” (Salin, 2003, p. 1221). The range of student and new graduate abuse or bullying falls in the range from Foster’s et al., (2004) report of 90% of students experiencing bullying to Randle’s (2003) report that most students found treatment from staff in the clinical experience to be only “distressing and psychologically damaging” (p. 397).

Culturally and organizationally sanctioned bullying is rampant as many researchers in workplace bullying report startling numbers and statistics discovered in their studies on this subject and scant organizational response to this phenomena. Quine (2001)—in her study to determine if support at work could moderate the effect of bullying in the workplace—found that “forty-four percent of nurses reported experiencing one or more types of bullying in the previous 12 months compared to 35% of other (healthcare) staff” (p. 73). Trossman (2008) reported that a survey of 4,000

critical care nurses conducted by the American Association of Critical Care Nurses (AACN) revealed that “65% of the nurses reported experiencing at least one incident of verbal abuse in the past year from physicians, nurse managers, other RNs, patients or other persons . . . [and] only one in four of these nurses reports that their facilities were fully committed to enforcing zero tolerance policies” (p. 12).

Organizations or institutions which support nursing bullying by indifference or by looking the other way are responsible for enabling the culture of bullying, a phenomenon which permeates the profession of nursing to its very core. Moreover, nursing educators who participate or quietly support a culture of bullying are also contributing to the socialization of bullying of students and new nursing graduates.

Precipitating factors: stressors and shortages. The second grouping of factors associated with bullying in nursing is composed of primarily the precipitating stressors in the profession such as high acuity of patients and distressing workloads, followed with the second precipitating factor weighing heavily on the nursing profession, i.e. the severe shortages of nursing personnel. A review of literature concerning both of these precipitating factors follows.

The stressors. It is known that the stressors in any workplace also lead to frustration in personnel. While workplace stress may lead to the frustration discussed previously in the enabling factor section, the effects of workplace bullying especially on students and new graduates due to stressors are considered to be serious and complex by many researchers and nurse leaders. While conditions of bullying for students and new graduates may be dependent upon multiple external and internal conditions, some researchers extricate the nurse shortage into a separate category and condense

contributing stress factors in the bullying of students and new graduates to: 1) inexperience dealing with high acuity patients, 2) burgeoning technology demands at clinical sites, and 3) demands from physicians, patients, patient families, and other hospital personnel. (Farrell, 2001; Hart & Rotem, 1994; Jackson et al., 2002). All three of these circumstances, which may realistically occur daily and simultaneously in the lives of students and new graduates, create an environment which supports insidious bullying behavior from individuals unable to deal with stressful settings or suffering from nursing “burnout” (Lutgen-Sandvik, 2007).

Additional stressors on students and new nurses which contribute to bullying in the profession included the stress of caring for patients who may be diagnosed with increasingly severe and/or complex diseases and disorders, even while the patients experience shortened hospital stays under nursing care. Additionally, the stress of caring for patients with potentially deadly pandemic infections as well as serious non-infectious diagnoses may also be significant contributors to bullying, triggering professional burnout along with nurse incivility (Farrell, 2001; Jackson et al., 2002). According to the Center for American Nurses (2009), iatrogenic and cross-infections, accidents in the workplace, and inferior working conditions are also cited as common complaints of students and new nurses, and they are introduced in the literature as stressors which may potentially lead to incivility and bullying of other nurses.

An aging global population is considered to be yet another stressor in nursing, as populations in most countries are aging. By the year 2050, “there will be a greater number of older people than younger ones in the world . . . and half of the world’s population will be older than 50” (Oulton, 2006, p. 355). Nurses, as the main care givers

in the healthcare system, will be called upon to respond to more people living longer, albeit not necessarily healthier lives.

These and other stress factors in nursing are frequently cited as triggers or precipitating factors which may precipitate nurse-on-nurse bullying, especially in clinical arenas which require high levels of expertise and the ability to respond quickly during life and death situations. Nursing students and new graduates are just beginning to learn nursing expertise and appropriate responses in their profession while they are being socialized into their profession. While learning to deal with the stressors that accompany nursing, they may additionally be subject to incivility and impatience from colleagues impatient, overworked, and unwilling to extend professional courtesy to these novices.

The shortages. Another precipitating or triggering factor in bullying is connected to the present and looming shortage of nurses in the United States and globally. The U.S. Bureau of Health Professions (BHP) predicts that by 2020, the nursing shortage will increase to more than 800,000 registered nurses in our country (BHP, 2002). Along with an aging population of patients, the nursing workforce is aging as evidenced by the prediction that in the U.S. and Canada, “50% of nurses employed today will retire in the next 15 years” (Oulton, 2006, p. 355). Organizations such as the MCHC have identified addressing the shortage of nurses as their major project in workforce development in the next two years (MCHC, 2009).

One frequent entry in nursing literature regarding the shortage and workplace bullying is associated with bullying’s negative contribution to the looming nursing shortage through heightened nursing attrition (Beecraft et al., 2008; Bowles & Candela, 2005; Johnson & Rea, 2009; Roberts et al., 2004). Aiken et al. (2001) indicated that

bullying contributes partially to the significant nursing shortage: “41% of hospital nurses were dissatisfied with their jobs and 21% planned to leave them in less than 1 year . . . among nurses younger than age 30, this figure was 33%” (Oulton, 2006, p. 36). Additionally, Bowles and Candela (2005) found that with attrite nurses due to bullying “30% of new nurses left their jobs in the first year and that 57% had left by the end of their second year” (p. 130). Other research corroborated that “bullying was more predictive of the intent of new graduates’ intent to leave than other reasons like environment, workload, or satisfaction with salary” (Johnson & Rea, 2009, p. 86).

Additionally, shortages and retirements in the ranks of nurses as well as in nursing faculty “will hamper the ability of nursing schools to educate enough nurses to meet the future demands” in the healthcare system (Oulton, p. 35). The barrier of dwindling nurse educators contributing to the nursing shortage is a nationwide phenomenon and common area of concern in most states (MCHC, 2009). Research in literature indicates that those concerned with healthcare delivery are currently more aware that the nursing shortage also contributes to rates of patient morbidity and mortality adversely, as well as negatively affecting the caliber and education of those remaining in the profession (Aiken et al., 2001).

While the two precipitating and triggering factors of stressors and the shortage are closely related, they both may independently contribute to vertical bullying which may occur daily as students and graduates of community colleges and socialized within nursing education. This bullying may then lead to the spiral effect of increased stress, and ultimately higher job dissatisfaction leading to high staff turnover rates, causing more shortages. Oulton (2006) described how “Nurses are changing jobs, leaving the country

and leaving nursing . . . because of the stress, the workplace violence, the bullying, and the harassment . . . and of an ultimate lack of feeling valued” (p. 37).

Motivating factors: rewards and the good nurse syndrome. The third grouping of factors which contributes synergistically to bullying in nursing includes: 1) motivating rewards and benefits achieved by the perpetrator of bullying and 2) the overarching motivation to be or produce the good nurse. The perpetuation of the good nurse syndrome is frequently referenced in studying the history of the nursing profession. This concept can be traced as far back as the “Nightingale nurses” who were chosen for their abilities to obey and follow the orders of the doctors above all else, belittling and shunning those who strayed from this ideal (Alavi & Gattoni, 1995). Discussion of literature concerning motivation of bullying by rewards and through the “good” nurse syndrome follows.

Rewards and benefits of bullying. The motivation for one nurse to bully another nurse is a topic of concern at many levels in the current literature in nursing. Most vertical bullying of students and new graduates is of a non-physical nature, i.e. a type of psychological bullying of a victim. Psychological bullying, which is sometimes called relational aggression rather than physical bullying, accounts for the bullying that is learned and eventually accepted by nursing students-turned-graduates (McKenna et al., 2003). Psychological harassment is said to be learned and accepted by many nurses and students, encompassing verbal attacks, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunities, disinterest, discouragement, and the withholding of information (Farrell, 1999; McKenna et al., 2003; Quine, 1999). In the literature, the perpetuation of psychological bullying is

considered commonplace for students and new graduates as they are socialized into their profession, a further discussion later in this chapter.

Other motivating mechanisms may be employed to perpetuate vertical bullying of students or new graduates; these mechanisms may be associated with the nursing profession's reliance on concepts concerning nursing's hierarchy and chains of commands, foundational concepts in the profession (Daiski, 2004). The reward received by the person who bullies utilizes mechanism "distortion of consequences" (Bandura, 1999) which allows the perpetrator to ignore or minimize their own bullying action while enforcing rules or regulations maintaining the standards and integrity of the profession. In other words, the bullier justifies their bullying in the name of defending rules and standards established by the profession, not by the perpetrator. The bullier avoids any effect of the bullying, and the rewards of the bullying are clearly maintaining professional standards with little or no self-censure for the bullying used to do so. Additionally, the bullier may associate bullying with hierarchical concepts and the notion of novices "paying one's dues," an experience the bully endured and now expects from the student or new graduate for being allowed to enter the profession. These concepts are explained further in Appendix B of this study.

Sometimes the motivation for bullying is the reduction of competition, or the expulsion of low performing nursing students or new graduates, a comparable finding in Salin's (2003) study of organizational bullying. In nursing, these bullying actions are frequently performed with patient safety and maintaining high standards as the stated goal for bullying. In nursing education, the dichotomy of the instructor serving two ends, i.e. teaching the student while protecting the patient, is sometimes cited as a motivating

and justified reason for bullying (Lee, 2007). The interaction with students is not interpreted as bullying by perpetrators but necessary communication with learners and novices. The goals or bullier's rewards for bullying in these instances must be viewed in light of Bandura's moral disengagement theory in that the nursing bullying is seen as necessary and that "the end justifies the means" (1999).

The good nurse syndrome. The final motivating factor is connected to the notion that bullying may be exhibited as nurses strive to be or produce the good nurse. From early in the 1800's, during two centuries in the development of nursing struggling to become a profession, the image of nursing has frequently been associated with a discussion of what makes a good nurse. (Alavi & Gattoni, 1995).

There is much in nursing literature concerning the image of nurses, how they are seen by the public through the media and how they view themselves (Brodie et al., 2004; Dahl, 1992; Fletcher, 2007). Fletcher noted, "Nursing and the public have stereotyped views of the nursing profession that persist to this day" (p. 207). The public image of the nurse is often portrayed in the media in four consistent images according to some researchers: ministering angel, battle-ax, physician's handmaiden, and naughty nurse (Bridges, 1990). The motivation within the profession to change and improve their image in the present and past has frequently been tied to the promotion of the idea of a good nurse, ironically with oppression and bullying sometimes used as tools in changing certain nursing stereotypes.

Good nurses have routinely been identified with the following characteristics: subservient while taking orders (Kalisch & Kalisch, 1982); high minded and morally serious (Hallam, 1998); women subordinate to men, especially in the medical profession

(Aber & Hawkins, 1992); and lacking autonomy and job independence (Austen et al., 1985; Seago et al., 2006). Fletcher (2007) illustrated the good nurse concept as follows:

Patients have identified a good nurse as someone who has the 'right' personality, which is more important than their education, and who carries out physicians' orders. The poor nurse is uncaring, incompetent, and demonstrates a lack of vocation or calling to nursing. (p. 209)

Bullies of students and new graduates have been known to hide behind the belief that the making of good nurses requires the intervention of experienced nurses in "weeding out" students or new graduates who are perceived to be uncaring or incompetent, or who are perceived to not have a "calling" to the profession. In compliance to what has been a professional tenet since the early days of the profession when matrons supervised and controlled the fate of the students and new graduates, senior nurses may feel a motivation or responsibility to mold novices into individuals who will be obedient and adapt to the system. The making or becoming a good nurse may come at a motivating cost that both the perpetrator and the bullied must be willing to pay, and that is having the novice be "subject to a rather full set of mortifying experiences" (Alavi & Gattoni, 1995) in learning the nursing profession.

Summary of Chapter Two

This review of literature began with a discussion of bullying, and definitions associated with bullying, followed with bullying in the workplace, bullying in nursing education, and the socialization of bullying in nursing and in nursing education. The socialization of nursing students in general and community college nursing students in particular is investigated, although limited information is available on community college

nursing student socialization. Finally, the conceptual framework for this study utilized an adaptation of Salin's model (2003) and that of Twale and De Luca (2008).

In the nursing profession and in education, there continues to be a growing interest concerning the relationship of nursing education and vertical bullying.

Freshwater (2000) and others (Hinchberger, 2009; Hoel et al., 2007) suggest, however, that there exists a gap in literature concerning non-professional behavior and vertical bullying connected to nursing education. Freshwater continues saying: "there are . . . few studies that comment on the extent of violence [bullying] in nursing and none that address this in relation to student nurses, and the part that the [nursing] education system or curriculum has to play in it" (p. 482).

The present study attempts to fill that gap in current community college education research. One overarching question concerning the relationship of community college nursing education and vertical bullying stems from a debate of which comes first—is nursing education the incubator for the socialization of vertical bullying in nursing culture, or is bullying socialized in the nursing culture despite education? This current study is attempting to discover answers to this and the other formal questions posed in this study in the full course of investigation on this topic.

A Final Thought in this Review of Literature. While investigating the phenomenon of the socialization of non-professional behavior and vertical bullying in nursing education, it is important to remember that bullying and non-professional behavior, while *experienced* at some level by a majority of nurses, may not necessarily be *practiced* by a majority of nurses. A recent study entitled *Silence Kills* (2005) done

through a partnership between the AACN and a training company called *VitalSmarts* reports that

52 percent of nurses . . . work with some people who abuse their authority . . . [and] 33 percent work with a few who are verbally abusive . . . however, most healthcare respondents are happy in their careers and believe their organizations do good work . . . and yet most respondents report that a number of their colleagues create problems that are common, frequent, persistent, and dangerous (p. 5-6).

Most nurses as healthcare providers—while having been exposed to bullying in their profession—learn to work and live with elements of bullying in their workplace or leave the profession if they are unable to do so. It is the investigation of the possible connection between the socialization of vertical bullying and community college nursing education which may shine a light on the phenomena and reduce its effects in the profession of nursing as well as in community college nursing education.

CHAPTER THREE

METHODOLOGY

This chapter three presents the design of this study and a discussion of the method used to investigate the topic of the socialization of vertical bullying through community college nursing education.

Purpose of Study

The purpose of this study was to examine the effects of vertical bullying and non-professional behavior on the nursing students and graduates who chose to learn the nursing profession through community college nursing education and, ultimately, to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. Professional socialization has been defined as the process by which the individual learns the characteristics and the culture of a profession (Gray & Smith, 1999). Using case study research, this study examined nursing behavior and practices from the perspectives of new graduates of community college nursing programs. Some of these graduates have experienced negative behavioral responses, aggression, and use of power experientially as they learned nursing. Graduates of community college nursing programs were interviewed to determine if and how negative behavior may have affected them as they were socialized into their profession.

Although there is an abundance of literature concerning non-professional behavior in four year schools of nursing, (Gaul, 1987; Munhall, 1980) there are few studies of this nature linked to bullying socialization in community college nursing education programs. Additionally, there is a lack of information concerning the socialization of vertical bullying through higher education. The completed case study

addressed this identified gap in research concerning the issues of non-professional behavior and vertical bullying in community college nursing education and its effect on the socialization on nursing students and graduates from community colleges. The current study produced information that may assist educators at all levels of nursing education, as well as nursing leaders as they strive to deal with this problem. Since approximately 60% of the nurses practicing in the United States today begin their education at community colleges (AACC, 2012), community college nursing education strongly impacts the culture and professional socialization of nursing in our country and the individual behavior learned and perpetuated through nursing education.

This multiple-case case study investigated how vertical bullying and non-professional behavior is socialized within the nursing education of community college students. The qualitative study investigated how nursing students who are now graduates learned the culture of their profession before becoming graduates, and “acquired the values, attitudes and practices that make a profession distinct” (Gray & Smith, 1999). The study investigated if graduates experienced non-professional behavior from their teachers, clinical nurses and other role models as they learned their profession.

Chapter three presents the review of the research questions, the chosen research design and the context of the study, including the where, when, and what of the study. Discussion of the participants is covered, including a detailed description of selected participants and the procedures utilized to identify these participants. Also included in this chapter is a review of the study’s instrumentation, data collection procedures, and data analysis, including validation and limitations, including strengths and weaknesses, followed by the chapter summary.

Research Questions

The following research questions guided the study:

1. What is the effect of vertical bullying on students in a community college nursing program?
2. Are community college nursing students socialized into a bullying culture?
3. How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
4. Do components of the academic structure (e.g. hierarchy, student discipline, faculty reward systems, etc.) support vertical bullying at the community college?

Research Design

A qualitative study was selected for this current study because qualitative studies are known to account for complexities in group behavior while revealing interrelationships among multifaceted dimensions of groups (Creswell, 2005). Qualitative research increases the scope of understanding and knowledge beyond that of the researcher, while helping the researcher uncover *why* something might be the way it is, rather than just uncovering that the phenomena does exist. For example, a quantitative study may reveal how many graduates of community college nursing programs are indeed bullied by superiors or nurse colleagues, or the number of graduates who considered leaving the profession because of bullying. A qualitative study concerning the same topic seeks to discover the dynamic and changing reality of socialization and bullying as perceived by the individual participants, as “real” and “deep” data is the expected result of qualitative inquiry. This current qualitative study was indeed

influenced by many complexities in the varied behaviors and responses of participants as I sought “rich, in-depth understanding” (Patton, 2002) of data about nursing socialization and vertical bullying. This approach produced in-depth information which may have been unobtainable utilizing quantitative methods.

As the primary purpose of qualitative research is to seek an understanding of individuals’ interpretations concerning an issue, the focus in qualitative research is holistic since revealing the total picture is the aim of the exposition. Investigations are done using small, non-random samples under natural conditions. The orientation is one of discovery as the theories evolve from on-going data collection and then are analyzed inductively. Finally and of major distinction in qualitative research, the researcher is the primary instrument in the collection of data and considered integral in the study. Quantitative research, on the other hand, targets much narrower topics or issues, gathering data utilizing objective methodologies using inanimate instruments. This process leads to prediction, comparisons or hypothesis testing while removing the researcher from the investigation (Merriam, 1998).

Chosen method. Because I was attempting to understand the phenomenon of socialization of vertical bullying in nursing education, I investigated beyond the quantitative numbers and percentages connected to bullying and socialization. Moreover, I wanted to gain knowledge of the participants’ views, impressions and feelings about possibly being socialized into a nursing culture which may accept vertical bullying and non-professional behavior as customary practice. It is the case study methodology that was chosen for the study as it allowed me to focus on individuals or groups, as well as

identified phenomena (Yin, 2003). All interviews occurred after acceptance of the study by the Old Dominion Institutional Review Board in the summer of 2011.

In qualitative research, it is important that the researcher choose a strategy or method of study according to the focus of the study and how and what the researcher wants to achieve (Gangeness & Yukovich, 2006). With consideration of the strategy to be used, in this instance the case study methodology, Gangeness and Yukovich (2006) also proposed the following about choosing the case study method: “the researcher reflects on the connection between self, method and feasibility of the research project, which enhances awareness of bias (and) subjectivity . . . the nurse researcher who values holism within the context and participant-engaging methodology will find the case study to be a good fit” (p. 8).

In this current study, three “cases” were identified as three community colleges from which most of the participants were registered nurse alumnae and from which the participants had completed their basic registered nursing education. They are referred to as Colleges One, Two, and Three. College One was an urban community college of approximately 5,000 students, one of a several community colleges within a large urban community college system, and composed of a very diverse population of students and faculty and staff. College Two was a suburban college of about 10,000 students from a small geographical region, also with a very diverse population, with the majority of the student population being minority students. College Three is a college which covers a large geographical region and straddles both suburban and rural boundaries, with approximately 9,000 students, with huge growth potential because of its location in the

state. These cases are highlighted and discussed further in the chronicles presented in Chapter Four.

In case study methodology, the researcher “explores in-depth a program, event, activity, or process, of one or more individuals” (Creswell, p. 17). The researcher gathers detailed data using many different information gathering processes over an uninterrupted amount of time. In the current qualitative case study, I investigated: (1) the possible effect of vertical bullying on nursing students’ and graduates’ behavior; (2) the possible socialization of vertical bullying into the nursing culture; (3) how socialization into vertical bullying may occur and the factors that may contribute to the socialization, and (4) possible components of the academic structure which may support non-professional behavior or vertical bullying. I gathered and described the perceptions of new graduate nurses regarding non-professional behavior in nursing; thus, the participants’ perception of real-world non-professional behavior was studied. The theoretical or philosophical framework for this study was based in realism or in a reality-oriented qualitative inquiry (Patton, 2002) utilizing an analytic inductive approach.

Patton (2002) also recommended using a “layered” case study approach (p. 447) in which information and the analysis of information begins with individual case studies, developing into further analysis of the cross-case patterns. It is this layered or multiple case study model which was applied for this study, with the researcher first analyzing individual cases, and then performing a final cross-case analysis of the participants from three community colleges selected for this study. It is this researcher’s opinion that case studies which use a multi-source method of collecting data would result in an increased,

broader assessment of participants' views concerning socialization and vertical bullying in nursing education.

The design of the case study can also be considered explanatory, exploratory or descriptive (Yin, 2003). While the explanatory design concentrates on cause and effect, and the descriptive design presents a description of a phenomena within its context (Yin, 2003), the exploratory design was selected for the study because it evaluates a condition or circumstance within an environment, looking towards future questions and research (Yin, 2003). In this instance, this case study led to a number of discoveries concerning the possible socialization of vertical bullying through community college nursing education, later discussed in Chapter Four of the current study.

Context of the study. The results obtained for this case study approach allowed for the comparison of the three cases, or community college programs, concerning the socialization of vertical bullying. Naturalistic conditions are the norm for the settings or contexts in qualitative inquiry. The settings of the current study were universities, colleges, and healthcare institutions in the Chicago metropolitan area.

Interviews took place on campuses of universities or colleges, campuses of healthcare institutions, in a few private homes at kitchen tables, and for a few participants, at quiet booths at area restaurants. Because of logistical problems, six interviews took place on the phone. No differences in quality of discussion or willingness to talk about sensitive content were perceived with this change of venue. The study was held in the late fall of 2011 and early spring of 2012.

Participants

In this study, I interviewed a targeted group of community college graduate nurses deemed to have insight into behaviors in nursing, utilizing criterion sampling (Creswell, 1998). Purposive or criterion sampling was utilized to select the participants in this study because of their experience and level of nursing education. Participants interviewed for this study were predominantly graduates of community college ADN programs, most graduates of five years or less. All participants were employed as registered nurses at area health care organizations, and most were full time employees. In this study however, there was one outlier in that one nurse participant who graduated from a nurse- diploma program asked to be included in the study as she is passionate about speaking out regarding the topic of bullying and the possible connection to nursing education. She was considered as part of the pilot group of the study. There also were some other participant interviews that were done as part of the pilot study, so that questions could be tested for understandability and clarity. As a result of those pilot interviews, questions were rearranged to produce a smoother “flow” of thought, assisting in both the researcher and the responder in collection of data.

Because of professional and personal contacts that I have with nursing administrators at nearby institutions, I was able to interview 21 participants who were nursing graduates from three different community college programs, most currently enrolled in Bachelors of Science in Nursing (BSN) completion programs at area universities. I was also able to assemble two focus groups composed of community college faculty and administrators who were open and direct in their responses and discussion of a highly controversial subject in nursing education. All participants were

assured of complete anonymity and discretion, and this researcher endeavored to maintain strict confidentiality for all involved in the study.

During this study period, I conducted formal and informal interviews. Although I also interviewed two focus groups of faculty and administrators, the major source of data collection was from the oral, comprehensive interviews with the graduate nurse participants in the study. A small pilot focus group of graduates was interviewed before the 21 participant interviews began so that the researcher was confident of the clarity and placement of the questions being asked. These questions that were asked of participants are included in the study's protocol in Appendix C. It was important to hold the pilot focus group and the faculty-administrator focus groups before interviewing the graduate nurse participants later in the study as the data collected from the focus groups was used to assist with crafting of the placement of the questions which were asked later of graduate nurse participants.

Regarding the best number of participants for a study such as the current study, Yin (1994) proposed that there were no rules or guidelines for the number of cases or participants needed to satisfy the requirements of a replication process in collecting data. If the results turn out as predicted, Yin proposed that six to ten cases may be sufficient to provide compelling support for the original propositions of the study. My study included responses from 21 nurse graduate participants.

Finally, with multiple-case case studies, Yin (1994) also suggested that "since the multiple-case studies approach does not rely on the type of representative sampling logic used in survey research, the typical criteria regarding sample size are irrelevant" (p. 46). The size of the sample, according to Yin, depends on the case number needed to reach

“saturation”, that is, collection of information until no new information is discovered, a concept which is supported as well by Creswell (2005, p. 244). Responses from 21 participants along with responses from the focus group participants were considered in formulating the results of this study, with saturation attained before reaching the twenty-first participant. A discussion of the study’s instrumentation follows.

Instrumentation

An in-depth interview protocol (Appendix C) was selected as the method for this qualitative, case-study regarding the socialization of vertical bullying through community college nursing education. This kind of method or instrument assists the researcher in obtaining valuable information concerning human attitudes and behavior (Yin, 1994). A set of questions about socialization and vertical bullying asked in the focus groups and to the graduate nurse participants was developed for this study utilizing information obtained in the review of literature for the study. Before delving into the interview questions which were all associated with one of the four research questions of this study (Appendix C), two introductory questions were asked of each participant which were 1) “what is your definition of ‘socialization’ into a profession?”; and 2) “how would you describe your socialization process into the nursing profession? These questions were foundational, open ended questions which allowed the participants to discuss and define their own understanding of socialization while setting the stage for the questions associated with each research question.

The questions asked in the interviews were developed by the researcher after review of the literature concerning the issues of vertical bullying and socialization, and adapted from other researchers’ questions asked in multiple questionnaires, combining

questions regarding socialization with questions about vertical bullying. These questions were pre-tested in the pilot focus group and discussed during the focus groups with nursing faculty and administrators. The questionnaire was rearranged after it was determined that clarity would be enhanced with a different sequence of questions.

Once the researcher and the participants were using the study's instrument and engaged in the interview process, it was frequently found that the subject of socialization into nursing needed to be explained and was confusing to some participants. The subject of bullying was not confusing to most participants, but was more of a "hot button" topic, sometimes with a variety of emotions accompanying participant responses. The interviewing process was what Patton (2002) described as an inquiry into reality. This "involves examining the nature of knowledge itself, how it comes into being and is transmitted through language" (p. 92). Using this instrument and operating from a reality oriented perspective because the study was qualitative in nature, I was aware of my responsibility as a qualitative researcher concerning the issues of reliability and validity, researcher bias, and the rigor of the study, all of which are of concern in any qualitative inquiry process. In an attempt to "minimize bias, maximize accuracy and report impartially" (p. 92) in the study, I acknowledged that reporting the views of nurse graduates required careful attention in not imposing my perspective into the reporting from participants regarding their reality. In order to increase the accuracy and credibility of the results of the study, I utilized vigorous triangulation of data. Reality-oriented inquiry required that through the instrument of this study, I—as the researcher—needed to "get as close as possible to whatever [was] going on" (p.93) in order to produce objective, valid, and reliable results.

A panel of three nurse-experts also assisted with this study, educators with many years and vast experience in the nursing profession and in nursing education. Before the focus group and final graduate interviews were held, this expert panel assisted in the review of the questions to be asked in focus groups as well those questions asked of the nursing participants, again addressing issues of clarity and understanding. The panel members included the following: Dr. Rita Amerio, past community college nursing instructor and now at Lewis University's School of Nursing; Dr. Anne Morgan, Professor of Nursing at Moraine Valley Community College; and Dr. Paula Hodkowski, now an adjunct faculty member at Moraine Valley Community College University. The panel members also assisted me in this study by reviewing the anonymous responses after collection of data, again for clarification and verification purposes.

Data Collection Procedures

For the purpose of this study on the socialization of vertical bullying through community college nursing education, each of three cases was composed of representatives from three different community colleges. Data was primarily collected from 21 community college nursing graduates who were studying in university BSN programs. Participants were volunteers who were chosen from recommended students from colleagues who are nursing education faculty or administrators at the universities. Data was collected within a three to four month period of time, usually on university campuses or in healthcare institutions, and in private or mostly free of distractions.

Interview data. The interviews lasted 45 to 55 minutes and were guided by questions which had been pre-tested and focused on participants' possible experiences with non-professional behavior and/or vertical bullying in their educational and

professional experiences. The questions which were asked of participants were guided by the four major research questions identified in this study (see Appendix C). Because these questions had been reviewed in the pilot group, by the expert panel of nurse educators and discussed in the educator focus group, it was anticipated that participant misunderstanding of the questions asked would be reduced. Interviews and focus group discussions were tape recorded after obtaining written permission of each of the participants (see Appendix D for example of permission form).

As previously discussed, all interviews followed the protocol for a replication strategy (Yin, 1994), with the first six interviews falling under the literal replication category, and the last of the interviews falling into the category of theoretical replication. The interview protocol (see Appendix C) was followed during the interviews, while participants were audio taped with their permission. Collection of data from the faculty-administrator focus group followed the same protocol. Interview notes were made during collection of data and review of documents which assisted the researcher with researcher journaling and were also used as back-up for the transcription of interview materials.

The question of knowing when enough data has been collected is a common concern in qualitative research. Lincoln and Guba (1985) also addressed this concern suggesting the consideration of the following four criteria when attempting to address this question: 1) stop when sources are exhausted; 2) stop when categories are saturated; 3) look for the emergence of regularities or the sense of “integration”; and 4) cease when there is “over-extension or the sense that new information being un-earthed is very far removed from the core of any of the viable categories that have emerged” (p. 350).

Qualitative research is emergent as the study progresses through investigative stages. During the collection of information from participants, revisions were made to the items in the instrument for clarification reasons. Some items were expanded upon, while others were reduced or refined. A replication strategy calls for identification of patterns in the data to be collected, which then calls for more data to be collected. The protocol for this study first called for collecting data, then analyzing and comparing patterns, and finally revising the data collected to insure the best study results.

Document review. Triangulation research methods for this current study included participant interviewing, the discussion from focus groups, and finally document review. One source of document data was the review of occupational reports which include returns of comments from graduates from three community college nursing programs. In these reports, past graduates from nursing programs delivered commentary regarding their experiences in the nursing programs. Additional document review included 1) a review of the syllabi or course outlines from three community college “Issues” courses, 2) a review of available on-line course outlines of regional and national workshops and seminars addressing bullying in nursing and nursing education, 3) a review of course content from available continuing education offerings on the subject of bullying, and 4) a review of current on-line blogs discussing bullying from web-sites such as Med-Scape and other on-line journals. In order that current information about the possible socialization of bullying might be included in data collected, I created a fictitious person and joined nursing blogs with the purpose of obtaining anonymous information concerning the socialization of bullying in nursing education and in nursing. Additionally, researcher journaling assisted in the triangulation of the data collection

through self-appraisal of the issues from the perspective of a nurse educator-administrator who has known and lived the nursing education experience for many years.

Triangulation methods are primarily used to reduce systematic bias in the qualitative research study, as well as distortion during the analysis of data (Patton, 2002). Since the researcher is the primary data collection “instrument” in qualitative research, data must be filtered through the researcher which brings the concern regarding researcher bias to the forefront. The researcher in qualitative research must decide what information is important to keep or omit, what information will be “attended to” and what will be “let go” (Merriam, 1998, p. 216). Strategies to reduce researcher bias must include continuous checking of data and findings against other sources which may be present during the data collection and analysis periods. This kind of constant triangulation attempts to lessen bias as it “increases credibility and quality by countering the concern . . . that a study’s findings are simply an artifact of a single method, a single source, or a single investigator’s blinders” (Patton, p. 563).

Data Analysis

In doing qualitative research, it is important that the researcher keep in mind that there must be simultaneous data collection and analysis of the data in order to produce findings leading to theories. As with my study concerning the socialization of vertical bullying through community college nursing education, through data collected from the focus group, interviews and document review, there was an interactive approach in the data collection, data which was analyzed and finally reported. Merriam (1998) described the qualitative analysis process as follows: “The process of data collection and analysis is recursive and dynamic . . . but this is not to say that the analysis is finished when all the

data has been collected . . . Quite the opposite . . . analysis becomes more intensive as the study progresses, and once all the data are in” (p. 155).

Unlike quantitative research, a qualitative research study is considered to be ever-evolving, with the researcher not knowing all the questions which will be asked during the study or where the questions will lead the researcher during and at the conclusion of the study. Qualitative research methodology could be compared to an artist painting a picture. As the artist first sets up the easel, he or she knows the subject that he or she intends to paint, but does not know the colors, shapes or background that will be utilized to get to the finished picture. Qualitative data collection and analysis may correspond to the artist’s process of blending of colors and shades during that artist’s labor, producing that unique creation at the end of the labor.

Strategy for analyzing data. Analyzing the raw data and verbatim transcripts from a complex multi-case case study was a challenge as this researcher made some sense out of the information gathered about the topic being studied. This activity involved constant content analysis. Patton (2002) suggested that “content analysis . . . involves identifying, coding, categorizing, classifying, and labeling the primary patterns in the data” (p. 463). This process of qualitative data analysis required that the researcher rely on organizational skills as well as intuition when collecting and analyzing data, continually evaluating the importance and relationships of the constantly evolving theory.

In data analysis, Merriam (1998) recommended the constant comparative method of data analysis. This method is “compatible with an inductive, concept– building orientation” (p. 159) and is the method which I employed with this study of the socialization of vertical bullying through community college nursing education. The

method of constant comparative analysis requires that the researcher works from an initial analysis of an incident or concept from initial findings. From the first analysis of the interview or document review, the next set of data is compared to the first set for the purpose of discovering new or repeated information leading to findings which may lead to eventual theory. There is continual comparison of concepts or incidents through the collection of the emerging data obtained in the study. The comparisons of data result in the eventual formation of categories which may be then further compared as more information is collected. In short, "Comparisons are constantly made within and between levels of conceptualization until a theory can be formulated" (p. 159).

The first step in analysis of data for this study involved data reduction (Creswell, 1998) which involved reading, then re-reading, then reviewing and reviewing more transcript material multiple times as the researcher developed common themes. A spreadsheet form was also developed for each of the four research questions, with columns for themes and rows for participants. As obvious themes emerged, common concepts were identified and codes were developed, a process of open coding (Creswell, 1998). Repeated axial coding followed, with categories grouped and regrouped, leading to emergent themes and then sub-themes.

Because data collection and analysis of data are interdependent and simultaneous in this kind of qualitative research, the challenges that the researcher faces in not knowing where findings will take the researcher or which findings will eventually be the significant findings are lessened. If the data had not been both collected *and* analyzed simultaneously in a study such as my current study, the prospect of analyzing large

quantities of data at the conclusion of the study would have been overwhelming and very unproductive. A discussion of how I managed this data follows.

Data management. The process of data analysis eventually leads to data management or a coding procedure so that the data collected can be used later in the final discussion of the findings. Merriam (1998) contended that “Coding is nothing more than assigning some sort of short-hand designation to various aspects of your data so that you can easily retrieve specific pieces of the data” (p. 164). Coding involves both identifying and organizing the collected data and then beginning the rudimentary categorization of data. In this current study, the core content of the interviews and other documentation were analyzed to determine significance.

Because of the large quantity of data collected, the management of data was a challenging but crucial undertaking. The data which was collected through interviews and document reviews was digitally recorded and then backed up in two different computer Word files and on one portable drive. One set of all hard copied interview tapes were kept in my safe at all times. All participants were assigned numbers and initials, and this information was kept in confidence by the researcher only. A professional transcriber was hired for the transcription of data and responses from the majority of graduate nurse participants and faculty-administrator interviews. Document review notes were transcribed into Word documents by the researcher.

In the data analysis of my proposed study, I used a computer software program to aid in some of the analysis of the data from the focus groups, interviews and documentation review. Coding was based on the information assembled through the literature review, as I looked for what was expected and consistent with the literature

review findings. I also looked for new information which surfaced and was coded as new information or unexpected findings.

Both inductive and deductive approaches were utilized in the coding of the information which was collected through interviews, a focus groups, and documentation review. Inductive analysis “begins with specific observations and builds toward general patterns” (Patton, 2003, p. 56). In the collection of data in this study, I expected significant patterns to emerge without assuming which themes would prove to be important in the final analysis. As the collection of data continued, I focused on data which revealed “patterns and major dimensions of interest” (p. 67). I explored the themes that emerged, and utilized the deductive approach in data collection. Both approaches were used to produce the depth of information that was required to examine and report on the topic of vertical bullying and its possible socialization in nursing education.

The use of software in supporting data analysis requires that the researcher keep in mind both the pros and cons of the use of computer software in data management. There are issues concerning the use of computer software with the fear that it may produce “unintended and possibly undesirable consequences” (Merriam, 1998, p. 173) by changing the nature of qualitative research or by being used inappropriately, further distancing the researcher from the data. Addressing these concerns in the analyzing of my data for my study using computer software, I was aware of these concerns and attempted to guard against them. Additionally, I performed some manual processes as I attempted to transform the patterns discovered into meaningful categories and themes (Patton, 2002).

Levels of analysis. The ultimate purpose of data analysis is to explore data and abstract concepts leading to the findings, which “can be in the form of organized

descriptive accounts, themes, or categories that cut across the data or in the form of models and theories that explain the data” (Merriam, 1998, p. 178). Responsible researchers must move past a stage of basic description of what is heard from participants or observed by the researcher to the next level of construction; these are categories and themes with patterns which are repeated.

The use of the constant comparative strategy in the analysis of the data supports this development of categories and subcategories. This process of analyzing data produces “units of data” considered by Merriam (1998) to be “any meaningful . . . segment of data” (p. 179). Units of data must reveal information which is relevant and be able to “stand for themselves” in the data analysis. The task surrounding units of data is to contrast one unit with the following unit in the analyzing process, looking for recurring consistencies in the analysis.

Initially, I gathered together all of the units of information from interviews, document reviews and focus group notes and organized this information so that it could be easily retrieved. Yin (1994) calls this a “case study data base” or the production of a case study record which is “the data of the study organized so that the researcher can locate specific data during intensive analysis” (Merriam, 1998, p. 194). Since my study was a multiple case study, my analysis included two stages of analyses. The first stage was a *within-case* analysis where “each case [or community college data] was first treated as a comprehensive case in and of itself” (p. 194). Each of the transcripts from the focus group, graduate nurse interviews and the material collected from the document reviews was analyzed on a within-case basis. I also completed a *cross-case* analysis, seeking to develop abstractions from one case (or community college data) to another.

Cross-case analyses occur when the researcher builds “a general explanation that fits each of the individual cases even though the cases will vary in their details” (Yin, p. 112).

Merriam (1998) warned that cross-case analysis may be challenging as this stage calls for the researcher to examine the “complex configuration of processes within each case” (p. 195) before noting patterns that transcend cases.

Finally, in my analysis of my multiple case study, keeping in mind suggestions from qualitative researchers Bogdan and Biklen (1992) while using the constant comparison method of data analysis, I attempted to focus on the topic of my study which is the socialization of vertical bullying and not focus on the question concerning *if* bullying indeed occurs in nursing education. So that the most relevant questions will be asked of the participants, I constantly reassessed the questions being asked, and modified them as necessary. A pilot focus group of nursing graduates was held to examine the questions to be asked; this was helpful in rearranging the questions in a more logical sequence.

In building upon information learned, I also tried to keep in mind findings from previous interview sessions as I planned for and participated in subsequent sessions. In an attempt to advance the development of categories leading to eventual theories with continual researcher journaling, I supplemented the observations that I made in memos in margins of the notes taken. As a final point, while analyzing the data from my study with an open mind, I continued to review the literature on my topic of the socialization of vertical bullying through community college nursing education in anticipation of further discovering supportive or conflicting information about my topic of choice.

Validation of Findings

Qualitative research requires attention to the trustworthiness and authenticity of the collected data in validating the findings. While “reliability and generalizability play a minor role in qualitative research . . . validity is seen as the strength of qualitative research” (Creswell, 2003, p. 195). Creswell proposed eight verification processes recommended for validation in qualitative research and suggested that at least two of these processes be employed in each qualitative study. In this current study, validation of data means that the following three processes—peer review, triangulation, and member checking—are utilized to assure the study’s accuracy and credibility (Creswell, 2005).

As mentioned in a previous section of this chapter, this study employed triangulation of various data sources, including interviews, focus groups, and document review, augmented with researcher journaling. Data from these methods was triangulated in the process of supporting themes discovered in the data collection. Member checking (Creswell, 2005) and peer review were also employed in validation of findings. Utilizing the three members of the panel of expert nursing professionals, the peer review process required that the researcher requested the assistance of these experts in reviewing the transcript of the interviews for accuracy before and after the interviews takes place. In member checking, this researcher asked participants if descriptions were realistic, if discovered themes were correct and if the researcher’s interpretation of the accounts were appropriate and fair. It was expected that both processes lead to greater accuracy and credibility of the final report generated from this study (Creswell, 2003).

Researcher bias. Validation of findings leads naturally to the issue of investigator bias, as minimization of researcher bias is an important consideration in

qualitative research. Patton (2002) stressed bias reduction in qualitative research requires “rigorous and systematic data collection procedures . . . whenever possible using multiple coders . . . to establish the validity and reliability of patterns and theme analysis” (p. 545). Merriam (1998) stated that “the researcher must be aware of any personal biases and how they may influence the investigation (p. 21). Patton further stressed that both qualitative and quantitative inquiry “seek honest, meaningful, credible, and empirically supported findings” (p. 51) as the researcher adopts un-biased neutrality while multiple viewpoints emerge.

The ultimate consideration of bias in qualitative research centers on the fact that the researcher is the main instrument in the collection of data, with the data being filtered through the researcher’s natural bias concerning the topic. Despite rigorous techniques in collection and analyzing of the data, the qualitative researcher has the final say as to what is and what is not important in the final report. The researcher must strive for neutrality and impartiality being aware that conscious reflexivity may be needed when their perspective interacts with the findings being collected in the data.

In addressing researcher bias in this current study, I strove for researcher objectivity in the collection, coding, and reporting of the data received. Because the participants were graduates from three different community college nursing programs, I was not partial to any particular community college or site. Therefore, I had no preconceived ideas regarding the type or amount of bullying which might have been reported from any college or site.

I was aware that as a college administrator with many years of experience working with other higher education professionals at the universities, I might have had

some preconceived opinions of the programs at some of the higher education institutions. These opinions were not relevant to the topic being investigated concerning the possible socialization of vertical bullying through community college nursing education. I asked each participant if they have any biases regarding the topic or me-as the investigator at the conclusion of each interview so that these biases can be disclosed. Each participant denied bias.

Finally, because this topic of vertical bullying and its socialization through community college nursing education has been one of great interest to me for many years, I was aware of the need to be as objective as possible as the investigator in the interviewing and data collection in this study. I aimed for the highest level of rigor in the study by not influencing participants' responses through word or action. In an attempt to provide accuracy and validity in this study, I asked non-leading questions, and assured participants of complete confidentiality at all stages of the study. A sample "Research Consent Form" is provided (see Appendix D).

Limitations

The current study concentrated on new graduates from community college programs, participants who might have been limited in nursing experience and exposure in practice in the nursing field. Because of the reduced number and unique requirement of being a new graduate of a community college nursing program currently studying in a BSN completion program, the generalizability of results from this population may be reduced. The concept of vertical bullying in nursing education could have been a sensitive and emotional subject for participants in the study; therefore, respondents' reactions to questions might have varied depending upon the emotions recalled from

experienced or observed bullying experiences. Furthermore, responses to questions about vertical bullying might not have been accurate reflections of the opinions of all new graduate nurses of community college programs. Responses could have been subject to individual interpretations of the meanings of terms used to elicit responses to questions about bullying. Responses might also have been influenced by individual emotions connected to anger, anxiety, or the shame associated with bullying experiences.

Summary of Methodology

The current case study addressed the identified gap in research concerning the issues of non-professional behavior and vertical bullying in community college nursing education and its effect on the socialization on nursing students and graduates from community colleges. The current qualitative multiple case study investigated how vertical bullying and non-professional behavior might have been socialized within the nursing education of community college students. This study also investigated how nursing students who are now graduates learned the culture of their profession through their socialization process. In this study, focus groups of instructors and nursing administrators reviewed and discussed the research questions while responding to the questions. Twenty-one nursing graduates of community college nursing programs were interviewed, and a review of pertinent documents was completed.

A set of questions asked in the focus groups and to the graduate nurse participants was developed for this study and is included in Appendix C. A panel of three nurse-experts also assisted with this study, all peers and educators with many years and vast experience in the nursing profession and in nursing education. Both inductive and deductive approaches were utilized in the coding of the information collected, and the use

of computer software was used in supporting data analysis. Attention was paid to the validation of data through three processes—triangulation, peer review, and member checking—utilized to assure the study's accuracy and credibility. Finally, addressing the issue of possible researcher bias, I strove for researcher objectivity in the collection, coding, and reporting of the data received in this study investigating vertical bullying and its possible socialization through community college nursing education.

In conclusion, this chapter describes the methodology used in this study of the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education. The study was employed to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. The following chapter presents the results which were obtained after this methodology was employed.

CHAPTER FOUR

ANALYZED DATA AND REPORTED FINDINGS

This study was done to examine the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education, and ultimately to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. Chapter four will include the following: a review of the purpose of this study; a review of the four research questions which guided the study; three chronicles highlighting the three college cases; a report on the three major findings or themes and subsequent minor themes; a discussion of cross analysis of the findings from three college cases; and finally a culminating chapter summary of the key findings.

Purpose of the Study

The purpose of this study was to examine the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education and ultimately to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. Vertical bullying occurs when abuse is conducted towards a student or new nurse from another person who is in a superior position in an organization (Thomas & Burk, 2009).

The investigation connected to this study was done to answer the following overarching question: does nursing education support the socialization of vertical bullying in the nursing profession? Based on the literature review and the information from participants in the study including focus group discussions and document review, this

researcher expected to find the educational process serves as a framework for the socialization of vertical bullying in community college nursing education. This study produced findings that indicated bullying behavior was identified and experienced at all three community colleges chosen as cases for the study. Further discovered was students and now graduates from each college case reported there were varying degrees of perceived vertical bullying at the colleges. Interpretation and acceptance of bullying behavior was also reported to be dependent on individual toleration of the behavior at each case-college. These findings will be described and further discussed in this chapter.

Review of Research Questions

The following research questions have guided the study:

1. What is the effect of vertical bullying on students in a community college nursing program?
2. Are community college nursing students socialized into a bullying culture?
3. How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
4. Do components of the academic structure (e.g. hierarchy, student discipline, faculty reward systems, etc.) support vertical bullying at the community college?

Chronicles of Vertical Bullying

The three chronicles presented are a compilation of participants' history and bullying experiences shared from interviews with the participants, the contribution from instructors and administrators, and the document review for the study. These experiences

foreshadow many of the findings which will be presented in this chapter four. With attention to the protection of privacy concerning this most sensitive topic of bullying, these three chronicles each represent a community college or case in this multiple case study.

Chronicle one. Mary Pat, a single mother of three, was a recent associate degree nursing graduate from College One, an urban institution which was one of a large community college system attracting students from predominately blue-collar, ethnically diverse communities. She was the oldest of five siblings; her father was a salesman and her mother was a nurse. She didn't choose nursing as her major at the start of her college career, but first went to college to study fashion design and marketing. Mary Pat was introduced to the nursing program at the community college through other students and instructors she met in her general education courses. They referred her to the academic requirements the nursing students had to meet. After one year taking mostly general education and some business courses, Mary Pat decided to try to change her major to nursing and apply for the program at the community college. Her father had always encouraged her to go into nursing, and since her mother had recently passed away, Mary Pat felt that she might continue in her mother's footsteps.

There was a long waiting list, but Mary Pat's advisor told her she had a chance to be successful in her application because she had a high GPA and had already completed some of the required general education courses. It took her two semesters to be accepted into the program. During that time, she continued to work full time and take the challenging science courses required for the program. When Mary Pat entered the two year associate degree nursing program, she thought she could continue working full time.

However she soon discovered the rigor of the classes conflicted with her work schedule. Mary Pat ultimately dropped to a part time position, and took out loans from the government and her father in order to continue in the nursing program. She completed the associate degree nursing program at College One within four semesters. When asked about the program, she commented, “I think most of my instructors were caring people . . . yeah there were one or two who were harder than some of the others, and I heard about a few students who had trouble with a few of them . . . but I kept my nose to the grindstone and I didn’t have any problems other than trying to keep my grade point average up and enough food on the table for three teen-agers.”

When asked to elaborate about her comment about treatment of fellow students, Mary Pat continued with the following statement:

I did see some other students treated with a condescending attitude by one or two instructors, but I don’t know if that is really bullying . . . I know that some clinical instructors gave heavier clinical assignments to the nursing students they didn’t like, or gave some of the students who usually got A’s lower grades in the clinical if they didn’t like them..you know it’s completely subjective in the clinical aspect of the nursing program . . . but looking back at those times, I think that just made us stronger and got us ready for the time when we were new nurses and had to work with experienced nurses with bad attitudes.

Mary Pat is a staff nurse now at a nearby hospital, working in the Mother-Baby and the Labor and Delivery departments for the last three years. She is starting to take classes so she can apply to a BSN program at a nearby university. Mary Pat and her classmate, Carol, along with five other alumnae of College One participated in this study.

They reported similarly that their experiences in the nursing program at this college were “predominately positive”, experiencing similar behavior in both theory and clinical experiences at the college.

Chronicle two. Terry is a single 23 year old nurse, a very recent graduate of the associate degree nursing program at Community College Two, a suburban two year college with a large nursing program well known in the area for producing capable and proficient nursing graduates. The college district serves a population from a broad range of economic and social strata, with a predominance of students at the college being first generation attendees. Terry applied to the nursing program immediately after graduating from an area high school, because she “always knew I wanted to be a nurse.”

Terry is the youngest of three sisters, and her parents are both college graduates. Her father a businessman, and her mother is in data-mining for a computer company. She graduated in the top ten percent of her high school class, and she says she deliberately chose to go to the community college for her first two years so she “could save some money for my bachelor’s degree.” She was admitted to the program after she had attended college for one year, taking some of her general education courses and science courses so that she could “just study nursing” after she was admitted to the program. She was able to work part time as a Certified Nurse Assistant (CNA) in a nearby nursing home while going to school. After being admitted to the program, Terry found the program to be challenging but “doable,” especially in the first three semesters. Terry reports that “I really had three wonderful semesters followed by a fourth semester from hell” and reports that she came close to leaving the program and the nursing profession during that last semester.

Terry reported the following about her fourth semester in the Community College Two nursing program:

From the very first day of my clinical rotation, I knew that I was in trouble with my instructor. In front of other students in the first preconference, she asked me if I was feeling well and if I knew about eating disorders. Every day she told me I was too quiet to be a good nurse and that I took too long to answer her questions. When it was my turn to function as med nurse, I was so nervous pulling up my injections, my hands were shaking and I was turning red . . . she just laughed and brought in one of the staff nurses to show her how red I was . . . I was so humiliated . . . I had always gotten As in clinical in the other three semesters, but I knew I would be lucky to just pass my fourth semester clinically. Every day during that semester, I would cry all the way to the hospital, and sometimes all the way home too . . . but I was determined to get through it . . . so I just took it because if I didn't I would just have to go through it again with her the next semester.

Despite Terry's experience in this nursing program, she successfully completed the program, graduated and is now a staff nurse in an ICU at a large suburban hospital. Because of her good work and high regard among her peers and supervisors, she was rewarded with a highly coveted day shift assignment. Terry is very proud of this and says that she wants to go back to the school to tell that instructor of her success so that the instructor will then know how wrong she was about Terry. Preparing to enter a bachelor's in nursing program next summer, Terry is engaged to be married to a naval officer in

June and they know they will be transferred to California for two years. Terry, Beth and five other graduates of the Community College Two program participated in this study.

Chronicle three. Ellen-our final graduate –graduated from the associate degree nursing program at Community College Three about three years ago. Her program at Community College Three was the traditional ADN curriculum which usually requires two years of study to become a registered nurse. Community College Three prides itself on being one of the most respected community colleges in the state, and is known as being very “student-friendly” concerning students’ abilities to easily transfer between majors at the college. Community College Three has a large geographical district which encompasses large and small cities in a Midwestern state, with some farmland, and a diverse student body. At this college, some students choose to stay in dorms rather than commute daily to the community college. The college is close to a variety of four year universities and has articulated transfer agreements with a number of senior institutions; therefore, it has a large number of students who are considered transfer students, including those in the nursing program.

Ellen, married with two children, considered herself an “older” student in the College Three nursing program, as she was in her thirties when she decided to go back to school to be a nurse. She already had a bachelor’s degree in Informatics, but she said she did not feel enough personal satisfaction in the job that she had, even though she was earning a good salary. She applied to the nursing program after she completed the CNA program at the college and was accepted within one semester. Because she had taken most of her general education courses with her other degree, she only had anatomy and physiology and microbiology to complete to fulfill her science requirements.

Ellen said that “it was tough going to the nursing program and being a part time employee, a wife and a mother, especially when my husband lost his job half way through my program.” She completed the program and says that she received support from most of the instructors that taught her in the program. She reported that “my problem was not with the instructors but with the preceptors at the clinical sites . . . even the instructors were afraid of some of them.”

When questioned further about this statement about preceptors in her program, Ellen related the following about her experience in the nursing program at College Three:

Most of my instructors in school were supportive, especially in the theory courses. My experience with bullying was in the clinical . . . usually in the clinical courses that didn't have an assigned clinical instructor from the college but had a nurse preceptor from the hospital supervising us . . . some of them were really nasty to the other staff nurses and to the students who got in their way . . . we would try to hide from them and ask each other how to do things [procedures] rather than ask them so they wouldn't think we were dumb . . . We didn't tell our instructors about the preceptors' treatment of us . . . the instructors already knew about some of them and so they would only make light of it anyway . . . Once in a while, we would talk about what happened on the floor in post conference as it related to diminished patient care when the preceptors would withhold important patient information from us, but we never called it bullying . . . and we never talked about ways to combat it when we became nurses.

Ellen is now a staff nurse at a mid-sized suburban hospital on the orthopedic floor, and she is investigating returning to school to get a masters degree in a computer

related field so that she can get a new job and apply Information Systems in nursing. Ellen, her colleague Anne, and five other graduates of the College Three nursing program were participants in this study, and they considered the college's program to be mostly supportive of their learning. Some did acknowledge that they had seen what this study presents as bullying from "a few" of the teachers and some of the preceptors.

Findings

This study examined nursing behavior and practices from the perspectives of students and new graduates of community college nursing programs. The investigation around this study is whether the socialization of vertical bullying in the nursing profession is supported by nursing education, specifically community college nursing education. This chapter presents the key findings realized from the triangulation of data from 21 in-depth interviews, two nursing instructor focus groups, and the review of documentation from a variety of sources. Three major findings or themes emerged from the investigation conducted in this study each endorsing the four research questions of the study.

The first major finding contributed to the investigation of the study and responded to the research question concerning the effect of vertical bullying on students who become graduates of community college nursing programs. This major finding was participants in this study believe the metaphor "Nurses eat their young." This statement was made by every participant – and most instructors- in the course of their interview, without prompting by the researcher at any time. Participants offered this metaphor typically in an explanatory manner, usually when describing a bullying situation they had observed or experienced. In addition, a variety of causes and effects of vertical bullying

which occur in nursing education and minor also emerged, supporting the outcomes or the how and why of the effects of bullying in nursing education. Participants described factors and reasons given for bullying behavior, including specific practices in nursing education which affect both nursing instructors and students in nursing, such as withholding information and the high occurrence of gossip contributing to bullying.

The second major finding documented that bullying is socialized through nursing education and confirmed nursing students and graduates are socialized into a bullying culture. Socialization occurs through observing and experiencing the misuse of power and uncivil behavior demonstrated by role models. Minor themes emerged from the participants and focus groups of instructors, including how students learn to “play the game.” Instructors remembered their own socialization into nursing as a result of their own nursing education bullying experiences. The instructors also reported that previous vertical bullying experiences influenced how they now interact and behave as instructors in the socialization of their students.

Academic support of vertical bullying is the third minor theme associated with learned bullying. This minor theme concerning the importance of each school of nursing’s rules and regulations related to the hierarchical structure of the nursing program, and the importance of the concept of chain-of-command in nursing and nursing education was repetitive in the findings in this study. In the unique culture of nursing tradition, every school of nursing has specific rules and regulations, better known as “rules and regs” which specify that school’s very important chain of command, a concept every nurse learns early on in their introduction to the nursing profession from their academic institutions.

Nursing and allied health education relies on three learning arenas in providing and delivering information necessary for the students' mastery of the content before officially entering their chosen profession. The first of these three areas includes the classroom teaching which provides the didactic information or the core curriculum of the subject. Secondly, the lab sessions for nursing and allied health provide teacher demonstrations and student return demonstrations of procedures discussed and described in the lectures. Finally, the clinical experiences required for student proficiency in the health sciences are held at healthcare institutions and are supervised by college instructors or hospital provided preceptors, professionals who supervise clinical hands-on student learning with patients.

The third major theme stresses the importance of the clinical experience in nursing education and in the socialization of vertical bullying. The distinction of the learning which takes place in clinical experiences is important when discussing the third major finding supporting the thesis of this study, which is socialization into a bullying culture is usually learned from observing and experiencing bullying in the clinical arena of nursing education, not commonly learned in the didactic or lab delivery of nursing theory. The third finding also reflected the frequently reported concern from participants to fit in while learning in the clinical arena. A minor theme concerning the importance of precipitating, motivating and enabling factors also emerged from discussion with participants in this study, supporting the study's premise that bullying is intensified when there is more than one bullying factor present.

Finding One: Nurses DO Eat Their Young

There are various causes and outcomes of bullying leading to diverse effects of vertical bullying on students in a community college nursing program. A major finding of this study was evident in data collected from every participant in the study, including focus groups and also found repeatedly in the document review. The pervasive statement was simply the following: “Nurses eat their young” (NETY). This statement was offered by every nurse participant, sometimes apologetically, sometimes with resignation, sometimes defiantly, but mostly stated as a matter-of-fact declaration, and without prompting from this researcher. Because this metaphor was so often offered as an explanation for the occurrence of bullying in the nursing profession and nursing education, it is a major finding of this study, and serves as a framework in the study.

Major finding: “Nurses eat their young”. Many participants followed that quote with a statement of how they hated the words or the thought of it, but how it represented what they had seen or experienced connected to bullying. One nurse participant who is now a manager stated the following:

Because you have kinda (sic) been taught that nurses eat their young – I hate that term and I ask my staff never to say it because it is not right, but it is known even by people not in the nursing profession. They know that term because they have heard it so often . . . so you just assume that you are going to go in and be treated without the same respect of nurses. (Nurse 0004)

This identical response using exactly the same language was noted in every response from the 21 respondents, suggested in both focus groups and sprinkled throughout the pages collected for document review.

Another major finding is every participant knew what bullying in nursing meant and responded they had seen or experienced much of this behavior in their nursing education or career. Study participants were asked to review and respond to this study's "List A" (Appendix A) which includes a list of bullying behaviors which may be seen overtly and covertly in connection to nursing and nursing education. A typical response from nurse participants was "A lot of these happen every day." One response concerning the frequent occurrence of bullying was as follows:

This is so timely . . . at work we were just all brought together because of the bullying that is still happening. The VP of Nursing said that this should stop, but it hasn't. On a daily basis, I see dirty looks and social exclusion . . . just the other day a new nurse went to her preceptor and asked her a question and she just looked back at her and stared and said nothing and just walked away . . . it happens all the time . . . [I see] ignoring and impatience and shouting and yelling at another nurse . . . one charge nurse who is very experienced just went after another charge nurse because of some issue, called her [bad names], loudly at the nurses' station, where guests were walking by..it was full of doctors..it wasn't done quietly at all. (Nurse 0010)

Another participant reported the following when asked if she had observed or experienced the behaviors listed as bullying:

Absolutely, I think we all have [laughter], I graduated in 2007 and I remember a couple of teachers that I had and I think their expectations were a little ridiculous . . . more so I just think that they were rude people to begin with – and there were two nursing instructors in particular that were quite nasty. No one could ever

please them and they always went after the weakest students and got rid of them as fast as they could. (Nurse 0012)

Since it is known that nurses do not literally “eat their young,” it is usually understood by nurses discussing this phenomenon the statement means experienced nurses verbally accost, humiliate, or intimidate newer or less experienced nurses in the profession. Sometimes this analogy to animals attacking their young offspring is applied erroneously to those who are bullying others in nursing, as it is also known and reported by participants in this study that some bullying nurses target other nurses who are perceived to be inexperienced or weaker in some way rather than those who are younger in age, mentioned in the previous quote from Nurse 0012. One of the two male nurse graduates participating in the study, responded with the following comment about NETY. I don’t think we should eat our young – it’s sink or swim and that is not acceptable. Nurses understand about eating our young more than any other profession . . . and you are going to see things, hear things that will change who you are forever (Nurse 0003).

Minor findings. While the major theme is NETY, there are other minor themes or findings which indicate support for the first major theme, and indicate the how and why of nurses bullying each other or NETY. There are many and various causes of this major finding leading to diverse effects upon student nurses and new graduates of community college programs. These minor themes, based on the foundational theme of NETY are organized in the following three categories: 1) the reasons given for bullying which affects participants; 2) the specific bullying patterns reported from participants which may effect and mold bullying into the nursing culture; and 3) the general effects of vertical bullying upon students or new graduates. In each of these three categories of the

minor themes, there are examples of specific behaviors which contribute to vertical bullying experienced by students or new nurses. Figure 3 clarifies this study's organization of the minor themes of the major finding, NETY.

Figure 3: Organization of Finding One Themes

MAJOR FINDING ONE: NETY	MINOR FINDING NETY' CATEGORIES	HOW AND WHAT PARTICIPANTS DESCRIBED
	Reasons Given for "NETY"	(a) Poor management (b) "Burned-out" nurses (c) Pressure to be a good nurse
	Patterns Reported with "NETY"	(a) Withholding information (b) Gossiping
	Effects Reported with "NETY"	(a) Fear (b) Intimidation (c) Minimization (d) Isolation (e) Lasting effects

Reasons for bullying . In this study, participants were asked to respond to the question "Are any of the following reasons (or causes) for the bullying you have seen as a student or new nurse?" Participants supplied variety of responses to this question. However, many respondents identified the following as causes of bullying in nursing and nursing education: a) poor management b) nurse "burnout" from high patient acuity levels and heavy patient loads; and (c) pressure to be a good nurse and not to cause trouble. These three causes of bullying to this study's foundational philosophy based on Bandura (1986), Salin (2003), and Twale and De Luca (2008) can be applied in the following way: 1) the failure of management or administration to address bullying

experienced by students or graduates (enabling factor); 2) nurse burnout (precipitating factor); and 3) pressure to be a good nurse (motivating factor). The reported opinions of participants concerning all three of these contributing reasons and factors have been submitted in the following account.

Poor management. Poor management, an enabling factor in vertical bullying, was another frequent finding regarding causes of bullying of students and new graduates. In the case of students, nursing bullying was seen as enabling by educational administration. In nursing practice, one new graduate stated “Management already knows [the floor nurses] are ‘cliquey’ . . . as a matter of fact one of the nurses that I work with went to management and requested that her weekend be changed because she could no longer tolerate working on the weekend with that clique” (Nurse 0010). Most respondents volunteered they thought management or administration was aware of bullying, but “people in authority” frequently did not address this issue in the workplace or in the nursing program. Another nurse participant added:

In the department that I am in now is different from the ER – I have only worked in 2 departments . . . currently I am working in the telemetry unit which was actually my first nursing job since nursing school so I have been there about 4 years. The management is very different between those two units . . . and I think a certain atmosphere comes from management . . . on the floor that I am on now I have definitely seen nurses give other nurses dirty looks, give the CNA dirty looks. Management knows and they look the other way. (Nurse 0012)

There were frequent references to the lack of support from nursing management and nursing administration regarding the occurrence of vertical bullying experienced by

students and now graduates in nursing practice. It is apparent nursing students and new graduates sometimes feel helpless and powerless in dealing with vertical bullying, and they resort to tolerating whatever bullying they encounter through a variety of passive responses. This contributes to the culture of quiet acceptance and a continuous cycle of vertical bullying within the profession and the education for the profession.

“Burned-out” nurses. One precipitating factor in vertical bullying identified in this study has been labeled “burned-out” nurses. These nurses no longer demonstrate the qualities most desired in functioning healthcare providers in the nursing profession because they do not demonstrate a caring, compassionate, and helpful demeanor in their interactions with patients and colleagues. The instructors in the focus group also talked about how burnout affects students and others in education and nursing. One instructor (Instructor V) offered this explanation: “Nurses are stressed to the max on the floors with patient load and high acuity and they burn out eventually . . . especially if they feel they can’t move in their profession . . . so they respond by bullying everyone they can . . . some nursing instructors are burned out too, and they feel defensive if they don’t know the answers for students and staff, and they lash out at students too.”

Many participants in this study referred to dealings with nurses and educators who appeared to be burned-out and exhibiting bullying behavior. Participants frequently connected high patient acuity and heavy workloads as precipitating factors leading to a higher incidence of vertical bullying. One participant added the following opinion concerning the issue of a burned-out nurse contributing to bullying in the profession: “The majority of them I see as reasons . . . I think frustration and lack of control is very

common . . . as well as having lack of knowledge or need to fit in, and definitely nurse burn-out and the pressure to be a good nurse.” (Nurse 0004)

Another nurse participant talked about the actions and effect of a burned-out preceptor in the following way:

My preceptor in the clinical . . . the minute she got there she talked about wanting to go home . . . constantly make comments about patients...the minute we'd walk out of the [patient's] room she's talk bad about the patient and then me . . . she was a very unhappy person [laughs] but it makes me angry with the educator at [hospital name] that they would even have her as a preceptor . . . I don't think precepting is something you should just throw at someone and say 'oh you are going to be teaching this person for the day' . . . I've seen that and then the preceptor takes it out on the student or new nurse . . . horrible.

(Nurse 0015)

One can only imagine how difficult it is for students and new nurses who must learn and work with preceptors who not only do not want to be doing what they are doing, but also do not want to be doing it with a student or new nurse. Patient care is a serious and important job with difficult and life-saving concepts to be taught and learned and applied every day. Hospital administration and educational institutions are responsible for insuring that students and new nurses are teamed up with nurses who are going to positively affect their learning and future approaches in their profession, and not produce another burned-out nurse.

It is apparent to anyone who has been a hospitalized patient or attended to a family member who has been a recent patient that healthcare workers—and specifically

nurses—are stressed and are working with sicker patients needing more advanced treatment with less assistance from auxiliary manpower. Many nurses, according to the respondents in this study, do burn-out and either leave nursing or stay in it, with an increased chance of lashing out in response to their frustration, sometimes at their patients but frequently directed at students and new members of the profession. The burned out nurse and the good nurse syndrome which follows are both precipitating factors in intensified vertical bullying in nursing.

The good nurse syndrome. Nurses frequently refer to the concept of the good nurse, a perception which may be defined differently by various populations. A good nurse, to most nurses and according to the literature, usually means possessing superior nursing knowledge and skill and the ability to give excellent patient care. Nurses are usually very pleased to be labeled a good nurse by others in the nursing profession or by physicians knowing the nurse.

The good nurse syndrome is another contributing factor to the effects of vertical bullying. The pressure to be a good nurse was a motivating factor identified in this study and was frequently mentioned as a possible reason for bullying. One participant, now a manager in an Operating Room (OR), stated the following about bullying related to the good nurse issue:

The good nurse thing happens a lot – the pressure to be perceived as a good nurse, that they want to feel like “I’m the person that people are going to come to when they have questions” . . . and I think again for the OR to be considered a good nurse or a high standard nurse by all the physicians is really desired so the physicians will say “oh I see so-and-so is not here today, I really like her in my

room” . . . then the nurse that is standing there – they really want to be seen as that nurse – I know one specific nurse that hides stuff when she is in charge of service . . . so she will hide things and when they can’t find it they come to her and then she comes in the room with the doctor “oh I’m sorry it was sitting right there” . . . so now all the physicians in her group think she is just the greatest – she knows where everything is. It happens more than you think in the OR – people want to be seen as the best in the group. (Nurse 0004)

Bullying patterns affecting students. When discussing effects of vertical bullying in a community college program, participants reported that there are specific patterns of bullying. Many participants, when reviewing a list of bullying behaviors (see Appendix A) responded that they had witnessed or experienced hostility, dirty looks, social exclusion, impatience, and condescending attitudes, especially when they were new students or in their orientation phase at their first nursing position (Nurses 0001, 0004, 0005, 0011, 0015). Some participants compared it to “hazing” which may occur when a military cadet is being initiated into a military school or level of military service (Nurse 0004). The two examples or patterns of behavior supporting vertical bullying most frequently cited by participants were withholding of information and gossiping.

Withholding information. After withholding information and then questioning the student’s or new nurse’s competence was frequently cited as bullying behavior experienced or observed (Nurses 0005, 0010, 0011, 0016). One nurse reported the following:

I have seen all of these behaviors in nursing . . . curt tones, exclusions, giving the silent treatment, impatience with the new nurses with less experience. I learned a

while ago that if I talked back or asked a question I would get the silent treatment.

The experienced nurses have been in that unit for 20 or 25 years and they know everything and everyone else knows nothing in their eyes, especially the new nurses. In this unit, full time nurses were to be seen as having more knowledge and experience, and the part time nurses, especially the newer nurses, were more bullied . . . they had to “catch” information on their own because the full time nurses kept it to themselves . . . there were never meetings to communicate information to everyone. It’s a toxic environment. (Nurse 0005)

Withholding information from new nurses was reported by new graduates and students regardless of the age of the nurse receiving the bullying. Nurse 0005 was not a young nurse, but reported she was new to a specialty area and was not full time, so she was not privy to all of the information full time and supervising nurses had about the patients or new processes and procedures. She believed she and other part time nurses in the clinical unit were not included in meetings or in ways to get information so they would “look bad” in front of physicians and other staff when they did not know something other full time nurses knew about the workings of the unit. This kind of bullying emphasizes the need some bullying nurses have for perceived power. Many participants mentioned instances where withholding information was a component of a bullying practice they had observed or experienced; but few connected this kind of behavior to potential threats to patient safety.

Bullying though gossip. The second pattern or example of vertical bullying frequently mentioned from participants was gossip and illustrates how nursing incivility incorporates bullying into the nursing culture. Almost every nurse participant

commented on the overwhelming use of gossip by staff nurses, instructors, and students as thinly veiled threats to humiliate and control. One participant added this statement regarding gossip:

There is always the gossip and rumor that goes on all the time . . . I can tell you that . . . it is like non-stop . . . “this person did this and if this person would have done their job then that would have never happened” . . . there is a lot of gossip that goes on and it starts when you are in school . . . (Nurse 0018)

New nurses particularly found the amount and severity of gossip in the nursing workplace to be very surprising and disturbing. New nurses who were older when they completed their nursing education were less apt to be disturbed by it as younger nurses in their first nursing position; however, most participants agreed gossip was connected to the vertical bullying they observed or experienced. Some commented some gossip in their workplace was inevitable and would never change because “it is a workplace of women.” This accepting attitude contributes to the gradual acceptance of vertical bullying in the profession of nursing, believed by this researcher and others studying the bullying phenomenon in nursing.

Interestingly, more than one participant mentioned the specialty clinical areas like the OR or Intensive Care (ICU) seemed to be most likely to use gossip in this way, and one OR nurse manager commented:

Gossip/rumor-mongering is a consistent thing that we hear about. It is huge in the OR . . . because of the way that we are built into teams so it is not that it is just nurses, and each team is its own little social group and has their own environment and their own stuff going on so . . . there is a lot of gossip about other teams as

well as other people and how things are being dealt with . . . a lot it is not necessarily about the one person . . . it's the entire team and it is through the whole OR department. Some get to do what they want, they think they are better than everybody else, they get special treatment by management and they think they work harder than other people and I think that - for motivating factors . . . it's looking at the physicians and the type of cases that they do. They do very acute cases, they are there all the time, they work really hard and we try to build them up because they were one of our more difficult teams that once showed a lot of lateral violence in their own team, . . . so we were trying to build them up and pretty soon it became gossip all over the OR that we were spending too much time with them . . . (Nurse 0004)

This idea presented by Nurse 0004, now a manager in an OR, cites the intensity and connection of specialized area to gossip and vertical bullying was also voiced by more than half of the 21 participants (especially nurses 0003, 0004, 0010, and 0013). Nursing instructors in the focus groups of this study also reported their students dealt with gossip when sent for experience to specialty units such as the OR, Emergency Room (ER), or Critical Care Units (CCU). These clinical areas are “insular” by design in most hospitals, and usually staffed with highly skilled and knowledgeable nurses. Many times these nurses are highly respected by other healthcare professionals. As supported by the previous quote from Nurse 0004, instructors recognized their students were exposed to vertical bullying through gossip when they rotated through some of these experiences, but they were unable to control this exposure because of the need for students to experience learning in the specialty units. This is another example of how students and

new nurses witness and learn silent acceptance of vertical bullying behavior, contributing to the socialization of vertical bullying in the profession.

The use of gossip as bullying behavior in nursing may be considered from two perspectives. Many participants' stories validate this pattern of behavior engrained in the culture of the nursing profession and as a contributor to incivility and bullying. Another observation is when bullying behavior is allowed or ignored by nursing management or administration, then it is allowed to continue. Therefore, a by-product of poor management or administration contributes to the culture of bullying in nursing. In any case, exposure of nursing students and new graduates to a clinical environment which fosters gossip as part of the day-to-day workforce practices leads to further assimilation and perpetuation of vertical bullying within the nursing profession, and further socialization into the profession.

General effects of bullying. According to many participants, bullying and incivility in nursing and in nursing education produces feelings of humiliation and guilt, and makes the individual feel "like a child." When participants were asked how they coped with bullying as students or as new nurses in orientation, the most frequent response was participants felt the need to take it, to try to fit in, or try to live up to expectations of instructors or preceptors (Nurses 0004, 0005, and 0012). A majority said they learned to put up emotional barriers, or pretended not to see what was happening to another nurse experiencing a bullying episode because they thought confrontation would make things worse. Some felt a sense of guilt after they had experienced observing bullying of another student or nurse (Nurses 0002, 0003, 0007, 0012), but many of these same nurses rationalized interference might have "made it worse." Many of these same

effects and responses were corroborated by respondents and members of the instructor focus groups, and also found in the review of documents for the study. As a result of the cultural norm of NETY, in this study the most often reported effects of bullying included the following: fear, intimidation, minimization, and feelings of isolation in the student or new graduate. Additionally, findings concerning the lasting effects of bullying of the student or new nurse were also disclosed in this investigation. These four effects of vertical bullying and its lasting effects are discussed in the following sections.

Fear. “Just do nothing” was a response echoed by many participants in this study. Students and new graduates especially reported they felt compelled to keep quiet about any bullying that they might experience in their clinical rotations or in other theory classes. When asked why most bullying in nursing and in nursing education goes unreported, every respondent said fear of what might happen is the motivating force for not reporting incivility or bullying behavior. Some of the specific fears cited included “fear of being targeted more by the instructor or preceptor” (Nurse 0010) or “fear of causing more trouble and then my life would be a nightmare” (Nurses 0014, 0015). One participant said she was afraid to report how uncivil a preceptor and CNA. were to her in the clinical area when she was a student because she was afraid they would tell the instructor “un-truths” about her and she would be failed in her last semester of the nursing program (Nurse 0011). She reported this in the following way:

I think it's fear, that it might have been my fault when I first started, that if I am going to get someone reprimanded for something, and I'm sure it was my fault because of that CNA in particular, if I call her in and she gets in trouble . . . she's going to make my life a nightmare . . . and they may persuade my instructor that

I'm not safe. So when I'm working with her I'm going to get nothing done . . . and if she does do anything, it's going to be with an attitude . . . so that's going to put a gap in my day because I'm going to have to deal with it the entire day. So is it better to keep your mouth shut, eat it, tolerate it and do more work because she's not doing it and she's getting away with it. (Nurse 0011)

Responses such as this from Nurse 0011 illustrate the pervasive emotion of fear students have during their program and new nurses after graduating working with preceptors and staff nurses. Previously, students may have been on a long waiting list for admission to the nursing program and know alienation of their clinical instructor or preceptor might lead to clinical failure in their program. They would be forced to leave the program and return the next semester if allowed based on the rules and regulations or leave the program and abandon hope of continuing on in the nursing profession. Fear of losing employment because of alienation of a supervisor or preceptor in a shaky economic climate could easily be the concern for the new graduate, causing the graduate to take any kind of bullying behavior encountered during the day, as highlighted in the previous quote. Both of these fearful reactions lead to continued silence and resignation about vertical bullying behavior from students and new nurses, especially when in the clinical area, while socializing the student or new nurse to accept it as inevitable.

From the respondents stories it is evident the fear of "what might happen" is an effect of the major finding of NETY and a driving force in the socialization of vertical bullying into the nursing culture. Fear of consequences was also reported in the discussion in the focus groups with nursing faculty and administrators. Nursing faculty and administrators also revealed faculty "put up with" bullying from nurses in the clinical

areas for a variety of reasons, including fear (Focus Group 1). Instructors reported they are sometimes reluctant to stand up to bullying or fear causing any conflict at the clinical site because it is sometimes difficult to get and keep clinical sites. Many nursing programs vie for the same clinical sites, making it a very competitive task for nursing program clinical schedulers. However, instructors and administrators sometimes report they feel responsible for contributing to a bullying culture when they counsel students to remain quiet in the face of bullying (Focus Group 1). One instructor contributed the following about taking it:

If nursing staff is not receptive to our students I tell the student [to] just put up with it while they are on that clinical site, but by doing that, I think I am reinforcing the bullying behavior because clinical sites are so important and I don't want to lose that clinical site by complaining to anyone about the bullying, I'm telling students then that they have to go along to get along. But I don't like it. (Focus Group 1, Instructor X)

Focus group discussion frequently included statements from instructors concerning their feeling guilty about their example of tolerating bullying behavior at clinical sites. Because there are so many difficulties in finding and keeping clinical sites for students' necessary practical experiences, instructors are reluctant to jeopardize losing a site because of a complaint about a bullying preceptor or nurse. Instead, instructors find ways to work around a clinical bully or bullying atmosphere on a nursing unit, further contributing to acceptance of NETY.

Correspondingly, nursing administrators (Focus Group 2) participating in this study discussed their frustration dealing with perceived powerful preceptors or instructors

who bully students and the students' fear of reporting bullying (Focus Group 2). In response to a question about their experience concerning student bullying, one nurse administrator stated the following: "Students are under so much pressure as it is and they feel they can't take any more pressure if they filed a complaint about an instructor or another nurse. They believe that all RNs and educators stick together and defend each other. They don't know that we don't like [the bullies] either (Focus Group 2; Admin. #2). Another instructor in the same focus group concurred with this thought, saying: "I agree . . . we sometimes contribute to bullying because we feel we can't do anything about it so we show that no matter what the staff says to the students, we have to put up with it and get along. You know you have to pick your battles" (Focus Group 2, Instructor X).

These focus group discussions point to the misunderstanding students have concerning responses to vertical bullying. Students and new graduates are not aware of the frustrations held by faculty and administration concerning dealing with bullying, especially when limited by institutional policy. Hospital administration also may not feel organizational support from senior management, which contributes to feelings of futility when middle management is faced with confronting vertical bullying behavior in a nursing situation. Fear runs rampant in nursing and nursing education, leading to the following effect of NETY: intimidation.

Intimidation. Another outcome or effect of vertical bullying reported by participants was intimidation. One new graduate spoke of the intimidation she witnessed at the expense of one of her friends in her fourth semester of a nursing program, as follows:

Intimidation – I’ve seen it, my friend was in her 4th semester –the smartest girl and her father is an ER physician but no one knew he was an ER doctor – that’s how quiet she was – she had an A in the class – she was going to be med nurse . . . we were at the hospital for class and she left to pick her patients . . . she got there about 2 o’clock in the afternoon stayed at the hospital til late, and did all her paperwork. She was all set and went to pass meds the first day . . . she passed meds and then the nurse came up to her and goes – “did you pass meds to bed 2” – “yea why?” “omg one of the meds was dc’d”. The nurse -instead of forgetting it - went and told the instructor that the med passed in bed 2 was suppose to be dc’d – so the instructor sent her (the student) home. She counted it as a med error – but the instructor called her back two days later and said “ . . . I’m going to give you a second chance this week – I’ve never done it before. But I’m telling you right now that you have to sign this paper”– she wouldn’t let her go to anyone in administration. Administration saw them in the meeting and the instructor said “oh we have everything taken care of“ and the girl was so quiet . . . she’s so quiet . . . she didn’t tell anyone what was happening. She was given a sheet and was told “tomorrow you are going to get 5 patients”– this is exactly how she said it “These patients are going to have the most meds, every route will be included and if your 9 o’clock meds are not passed by 10 o’clock – if I walk into that room at 10:01 and that pill is not down his throat, you fail.” That’s exactly what she said to her, “sign this paper”. She went to pick up her patients her first patient had 24 meds, so she is like ok, so the second patient had 20 meds, third patient 18 meds, fourth patient 18 meds, physically impossible because this teacher won’t let

you pick from until ½ hour before – physically impossible. She went to administration and says “I just want you to look at the work that I did the night before – she had an A in the class mind you – and asked her what she thought and she said “yea it’s your last semester, so we always give you one that is a little heavier” – goes to the second page with 20 meds and so on and so on and she didn’t know what to say. The girl called the instructor on the way to the hospital she said “it is physically impossible for me to do this. I’m not even coming to clinical.” So she quit that day because she said she couldn’t physically do it. We know this because that instructor always picks on the weak and she was the weak link in her clinical group. Personally wise and intelligently very smart girl and it’s just a shame that somebody like that didn’t get through her 4th semester. (Nurse 0014)

Nurse 0014 was not the only graduate who told the story of this “A” student who was driven from the program. The experience described in which the student left the program in her fourth and final semester is unfortunately a common occurrence. All nursing students must demonstrate competency and safety in their most important “Med-Nurse” experience. The experience requires student nurses to administer medications. They may have five to 50 patient meds to distribute in the return demonstration for instructors in their clinical rotation, depending upon the patient load for any particular day. Students must know all information about the meds being administered including drug classification, usual dosage, and side effects. Failure to successfully and safely pass meds usually leads to failure of that course, sometimes with no chance to re-enter the program. Instead of being helped to be successful at a very stressful time, this very capable student

chose to leave the program and nursing rather than endure the treatment she received from her instructor. The question remains: how many other bright and capable individuals have been lost to the nursing profession because of similar treatment?

Minimization. The third effect of the major finding of NETY was minimization, reported by many respondents in this study. Minimization is an attempt to make the student or new graduate seem insignificant. A few participants reported that some bullies would present hostile behavior in a light-hearted manner even when the victim and others knew it was not a joke. Graduates reported they frequently experienced minimization from a preceptor when they were students in the clinical area, or from a staff nurse or instructor referring to them as “just the student’s observation” (Nurse 0015) or saying “when you are a real nurse” (Nurse 0018). Participants reported this minimization affected their confidence level and caused them to feel disrespected, isolated, and powerless in their sphere of influence.

In the review of documents for this study, one graduate from a nursing program reported the following: “[Instructor name] made my friend cry every day in the clinical . . . she decided early-on that my friend was not going to make it, even though she had good grades in all her previous classes and clinical . . . she made my friend feel dumb and worthless . . . once she pointed to my friend’s face –in front of all of us- and said “can’t you put your make-up on better than that?” I don’t know why she’s allowed to get away with that” (Doc. Review: Doc 15/ graduate survey).

Many participants in the study mentioned that they experienced a condescending attitude from some instructors as they were socialized into their profession (especially Nurses 0012, 0016, 0018). One stated the following:

As a nursing student, there was condescending [sic] from some instructors . . . one time I remember the instructor saying to us ‘you are just students, you don’t know this’ when we really did . . . but you kind of expect that and I don’t know if that’s really bullying . . . and I think there were a few instructors that wanted to make themselves known . . . they would be sure that when you were at clinical they would . . . like to show their knowledge and talk down to you more than the others . . . but I don’t know if you’d call that bullying. (Nurse 0018)

One participant uniquely reported demonstrating similar behavior after becoming a preceptor, stating the following:

I might have become more of a bully early on than I am now . . . Age and more education and teaching have really helped me a lot in becoming a better nurse and preceptor than when young . . . I was cocky – bigger than life sometimes and overwhelming to people. I think sometimes female new grad nurses take that as bullying or being pushed around. I didn’t think I cared at first but now that I understand that is the case. Now I try to take their feelings more into consideration. (Nurse 0003)

The quote from Nurse 0003 was interesting because Nurse 0003 was one of the two male nurse participants in this study and one of the few who admitted he felt he had probably bullied female students in the past. He said that he felt he had interpreted bullying behavior differently than his female classmates when it was experienced in his nursing program. He said he thought some students were ‘just too sensitive’ when he was a student. After a few years of experience in the field and more education, he now understands what bullying is and the effect of bullying on students and new nurses. As a

preceptor, he has changed his approach with students. This discussion with Nurse 0003 gives hope to this researcher that education and encouraging feedback can positively affect the culture of nursing and nursing education.

Feelings of Isolation. The fourth effect of “Nurses eat their young” – feelings of isolation- was also reported as effects of bullying in this study. Some participants cited cliques of nurses contributing to their feelings of being cut off, undervalued, and non-confident in the learning or working environment (Nurses 0001, 0002, 0010, 0012). Many of these same participants cited their frustration dealing with cliques as students or new graduates in their orientation period as reported with this example:

There are definitely cliques on my floor. Primarily age based – late 20’s to late 30’s and these buddies are about 7 or 8 nurses in that group and they are particularly out-standish [sic] with some of the older nurses, particularly the nurses that are in their 50’s and 60’s. Why I’m not certain . . . I’m pleasant with these ladies because it’s my job and I get paid but I’ve seen them [the cliques]– they are not willing to let people in their inner- circle. I think it’s based on age – I don’t know . . . we are all primarily the in the same age group and they work together . . . Most of these nurses are also relief charge nurses and they have an interesting way of covering for one another when they are in charge. If they see somebody is due for an admission, I have physically seen if you are in their circle you will get a transfer; if you are not in their circle, you’ll get an admission because it takes more time. I work at [hospital name] but I’m sure this kind of thing happens everywhere you go . . . You are going to have your cliques, social isolations yea, I’m sure that is anywhere you go. (Nurse 0016)

The kind of vertical bullying described by Nurse 0016 is based on a kind of reverse age discrimination, contrary to previous references to vertical bullying seen demonstrated by experienced nurses withholding information. In the bullying described by Nurse 0016, younger but not more experienced nurses formed cliques, isolating older nurses and contradicting the usual concept of NETY. This illustrates how nurses being bullied by nurses in supervisory roles, no matter what the age of either side, support the culture of vertical bullying in the socialization of nurses.

Another participant talked about how cliques had affected her contributing to her feelings of isolation, especially on the weekends when their high stress orthopedic unit was frequently short-staffed [a precipitating factor] and when “one of their buddies is in charge . . . so they want to look good to their friends [motivation factor] . . . and their [bullying] behavior is even more pronounced . . . I think some people [nurses] are more offended by the clique behavior than others . . . others just blow it off and can tolerate it . . . some of the ones that are most bothered by it and talk against it are the older ones . . . and there are really no older nurses in that clique” (Nurse 0012). This quote illustrates how bullying isolation can be intensified by more than one factor, a foundational concept for this study on socialized bullying.

Finally, the lasting effects of vertical bullying are as varied as students and graduates who experienced or observed bullying as they are socialized into their profession. Participants frequently agreed with the study’s statement and question regarding Randle’s (2003) conclusion—the way a student was treated during nursing school affected the way that nurse treated others later. However, the majority of

respondents frequently stated the bullying treatment they experienced or observed produced the opposite kind of behavior in their nursing socialization.

One of the respondents (Nurse 0015) disagreed with Randle (2003) and commented: "That could be . . . but really I don't believe that because even if you are treated bad you can also take the best out of the situation." Another recent graduate who remembers very positive experiences responded differently (Nurse 0017) said, "Yes I believe that there is a correlation but only in a good way. I look back on my days back when I was a student and I think of that nurse (who) actually took the time to explain things to me . . . and now I am a preceptor and I say the same thing to myself when the students are there 'I will teach you.'" Finally, in the review of documents, another nurse revealed the following in a statement concerning the lasting effects of bullying . . .

I was bullied as a student nurse, rather brutally and thought that I was over it. I've worked as a nurse for 7 years and finally left nursing altogether this year. As a student nurse I had a horribly mean preceptor for one of my last placements [clinical]. She would actually whisper in my ear while I was doing the narc [narcotics] count . . . that I would never make it as a nurse, that I was stupid and that I'd never get a job when I graduate . . . She made up lies to complain about me to my teacher. . . . my teacher and school totally supported me and removed me from that placement, but the effects were strong and long lasting. I went into that placement as a confident, caring, smart nurse and her meanness and contempt shook me to my core and self doubt entered my mind and never left, I'm sad to say . . . thanks to nurse bullying and a lack of professionalism, I will not be giving

the care I so love to give as it took too much out of me to do so. (Doc Review:

Doc 12: Medscape /student wrote: Posted 2011/09/18 at 5:36 PM ET)

Many participants in this study talked about these lasting effects of bullying from instructors, and particularly from preceptors. Most said because of the bullying treatment they received or experienced, they would never treat students or new nurses in the same way. Unfortunately, many of these same nurses said they “did nothing” when they observed bullying that another nurse preceptor inflicted upon another student or new nurse. This choice to do nothing or put up barriers is another contributing factor that insures that vertical bullying will continue to be socialized within the culture of the nursing profession.

Finding Two: Vertical Bullying is Learned Through Socialization

From this study, it has been determined that bullying is learned as students are socialized through nursing education. Nursing students and graduates are socialized into a bullying culture through experiencing bullying role models and observing the misuse of power.

For the purpose of this study, socialization was defined as “the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession” (Cohen ,1981, p. 168). The second major theme of this study documented bullying is learned and socialized through nursing education and confirmed nursing students and graduates are socialized into a vertical bullying culture through observing the behavior of role models in nursing and nursing education, and sometimes through experiencing the misuse of power.

A discussion of this study's findings concerning the themes of role models and the issue of power misuse follows in this chapter. The chapter included the findings concerning the socialization of vertical bullying organized in the following way: 1) the role of the instructor in learned bullying, including new and experienced faculty ; 2) responses to socialized vertical bullying; and three minor findings which include a) issues of power, b) how instructors remember bullying, and c) academic support.

Instructors' roles in the socialization of bullying. Instructors in the focus groups were aware of their responsibility in the socialization process of students and new graduates in the profession of nursing. This corresponds to the findings in the literature review for this study which supported the importance of faculty in the socialization of nursing students. Most instructors participating in the focus groups were very vocal about being seen as role models, and frequently mentioned the pressure students and new graduates may feel as they are forced to comply with the behavior they are learning from role models. Instructors conveyed their views with the following statements:

Socialization into nursing happens because of what students and new graduates experience. It's affected by how they were treated and what they saw on the units, and how the nursing management interacts with nurses. Socialization of nurses definitely is influenced by the actions of others in nursing. If new nurses see nurturing, then they will be nurturing too. If not, then they won't be. Whatever they see, they will copy and incorporate into their own interpretation of what a nurse should be. (Focus Group 2, Instructor 1)

Most participants indicated that they felt that nurse educators share a great responsibility in assisting students in this socialization into the profession. Instructors in both focus

groups also indicated how important their role was in this socialization. One instructor stated the following:

Socialization into nursing starts with the first welcome into nursing from the representatives of the nursing program. Many times, the welcome includes the message, if you fail in this program, you will have to leave and you have no chance of ever coming back. This message given to new students is but another form of bullying that starts the first day of their learning to be a nurse.

Socialization into nursing is also learned by what is seen from observing instructors as role models. If students are older when they start, they may be more experienced and be more self-assured even if they are being taught by bullies to be bullies. (Focus Group 2, Instructor 2)

Socialization into nursing begins the first day of the student's nursing program, when students begin their orientation into their new profession. In the focus groups, instructors agreed nursing educators share a great responsibility as role models for nursing students. It must be noted not all graduates who were respondents in this study felt instructors were negative role models. In the document review for this study, one response from a graduate survey offered the following instructor review: "Even though some of my classmates had problems with one or two of the instructors, there were mostly good instructors for me . . . Mrs. [name] was really knowledgeable and helpful . . . most keep current by working in nursing on the side . . . I would be honored to someday be as good as some of them" (Doc. Review: Doc. 16; Graduate Survey).

Finally, another faculty member added a noteworthy insight into the concept of role modeling by contributing the following:

In our faculty, we once had an exercise regarding role models in nursing education and the results were interesting. When asked if they considered themselves as role models in nursing education, the instructors who did not see themselves as role models also did not have role models in their own nursing education experiences, and tended to be bullies to students. And the instructors who considered themselves as role models tended to have positive role models in their own nursing education history. So I think if you didn't have good role models in your education experience, you don't role model for your students and may think bullying is ok to do. (Focus Group 1, Instructor X)

This insightful comment from one instructor points to a definite connection between nursing instructors who were socialized into their profession, some acknowledging their responsibility as positive role models while others deny this role, possibly because they never had positive role models in their own educational experiences. This is a powerful response and finding connected to the importance of role models in the socialization of nursing students.

Both in the discussions from the focus groups of nursing instructors and administrators and from document review, there was frustration from instructors especially concerning the treatment their students encountered as they were socialized into nursing. Document review produced the following:

I have been an RN for 30+ years. I have only great memories. I was nurtured and mentored to be who I am today. I teach nurses. I also work in an acute care hospital. My knowledge and my experience look after me.

The outright abuse thrown at my students is hard to bear. Today, it is hard

to be a good nurse. Beautiful inexperienced nurses do not have a good mentoring system in place and consequently could become insecure and vulnerable. Could this perhaps result in they themselves resorting to bullying in defense [sic] of . . . my dilemma is . . . when encouraging my students to stand up for themselves, I find it sometimes hard to distinguish the bullied from the bully. (Doc Review: Doc 12: Medscape /posted 2011/10/09)

This finding emphasizes the frustration that many nurses feel when dealing with socialized bullying in the profession, especially nursing instructors who worry about their students and the effect of bullying upon these students. Some instructors attempt to teach their students how to defend themselves while not resorting to bullying as they are socialized in their profession. The challenge continues when these same instructors are called to assist new nursing faculty learn how to defend themselves from bullying instructors while helping their students. This challenge is discussed in the following section.

New faculty. It was reported by the focus groups that socialization of students into nursing is affected by the socialization of new faculty into the profession of teaching nurses. Nursing faculty as participants reported they experienced vertical bullying at the hands of other faculty as reported by more than one faculty member, as follows:

As instructors, the tenured faculty and the non tenured faculty are separated by their own choice. The non-tenured faculty are afraid of the tenured and they feel that they should keep quiet and not cause waves until they get tenure. They don't

talk at department meetings because they feel they'll be put in their place. So they all agree with what's said by the tenured faculty or keep quiet because the tenured faculty sit on their non tenured committees – so they are bullied silently by the tenured faculty and the non tenured faculty have to find support among themselves. (Focus Group 1, Instructor K)

In agreement with data submitted by a second focus group, another instructor offered the following:

New faculty have been bullied from the first time they walked in the door of the college. They are treated like they are low down on the totem pole. The tenured faculty continually poke holes in what they say if they say anything. There is usually no joint acceptance of new ideas from new faculty, and the tenured faculty are threatened by new ideas anyway. I've seen tenured faculty listen to new ideas by new faculty, completely dismiss it and then turn around and reword the idea and present it as their own. I've also been ridiculed and one tenured faculty member actually knocked on my forehead to show how stupid I was. (Focus Group 2, Instructor X)

This disclosure from a faculty member in the focus group discussion supports one finding that has been discussed earlier in this chapter, the frequent use of fear and intimidation in socialized vertical bullying. This version of vertical bullying is at a different level because new instructors, are as vulnerable as new students; they are reportedly minimized and isolated just as students and new graduates. New instructors are fearful of not receiving tenure if they disagree with experienced faculty who are members of their non-tenured committees. The danger is silence in the face of bullying may indicate acceptance

of behavior and another chance vertical bullying is gradually assimilated into the profession, again through nursing education.

Experienced faculty. New nursing faculty members are not the only ones bullied, as reported by members of the focus groups. Experienced faculty member reported the following experience:

I knew another faculty member who didn't talk with me for over a year because she thought I was going to get her fired. She finally talked with me when I helped her with an issue, but I never knew why she ever came to the conclusion I was out to get her. (Focus Group 1, Instructor H)

While experienced faculty are not as intimidated by bullying faculty as new faculty, they also must deal with the repercussions of bullying faculty members, and the challenges faced when they have to "stand up" for bullied students. Instructors in the focus groups discussed how bullying members of their faculty put pressure upon experienced faculty not to do extra assignments as "that will make us look bad." This kind of socialization of vertical bullying in nursing education is insidious and difficult for administration to eradicate.

Two responses in nursing socialization. The finding that indicates community college students learn by being socialized into a bullying culture produced the following responses to learned vertical bullying, each viewed from a different lens concerning the socialization of vertical bullying: 1) students learn to "play the game" as they are socialized into a vertical bullying culture, and 2) some instructors remember how they were bullied as students from role models and this affects their behavior as educators.

First response: Play the game. One discovery in this study was the response from a few graduates concerning the importance of learning how to “play the game” and to be able to “talk” with instructors and preceptors in order to successfully complete a program or get along in the clinical. More than one student reported knowing how to “play the game” in nursing school during their socialization into nursing was important, and is something they value in their practice to this day (Nurses 003, 0014, 0015). One participant talked about others in school failing because they didn’t know how to “talk”, as explained as follows;

Even in the nursing school here there are girls here to be honest that they failed and you know why they failed because they don’t know how to talk. I’ll be really honest they are really smart girls. . . . the girls that failed . . . it’s not because they were not intelligent . . . it was because they don’t know how to have a relationship with the instructor. They come across harsh – there are 2 or 3 that I can tell you right off the top of my head that failed because they don’t know how to talk period – they don’t know how to express themselves and they come across to the teacher just in the wrong light. . . . And unfortunately the teacher is not their friend so they don’t really know how they really are – so when they express themselves and they are not doing it the right way or like they act like – well if you want to ask a question or even if the teacher tells me they sky is blue and that day it is not blue you are going to agree with them . . . but if you have a question you don’t tell them they are wrong . . . you have to know how to express yourself in your role as a student. . . . I’ll be honest when I was coming into [college name] they were like ‘oh nursing school if the teachers don’t like you – you are

not going to pass' . . . Just the talk you know what I mean between girls and I'm like 'you guys are crazy they won't fail you' if you know what I mean, if that is the case. They told me that if the teacher didn't like me I wouldn't pass nursing school. And I was like 'you guys are so full of it – if you provide the grades how are you not going to pass?'. But it happened – I learned it there. There was one girl who wrote a paper and I've seen favoritism happen between students and teachers. We had to write a paper – it was for a class – so a girl comes in and turns in her paper to the teacher and goes and sits down. They were talking up at the front desk and said something – I don't remember the exact situation right now- but the other girl who turned in her paper said you couldn't do this, this and this. She said "Are you kidding me that's what I did on my paper". So she goes back to the teacher and asks if she could have her paper back – it wasn't due yet – but the teacher knew why she wanted her paper back so you know what she did? . . . instead of giving the girl back her paper, she straight out gave her a F and not only gave her the F but said she was plagiarizing so one girl failed for plagiarism – this girl was a pain she was a pharmacy tech for years and years and had no qualms about challenging the instructor so she came across . . . she was from overseas so her vocabulary skills were not the best . . . so she came across harsh like kind of saying ' I know this better than you'. Well, she got a straight failure for what she did and the other girl did the exact same thing and she was given a second chance, not fair . . . let's put it that way. She couldn't play the game.

(Nurse 0012)

Learning to “play the game” or how to get along with instructors or preceptors, according to more than one graduate participant, was an important skill to learn to succeed in the nursing program. Graduates talked about how some of their classmates were singled out from the first day because they were different in some way or not willing to keep quiet and challenged some of the instructors’ points of view. Graduates were quick to point out that not all instructors were like this, and that some instructors encouraged students’ voicing diverse opinions and ideas. However, graduate respondents from one of the schools in particular had several instructors who were known in the nursing community for failing students in the clinical within the first few weeks of a program. This kind of bullying behavior contributes to a threatening atmosphere and is not conducive to an optimal learning environment.

Second response: Instructors remember. A second response to the socialization of bullying in nursing education from the nursing instructors is the following: the educators have not forgotten the bullying that they experienced as students being socialized into nursing. In the focus groups, the instructors and administrators in nursing shared their own experiences of being bullied, some as long as twenty or thirty years ago. One of the accounts includes the following:

As an instructor, I have always been aware of and hated bullying. I had a terrible bully of an instructor in nursing school; she came from a military background. Our post conferences were not dismissed every day until someone was in tears. Then she was happy. I was a little older than the other students and she went after me, too. But she really hated another student, my friend, for no reason. She was a good nursing student but the instructor took my friend out in the hall and cursed

her out so bad that the woman left the program. I went to the Dean about her and told about the instructor's behavior. No one should have been treated like she was treating students. Suddenly, we had two clinical instructors, and the next semester, the bad one did not come back. (Focus Group 1, Instructor J)

And another instructor added the following concerning her own socialization into nursing:

Because of the way I was treated as a student, I swore I would never treat anyone that way. Some instructors would grab students by their collar and drag them out in the hall and scream at them in front of everyone. It was terrible. Yes – it definitely starts there. I think it stems from militaristic origins in nursing. The feeling of some nurses is that “If I had to do it, then they have to do it too . . . If I went through hell, then they have to go through it too.” (Instructor Y)

A response of this kind from instructors regarding a kind of “hazing” which students should be expected to endure in nursing education was heard frequently in this study. This reported attitude supports the findings of some researchers in the literature review who have traced the training of nurses to its militaristic foundation, where nursing students just had to endure whatever treatment was delivered by “the head-mistress,” a kind of sergeant-at-arms for new inductees into the profession. By nursing instructors and preceptors justifying their bullying treatment of students and new nurses with statements such as “if I had to experience it, then they do too,” the insidious assimilation of vertical bullying into nursing through nursing education continues.

Minor finding one: The issue of power. The participants in this study confirmed the misuse of power was a frequent contributing factor in vertical bullying as

they were socialized into nursing as a student. When asked about how power was influential in their socialization as a student or new nurse, responses concerning their treatment included the following:

As a nursing student I have seen [misuse of power] many times, not only in staff on floor but also in nursing instructors. It puts students in an extremely uncomfortable position when you're being bullied by the person who is in charge of whether you pass or fail that year of nursing. I had one particular nursing instructor who never said a nice thing to students but yet never hesitated to dish out on every little mistake you made including discussing this with your fellow classmates. I remember clearly that out of a clinical group of eight, this instructor made seven students cry. During my evaluation very negative, derogatory, and unprofessional comments were said yet not written. I never addressed this issue with this instructor as I knew she was the type to fail a student for not agreeing with her. In her mind, students were being babied by being told what they were doing properly in clinical . . . I know I went home and cried my eyes out, I thought I was never going to make a good nursing student. Only through talking things over with my mom who is a nurse and my fellow classmates who said what an amazing job I am doing and that patients I had had and they then had, had commented on what a difference I had made for them. I believe to address bullying in nursing it first has to be addressed from a student level because we go through school knowing it is part of the profession which just shouldn't be true.

(Doc Review: Doc 12: Medscape /student28 wrote: Posted 2011/09/25at 8:28 AM ET)

Another student-now-graduate reported a similar experience with the following response:

I think with teachers, especially nursing instructors that have been doing it a long time, I think they might get on a little power trip and make it their right to test us and push us. However, I don't think they realize that they are doing it in the wrong way. So I think a lot of it is just a big ego and they just feel that it is their right – you know they are going to make us better by doing this . . . this is all coming from my last semester . . . it was horrible, like I said before . . . I really had to grow up that semester and but I feel that my teacher saw me as this young naïve girl and so she found that she needed to just push me and push me and push me and push me to see how I would respond. I think sometimes they feel like they need to weed out the weak or something. (Nurse 0009)

These findings regarding contribution of the abuse of power to vertical bullying validated the findings in the literature review for this study. It must be remembered that not all graduates considered the treatment they observed or experienced as abuse. A dissimilar discussion regarding abuse of power to “make us better” was also described by other graduates when they were defending instructor or preceptor actions upon remembering their nursing program. Just like the saying “beauty is in the eye of the beholder” so also is the interpretation of bullying misusing power, another way that vertical bullying is subtly absorbed and socialized through nursing education. Another instructor participant added a similar opinion about power in nursing education:

Sometimes there is the “break them down/then save them” attitude so that it appears that a select few make it through the program. It's the Freire syndrome – that the oppressed becomes the oppressor eventually. Students begin to feed into

the bullying and begin to participate in the bullying. “If I don’t play the game, then I am the next to go.” (Focus Group 1, Instructor J)

Both instructors and graduate nurse participants agreed the misuse of power was a great contributor to bullying behavior socialized through nursing education. Much discussion in the focus group of instructors corroborated this finding, with one instructor validating that some instructors use power to intimidate students, adding :

Some instructors think and talk about how much power they have and how they have found another student who is “afraid of me.” I think they definitely adhere to the military model of “breaking them (the students) down” before they build them into good nurses. They use the “wear and tear” approach so that others think they are so special. (Focus Group 1, Instructor X)

One experienced instructor talked about the connection of bullying and lack of self-respect, with the following thought:

I think that is causing them to be bullies sometimes – they have to build themselves up to put others down. This really happens when the older faculty goes after the newer faculty. The new faculty doesn’t fight back and hide from them – and they teach the new faculty to disrespect the students over and over. (Focus Group 1, Instructor V)

This instructor response confirms the finding bullying is taught and learned in nursing education at many levels, and followed Bandura’s social learning theory (1977b).

Bullying through power abuse is not only learned by students who become new graduates; it is taught by experienced educators and learned by new faculty as well, more evidence of its socialization through nursing education.

Minor finding two: The importance of role models. An important finding in this study was students and newly registered nurses learn how to think, act, and identify with the profession of nursing by observing and copying the behaviors of instructors, preceptors, and other registered nurses, citing these individuals as role models. The majority of respondents in this study –when given four choices for the sources of their socialization into the nursing profession- overwhelmingly chose the examples of their instructors and preceptors in the clinical area to be the most influential factor in their socialization into nursing. One participant stated the following;

Your teachers were the ones . . . your instructor was your best example in socialization . . . the clinical time you spent with her . . . we'd learn from their experience . . . so they would go to the room, communicate with other nurses or doctors and they were a great example . . . they were the closest and most obvious to help us without a doubt. You can be taught something in the classroom but in clinical is where it really happened . . . you become cultured into nursing best in clinical and [the instructors] do it. (Nurse 0014)

Another participant added the following:

Because I was a nurse's aide before I was a nurse, it helped me because I saw how nurses acted and what they were expected to do . . . the preceptors were my role models . . . I looked up to them because they showed us how to handle everything. (Nurse 0004)

In nursing as with most other related allied health professions, learning how to be a nurse takes place predominately in the clinical area as the student learns the professional knowledge and skills as well as “internalizing the values, traditions,

obligations and responsibilities of the profession” (Tradewell, 1996, p. 183) from those identified as student role models. An overwhelming number of participants in this study reported their socialization into nursing was predominantly influenced by observing other nurses, particularly their instructors and the preceptors in the clinical areas during their apprenticeship as a student.

Despite the overwhelming response that instructors play a major and powerful role in socialization, some of the participants who had been employed in other healthcare professions other than nursing seemed to indicate their socialization into the nursing profession was different than it might have been for other participants. They reported their socialization process in the following ways:

I was a Tech in the ER for a long time, about 13 years before I went to nursing school, so I had watched how nurses interacted . . . I was used to drawing blood and doing EKGs . . . I did everything that a nurse did . . . so it's the people who I worked with that influenced my socialization the most . . . because I worked in the ER so long, I was considered part of that culture..and I knew what to do and how I should do things like a nurse when I was a student. (Nurse 0003)

This statement by a participant in the study verifies the socialization and learning of the culture of the profession takes place by being an apprentice in healthcare and exposed to different role models in a variety of experiences. If nursing socialization and learning included repeated exposure to vertical bullying as experienced or observed from role models, then the learner gradually absorbed an acceptance of vertical bullying while they were learning how to act as a nurse.

Minor finding three: Academic support. This final minor theme concerning the connection of bullying to community college nursing education through academic components became apparent in the findings which emerged, particularly from the focus group discussions, some of the participant comments, and some of the documents reviewed for this study. Responses from graduates indicated the socialization of vertical bullying into the nursing profession is connected to nursing education through components of the academic structure. Additionally, both focus groups of instructors and administrators reported the hierarchical structure of nursing and nursing education contributes to an atmosphere of vertical bullying in nursing programs.

More than one instructor talked about issues centered on seniority in a nursing faculty group and playing a role in decisions such as faculty course selection and teaching assignments. Instructors reported they have experienced and heard senior instructors warn new instructors not to perform extra services for students or the program because “you will make the rest of us look bad” (Instructor V). Instructors in one nursing program reported the treatment some instructors received when there were different levels of instructors within a program as an example of how hierarchy in nursing education can support and encourage academic bullying. One instructor offered the following:

When I first started teaching, I taught in the LPN department of the college and we all worked together and helped one another. Then the LPN and RN departments were joined together and it was an eye opening experience. It turned out to be a very dysfunctional faculty where new faculty were constantly bullied, and it was survival of the fittest for any new faculty. (Focus Group 1, Instructor J)

There is one other related study in the literature which suggests the formality and rules and regulations which accompany the discipline and profession of nursing add to the hierarchical structure in nursing education, and provides more opportunities for bullying (Lewis, 2006). After an episode of bullying exhibited between new and experienced instructors, another instructor in this study added, “I have been afraid to go to the HR department when I have been bullied by colleagues because I would have to prove it legally and if I couldn’t, it would make me look stupid, so they win again” (Focus Group 2, Instructor Y).

A different instructor talked about some faculty receiving a kind of reward and recognition from other bullying instructors when the newer faculty began to bully and treat students in the same bullying fashion as the bullying instructors. “Some instructors laugh among themselves and tell each other that it’s their job to get rid of the inferior students. I’ve heard them comparing names and telling another new instructor to fail student X soon and not let them get past the 3rd or 4th week. Then they will have fewer students in their clinicals . . . They completely lose the human part of nursing” (Instructor V).

The chain of command concept. Cooper et al. (2009) found in schools of nursing “a hierarchy exists that reflects the dynamics of other workplace environments . . . if the teacher-learner relationships are not positive, the student’s need for support and respect can go unmet, disempowering the student” (p. 3). More than one participant (Nurses 0001, 0004, 0014, 0016, and 0017) and many others mentioned the chain of command in relation to student discipline and student support in nursing. Participants responding to the questions concerning chain of command and discipline frequently

referred to the programs' rules and regulations with an assumed attitude concerning the importance of following these rules or suffering the consequence of being terminated from the program (Nurses 0001, 0004, 0010, 0015, 0019). One sub-theme concerning the importance of each school of nursing's Rules and Regulations related to the hierarchical structure of the nursing program. The importance of the concept of chain-of-command in nursing and nursing education was repetitive in the findings presented for this study.

Findings concerning academic support also established participants frequently stated their curriculum did not prepare students and eventual graduates of nursing programs for the frequent occurrence of vertical bullying in the nursing profession. When participants were asked if they ever discussed vertical bullying in their nursing curriculum, only one participant (Nurse 0012) volunteered that one assignment in their Nursing Issues courses was centered on nurse incivility. A document review of the curriculum for all three community colleges revealed no mention of vertical bullying in any of the nursing education courses.

Finding Three: The Importance of the Clinical Experience

The third major finding of this study supporting the student socialization into a bullying culture is it is usually learned from observing and experiencing bullying in the clinical arena of nursing education and less commonly learned in the educational delivery of nursing theory area. The reader is reminded nursing education, like most healthcare education, has three distinct arenas where learning takes place. Didactic learning or learning of the theory of a subject usually occurs in the classroom. Learning procedures and the practical application of the content occurs in the second learning arena or scheduled labs, where students are provided with demonstrations from instructors and

then give return demonstrations to insure student competency. The third arena of learning is clinical, where students learn by providing care to patients. It is most pivotal in the learning and socialization of nursing students.

The aspect of clinical learning is what sets healthcare education apart from many other kinds of learning, and it is frequently a component of nursing programs required for accreditation in the professions. Additionally, respondents to this study confirmed the importance of their clinical experiences in learning to be a nurse, and most vertical bullying was clinically based. Many participants spoke of bullying which happened in their clinical experience; only one spoke of bullying that she observed in a classroom locale (Nurse 0008).

Instructors in the focus groups also were very vocal in reporting students learn to be a nurse in a bullying culture in the colleges' clinical rotations. One instructor reported the following incident:

I was with my eight students and we observed the bullying of a staff nurse by a nurse manager, loudly and in front of many others including nurses and physicians. My students appeared to be embarrassed and quickly left the area. I did not comment at the time. I later talked with my students about the incident. They were appalled at the treatment of the staff nurse by the nurse manager. I wonder to this day if I should have said something at the time of the incident. I also think that by not saying anything, I sent a silent message of condoning this behavior. (Focus Group 1, Instructor H)

Instructors in the focus groups agreed that sending "a silent message of condoning" vertical bullying was something they now regretted. They did say, however, they

practiced the frequent response of not “making waves” so they would not lose a clinical site which was so important for student experiences. They felt their behavior of seeming to silently condone vertical bullying observed at the clinical site was justified at the time because “the end justifies the means.” This is interpreted as another example of the disturbing insertion of the acceptance of vertical bullying throughout nursing education.

Both graduates and faculty reported students observe and learn bullying from faculty and preceptors who may not intentionally bully students but demonstrate bullying because of stress levels or because they feel threatened. The following was reported by faculty and other participants:

Nurses are stressed to the max on the floors with patient load and high acuity and they burn out eventually, especially if they feel they can’t move on in their profession. So they respond by bullying everyone they can. Some nursing instructors bully because they feel defensive if they don’t know the answers for students and staff, they lash out at the students. Another example of bullying is when the instructor says to the unprepared student “Who did you have in 2nd semester that you don’t know this?” That is also another form of instructor bullying. (Focus Group 1, Instructor V)

Instances where instructors bully students by verbally attacking not only the students but the previous instructors or preceptors of the students was a reported way of instructor intimidation which tells the students “not only are you not okay, all the others who taught you are not okay.” According to instructors and graduates reporting this response, this kind of reaction frequently accompanied situations in which instructors

appeared to feel threatened, leading to this kind of verbal attack and subtly teaching students this kind of bullying response by their example.

Some participants reported, however, they never received poor treatment from their instructors during their socialization into clinical nursing in their nursing programs, but frequently followed up with a statement like the one heard from Nurse 0007, as follows:

I know that some students were treated bad, but I never was . . . I was lucky . . . but I know that the students that were bullied, you could see a change in them if they continued in the program . . . I saw some of them so upset that they would vomit in the parking lot before they went into clinical . . . that had to affect them for life, whether or not they continued in the program . . . I told one of them "You are letting this overtake you" . . . she was always on the defensive and she was always afraid of what was going to happen next. (Nurse 0007)

This response from Nurse 0007 is interesting because that Nurse 0007 thought her approach with the student she discussed was supportive and helpful to the student being bullied. Another interpretation might be that even though both students knew the bullying was wrong, Nurse 0007 indicated she felt the bullied student's reaction was permitting the bullying to occur by "letting this overtake you." This attitude assigns some kind of guilt upon the bullied student, who is trying to find ways to cope with the clinical bullying. Again, reactions to bullying such as demonstrated by Nurse 0007 further indicates insinuating acceptance of vertical bullying in the nursing profession through education, as it tells the bullied student to just get through it in order to be successful in learning.

Finally, other nursing educators and administrators report that they are aware of the socialization of bullying at the college, and report the following:

Students tell horrible stories about what happens in their clinicals – but it’s hard to know what is true. They are not willing to put much in writing; they all say “let me finish this program first” because they are all afraid of retribution. Our occupational surveys indicate that sometimes a few graduates will report back in a follow-up survey sent from the college, but few report it before graduating.

(Focus Group 2, Administrator 2)

Frustration from instructors and administrators abounds regarding their inability to address student bullying in nursing education because students are afraid to report it due to feared retribution. This response of “let me finish this program first” adds to the “Wall of Silence” referred from Murray (2009) concerning academic bullying as well.

Additionally, some graduates (Nurses 0005, 0009, 0010, 0015, 0016) and instructors (Focus Group 2) mentioned faculty unions protect instructors from being fired further permits bullying, and some have stated unions frequently perpetuate bullying.

Minor finding: Clinical “fitting-in” and “not fitting-in”. The apprenticeship period begins as the student assumes the role of nursing student and continues as the student becomes the new graduate, still learning the values and norms of their new profession. While discussing their need to learn to go from “acting like a nurse” to “being a nurse,” many participants stressed that they felt pressure to fit in with the professional clinical norms and values of nursing (Nurses 0003, 0010, 0011). Participants articulated this pressure as delivered in the following excerpts:

When we were learning how to be a nurse at my community college, there was an importance placed how to be a professional when we were in clinical . . . how to fit in and speak professionally and act professionally. We were actually graded on how we looked . . . I think because we came from a community college program, we had to prove that we were as good as and could hold our own with the collegiate programs . . . the instructors told us “you need to look and talk like a nurse so that you fit in with the others” . . . looking back on it now, I really appreciate that. (Nurse 0010, p. 1)

This response emphasizes the pressure community college students and new graduates feel, especially in the clinical area, to be seen and considered as good or as competent as the bachelors’ prepared nurses. Regardless of their two or four year basic nursing degree, all nurses challenge the same national accrediting exams in search of their registered nurse state licenses. Despite the similarities in pass rates between the two year and four year programs, ADN graduates frequently feel less than the BSN graduates. Therefore, fitting in at the clinical site-whether by looks as mentioned by Nurse 0010- or performance is very important to the confidence level and self-esteem of new community college graduates in nursing. Nurse 0010 interpreted the demands of her instructors in a most positive manner, while others might have taken these demands as a negative mandate.

Regarding a less positive clinical learning experience, another participant reported the following:

My last semester in my program is when I really learned how to be a nurse but I didn’t learn it because of my instructor . . . it was in spite of her . . . I had to do it

on my own and it was the hardest time in my life. The teacher did not help me; she made me feel small and not respected. Every day she told me that I was too meek to be a nurse and I wasn't acting like a nurse but like a meek little child.

..So I had to show her and prove that I could do it, and I had to act like a nurse not a student. I knew that if I was going to make it out of the program alive, I had to grow up a lot and act more confident . . . I told myself that I could do this despite what my teacher was telling me. (Nurse 0009, p.1)

Conversely to the previous positive perception of fitting in of Nurse 0010, the response of Nurse 0009 was quite different. Not fitting in in the clinical for this respondent began in her fourth and final semester. At the hands of her instructor, she was made to feel “small and not respected.” The clinical instructor decided early-on that this student was too “meek,” and came close to driving her out of the nursing profession. Instead of finding ways to positively encourage this student to be more confident in her role as a nurse, the instructor bullied her. This student eventually succeeded as she says “in spite of” the instructor rather than “because of” the instructor. This graduate reported that she is now a successful intensive care nurse and preceptor, again “in spite” of her past instructor. This example is another reminder and also emphasized the importance of the clinical for students during the learning and socialization of vertical bullying through nursing education.

Cross-case Analysis of Study Cases: Reflection on Study Findings

This final section of Chapter Four will outline the findings from participants in the study as they represent the three cases or representative community colleges selected for this multiple case study. With reference to the previously highlighted four major

findings of this study which reflect the study's research questions, ideas and opinions from participants concerning vertical bullying and its connection to community college nursing education have been compiled.

Cross-case Analysis of Finding One: Nurses Do Eat Their Young

Concerning this first and major finding, every nurse graduate from all three community colleges mentioned the NETY theme. Every nurse participant from every selected college was able to give their description of what vertical bullying looked like, usually including a bullying incident they had observed or personally experienced. All nurse participants in this study had witnessed vertical bullying during their nursing education, although participants from College One reported the least amount of experienced bullying as students. Conversely, participants from College Two frequently referred to observing vertical bullying and particularly humiliation from instructors as part of their experience during their nursing program. Participants from College Three referred to vertical bullying at the hands of their clinical preceptors during their phase of nursing education. Of particular interest was the finding reported by participants from College Three. They expressed the most regrets at not intervening when observing the preceptor bullying of a colleague. These graduates frequently referred to their need to "stay out of it" and "do nothing". They further reported they thought their instructors knew about the preceptor bullying of students but these instructors also did not confront the preceptors or become involved when students were bullied by these hospital employees.

Participants from College Two reported the highest incidence of fear, intimidation and minimization as compared to the other respondents from the other two community

college programs. Reported feelings of the fear of consequences for reporting vertical bullying to administration or management were recurrent in the findings from all three college cases. Concerning reported bullying, specific fears of being targeted by instructors were voiced, with the common theme of fear they might be failed heard mainly from College Two representatives. College One graduates shared they felt more comfortable going to someone concerning vertical bullying. Reported also were references to just “going along” or the need to just take it were noted in the participants’ responses from all three college cases.

Another finding from college participants was four of the seven representatives from College Two referred to coping mechanisms they learned in dealing with vertical bullying, including how to stay “under the radar” and how to talk with instructors, some stating the techniques they learned for dealing with academic bullying were useful to them now as practicing graduate nurses. All three representative groups talked about cliques in nursing and in nursing education as contributing forces in vertical bullying. However, only two representatives from College One talked about cliques experienced in their nursing program.

Representatives from all three colleges referred to the stress in nursing and nursing education from high acuity patients or heavy workloads in clinical situations as possible causes of vertical bullying. Some respondents suggested stress leads to preceptor and instructor burn-out. This explanation was offered predominately from representative from Colleges Two and Three. Participants from all three colleges shared they felt bullying in nursing education or in the profession of nursing did not affect patient care.

Instead of “taking it out on the patients,” they take it out on students and new graduates (Nurse 0005).

Finally, the prevalence of gossip and how it causes and contributes to vertical bullying in nursing and in nursing education was heard from representatives from all three college cases. The two male graduates contributing to the study who came from two of the three colleges (College One and Two) both emphasized how extreme bullying through gossip was part of the culture which they experienced as students and new graduates. Nevertheless, the pervasiveness of gossip contributing to a bullying culture was heard from a majority of participants from all three institutions.

Cross-case Analysis of Finding Two: Bullying is Learned Through Socialization

During the interview process for this study, the definition of the term “socialization” was discussed, before the following question was asked of all participants: “when and how did you learn to really be and act like a nurse?” During the discussion that ensued from that question, every nurse respondent mentioned the importance and the power of role models in their socialization as nurses, mentioning specifically their instructors and clinical preceptors. The power the role model-instructors have over the students was addressed in a more positive manner by graduates from Community Colleges One and Three, and in more negative way from graduates from Community College Two. Some graduates from Community College Two, however, did mention the majority of the instructors exhibited positive qualities and talents as nurses providing the graduates positive examples of how to behave as nurses. One stating “there were only a few that were nurses that you would not want to be like” (Nurse 0009).

Representatives from all three groups mentioned the concept of “power” connected to vertical bullying. They talked of coping mechanisms they used when faced with the misuse of power, especially in nursing education. Most respondents suggested that -because they were students- they felt helpless in the face of this power in vertical bullying, and frustrated as new graduates as they might lose their jobs if they confronted this power in their new workplace. Representatives from all three cases also voiced feeling guilty when they could not help other students or colleagues being bullied “because it would probably just make it worse” (Nurse 0010).

Cross-case Analysis of Finding Three: The Importance of the Clinical Experience

Nurse representatives from all three programs discussed vertical bullying predominately from a clinical perspective, not usually in reference to vertical bullying seen in didactic learning. A frequent reference to “fitting in” clinically was predominately heard from representative from College Three. More than one of these College Three representatives referred to the pressure their program put on “talking and looking like a nurse”. The College Three representatives reported learning how to act in the clinical environment was a positive aspect of their learning experience, and did not seem to be viewed at all negatively or as a form of punishment. More than one of the CollegeThree graduates voiced appreciation for the way the program emphasized professional values and behavior in their clinically related curriculum component of their nursing program.

Representatives from all three college cases commented about the academic support for verbal bullying they had observed or experienced as students. When asked about the hierarchy in nursing education and its connection to verbal bullying, most participants responded with a reference to the concept of chain of command and its

importance in nursing. From the responses, there seems to be no difference in the responses concerning the role or concept of chain of command from one college case to the next. Most respondents, despite their training institution, shared they began to understand the concept of chain of command while in their nursing program and continue to utilize this concept in their workplace as needed in their roles of graduate nurses.

Concerning hierarchical aspects of vertical bullying in their nursing programs, some graduates from Colleges Two and Three made reference to their college program's rules and regulations. They did not use the stated chain of command concept to report vertical bullying while in their nursing program because of perceived consequences from instructors (Nurses 0001, 0004, 0010, 0015, 0019). All graduates from all three programs indicated in responses they did not feel their academic program's curriculum prepared them for the vertical bullying they encountered as new graduates in the nursing profession.

Summary of Chapter Four

After an introduction of representative graduates from three different community colleges, this chapter consisted of the following: a review of the four research questions which guided the study; a report on the four major findings or themes and subsequent sub themes; and finally a cross analysis of the findings from the three cases or colleges.

The first major finding supported discovery that participants in this study believe the metaphor NETY. This major finding supports there are a variety of causes and effects of vertical bullying which occurs in nursing and nursing education. Minor themes also emerged which supported the how and why of the effects of bullying.

The second major finding indicated bullying is learned and socialized through

nursing education and confirmed nursing students and graduates are socialized into a bullying culture through observing and experiencing the misuse of power and bullying from role models. Two responses from different lenses emerged: 1) students learn how to “play the game” and 2) instructors remember experiencing bullying through their own socialization into nursing. Finally, there is academic support for the socialization of vertical bullying into the nursing profession connected to nursing education through components of the academic structure.

The third major finding supporting the thesis of this study is that socialization into a bullying culture is most often encountered in the clinical component of nursing programs and learned from observing and experiencing bullying in the clinical arena of nursing education. Conversely, bullying is not commonly learned in the didactic delivery of nursing theory. Findings regarding the concern to fit in while learning in the clinical arena, and a sub-theme concerning the importance of precipitating, motivating, and enabling clinical factors also were confirmed.

Cross case analysis and comparisons of findings reported from nurse participants representing the three college cases in this multiple case study were presented in the final section of this chapter. The following chapter will present discussions and further analysis of findings in relation to this study’s research questions, conclusions, and recommendations for future study of this topic.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

This study investigated the socialization of vertical bullying through community college nursing education. When interviewing the participants in this study, vertical bullying was defined as abuse which is conducted towards a student or new nurse from another person who is in a superior position in an organization (Thomas & Burk, 2009). Unfortunately, bullying is a common occurrence in nursing and in nursing education, and the effects of vertical bullying upon students and graduates are far-reaching and long-lasting. This study confirmed that almost all nurses know about, have observed, or have experienced vertical bullying as a student or a new registered nurse in a clinical setting. A significant number accepted this behavior under the adage “Nurses Eat Their Young” (NETY).

Statement of the Problem

Vertical bullying in nursing is a known phenomenon that occurs within the profession of nursing, especially in clinical settings and within the discipline of nursing education. Because of their experiences with bullying, some nursing students leave their nursing profession before finishing their program. It has also been cited as a cause for high turnovers of graduate nurses in the healthcare workplace. Embree and White (2010) reported that more than 60% of new graduates leave their first clinical position within the first six months because of the non-professional behavior and bullying that they experience on the job.

Discussion of the problem. This study explored the socialization of vertical bullying through community college nursing education; it was not intended to determine

if bullying occurs in the nursing profession. The literature review for this study alone cited numerous studies which support that non professional behavior and vertical bullying are very prevalent in nursing and in nursing education, and it is increasingly identified as a severe problem for students in nursing education and nursing program graduates (Gallant-Roman, 2008; Holmes, 2006; Hutchinson et al., 2008; Palmer, 2003; Quine, 2001; Stanley et al., 2007; Yarnada, 2000).

In reality, there are hundreds of studies—utilizing both qualitative and quantitative research methods—supporting the fact that vertical bullying does indeed occur in nursing. The findings in this study confirmed that nurses and nursing educators already know that vertical bullying is “alive” and commonly witnessed or experienced in the nursing profession and in nursing education. In my literature review, nursing bullying was defined as “a complex interaction between work groups and organizational characteristics . . . with nurses acculturated into tolerant work group norms which perpetuate and normalize bullying” (Hutchinson et al., 2008, p. 148). My study found that vertical bullying is indeed part of the culture of nursing, known and identified by nurses and nursing students. The consistent response from participants of NETY adds credence to the finding that bullying is socialized into the culture of nursing. Furthermore, bullying socialization begins subtly in early nursing education, as students are exposed to clinical gossiping, innuendo, and isolation shown to them by instructors and clinical preceptors. By the time students become graduates, bullying becomes just “part of the job”—something to be avoided and sometimes tolerated.

One major conclusion in my investigation was that most students and registered nurses accept the fact that vertical bullying has and can happen routinely in their daily

professional lives. Many students and new graduates also find ways to cope with the behavior, and choose not to bully, even while being bullied, while some may unconsciously incorporate this negative behavior into their daily professional lives. Through this study, I investigated the effects of vertical bullying upon students and graduates from community college nursing programs, comparing the results to current literature on this topic. In chapter five, the discussion of findings demonstrate that in comparing this study to previous research, there are some similar and some divergent results. This investigation also produced findings regarding vertical bullying causing fear and intimidation of participants. Additionally, it was found that participants were affected by exposure to influential role models, the misuse of power, vertical bullying in the clinical, and significant academic support in the socialization of vertical bullying. All of these factors are discussed in the following sections, as they relate to the study's research questions.

Purpose of the Study

The purpose of this study was to examine the effects of vertical bullying and non-professional behavior upon the nursing students and graduates who chose and learned the nursing profession through community college nursing education, and ultimately to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession. Previous chapters of this investigation included the study's: 1) background and reasons for choosing to do this study, 2) review of literature, 3) methodology, and 4) findings. This chapter presents the following: a review of the research questions for the study and the methodology chosen; a discussion and summary

of findings related to the study's research questions; implications for practice and further research; and finally this researcher's statement of conclusion.

Research Questions for this Study

The following research questions have guided the study:

1. What is the effect of vertical bullying on students in a community college nursing program?
2. Are community college nursing students socialized into a bullying culture?
3. How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
4. Do components of the academic structure (e.g. hierarchy, student discipline, faculty reward systems, etc.) support vertical bullying at the community college?

A Review of the Methodology

A brief review of the methodology reminds the reader that formal interviews of more than 21 nursing graduates comprised the data for this current qualitative multiple case study. When I formally interviewed the nurse participants, I had face to face interviews with the majority of the respondents, and telephone interviews with six of the respondents. There did not seem to be a difference in the quality or willingness to share information from one venue to the other. All responders were given the permission form to sign, with the issue of complete confidentiality addressed at the onset of the interview session. Responders were told that they could opt out of the interview at any time with no penalty and without question.

The interview questions were asked in a logical sequence to all respondents (see Appendix C), giving them sufficient time to respond and with the understanding that they might return to discuss a previous question if desired. Triangulation of this study was accomplished by including the results of taped and transcribed notes from two nursing instructor/ administrator focus groups, analysis of documents, as well as the use of researcher journal notes. Peer review and member checking was utilized throughout the collection and analysis of data. The following is a discussion of some of the findings from this study on the socialization of vertical bullying through community college nursing education.

Response to Research Question One: What is the effect of vertical bullying on students in a community college nursing program?

Negative vertical bullying behavior seems to be simply accepted and taken for granted, as witnessed in the unanimous proclamation in this study of NETY. These statements from participants were sometimes said in amazement, sometimes apologetically, and many times said with resignation. Statements like this may serve as a defense of a condition because the individual feels powerless to change this experience so one might as well “make the best of it”. This significant finding of the study warrants further exploration, and it is examined in the following sections concerning the effects of vertical bullying.

Effects of vertical bullying on students. The findings of this study connected to the first research question all seem to evolve from the effect of acceptance of vertical bullying that is expressed in the metaphor NETY. There are really four effects of this acceptance identified in this study: 1) fear, 2) intimidation, 3) minimization, and 4)

feelings of isolation. It is the first and second of these effects which seems to be a significant reason for concern for students as they learn and become graduate nurses.

Learned behaviors enabling bullying. While interviewing participants, I asked them to read the list of given responses in the protocol and identify any of those which were similar to the usual response which they had to a bullying event, whether observed or experienced. Many participants (48%) listed their first response as “do nothing,” while another 37% listed “put up barriers” as their usual response to bullying (Appendix E). These responses directly mirrored the findings of Cooper et al., (2009) in the quantitative study of more than 600 nursing students from 20 schools of nursing in a southern state in the United States. Over 70% of the respondents for the Cooper et al. (2009) study utilized passive responses, similar to the reported responses in this study. In this study, consistent with previous research, is the following: students and new graduates generally do not actively acknowledge bullying of another and usually avoid conflict rather than confront another person who may be bullying them (Hoel et al., 2007; McKenna et al., 2003). Some researchers concluded that students and new nurses feel guilty, assume that they are to blame or are the real cause of the bullying incident, and feel powerless against vertical bullying (Anderson, 2001; Duffy, 1995). No participant in this study assumed blame for a bullying act; however, eight of the participants verbalized that they did feel that it was not worth the effort to report the bullying behavior they observed or experienced, further supporting these findings in the literature.

In previous research, one mixed methods study of 39 students (Randle, 2003) over a three year period indicated that 34% of the nursing students experienced bullying from instructors or preceptors at some time in their nursing program. In this same study, it was

noted not one nursing student reported this bullying. This finding was supported in my investigation as most nurses reported that they routinely did not and do not address or confront vertical bullying, usually choosing to “do nothing” or pretend “not to see” (Appendix E). The reactions of the students and new graduates in Randle’s study mirrored the findings in my investigation since the participants reported that they would rather choose to remain silent about the bullying than confront the bullies. One difference in these two findings was that Randle’s participants reported humiliation, belittling and isolation of patients due to vertical bullying. In this study, no participant reported the vertical bullying affected patient care. Conversely, most participants reported they had never seen patient care affected. Many of these nurses responded they “felt bad” they “didn’t say or do anything” but many felt their silence was the best choice so the “situation didn’t become worse.”

Fear or “just take it.” In another section of the interview, most participants reported their usual response to bullying as a student was to “just take it,” a finding that corresponds to findings from many other student-bullying studies (Farrell, 1999; McKenna et al., 2003; Quine, 2001). Avoidance and fear of consequences was also a usual response to bullying experiences reported by graduates, with the usual reason for the avoidance being a response of “I didn’t want to make it worse.” Many students waited for many semesters to be admitted into nursing programs, and they did not want to complain about bullying treatment, especially if it was directed at them. They felt if they complained, they were going to be singled out by the instructor and their life as a student would be even more difficult. Many felt guilty when they could not help other students who were being bullied, and they did not trust the administration to protect them from the

instructors' retaliation for any complaint about them. They learned how to survive and protect themselves, or how to "talk" with instructors. This finding (of learning how to "talk" with instructors) was an unexpected discovery in the study by this researcher, as no reference to this kind of effect of bullying or such a coping mechanism has yet been uncovered in the literature reviewed by this researcher. This unexpected response was obtained as a result of the comfort level of the nurse respondent in this study, an advantage of the nurse researcher in knowing the language and the culture of nursing education.

Reasons for "taking it." Students who became graduates nurses carried over this survival strategy for vertical bullying into their professional workplace as they dealt with workplace bullying as new graduates. Graduates reported they had many reasons for "taking it" as they were bullied by preceptors, many including economic concerns and the need to keep their nursing positions. One participant knew if she complained it would cause trouble for her and she would lose her nursing position, a job with a convenient schedule for raising her daughter. For others, keeping quiet when they and others were being bullied was tied to their perceived need to "fit in" and not be seen as a trouble-maker. These were expected themes and were supported in the literature review for this study.

The need to "fit in," or conform to the norms of the profession, was a common thread in the responses of participants in this study when asked about their socialization into nursing, and mirrored the findings of other seminal studies (Hoel et al., 2007; McKenna et al., 2003). The concerns about conforming to professional norms also mirrored the finding of Dellasega (2009) who proposed students and new graduates

eventually accept vertical bullying as part of the “package” of being a nurse, protecting themselves in a variety of ways. This gradual effect of acceptance of “relatively low-key negative experiences and not necessarily the grave bullying incidents” (Hoel et al., 2007, p. 276) is said to be a grave threat to positive socialization into the nursing profession. My study also agreed with Hoel’s study and indicated there is a gradual acceptance of vertical bullying as students proceeded through the nursing program and became new graduates in clinical practice.

The effect of learning how to take it and fit in was mirrored in the responses which were heard from the instructors in the focus groups in this study. More than once, these instructors referred to the need to accept the bullying they observed or experienced in clinical areas when they felt they were threatened with losing clinical sites if they registered any complaint about preceptors or staff nurses interacting with their students. Echoing the same frustration as their students, the educators choose to endure or continue to observe bullying without saying anything or reporting the behavior.

This outcome leads to the following important finding from this study. When students and new graduates learn and are socialized into a culture of accepting and enduring bullying as exhibited from their role model-instructors, who also tolerate and accept bullying in the clinical area, it results in perpetuation of the behavior and the acceptance of the behavior. Therefore, there is a “triangulation of acceptance” where students, graduate nurses, and educators expect they will observe or experience vertical bullying in nursing education and in nursing. This kind of acceptance of bullying also contributes to the normalization of bullying discussed earlier in this chapter. In this study, evidence and reports of this continuation of vertical bullying clearly demonstrate the

intense connection of nursing education to vertical bullying in the profession, further supported from the effects or outcomes of the major finding of NETY: fear, intimidation, and isolation. These effects are routinely felt and perpetuated by nursing students, graduates, and instructors, as explained in the following sections.

The effect of fear. The thread of fear was found in many responses from students-now-graduates, instructors, and in the document review. Instructors advise students they have to “go along to get along,” modeling behavior that unconsciously conveys there is a reason to be afraid of consequences if there is not compliance with the cultural norms of the clinical site. This kind of submissive behavior is an effect of vertical bullying and confirms the findings of other researchers that conforming to group norms is a significant contributing force of bullying in nursing and nursing education (Hoel et al., 2007; McKenna et al., 2003), thereby perpetuating the practice of vertical bullying. More importantly, this finding suggests the strong connection and evidence that bullying is accepted and socialized into nursing through the fear of threats, and learned initially in early nursing education, and is in agreement with the research of Baltimore (2006).

The effect of intimidation. Vertical bullying felt by students was also frequently mentioned by graduates in reference to their time as students as well as their experience as new nurses. The nurses did not usually admit to demonstrating bullying behavior themselves, with one or two exceptions. As one of two male nurses participating in this study, one graduate nurse participant admitted he had become somewhat of a bully as a new graduate and preceptor of new nurses. He and one other participant referred to a kind of “necessary” bullying which is needed to make nurses “stronger” or able to withstand bullying. This participant felt gender played a role in bullying, and talked of how some

experienced nurses tried to bully him as a new nurse and continued until he learned how to “play the game” and intimidate others in return. One important finding from this interview was he felt that “age, experience, and more education” have helped him become a better nurse preceptor. This finding mirrored the findings of Lewis (2006) who concluded bullying was learned behavior rather than a psychological defect.

The effect of isolation. Isolation is frequently experienced by students and graduates, caused by exclusion through cliques in nursing and nursing education—another effect of vertical bullying as NETY. The age of nurses isolated by vertical bullying as a result of cliques of nurses was mentioned by more than one of the participants. A significant discovery connected to this finding is nurses do not really only “eat their young.” It can happen to anyone at any age. In vertical bullying, the age of the bullied and the bully varies according to the circumstances of the bullying. In this study, vertical bullying occurred from nurses who bullied older nurses as well as new graduates. This upholds the finding that vertical bullying can occur despite differences in age between nurses and is consistent with the findings of other researchers, including McKenna et al. (2003).

Another important finding in my study parallels the findings of Hinchberger (2009), that “many students and new graduates accept vertical violence (and bullying) as ‘rites of passage,’ only to mimic and repeat this behavior later in their careers” (p. 43). The study concludes that “Yes, it does seem that nurses learn to ‘eat their young’ AND each other as part of their profession” (Hinchberger, p. 43).

In this study, some participants described and distinctly identified bullying experiences during the interviews. Others described events which would usually

represent vertical bullying activities by most, but were interpreted and seen as “useful and necessary professional interrogation” by some participants. Many participants referred to bullying as a kind of “hazing” that they needed to “go through” if they were going to be “worthy” enough to be a nurse. Unfortunately, some of the instructors in the study also reported some of their colleagues in nursing education have stated students need to “go through the same things” they did as student nurses. This is an attitude of “if it was good enough for me, it’s good enough for them, too”. Regrettably, this mindset only perpetuates vertical bullying in nursing and in nursing education as a result of the nursing socialization process.

Role of preceptors. In nursing education, some colleges follow the preceptor model of nursing education, similar to Community College Three’s program, utilizing staff nurses in hospitals as preceptors for students when the clinical instructors are not present. When considering the lasting effects of vertical bullying, the findings for this study indicated that even though many students were educated within the context of a bullying culture, most graduates now serving as clinical preceptors reported they felt they were able to turn negative behavior into positive outcomes by consciously acting differently and positively in their preceptor role. If this self-reported behavior is true, this finding produced some hope for addressing vertical bullying in the future and does not support the finding of Randle (2003) who proposed the way a student is treated during nursing school determines the way the student will treat others later as graduate nurses.

Response to Research Question Two: Are community college nursing students socialized into a bullying culture?

A major finding in this study is nursing students are socialized into a bullying culture through an educational system that relies on threats, oppression, and dominant

groups, all of which is information also presented in the literature review for this study (Begeley & White, 2003; Dellasega, 2009; Freshwater, 2000; Pearson, 1998, Roberts et al., 2004; Sinclair, 2000). In connecting education and vertical bullying, Freshwater (2000) proposed nursing education and teaching students how to be good nurses is controlled by those in power who dictate the curriculum and support “covert conflict within the profession, manifested as internalized self depreciation” (p. 482). The curriculum, however, does not formally define “a good nurse” or teach students how to react to vertical bullying. Noting this lack of instruction concerning vertical bullying in most nursing curricula, this study’s findings and others (Duffy, 1995; Kolanko et.al., 2006; Magnussen & Amundson, 2003) determined students are socialized into a vertical bullying culture in the nursing profession, not only by what is said, but by what is left unsaid.

In this study, the concept of socialization into nursing was discussed with each of the respondents and with the instructors in the focus groups at the initiation of the conversation. This study was based on Gartner’s (2007) definition of professional socialization: “It is the process through which an individual learns to adopt the values, skills, attitude, norms, and knowledge needed for membership in a given society, group or organization” (p. 371). This definition was discussed with each participant and each participant was asked how socialization factors contributed to their learning of how to be a nurse, usually by an accompanying question: “How and when did you learn how to adopt the values, skills, attitudes, norms and knowledge of a nurse?” In order for the participants to further discuss their own socialization experiences later discussed in the

interviews, it was important for the participants to have a frame of reference and understanding of the term nursing socialization.

The findings of this study mirrored findings from a number of previous studies (Duchscher, 2008; Hoel et.al., 2007; Reutter et.al., 1997) which stressed the need for students and new nurses learning the norms and values of their new profession while forging and downplaying their previously held norms and values. Most respondents acknowledged their instructors played a pivotal role in their socialization into nursing, many stressing the power faculty and preceptors had in their initial socialization into nursing. More than one respondent talked about their need to “prove themselves” as a good nurse, especially to instructors, while they were students. This echoes Reutter’s (1997) finding that proving oneself may mean “accommodating to each instructor’s different expectations” (p. 153), an activity which may also contribute to the students’ exposure to vertical bullying. Such a finding is noteworthy as students’ accommodations may be a difficult task because they are frequently changing hospital or clinical rotations and have little control over this aspect of their educational experience.

The finding in this study concerning the importance of role models in nursing was heard frequently. Many graduates praised their instructors as role models, and said they would “not change one thing” in their experiences they had as students in their programs, despite observing bullying of another student. All participants reported they had either experienced or observed bullying from selected faculty or preceptors in their initial socialization into nursing as a student or as a new graduate. These results correspond to other studies which find nursing faculty impede educational experiences (Magnussen & Amundson, 2003), and some instructors’ negative actions lead to a hostile environment

where learning is diminished, even if instructors do not intentionally set out to bully students (Kolanko et al., 2006).

More than one respondent in this study referred to the power that instructor-role models had, and the power preceptors had when graduates were new nurses. The reported need for respondents to fit in and “get through” their clinical rotations or preceptor-led orientation experience despite the misuse of power was a frequent response in this study. These findings matched those of Kolanko et al. (2006) and others (Cooper et al., 2009; Hoel et al., 2007; Thomas & Burk, 2009) who found students and new graduates felt they had too much to lose if they stood up for themselves or confronted those who bullied them. The concepts of vertical bullying and the misuse of power in nursing education add to the feelings of powerlessness reported by nurse graduates and apparent acceptance of inevitable bullying in the profession.

Some findings of this study seem to differ from the results of many of the studies cited in the literature review for this study, especially concerning how graduates treat others as they were treated as students. Regarding this finding, many study participants reported they did not and do not agree with the norms and values displayed by powerful role models, instructors, or preceptors. Without prompting from the researcher, many participants volunteered they made conscious efforts to treat students and new nurses positively and differently than they were treated in those same roles. Experience, education, and maturation in their professional role seemed to affect different responses to vertical bullying by some new graduates as they reported a comfort level in challenging powerful role models after a few years working in their profession.

One disturbing finding in this study was the practice of bullying new, inexperienced faculty by the more experienced instructors in nursing programs. Just like in student and graduate bullying, fear plays a role in faculty to faculty bullying. New faculty fear of experienced faculty members negatively contributing to the new faculty member's tenure process was a finding cited routinely. This reported finding was a major precipitating factor for the bullied faculty member not to intercede when observing the bullying of another instructor or a student. This finding, though surprising in its intensity and passionate response from focus group participants, is also supported in the literature (Baltimore, 2006; Kolanko et al., 2006; Lee, 2007; Olson, 2007; Twale & De Luca, 2008). One other finding from this study, which mirrors the findings in the literature review, was the participants' stress upon clinical vertical bullying and not necessarily didactic bullying. This concept is covered in the next response to research question three.

Response to Research Question Three: How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating, and motivating factors contribute to this socialization?

Bullying is socialized through community college nursing education primarily in the clinical education component of the program. One of the distinguishing requirements in health education programs is the required clinical learning experience. By witnessing non-professional behavior and vertical bullying modeled in their clinical rotations, students and new graduates of community college programs may appear to be first-hand unwilling victims and learners of bullying techniques in their clinical learning experiences (Thomas, 2010). The results of this study indicate an important insight that bullying has been predominately occurring in the clinical environment and not necessarily in the classroom.

From the responses in this study, it is again apparent that students and new graduates practicing in the clinical environment fear making mistakes. Students are assigned to clinical experiences in a rotation, which means students may only be at one hospital location for a few weeks before being placed at the next, and then the next. The opportunities for students in developing helpful relationships with staff nurses and preceptors dwindle, and they have not yet learned the communication skills of an experienced practitioner. By nature, students are intimidated by faculty, physicians, and other experienced staff nurses. These factors make students vulnerable to any uncivil or bullying behavior they may encounter as they are socialized into their profession in a clinical environment.

Also apparent from the interviews and discussion with participants in this study is the awareness that whatever clinical bullying has been observed and encountered by students seems to be taken for granted and not questioned many times, and sometimes defended with statements like “well, she could be excused because it was a very stressful day” or “sometimes the only way for some people to learn is to make them squirm . . . it didn’t hurt her.” Approaches like these contribute to the gradual socialization and normalization of a bullying culture through clinical nursing education. In support of this finding, Hoel et al. (2007) proposed “the clinical is seldom entirely negative; most students report a mixed experience . . . a combination of positive and negative experiences, where there is always ‘light at the end of the tunnel’ . . . [It] might lead to higher levels of tolerance for negative behavior and prevent students from taking actions against the problem” (p. 276).

Finally, the findings of this study focus on the experiences of ADN students and graduates mirrored the findings of Thomas (2010) who studied clinical bullying from the perspective of the junior level BSN nursing student. When describing vertical bullying events in the clinical, junior level students, Thomas reported “condescending, overbearing, rude, sarcastic, disrespectful, patronizing and degrading” (p.301) treatment, some of the same descriptions given by the ADN graduate participants in this study. Another similar study of senior year students’ clinical bullying experiences (Longo, 2007) confirmed these same findings, also found in the studies regarding bullying experiences of BSN students (Day et al., 1995; Hart & Rotem, 1994; Hoel et al.,2007; Magnussen &. Amundson, 2003). There is a scarcity of similar studies involving the associate degree nursing student in clinical practice, a fact that will be addressed later in this chapter in the implications for research section.

Factors Contributing to Socialization of Bullying

A critical finding of this study is that particular factors contribute to the socialization of bullying into nursing, especially in the learning which occurs in the clinical environment. The foundational philosophy for this study on the socialization of vertical bullying is based on the adapted theories of Salin (2003) by Twale and De Luca (2008). The premise is vertical bullying in the clinical environment is frequently the result of many interacting factors which may occur simultaneously and intensify the bullying experience as students are learning (see Figure 2.3). The results of my study strongly support this premise.

The reader is reminded that in employing Salin’s (2003) framework in the study of vertical bullying in community college nursing education, three groups of bullying

factors are presented and fall under one of the following: 1) enabling; 2) motivating; and 3) precipitating of bullying. The enabling processes “provide fertile soil for bullying” (Salin, p. 1219). Motivating processes are circumstances which “make it rewarding to harass others” (Salin, p. 1222). Lastly, precipitating processes “often act as the actual triggers of bullying” (Salin, p. 1224). According to Salin’s model, “bullying can be understood as the result of an interaction between these three groupings of explanators, (sic) or at least two of them” (Salin, p. 1217).

Respondents in this study gave examples of these three factors in relation to bullying conditions that they observed or experienced. The enabling factor was frequently identified as the administration knowing that vertical bullying was occurring, but usually not responding or acknowledging that it was occurring. The burned-out nurse and stress from high acuity patients were frequently cited as precipitating factors. Finally, the motivating factor of the need to be a “good nurse” was cited by participants as commonly associated with vertical bullying in nursing education. Respondents suggested bullying was intense when two or more of the three factors were present during the bullying episode. This common response is also supported in research reported in recent studies (Hutchinson et al., 2008; Simons & Mawn, 2010).

Application of the model. The concept of intensified bullying and the three identified factors: enabling factors, precipitating factors, and motivating factors (see Figure 2.3) were presented to participants as the foundational philosophy for this study was based on the adapted theories of Salin (2003) by Twale and De Luca (2008). During the interviews, I asked participants to choose one vertical bullying incident they

had experienced or observed and to then apply the bullying-intensification model, if possible.

Following the explanation, every participant was able to apply this adaptation of the factor intensification theory to clinical bullying observed or experienced in their socialization in nursing. After I asked them to identify one bullying incident they had observed or experienced, every participant effortlessly identified the enabling, precipitating, and motivating factors involved in the identified incident. They discussed how each of the factors contributed to the bullying event. With student and new graduates experiencing excessive pressure to conform to predominant group norms (Hoel et al., 2007), the finding is intensified vertical bullying experiences only add to the negative socialization that may occur through experiences in the community college nursing program.

This finding is notable in two ways. First, based on the literature review for this study, the model of intensified bullying has not yet been applied to bullying in community college or any level of nursing education. While this model of intensified bullying has been proposed in the research of Salin (2003) concerning organizational bullying and Twale and De Luca (2008) pertaining to academic bullying, this study's application of this model showing intensified bullying in nursing and nursing education is groundbreaking and must lead to future research. Secondly, as nursing professionals seek ways to address vertical bullying of students and new graduates, identification and use of this model will enable administration and healthcare management to teach about and begin to eradicate vertical bullying in nursing and nursing education. I consider

these concepts to have significant implications for practice, as detailed later in this chapter.

Response to Research Question Four: Do components of the academic structure support vertical bullying at the community college?

Nursing and nursing education is part of a hierarchical system, as discussed in the literature associated with this study (Cooper et al., 2009; Lewis, 2006; Thomas & Burk, 2009). Crawford (1999) proposed rigid hierarchical systems, such as in the nursing profession, support negative bullying behaviors as means of control rather than encouraging and empowering members of the profession. Findings from Lewis (2006) cite the notorious nursing “Rules and Regulations” and resulting “chain-of command” associated with nursing and nursing education to be the “guardian” for bullying in nursing education, carrying into the nursing profession as well.

Identifying a power imbalance which is attributed to the higher education hierarchical configurations, Cassell (2010) connects 72% of all bullying incidents in higher education to this imbalance. With reference as to how the hierarchical academic support affects student socialization of bullying, Cooper et al. (2009) summed it up with the following words:

In schools of nursing, a hierarchy exists that reflects the dynamics of other workplace environments. The classroom (and clinical area) embodies the structure of workplace units. Instructors and faculty represent supervisory positions. Students embody the status of subservient workers. If teacher-learner relationships are not positive, the student’s need for support and respect can go unmet, disempowering the student. (p. 3)

In this study, I found the academic support for bullying in nursing education is strong and frequently supported by an equally intense collegiate or institutional bullying structure (Twale & De Luca, 2008). This finding was not a surprise. What was a surprise associated with this finding in my study was the intensity of the responses from the instructors and administrators in the focus groups who reported the nursing hierarchy and seniority associated with academic divisions intensified the departmental bullying of new faculty. This finding mimicked the Salin (2003) motivating-precipitating-enabling model previously discussed. The intensity of the responses from instructors and administrators may also mirror the Salin-Twale and De Luca factor-intensity model of this study as instructors and administrators report frustration with the many factors which may be causing the vertical bullying they must observe and sometimes endure from other instructors and colleagues.

Additionally, the need to maintain the hierarchical system in nursing was found to be strongly associated with academic support of vertical bullying in nursing education. While the current hierarchical system sometimes seems distressing and a source of frustration for the instructors reporting from the focus groups, it also seems to be important and a necessary component of nursing education for other nursing instructors. Randle (2003) proposed the important chain of command concept in nursing and nursing education remains in place to help maintain nursing status. The historical ties back to the early military foundation of the nursing profession (Alavi & Cattoni, 1995) and the history of the association of religion to higher education also is said to synergistically contribute to the academic reinforcement of hierarchical-related bullying in nursing education.

From the interviews with participants and instructor focus group members, the findings acknowledged bullying occurred but was not usually reported to the administration or management. With graduates who reported bullying during their nursing program, bullying preceptors usually were not identified to instructors and rarely sanctioned for poor precepting. This may be critical weakness associated with the use of nursing staff as the preceptors in nursing education. While many preceptors are very knowledgeable and skilled in the art and science of nursing, some are not eager or willing to take on the role of clinical instructor or are overwhelmed by their own heavy clinical assignments and not able to provide positive role modeling to the students designated to learn from their example. From these facts, it is important to note again the following: vertical bullying is supported through the academic structure in nursing education not only by what is done, but also by what is not done.

In the document review for this study, there was no mention or inclusion of vertical bullying in nursing curricula. There was no indication that students might learn to identify and investigate the phenomena of vertical bullying in the nursing profession before they were expected to deal with it as graduates. Some curricula in nursing education made mention of incivility in nursing as a broad topic of discussion, but did not address the bullying phenomenon for students, or how students and graduates might respond to it in the clinical area. In short, vertical bullying continues in the nursing profession, partly dependent on the current academic structure in higher education. Specifically, nursing education seems to reward negative behavior while supporting a code of silence and the academic acceptance of vertical bullying.

Comparison of Findings

The foundational theory for this study of the socialization of bullying through community college nursing education was the work of Twale and De Luca (2008) who studied and reported on the organizational, institutional, and cultural factors which support incivility and bullying in academia, particularly higher education. While the authors proposed academic bullying “is indeed a reflection of society at large” (p. 3), the researchers concluded that an academic bullying culture in higher education was on the rise. Because of institutional norms and academic incivility, hostile academic work environments have evolved and bullying in higher education is prevalent. The following section compares the findings of Twale and De Luca (2008) regarding academic incivility and bullying in higher education and the findings of this study on vertical bullying through community college nursing education.

Similarities. There are a number of similarities concerning incivility which occurs in the workplaces in academia and in healthcare, including a shift to corporate norms and hierarchical organizations which may foster and protect a culture of incivility or bullying. In both the Twale and De Luca (2008) study of incivility in higher education and the current study of vertical bullying socialized through nursing education, there appears to be a common thread of outward denial that the behavior is occurring which runs through both professional environments. Twale and De Luca proposed the following: “department colleagues pretend all is well through their civilly and adapted façade” (p. 10), and “bystanders know what is going on, but they usually do nothing to help victims for fear of retaliation” (p. 15). Twale and De Luca added: “whether the

silence is totally out of fear or out of embarrassment, frustration, or importance is difficult to determine” (p.15).

Victims of incivility and bullying who were participants in my study repeatedly cited examples of denial which they observed or experienced as a victim of bullying, stating they felt humiliated and powerless because of the bullying, just as reported in Twale and De Luca (2008). Members of both professions who experienced incivility and bullying also reported a gradual desensitization concerning bullying, “because the socialization into the culture dictates otherwise” (Twale & De Luca, p. 9). Some members of both professions also consider administrative inaction concerning incivility and bullying as sanctioning bullying in their profession and a contributing factor in the normalization of bullying in their profession, with Twale and De Luca attributing educational leaders overlooking bullying as a “culture of arrogance” (p. 9).

Incivility and bullying in both nursing and higher education is seen as similar in the behaviors exhibited in both environments. Victims in both professions report they have experienced or observed disrespect shown to others, rationalization used to explain or excuse the behavior, hostility from many levels, and bullies who frequently “employ ineffective strategies to correct problems” (Twale & De Luca, 2008, p. 17). Additionally, it has been reported by these researchers that in higher education, bullying is frequently at the worst during stressful times, particularly when “the bully aligns personal interests to his or her own agenda in the belief that he or she is acting for the greater good of others or the organization” (p. 17). This phenomenon of stress contributing to bullying was reported as well by nurse participants in this study, citing examples of nurses working in Intensive Care or specialty units exhibiting or experiencing severe workplace bullying in

a stressful environment. Whether vying for tenure at a university as a new faculty member, or learning to work in an unfamiliar ICU as a new graduate nurse, in both environments there are reports of bullying in the forms of competition, gossiping, divulging confidences, public criticism, and patronization towards the victims of bullying.

There are also similarities regarding the culture of both higher education and nursing education supporting incivility and bullying. Both professions contribute to hierarchical organizations in their own way; Twale and De Luca (2008) further stated that these kinds of organizations which support bullying “may serve as an incubator for the establishment or maintenance of a bully culture” (p. 18). Bullying behavior in both cultures is reported to include manipulation, intimidation, gossiping, public humiliation, exclusion, unfair treatment, withholding of information, belittling, passive aggression, shunning or devaluing of victims. Members of both professions reported they may eventually become desensitized to bullying. In a “culture of arrogance,” said Twale and De Luca, leaders often overlook or dismiss opportunities to resolve problems connected to bullying “because the socialization into that culture dictates otherwise” (p. 9). Just as with new nurse graduates who keep silent when experiencing or observing bullying of a colleague, new faculty in higher education must be accepted by those faculty already established in the profession and “socialized to accept and support the prevailing value . . . [New] faculty are as likely to accept the bad with the good but not speak out against a bully culture” (p. 96).

There are some other basic similarities between the findings reported by Twale and De Luca (2008) and the findings from this current study of the socialization of

bullying through community college nursing education. Twale and De Luca's findings regarding victims who challenge the bullying system indicated bullies are "harder on" the challenging victims, causing them to either retreat and isolate themselves from the bullies or leave the organization. This is mirrored in the current study of nursing bullying as it was reported that many new nursing graduates who experience bullying leave their position within the first six months of hire. Twale and De Luca (2008) also reported that faculty in higher education are frequently targeted as "deserving aggression" (p. 26) when they "buck" the status quo. In the nursing study, it was reported that new nurses who stand up against a prevailing bully may be labeled "bad" nurses, minimized, or forced to retreat.

It is apparent that the members of both professions tend to respond to bullying in their professions with passivity. Ultimately, neither of these professions now have an overarching professional code of conduct which could be used to identify and alleviate unprofessional behavior in the workplace, although the Joint Commission (on Healthcare Accreditation) (2008) is attempting to initiate the adoption of their civility code at all accredited healthcare institutions.

Differences. There are also major differences in the findings from Twale and De Luca (2008) and the findings from the current study on the socialization of bullying through community college nursing education. According to Twale and De Luca, the academic issues which contribute to incivility and bullying in higher education are frequently connected to (1) tenure and promotion issues and 2) the accepted "patriarchic or paternalistic behavior" (p. 56) in academia. Faculty in higher education are more apt to work in isolation in their profession, compared to new nurses who must rely on

continuous, daily interactions with other nurses on their team. The professional isolation of new faculty members who climb the tenure ladder while teaching and doing research in a paternalistic, hierarchical environment is very different from the bullying environment of the new graduate nurse in health care. These differences are further examined in the following discussion concerning the connection of tenure and paternalism to bullying.

According to Twale and De Luca (2008), “tenure and promotion are often shrouded in secrecy and mystery” (p. 73). These researchers also proposed that “the ambiguity and mystique that often surround the tenure process provide a fertile ground for insecurity, suspicion, and rumor” (p. 55). Tenure documents, especially at research institutions, “offer lip-service to the importance of teaching, but in reality often favor and reward research pursuits” (p. 74). New faculty, alone on their tenure track, frequently “receive poorly defined messages or inconsistent feed-back” (Twale & De Luca, p. 74) which produces a ripe environment for incivility and bullying in the academic profession. While competition can be part of the culture of many occupations, including nursing, there is strong competitiveness in the higher education profession, frequently leading to incivility and bullying. New faculty members are socialized into an environment of “constant battles for dominance among institutions, academic programs, athletic programs, academic journals, [and] fields of study” (Twale & De Luca, p. 64) where the expectation is survival. While both professions tolerate and sometimes even support the passive-aggression exhibited by bullies in these professions, bullying in academia is accompanied with “lowered salaries, reduction in academic status, and fewer opportunities offered for advancement in the academic profession” (Twale & De Luca,

2008, p.120). Negative outcomes such as these are not as usual or prevalent in nursing for new graduates experiencing bullying, although new nurses experience other forms of negativity.

Paternalism and gender issues connected to bullying in academia highlight another major difference between the reported bullying of new nurse graduates and new academic faculty reported by Twale and De Luca (2008). While members of both professions report the use of “clique behavior” and “social distance” (Twale & De Luca, p. 56) experienced by victims, patriarchal and paternalistic actions frequently “victimize unsuspecting academic colleagues” (p. 57). The bully in academia is frequently shielded as these actions have become normalized in the profession. New faculty experience bullying through paternalism with statements such as the following: “the committee is operating in the best interest of (you) the candidate” (Twale & De Luca, p. 57). Eventually, the new faculty member may erroneously feel assisted in their journey towards tenure; in time, the new faculty member may be made to feel indebtedness to the bullying colleague. Due to the absence of a tenure process in nursing, new graduate nurses are spared this disturbing incivility.

Another difference between this study’s reported bullying in nursing education and Twale and De Luca’s (2008) results centers on gender issues in academia. The history of the development of professionalization in academia documents male dominance and mistrust of ‘newcomers’ in academia, especially women and minorities. While nursing has historically been a female-oriented profession, higher education conversely has been “a male strong-hold” (Twale & De Luca, p. 52). The insecure, or the bullier in the male professoriate, may seek ways to re-establish male dominance through

incivility. Additionally, these researchers suggest that some “men may use the organizational system in higher education to actively bully others, while (some) women have been socialized not to be aggressive and thus use a more sugar-coated passive approach” (p. 53). Gossip is a bullying technique common in both nursing bullying and academic bullying; it is considered “an acceptable feminine form of power and aggression” (p. 53). According to Twale and De Luca (2008), the academic bully is more apt to be driven by the competitive, an historically male trait, which rewards success and overlooks incivility, thus adding to the bullying culture in academia.

Administration. Finally, common to both academia and nursing is the reported view that bullying emerges because administration does not recognize bullying as a problem or denies that bullying exists in their organizations. Twale and De Luca (2008) proposed that the avoidance exhibited by authority figures “may also stem from the fact that administrators and faculty have other things they see as more pressing” (p. 22). These researchers add that administrators may not know what to do about bullying as “no repertoire of proven solution exists” (p. 22). Nevertheless, leaders and administrators in all professions have a great responsibility to directly recognize and effectively deal with bullying issues instead of ignoring them. Twale and De Luca (2008) asserted, “Weak or laissez-faire leadership, though not uncivil, can inadvertently instigate incivility through inaction” (p. 22). The following section on implications for practice includes suggestions for administrative action against bullying.

Implications for Practice

The findings of this study clearly support that vertical bullying is socialized through nursing education, specifically community college nursing education as

graduates of community colleges were interviewed for this study. Nearly 60% of the nurses practicing in the United States today began their education at community colleges (AACC, 2012). Most community college educators know community colleges, as the predominant educator of the nation's nursing and allied health professions workforces, are essential in providing high-value health care education and generating economic advancement (AACC, 2012). Because of the importance for leaders in higher education at all levels in responding to the vertical bullying occurring and supported by nursing education, for the good of the nursing profession and for the nursing workforce, the findings from this study of vertical bullying and community college nursing education must influence future practice and be generalized throughout all levels of nursing education. Implications for practice for particular segments of leaders are hereby specified.

Upper level leadership. Leaders throughout the community college must be aware of the national discussion in nursing and higher education regarding the movement to require the bachelors in nursing degree (BSN) as entry into the profession. Some states have adopted the "BSN in Ten" movement which requires that graduates of ADN and the few remaining diploma programs receive their Bachelors of Science in Nursing within ten years of graduation from their nursing program. There is national movement of healthcare institutions to seek Magnet status from the American Nurses Credentialing Center (ANCC, 2012), and currently seven percent of the nation's institutions have attained that goal (AACC, 2012). This Magnet movement has also fueled the pressure to employ an all BSN workforce, which has to date occurred in 386 of the nation's 5,795 hospitals (AACC, 2012).

Community colleges are naturally challenged by this Magnet movement because of its stress on hiring BSN only graduates. Rural community colleges are not as affected as urban institutions since Magnet status is usually not a plan of rural institutions, so rural institutions will continue to hire community college graduate nurses. Approximately 70% of the country's rural nursing workforces are ADN graduates, as well as 70% of the nation's nurses in long-term care and geriatrics (AACC, 2012). It is apparent that community college prepared registered nurses meet a great healthcare delivery need across the country. However, the healthcare industry and higher education are in a debate about the entry level and educational preparation of nurses, affecting not only the future of higher education but of the nursing profession.

Since most new nurses are initially educated at the community college level, leaders at community colleges are taking action to maintain this necessary level of nursing education. Nursing educators in Illinois are partnering community colleges with four year institutions in an attempt to meet community and student needs. "Two-plus-two" agreements in which universities accept the ADN degree as the first two years of a four year BSN program are common and are now being encouraged in Illinois and across the country. Collaborating with universities in establishing the "two plus two" agreements was only one community college response. Many community colleges have also responded to the BSN challenge by partnering with universities in the formation of 175 RN (ADN) to the Masters in Science (MSN) nursing programs nationwide, with 32 new RN to MSN currently in formation stages (AACC, 2012).

The current study on the socialization of vertical bullying through nursing education is now being offered in the described current climate of change and uncertainty

in higher education. As providers of the predominant numbers of nursing graduates in the country, this study is all the more important for community college leaders as its findings concerning the socialization of bullying through nursing education impact decisions about the formation of educational policy and practices for future nursing education. These facts, and the movement toward a higher educational requirement for practice in the nursing profession, have meaning not just for the leaders in community colleges but for nursing leaders at all levels of nursing education. Leaders in higher education, while addressing how education will provide new nurses in the future, must also address the issue of vertical bullying socialized through nursing education.

If the community colleges' partnering response to the BSN challenge is successful, there will be further reason for community college leaders to raise the awareness of vertical bullying in the socialization of students into nursing through nursing education. Providing nursing leaders, future instructors in nursing, and potential administrators with training and expertise on how to recognize and alleviate bullying in the profession will be the additional and direct responsibility of the community college system in educating the entry level practitioner. There will be an unprecedented opportunity for community college leadership to directly impact nursing education, for the good of the nursing profession as well as for the good of multitudes of registered nurses, and ultimately for the good of patient care. The next section provides recommendations for administrative responses to address vertical bullying in nursing education which will hopefully lead to the prevention of this phenomenon.

Administrative responses. It is obvious that the findings from this study emphasize to community college leadership the need to initiate a change in the nursing

profession by supporting and encouraging the reporting of vertical bullying. Awareness of community college leaders concerning the incidence and impact of vertical bullying is imperative if prevention is to be gained. With clear directives on definitions and consequences of vertical bullying in nursing programs, administrations must establish a program of both education and discipline. There must be graduated systems for discipline connected to vertical bullying of both students and new faculty. There must also be anti-bullying policies which clearly define unacceptable behavior. All faculty, staff, preceptors, and administrators should be trained to recognize vertical bullying and to understand its consequences. There must also be established protocols for those students and personnel who can safely report incidents of bullying without experiencing repercussions from these actions.

Eradication of vertical bullying from nursing education and ultimately from nursing practice will require a paradigm shift within the culture of the profession. Workplace environments which support bullying behaviors with hierarchical policies must be identified and improved. Supporting nurturing and collegiality in nursing programs, for instructors as well as students, will require very skilled leadership as this paradigm shift requires a culture change in long accepted practices. Additionally, changes in community college nursing curriculum, including the introduction of vertical bullying information and ways to address it, must be sustained and encouraged by community college administrators. The curriculum for dealing with vertical bullying must be clear and thorough, and the consequences of the behavior identified. Lack of clear definition concerning bullying behavior would impede the movement to bring vertical bullying away from the “white wall of silence” identified in this study, and would allow dangerous

individual interpretation of vertical bullying behavior. That all are speaking “the same language” is imperative when planning ways to counteract vertical bullying and brainstorming ways to deal with it.

Recognition of the vertical bullying phenomena and the importance of eradicating it must come “from the top” of organizations, whether the top administrators are leading the healthcare institutions or the educational institutions. Symposiums regarding vertical bullying offered through higher education for all levels in healthcare will assist in (1) confirming its presence as it is named and defined as a problem in nursing and nursing education, and (2) beginning to develop measures to uniquely address it in each institution. Culture change begins with “buy in” and agreement of the language to be used in bringing about the change. Once the problem of vertical bullying is identified and then awareness is raised concerning its socialization into nursing, core values and coping strategies can be systematically driven down into the institutions.

Another tool in the eradication and prevention of vertical bullying in nursing education and in nursing can be found in the use of simulation learning now utilized in healthcare education. By introducing real-world vertical bullying situations in clinical lab learning, through group role playing controlled in a lab, students can learn to identify and develop strategies to deal with vertical bullying as they develop their critical thinking skills. Simulation episodes could include the three factors highlighted in this study, with student recognition and gradual expertise developed under supervised learning.

An important aspect of dealing with vertical bullying behavior is promotion of community or public awareness regarding this phenomenon. Strong partnerships with healthcare organizations regarding programs to identify and deal with vertical bullying

must be rooted in unified visions concerning appropriate behavior in healthcare and educational workplaces. This study highlighted the cost in employee turn-over and personnel morale due to vertical bullying. Behavior which includes threats, intimidation, mockery or teasing, and feelings of not being safe constitute bullying. A community-wide zero tolerance movement concerning these behaviors must be expected by all community members, no matter what the workplace.

After comprehensive education programs are established in institutions, there must be measures of support made available for victims of vertical bullying which are confidential and inclusive. There must also be established strategies aimed at intervention made available for students, faculty, observers, or any personnel who experiences or witnesses vertical bullying. Finally, an “open door” policy, with promised “safe-zone” assurance for students and faculty alike, must be promoted and maintained by community college leaders if a vertical bullying transformation is permanently achieved through nursing education.

Mid-level leadership. The finding that socialization into nursing results from observation and imitating behavior concurs with a study also based on the findings of the behaviorist Bandura (1977). This theory of Bandura’s is frequently referred to as “observational learning,” directed by the following four processes: attention, retention, rehearsal, and motivation. As a concept is learned by an individual, the concept must be noted as important enough for attention and “attended to” by the learner. It must be then retained and sometimes coded by the learner so that it can be brought back into consciousness at a later time. It must be reviewed, practiced, and repeated in the mind and actions of the learner. It is then kept until the learner is stimulated to act on it.

After defining socialization and discussing how and when the participant learned how to behave or act as a nurse, I explained the foundation of this study utilizing Salin (2003), and Twale and De Luca (2008). Participants were then asked about contributing factors in their socialization into nursing. As reported by the majority of participants in this study, socialization into nursing for the new student nurse or new nurse graduate is the result of a multitude of factors, with observation of the behavior of others being a major contributor, followed by the environment in which they learned or worked, and then followed by personal factors contributing to their nursing socialization. Without exception, it was the observation and learning from the mid-level leadership -or the instructor and preceptor role models- which was reported by a majority of participants in this study.

From this finding, it is logical to deduce that change in the culture and organization of nursing education can more easily be achieved if vertical bullying is systematically identified and eradicated in the nursing education provided for students. Some members of the focus groups of nursing instructors and nursing administrators reiterated that some nurse instructors and preceptors “really did not think what they were doing was bullying.” According to some focus group participants, some bully because they are “protecting” the profession of nursing, maintaining high standards to “keep the patients safe.” Some instructors and preceptors walk “a fine line” between nurse and educator, coming down on the side of the nurse if they feel a student does not “measure up.”

Many nurse educators have minimal instruction in educational pedagogy and are taught to be nurses first and educators later. Many learn to teach on the job, with some

being very successful at molding students into new nurses, and others not so successful. Some instructors may eventually resort to vertical bullying in nursing education, out of frustration or lack of knowledge and understanding regarding fundamental principles of how to be a good educator. I am convinced after doing this study that some of these same instructors have no insight as to their responsibility of positive role-modeling or of the damage that they may be doing to students and the nursing profession through vertical bullying. Mid-level leaders in community colleges need to be aware of these facts as they promote affirmative teaching in nursing education.

Implications for practice to improve nursing education while assisting in the eradication of vertical bullying would include training for both nursing instructors and preceptors, raising awareness of what is acceptable in teaching and what is considered harassment and uncivil behavior. Middle management and leaders in healthcare institutions must also be mentored regarding vertical bullying. Woelfle and McCaffrey assert “Managers should be educated in recognizing [bullying] . . . and they should be addressing it in their [clinical] units” (p. 130). Partnerships between education, specifically the community colleges, and the healthcare institutions addressing nurse and preceptor training must occur if the pervasive vertical bullying is to be wiped out.

Leadership for caregivers. A major finding in this study was about clinical vertical bullying and when it occurred in the clinical environment. It was heard from more than one participant that the stress of very sick patients with heavy loads of patients made vertical bullying even more intense. One implication for practice for community college nursing educators, administrators, and preceptors is connected to the opportunity to teach the members of the caring profession how to care for one another, especially in

very stressful times. Although it may seem obvious and a clear responsibility of the nursing profession, teaching the caring profession how to deal with vertical bullying and care for one another is an important responsibility for nursing leaders in community colleges.

One approach that has been suggested in support of stemming vertical bullying is found in the work of Kupperschmidt (2008), who proposed that a kind of “paying it forward” in nursing called “carefronting.” Utilizing instructors, nurses in continuing education, and preceptors, this approach is based on the premise that nurses resist vertical bullying of one another if they are taught how to care for one another. This approach also educates the preceptor about bullying and possible interventions to defuse hostility while teaching the preceptor mentoring techniques and how to protect the student or new nurse (Thomas, 2010).

Community college leaders at all levels have a great responsibility in the prevention of vertical bullying so that professional nursing socialization does not include this phenomenon of vertical bullying in the future. In a prevention mode, community college leaders must support and provide new venues to discuss, share and problem solve vertical bullying issues before bullying occurs, utilizing discussion boards and “seminar-days” for discussion of professional behavior and ethics, perhaps two days within each course. Curriculum must include “real-life” practice, utilizing the simulation experiences in the lab to prepare students for possible bullying experiences they may encounter as new graduates. These measures are “small steps” but necessary if community college leaders are going to address this important issue in the future in community college nursing education. The next section will discuss how the current study might lead to these

small steps through advanced research related to the topic of the socialization of vertical bullying.

Implications for Research

As mentioned in the introduction for the proposal of this study, much of the previous research on bullying and socialization has been done utilizing populations of students from universities' BSN students (Hoel et al., 2007; McKenna et al., 2003; Mozingo et al., 1995; Thomas & Burk, 2009). A review of literature in this study confirmed that few studies on this topic include community college students in the population, making this study unique and vital.

This current study on the connection of community college nursing education and the socialization of bullying is essential for two reasons. First, the evidence that vertical bullying is indeed socialized through nursing education breaks new ground while discovering not *if* bullying occurs but how and why vertical bullying may be perpetuated through socialization in nursing education. In this qualitative study, because I found indications that the socialization of bullying into nursing begins with the education received in a basic nursing program, a follow up quantitative study is recommended and may assist in further discovery of this phenomenon. A quantitative study would provide a verification of this phenomenon and a resolution to this study's limitation of a small number of participants.

Subsequently, with the surge of two plus two agreements and RN to MSN college partnerships in preparation of entry level practitioners (see previous Implications for Practice section) community colleges will continue to be the main providers of the new registered nurses in the healthcare workplace. The results of this study of the socialization

of vertical bullying utilizing graduates of community college programs generalized across all levels of registered nurse preparation is important for community college leaders and all higher education leaders. My findings are expected to assist in the future development of strategies designed to alleviate this problem of vertical bullying in nursing education and ultimately in the nursing profession. Therefore, future studies to address successful and unsuccessful strategies in alleviating vertical bullying in nursing education in general are necessary.

Although this study was designed utilizing in-depth interviewing with member-checking and peer review, data were collected and analyzed over a six month period. Expanding this research over a longer period of time is recommended, similar to the longitudinal three year study of nursing students done by Randle (2003). This alternate approach would be expected to produce confirming or divergent results concerning the bullying socialization process, adding to the depth of knowledge due to longer exposure to respondents and opportunity for deeper collection of data. Another aspect which may be studied longitudinally may be a study of the degree of socialized bullying in nursing depending upon the level of education of the participants over a period of time, or the response to bullying depending upon the level of experience of the new graduate in nursing. Either of these topics will expand the body of knowledge concerning this focal topic, leading to possible responses and resolutions in the future.

Another predominant theme from my study was the finding of the normalization of vertical bullying in the profession of nursing which has its roots in early nursing education. My findings support those of Hutchinson et al. (2008) that “nurses passively tolerate or ignore witnessed bullying, normalizing the behaviours as an acceptable part of

their work experience” (p. 148). Like Hutchinson et al. (2006), I believe that ignoring or accepting vertical bullying in nursing and nursing education is not a neutral act. This acceptance clearly insures bullying’s normalization and that bullying will continue, making it as contagious as any disease nurses are treating. Further study must be done on this normalization of bullying if it ever has a chance of eradication from nursing.

The current study confirmed that instructor and preceptor role models are vital in the socialization of community college nursing students and new nursing graduates, repeatedly found in the literature. A follow up to my study could be done to study the cultural significance of role models in the socialization of bullying for all levels of students, from the first semester throughout the nursing programs. This approach would provide a different perspective concerning the response to bullying early and then later in the socialization process. Additionally, since it seemed that college role models differed in my study because one college utilized preceptors in the clinical environment more than the other two colleges.

Another frequent reference in my study was to the concept of “a good nurse.” Instructors as well as graduate participants talked about being a good nurse, but even at the end of this study, I am not sure of its definition or what that really means. In the literature review and according to Randle (2003), a good nurse is represented by female stereotypical attributes like compassion and caring, but I believe not all participants would necessarily agree with Randle. I believe further study in this concept of a good nurse related to my topic of the socialization of vertical bullying is certainly warranted.

One interesting outcome of this study was bullying seemed to be socialized into nursing through clinical interactions, rather than in the presentation of theory. This

finding, if generalized across all nursing education, narrows the field of concentration for those who will be attempting to eliminate bullying from the curriculum. Education of preceptors and staff nurses, as well as clinical faculty, would be a first step in the elimination of the disrespect and hostility experienced and reported by the ADN participants in this study. As reported by some of this study's participants, some hospitals have already taken an initial action and established programs addressing bullying of staff, urged by the Joint Commission on Healthcare Accreditation mandate (2008) from this healthcare industry accrediting body. Despite the fact that there is more opportunity for bullying with one to one clinical contact between students and instructors or preceptors, a follow up study could be initiated studying why it happens more in a clinical setting than in the classroom. Another investigation might be done to determine what kind of training could be done to assist in the prevention of vertical bullying in the clinical environment.

My study also determined that the involvement of administration in colleges and healthcare institutions is paramount if vertical bullying is to be eradicated from nursing education as well as the nursing profession. My study's findings concerning the socialization of vertical bullying through nursing education are important pieces of information not only for administrators of nursing programs with a background in nursing. These findings are useful and necessary for those administrators without a formal background in nursing as they are dealing with vertical bullying and trying to determine how to deal with it. A future qualitative study of responses of non-nursing administrators supervising nursing and nursing education to vertical bullying is highly recommended.

As a final recommendation for future research, because this study's results indicated there were differences between colleges concerning the bullying culture, I recommend further studies to examine why there are different levels of bullying depending upon the academic culture of the institution. By examining the differences between institutional responses to vertical bullying, the learning environment and culture from one site to others might be studied from the perspective of what makes one site more supportive of nursing students than other selected institutions. Information gathered from such a study would only lead to further development of supportive and encouraging nursing education at more community colleges and other higher education institutions.

Conclusion

There were many discoveries which came from this study concerning the socialization of vertical bullying through community college nursing education. Foremost was the finding that all of the participants in this study—once students and now graduates—learned their profession in an environment in which the possibility of negative behavior and bullying was as routine and accepted as the positive and supportive behavior expected in nursing education. According to participants, vertical bullying could happen at any time in the learning setting, depending upon the people and the circumstances.

I believe that socialization of bullying into nursing through education is aided by lack of recognition of its existence, partly due to the power from influential role models and the frequent bullying conditioning students experience. There was also no surprise in the finding concerning the importance of role models in nursing education, or the finding of how the misuse of power affected the learning of students in nursing. The finding that

the clinical environment was the primary site of bullying was important and will be helpful for administration and healthcare management in responding to vertical bullying in the future. Finally, and somewhat disturbingly, is the affirmation that there was academic support for vertical bullying, albeit from the administrative level which has been reported to respond to vertical bullying hesitantly and passively when students were brave enough to report it.

The metaphor “Nurses eat their young” (NETY)—introduced voluntarily by every nurse participant—was a major finding in this study as it became an answer which lead to another question. It was an answer because it clearly indicated the pervasiveness of vertical bullying in nursing and nursing education since so many participants accepted it as inevitable nursing behavior. After frequent and repeated uncivil behavior observed or experienced by students and new graduates, vertical bullying has become normalized by some in nursing. It naturally led to the question: why is this concept so accepted by nurses? Another question that comes to mind regarding the socialization of vertical bullying is the following: if negative behavior or bullying is not taken or remembered as malicious by the student or graduate because of conditioning, denial, or fear of repercussions, how much more prevalent is this negative behavior if it is accepted as a norm of “eating their young” by the members of the profession?

This study suggests the answers to some of these questions are connected to the early socialization of vertical bullying that occurs in nursing education. As recommended in the Implications for Research and Practice sections, further studies are essential and further action is crucial. All students are entitled to learn in an environment which is encouraging and supportive. Educators know the importance of this kind of environment

to ensure student learning, and all leaders in education, including nursing education, should have this as their goal.

Educators also know the adage “it just takes one.” Just from the results of this study alone we know that *it just takes one* bullying instructor in the final fourth semester to destroy the positive and joyful learning experiences of an enthusiastic and competent nursing student. *It just takes one* staff nurse-preceptor, untrained and unwilling to show patience while instructing nursing students and new graduates in the clinical environment, to turn a good and dedicated nurse into an uncaring nurse. But it also *just takes one* administration or healthcare management team to acknowledge the prevalence of NETY in nursing and nursing education and then find ways to begin to eradicate this smudge called vertical bullying. I am hopeful that this study will be the first step in facilitating this eradication of vertical bullying in nursing education and further in the profession of nursing.

Finally, of all that was learned in this study concerning the socialization of vertical bullying through community college nursing education, I am still struck with one more unanswered question: if nursing students are socialized into a vertical bullying culture through nursing education, why is not every nursing student or nurse a bully? It seems most nurses know what bullying in nursing means; so what makes the difference and what keeps some nursing students in school and graduate nurses practicing their profession, despite the ever-present threat of vertical bullying in their professional lives?

At the conclusion of this study, I want to thank the millions of nurses who endure vertical bullying while learning or tending to those placed in their care. This study is dedicated to all of these nurses. It just takes one first step. To those nurses, please

consider this study as the first step in responding to this issue while attempting to provide the support needed to do what you do best . . . care for the sick.

References

- American Association of Community Colleges (AACC). (2012). Facts about allied health professionals. Retrieved March 17, 2012, from <http://www.aacc.nche.edu/Content/NavigationMenu/HotIssues/Nursing/Facts>
- American Association of Critical Care Nurses (with VitalSmarts) (AACN). (2005). *Silence Kills: The Seven Crucial Conversations for Healthcare*. Industry publication.
- American Nurse Credentialing Center (ANCC) (2012). Magnet status. Retrieved April 24, 2012 from <http://www.nursecredentialing.org>
- Aiken L.A., Clarke, S.P., Sloane, D.M., Sochalski, J.A., Busse, R., & Clarke, H., (2001). Nurses' reports on hospital care in five countries. *Health Affairs*, 20, 43-53.
- Alavi, C. & Cattoni, J. (1995). Good nurse, bad nurse. *Journal of Advanced Nursing*, 21, (4) 344-349.
- Almost, J. (2005). Conflict within nursing work environments: concept analysis. *Journal of Advanced Nursing*, 53(4), 444-453.
- American Nurses Association (2001). Code of Ethics for Nurses with Interpretive Statements. American Nurses Publishing.
- Anderson, C. (2001). Defining the severity of workplace violent events among medical and non-medical samples. *Gastroenterology Nursing*, 24(5), 225-230.
- AONE. (2008). Principles and elements of a healthful practice work environment. Retrieved February 9, 2010 from <http://www.aone.org/aone/resources/home/html>.
- Baltimore, J. (2006). Nurse collegiality: fact or fiction? *Nursing Management*, (May): 28-36.

Bandura, A. (1977a). Self-efficacy: Toward a unifying theory of behavioral change.

Psychological Review, 84, 191-215.

Bandura, A. (1977b). *Social learning theory*. Englewood cliffs, NJ: Prentice-Hall.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*.

Englewood Cliffs, NJ: Prentice –Hall.

Bandura, A. (1999) Moral disengagement in the perpetuation of inhumanities.

Personality and Social Psychology Review, 3(3) , 193-209.

Beecraft, P., Dorey, F., and Wenton, M. (2008) Turnover intentions in new graduate nurses: A multivariate analysis. *Journal of Advanced Nursing*, 62(1), 41-52.

Begley, C., & White, P. (2003). Irish nursing students changing self-esteem and fear of negative evaluation during their preregistration programme. *Journal of Advanced Nursing*, 42(4), 390-401.

Bellinger, K., Reid, J., & Posey, S. (1985). Beliefs held by associate degree nursing students about role models. *Community College Review*, 13, 32-36.

Bogdan, R.C., & Biklen, S.K. (1992) *Qualitative research for education: An introduction to theory and methods*. Needham Heights, MA: Allyn and Bacon.

Bowles, C. and Candela, L. (2005). First job experience of recent RN graduates: Improving work environment. *Journal of Nursing Administration*, 35(3), 130-137.

Brady, M. (1990). Status passage into nursing: Another view of the process of socialization. *Journal of Advanced Nursing*, 15, 1220-1225.

Cassell, M.A. (2010). Bullying in academe: Prevalent, significant and incessant. 2010

- International Applied Business Research (IABR) & International College Teaching and Learning (ITLC) Conference Proceedings*. Retrieved from http://www.gimi.us/CLUTE_INSTITUTE/ORLANDO_2010/Article%20450.pdf
- Celik, S., & Bayraktar, N. (2004). A study of nursing student abuse in Turkey. *Journal of Nursing Education*, 43, 330-336.
- Center for American Nurses. (2009). Lateral violence and bullying in the workplace . Retrieved February 9, 2009 from <http://www.centerforamericannurses.org>
- Cohen, H. (1981). *The nurse's quest for a professional identity*. Menlo Park, CA. Addison Wesley.
- Cohen, N.H. (1995). *Mentoring adult learners: A guide for educators and trainers*. Melbourne, FL: Krieger.
- Cooper, J.R.M., Walker, J.T., Winters, K., Williams, P.R., Askew, R., & Robinson, J.C. (2009). Nursing students' perceptions of bullying behaviours by classmates. *Issues in Educational Research*, 19(3), 212-226.
- Crawford, N. (1999). Conundrums and confusion in organizations: The etymology of the word "bully". *International Journal of Manpower*, 20(1/2), 86-93.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Creswell, J.W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.
- Creswell, J.W. (2005). *Educational research; Planning, conducting and evaluating quantitative and qualitative research*. Upper Saddle River, NJ: Pearson Merrill Prentice Hall.

- Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43-50.
- Day, R.A., Field, P.A., Campbell, I.E., & Reutter, L., (1995). Students' evolving beliefs about nursing: From entry to graduation in a four year baccalaureate programme. *Nurse Education Today*, 15(5), 357-364.
- Dellasega, A. (2009). Bullying among nurses. *American Journal of Nursing*, 109 (1), 52-58.
- Diener, E., Dineen, J., Endresen, K., Beaman, A.L., & Fraser, S. (1975). Effects of altered responsibility cognitive set and modeling on physical aggression and de-individuation. *Journal of Personality and Social Psychology*, 31, 328-337.
- Duchscher, J.B. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum*, 43(4), 191-206.
- Duffy, E. (1995). Horizontal violence: A conundrum for nursing. *Collegian*, 2(2), 5-7.
- Dunn, T. (2003). Horizontal violence among nurses in the operating room. *AORN On-Line*, 78 (6), 977-988.
- Du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*, 21 (1), 164-171.
- Embree, J.L., & White, A.H. (2010). Concept analysis: nurse-to-nurse lateral violence. *Nursing Forum*, 45(3), 166-173.
- Farrell, G.A. (1997). Aggression in the clinical setting: Nurses' views. *Journal of Advanced Nursing*, 25, 501-508.

- Farrell, G. (1999). Aggression in clinical settings: Nurses' views- a follow-up study. *Journal of Advanced Nursing*, 29(3), 532-541.
- Farrell, G. (2001) From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35(2), 481-484.
- Fetzer, S.J. (1998). An investigation of the antecedents of profession-hood among associate degree nurses. Unpublished manuscript/ dissertation. Adelphi University.
- Freshwater, D. (2000). Cross currents: Against cultural narration in nursing. *Journal of Advanced Nursing*, 32(2), 481-484.
- Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing*, 26, 529-536.
- Gallent-Roman, M. (2008). Strategies and tools to reduce workplace violence. *American Association of Occupational Health Nurses Journal*, 56 (11), 449-454.
- Gangeness, J., & Yukovich, E. (2006). Revisiting case study as a nursing research design. *Nurse Researcher*, 13(4), 7-18.
- Garrett, A., Manuel, D., & Vincent, C. (1976). Stressful experiences identified by nursing students. *Journal of Nursing Education*, 15, 9-21.
- Gartner, S.K. (2007). "I heard it through the grapevine": doctoral student socialization in chemistry and history. *Higher Education*, 54, 723-740.
- Gaul, A. (1987). The effect of a course in nursing ethics on the relationship between ethical choice and ethical action in baccalaureate nursing students. *Journal of Nursing Education*, 26(3), 113-117.
- Gray, M., & Smith, L. (1999). The professional socialization of diploma of higher

- education in nursing students. (Project 2000): A longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education In Nursing*, 35(6), 257-263.
- Hampshire, M. (2000). Are nurses their own worst enemy? *Nursing Times*, 96(38), 10-11.
- Hart, G., & Rotem, A. (1994). The best and worst: Students' experiences of clinical education. *The Australian Journal of Advanced Nursing*, 11(3), 26-33.
- Haselhuhn, M.R. (2005). Adult bullying within nursing workplaces: Strategies to address a significant occupational stressor. (Thesis for Masters of Nursing ed). Detroit: University of Michigan.
- Hastie, C. (2002). Horizontal violence in the workplace. Retrieved Nov. 1, 2007 from <http://www.acegraphics.com.au/articles/hastie02.html>
- Heslop, L, McIntyre, M., & Ives, G. (2001). Undergraduate student nurses' expectations and their self-reported preparedness for the graduate year role. *Journal of Advanced Nursing*, 36(5), 626-634.
- Hinchberger, P.A. (2009). Violence against female student nurses in the workplace. *Nursing Forum*, 44(1), 37-46.
- Hinshaw, A.S. (1977) Socialization and re-socialization of nurses for professional nursing practice. NLN Publication No. 15-1659, 1-15. New York: National League for Nursing.
- Hoel, H. Giga, S.I., & Davidson, M.J. (2007). Expectations and realities of student

- nurses' experiences of negative behaviour and bullying in clinical placement and the influences of socialization processes. *Health Services Management Research*, 20, 270-278.
- Holmes, C. (2006). Violence, zero tolerance and the subversion of professional practice. *Contemporary Nurse*, 21(2), 212-215.
- Hutchinson, M., Jackson, D., Vickers, M., & Wilkes, L. (2006). Workplace bullying in nursing: Toward a more critical organizational perspective. *Nursing Inquiry*, 13(1), 118-126.
- Hutchinson, M., Jackson, D., Wilkes, L., & Vickers, M.H. (2008). A new model of bullying in the nursing workplace: Organizational characteristics as critical antecedents. *Advances in Nursing Science*, 3(2), 60-71.
- Jackson, D., & 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.
- Jackson, D, Clare ,J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace-a factor in recruitment and retention. *Journal of Nursing Management*, 10,(1), 13-20.
- Johnson, S., & Rea, R. (2009). Workplace bullying: Concerns for nurse leaders. *Journal of Nursing Administration*, 39(2), 84-90.
- Joint Commission. (2008). Joint Commission alert: Stop bad behavior among health care professionals. Retrieved Aug. 16, 2009 from http://www.jointcommission.org/NewsRelease/nr_07_09_08.htm
- Jones, J. (2006). Nurses remain atop honesty and ethics list. *Gallup News Service*. Retrieved Nov. 1, 2007 from <http://www.gallup.com/poll/20254/Nurses>

- Kelly, B. (1993) The “real world” of hospital nursing practice as perceived by nursing undergraduates. *Journal of Professional Nursing*, 9(1), 27-32.
- Kleehammer, K., Hart, L., & Keck, J.(1990). Nursing students’ perception of anxiety-producing situations in the clinical setting. *Journal of Nursing Education*, 29, 183-187.
- Kolanko, K.M., Clark, C., Heinrich,K.T., Olive, D., Serenbus, J.F., & Sifford, K.S. (2006). Academic dishonesty, bullying, incivility and violence: Difficult challenges facing nurse educators. *Nursing Education Perspectives*, 27(1), 34-43.
- Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing*, 31(1), 235-241.
- Kupperschmidt, B.R. (2008). Conflicts at work? Try carefronting. *Journal of Christian Nursing*, 25(1), 10-17.
- Lee, C. (2007). Academic help seeking: Theory and strategies for nursing faculty. *Journal of Nursing Education*, 48(19), 468-475.
- Lewis, M. (2006). Nurse bullying: Organizational considerations in the maintenance and the perpetuation of health care bullying cultures. *Journal of Nursing Management*, 14, 52-58.
- Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work/ Organizational Psychology*, 5(2), 165-184.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.
- Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing*, 27, 177-178.
- Lutgen-Sandvik, P., Tracy, S.J., & Alberts, J.K. (2007). Burned by bullying in the

- American workplace: Prevalence, perception, degree and impact. *Journal of Management Studies*, 44(6), 837-962.
- Lynaugh, J.E. (1993). *Nursing History Review: Official Journal of the American Association for The History of Nursing*. Philadelphia, PA: University of Pennsylvania Press.
- Magnussen, L., & Amundson, M.J. (2003). Undergraduate nursing student experience. *Nursing and Health Sciences*, 5, 261-267.
- Marks, Z. (1988). The psychological coping styles of nurses: a critical perspective. Unpublished theses. Monach University, Australia.
- McKenna, B.G., Smith, N.A., Poole, S.J., & Coverdale, J.H. (2003). Horizontal Violence: Experiences of Registered Nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90-96.
- Merriam, S. (1998). *Qualitative research and case study applications in education*. San Francisco, CA: Jossey-Bass.
- Merriam-Webster On-line Dictionary, (2012). Retrieved Nov. 17, 2012 from <http://www.merriam-webster.com>
- Metropolitan Chicago Healthcare Council. (2006). Caring for the future: A plan for meeting metropolitan Chicago's growing healthcare workforce needs, from www.mchc.org
- Moccia, P. (1988). At the fault line: Social activism and caring. *Nursing Outlook*, 50(4), 154-159.
- Molzahn, A.E. (2008). Commentary. *Western Journal of Nursing Research*, 30, 278-280.
- Mooney, M. (2006). Professional socialization: The key to survival as a newly qualified

- nurse. *International Journal of Nursing Practice* 2007, 13, 75-80.
- Mozingo, J., Thomas, S.P., & Brooks, E. (1995). Factors associated with perceived competency levels of graduating seniors in a baccalaureate nursing program. *Journal of Nursing Education*, 34, 115-122.
- Murray, J.S. (2007). Before blowing the whistle, learn to protect yourself. *American Nurse Today*, 2(3), 40-42.
- Murray, J.S. (2009). Workplace bullying in nursing: A problem that can't be ignored. *Med Surg Nursing*, 18(5), 273-276.
- Olson, L. (2007, July). Professional ethics in relationships with colleagues. *CHART: the Journal of Illinois Nursing*.
- Oulton, J.A. (2006). The global nursing shortage: An overview of issues and answers. *Policy, Politics & Nursing Practice*, 7(3), 34S- 39S.
- Palmer, C. (2003). The nursing shortage: an update for occupational health nurses. *AAOHN Journal*, 51(12), 510-513.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage Publications.
- Pearson, J. (1998). An explanation of the empowerment of nursing students in a clinical context. *Nursing Praxes in New Zealand*, 13(3), 45-55.
- Quine, L. (1999). Workplace bullying in NHS community trust: Staff questionnaire survey. *British Medical Journal*, 318 (7178), 228-232.
- Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6 (1), 73-84.
- Ramsey, D. (2001). Why this British nurse is quitting the profession. *Nursing Review*,

Australia's Independent Voice of Nursing, February 8.

- Randel, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Reutter, L., Field, P.A., Campbell, I.E., & Day, R. (1997). Socialization in nursing: Nursing students as learners. *Journal of Nursing Education*, 36, 149-155.
- Roberts, B., Jones, C., & Lyman, M. (2004). Job satisfaction of new baccalaureate nurses. *Journal of Nursing Administration*, 35(9), 428-435.
- Roberts, S. (1983). Oppressed group behaviour: Implications for nursing. *Advances in Nursing*, 5, 21-30.
- Royal College of Nursing (2002). Working well. Retrieved February 9, 2009 from <http://www.rcn.org.uk/news/pdfs/1778-workingwell.pdf>
- Salin, D. (2003). Ways of explaining workplace bullying: a review of enabling, motivating and precipitating structures and processes in the work environment. *Human Relations*, 56(10), 1213-1232.
- Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing*, 12(3), 399-403.
- Simons, S.R. & Mawn, B. (2010). Bullying in the workplace- a qualitative study of newly licensed registered nurses. *American Association of Occupational Health Nurses Journal*, 58(7), 305-311.
- Simpson, I.H. (1979). *From student to nurse; A longitudinal study of socialization*. Cambridge: Cambridge University Press.
- Sinclair, B. (2000). *An explanatory study of Kanter's theory: Empowerment in nursing education*. Unpublished theses: London, ON: The University of Western Ontario.

- Spiers, M. (2007). Standing firm against bullying. *WIN*, 15 (4).
- Stanley, K., Martin, M., Michel, Y., Welton, J., & Nemeth, L. (2007). Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing*, 28, 1247-1265.
- Stevenson, K., Randle, J., & Grayling, I. (2006). Inter-group conflict in healthcare: UK students' experiences of bullying and the need for organisational solutions. *OJIN: On-line Journal of Issues in Nursing*, 11(2), 6.
- Thobaben, M. (2007). Horizontal workplace violence. *Home Health Care Management and Practice*, 20(1), 82-83.
- Thomas, C.M. (2010). Teaching nursing students and newly registered nurses strategies to deal with violent behaviors in the professional practice environment. *The Journal of Continuing Education in Nursing*, 41(7), 299-328.
- Thomas, S.P., & Burk, R. (2009). Junior nursing students' experiences of vertical violence during clinical rotations. *Nursing Outlook*, 57, 226-231.
- Tradewell, G. (1996). Rites of passage: Adaptation of nursing graduates to a hospital setting. *Journal of Nursing Staff Development*, 12(4), 185-189.
- Trossman, S. (2008). Behaving badly? Joint Commission issues alert aimed at improving workplace culture, patient care. *The American Nurse: Official Publication of ANA*. p. 1-12.
- Tschuudin, V. (2007). Editorial. *Nursing Ethics*, 14(4), 441-442.
- Twale, D., & De Luca, B.M. (2008). *Faculty incivility: The rise of the academic bully culture and what to do about it*. San Francisco, CA: Jossey-Bass.
- Vessey, J.A., DeMarco, R.F., Gaffney, D.A., & 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.
- Wilson, A., & Startup, R. (1991). Nurse socialization: Issues and problems. *Journal of Advanced Nursing*, 16(12), 1478-1486.
- Woelfle, C., & McCaffrey, R.(2007). Nurse on nurse. *Nursing Forum*, 42(3), 123-131.
- Yamada, D. (2000). The phenomenon of “workplace bullying” and the need for status-blind hostile work environment protection. *Georgetown Law Journal*, 88(3), 475-536.
- Yildirim, D., Yildirim, A., & Timucin, A. (2007). Mobbing behaviors encountered by nurse teaching staff. *Nursing Ethics*, 14(4), 447-463.
- Yin, R.K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.
- Yin, R.K. (2003). *Applications of case study research*. Thousand Oaks, CA: Sage Publications.
- Zapf, D., Einarsen, S., Hoel, H., & Vartia, M. (2003). Empirical findings on bullying in the workplace. In Einarsen, S., Hoel, H., Zapf, D., Cooper, C.L. eds. *Bullying and emotional abuse in the workplace: International perspectives in research and Practice*. New York: Taylor and Francis.

Footnotes

#1: chain of command is a commonly accepted nursing concept and phrase which originates from the nursing profession's militaristic foundation and commonly refers to the accepted line of authority nurses follow in daily activities and responsibilities. (Lynaugh, 1993)

Footnote #1: chain of command is a commonly accepted nursing concept and phrase which originates from the nursing profession's militaristic foundation and commonly refers to the accepted line of authority nurses follow in daily activities and responsibilities. (Lynaugh, 1993)

APPENDIX A

BULLYING BEHAVIOR

Hostility	Dirty looks/gestures	Invasion of personal space
Curt tones of voice	Social exclusion/isolation	"Silent treatment"
Making light of bullying	Calling the nurse "crazy"	Referring the nurse to workplace counselors
Harassment	Pressure not to claim employee benefits (e.g. sick time, conference time, travel expenses)	Excessively critical
Repeated reminders of errors and mistakes	Intolerance	Impatience
Intimidation	False/exaggerated incident reports against the nurse	Shouting/yelling/ swearing at the nurse
Throwing objects (e.g. surgical instruments)	Failure of manager to maintain hostile-free work environment	Insulting or threatening phone messages/emails
Theft	Attempting to turn others against the nurse	Unfair treatment
Gossip/rumor-mongering	Threats	Humiliation
Condescending	Deception/lying	Vindictive
Punishing	Hinting that the nurse should quit or transfer	Verbally attacking the nurse in public/private
Excluding the nurse from important meetings or activities	Withholding pertinent information from the nurse	Blocking opportunities for promotion/training
Unjust used of authority	Excessive monitoring	Unreasonable deadlines
Ignoring/undervaluing belittling the nurse's work	Defamation: false attack against the nurse's reputation	Excessive teasing or cruelty
Questioning the nurse's competence	Excessive sarcasm	Destruction of property

BULLYING BEHAVIOR

OVERT

COVERT

(From Haselhuhn, 2005; Cowie, Naylor, Rivers, Smith, & Pereira, 2002; Farrell, 1999; Farrell, 2002; Glendinning, 2001; Hoel, Faragher, & Cooper, 2004; Jackson, Clare, & Mannix, 2002; Keashly & Jagatic, 2003; Quine, 2001).

APPENDIX B

BANDURA'S COGNITIVE MECHANISMS

Bandura's Cognitive Mechanisms of Moral Disengagement			
Type of Activity	Mechanism	Definition	Behavior Examples
I Cognitive Restructuring of behavior <i>(Invests harmful conduct with high moral purpose and leads to elimination of self-censure while engaging self-approval)</i>	(A) Moral justification	(A)Detrimental conduct is made personally and socially accepted...seen as being worthy/ moral	Protection of valued culture...the "end justifies the means"...feeling of moral superiority
	(B) Euphemistic labeling	Makes harmful conduct respectable while reducing personal responsibility	Sanitizing language/ respectable jargon...Acts done by nameless forces... "mechanical" people
	(C) Advantageous comparison	Harmful behavior is compared and "colored" and contrasted to other behavior and viewed good	Reprehensible acts made righteous...Removes other options...act will prevent worse outcome
II Cognitive minimizing the role if the individual in harm caused	(D) Displacement of responsibility	Individual views their actions as stemming from dictates of authorities...do not feel resp. for action	Simply carrying out orders ...Other will take blame... Insidious support/ Keep

<i>(Because they are not the agents of action, they are spared self-condemnation)</i>			Intentionally uninformed
	(E) Diffusion of responsibility	Obscuring personal agency in an act by division of labor or group decision making	Routine activities subdivided to diminish resp...when everyone is resp./ no one feels resp.
III Cognitive disregard or distortion of one's action <i>(As long as the harmful results of one's conduct are ignored, minimized, distorted or disbelieved, there is little reason for self-censure)</i>	(F) Distortion of consequences	Disregarding or avoiding the effects of one's actions	Use of hierarchical/ chains of commands...Superiors formulate plan carried out ...Intermediaries neither make decision nor carry it out
	(G) Dehumanization	Disengagement of self censure by stripping people of human qualities	Treatment of people as anonymous...the IN-group vs. OUTgroup...Degrading and tyrannical treatment of others
	(H) Attrition of blame	View themselves as faultless victims driven to imperious conduct by forcible provocation	Victims blamed for bringing it on themselves; Compelling circumstances cause action...considered excusable; feeling of self- righteousness

(Condensed from Bandura's Theory of Cognitive Mechanisms of Moral Disengagement, 1999)

APPENDIX C

PROTOCOL QUESTIONS ASKED OF PARTICIPANTS

Research Questions:

1. What is the effect of vertical bullying on students in a community college nursing program?
2. Are community college nursing students socialized into a bullying culture?
3. How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
4. Do components of the academic structure (eg. student discipline, faculty reward systems etc.) support vertical bullying at the community college?

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
As a student in a Community College nursing program, did you ever observe or experience bullying behavior? If yes, during or after the program? Examples?	Reciprocal Determinism	#1 What is the effect of bullying on students in a community college nursing program?
Here is a list of examples of bullying behaviors observed by others in nursing (List A). Have you observed or experienced any of these as a student in a community college program? As a new grad?	Reciprocal Determinism	#1 What is the effect of bullying on students in a community college nursing program?
What response did you observe (or have) after above	Reciprocal Determinism	#1 What is the effect of bullying on students in a

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
experience?		community college nursing program?
Have you observed (or experienced) any of the following responses to bullying behaviors of others? Passivity? Confrontation? Reporting behavior? Unhealthy coping behavior?	Reciprocal Determinism	# 1 & #2 What is the effect of bullying on students in a community college nursing program ? Are community college nursing students socialized into a bullying culture?
What do you think of the philosophy that verbal abuse is the most frequent form of bullying for students in nursing programs? (Celik & Bayraktor, 2004) Why?	Social Cognitive theory	#1 & #2 What is the effect of bullying on students in a community college nursing program ? Are community college nursing students socialized into a bullying culture?
How did the following socialization factors contribute to your learning how to be a nurse: Behaviors of others? Personal factors? Environment? (Who/what/when as needed)	Reciprocal Determinism	#2 Are community college nursing students socialized into a bullying culture?
What is your opinion of the statement “ bullying has its origin in the schools of	Social Cognitive theory	#2 Are community college nursing students socialized into a bullying

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
nursing"? (Baltimore, 2006). Why?		culture?
It is found that most bullying in nursing goes unreported. Why do you think nurses or nursing students might fail to report bullying behaviors?	Social Learning theory	#2 Are community college nursing students socialized into a bullying culture?
What do you think of the researchers opinion that " the way a student nurse is treated in nursing school " is the way that nurse will treat others later? (Randle, 2003). Why?	Reciprocal Determinism	#2 Are community college nursing students socialized into a bullying culture?
Some researchers have discovered that there are coping mechanisms employed when bullying is observed (or experienced) (Cooper et al., 2009). As a nursing student/ graduate, have you ever observed (or experienced) any of the following behaviors in response to bullying? <ul style="list-style-type: none"> • Did nothing • Put up barriers • Spoke directly to bully • Pretending not to see • Reported the behavior • Unhealthy coping • Warned bully • Shouted at bully • Demonstrated same 	Social learning theory	#2 Are community college nursing students socialized into a bullying culture?

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
behavior <ul style="list-style-type: none"> • Went to physician • Took it as a joke 		
In your observation (or experience) of bullying in nursing, were any of the following involved in the bullying: Faculty? Supervisors? Colleagues? (Ozturk, 2008)	Social Learning theory	#2 & #3 2 Are community college nursing students socialized into a bullying culture? How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
Please describe any bullying behavior you observed (or experienced) which was modeled by another nurse or instructor.	Social Cognitive theory re: attention phase	#3 How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
What did you learn from above experience?	Social Cognitive theory Re: retention phase	#3 How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
		motivating factors contribute to this socialization?
Concerning above experience, did you ever respond to a subsequent similar experience- negatively or positively- because of what you learned from this experience?	Social Cognitive theory Re: rehearsal phase	#3 How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
Concerning above experience, has your overall approach to behavior in nursing been affected by this experience?	Social Cognitive theory Re: motivation	#3 How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
If instructors were involved in bullying observed or experienced by you, what behavior(s) did they display? (Magnussen & Amundson, 2003).	Social Learning theory	#3 How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
Please review List A again/ list of examples of nursing	Twale & De Luca/ Salin Re: Enabling/	#3 How does this

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
bullying behaviors. I am asking you to also think of any instances you may have observed or experienced one more time as you review this list. Did any two of these examples occur at the same time? At any time, did three kinds of bullying behaviors ever occur at one time? Pl explain.	Precipitating/ Motivating factors	socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?
<p>In your opinion, are any of the following associated or considered reasons for bullying behaviors? Please explain.</p> <ul style="list-style-type: none"> • Fear of retaliation • Misuse of power • Feelings of alienation • Frustration • Lack of control • Feeling of powerlessness • Seniority” hazing” issues • High pt. acuity levels • Heavy pt. loads • Lack of knowledge • Need to “fit in” • Not knowing “role” • Short-staffed • Nurse “burn-out” • Pressure /good nurse 	<p>Twale & De Luca/ Salin model</p> <p>Re: Enabling/ Precipitating/ Motivating factors</p> <p>Enabling</p> <p>“</p> <p>“</p> <p>“</p> <p>“</p> <p>“</p> <p>“</p> <p>“</p> <p>“</p>	<p>#3</p> <p>How does this socialization into a bullying culture take place at the college, and how do enabling, precipitating and motivating factors contribute to this socialization?</p>

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
<ul style="list-style-type: none"> • Trying to live up to expectations • Pressure not to cause trouble • Need to follow chain of command • Pressure to maintain high standards • Novices need to 'pay dues' • Increased technology needs • Physician/ patient/ families demands 	“	
	Precipitating	
	“	
	“	
	“	
	“	
	“	
	Motivating	
	“	
	“	
	“	
	“	
	“	

Questions to be asked re: Bullying and its Socialization		
QUESTION	Aspect/ Theoretical Framework	Refers to Research Question . . .
<p>It has been found by some researchers that nursing relies on a hierarchical structure, especially in nursing education concerned with discipline and chain of command. (Lewis 2006; Crawford, 1999).</p> <p>In your opinion, what is the connection between student discipline and rewards and bullying in nursing education?.</p>	Social Learning theory	<p>#4</p> <p>Do components of the academic structure (e.g. student discipline, faculty reward systems etc.) support bullying at the community college?</p>
<p>On a scale of 1 (being low involvement) and 10 (being high involvement), in your opinion, how influential is the community college nursing program in support of bullying in the nursing profession? Please explain.</p>	Social Learning theory	<p>#4</p> <p>Do components of the academic structure (e.g. student discipline, faculty reward systems etc.) support bullying at the community college?</p>

APPENDIX D
RESEARCH CONSENT FORM

Researcher: Margaret M. Machon
c/o Moraine Valley Community College
9000 West College Parkway
Palos Hills, IL 60465
Phone: (708) 974-5484
Email: machon@morainevalley.edu; p_machon@yahoo.com

Thank you for agreeing to participate in this study which will take place from ____ to ____.

(dates to be determined)

This form outlines the purposes of the study and provides a description of your involvement and rights as a participant.

The purposes of this project are:

- 1) to partially fulfill the requirements for the degree Doctor of Philosophy in Community College Leadership and
- 2) to examine the effects of bullying and non-professional behavior on the nursing students and graduates who chose to learn the nursing profession through community college nursing education and, ultimately, to discover the effect of this non-professional behavior upon the professional socialization of those in the nursing profession.

The methods to be used to collect information for this study are explained below. From this information, I will write a dissertation and include the data collected into a case study.

Research Design

This qualitative research study will employ a multiple case study approach. This study will be framed by a variation of Bandura's social cognitive theory of learning. A multiple case study was selected for this qualitative research study on the effects of bullying and non-professional behavior on the socialization through nursing education because I want to examine the possible connection of these topics. Data will be collected using interviews, focus groups and document review as well as researcher journaling.

You are encouraged to ask any questions at any time about the nature of the study and the methods that I am using. Your suggestions and concerns are important to me; please contact me at any time at the address/phone number listed above.

I will use the information from this study to write a case study report about the data collected in this study. This report will be read by you (if you would like), the dissertation committee, and optionally, by one other person for validation purposes with your permission, in order to check on the accuracy of the report. The report will not be available to any other person to be read without your permission.

Assurances

I guarantee that the following conditions will be met:

- 1) Your real name will not be used at any point of information collection, or in the written case report; instead, you and any other person and place names involved in your case will be given pseudonyms that will be used in all verbal and written records and reports. Confidentiality of student information will be protected consistent with the 1974 Family Educational Rights and Privacy Act (FERPA).
- 2) If you grant permission for audio taping, no audio tapes will be used for any purpose other than to do this study, and will not be played for any reason other than to do this study.
- 3) Your participation in this research is voluntary; you have the right to withdraw at any point of the study, for any reason, and without any prejudice, and the information collected and records and reports written will be turned over to you.
- 4) If you desire, you will receive a copy of the final report before it is handed in, so that you have the opportunity to suggest changes to the researcher, if necessary.

Do you grant permission to be quoted directly?

Yes _____ No _____

Do you grant permission to be audio-taped?

Yes _____ No _____

I agree to the terms

Respondent _____ Date _____

I agree to the terms:

Researcher _____ Date _____

Adapted from <http://kerlins.net/bobbi/research/qualresearch/consent.html> and from the consent form from research proposal of Susan Phelan, PhD / CCL program.

APPENDIX E**RESPONSES TO BULLYING**

Study responses to incivility/ bullying of 21 participants (usual response)

RESPONSE	RESULTS
Did nothing	48%
Put up barriers	39%
Spoke directly to bully	2%
Reported the behavior	6%
Unhealthy coping	0%
Warned the bully	0%
Shouted at the bully	0%
Demonstrated same behavior	0%
Went to physician	2%
Took it as a joke	3%

VITA

Margaret M. O'Connor Machon
1242 Abbey Oaks Drive
Lemont, IL 60439
(630-243-9538
machon@morainevalley.edu

Doctor of Philosophy Community College Leadership - Candidate OLD DOMINION UNIVERSITY <i>Dissertation: The Socialization of Bullying Through</i> <i>Community College Nursing Education:</i> <i>A Multiple Case Study</i>	2005 - Present Norfolk, VA
Masters in of Science in Education GEORGE WILLIAMS / AURORA UNIVERSITY Major: Community Health Education	1980/ June Downers Grove, IL
Bachelors of Science in Nursing D'YOUVILLE COLLEGE Major: Nursing	1968/ June Buffalo, NY

Professional Experience in Education:

Dean of Career Programs	Jan 2008 to present
Assistant Dean Career Programs	Aug. 2001 to Jan 2008
Director of Health Sciences	July 1999 to Aug 2001
Moraine Valley Community College	
Adult recruiter/ Admissions Counselor	
St. Xavier University/ Chicago, IL	Sept. 1996 to July 1999
Manager / Human Resource Development Center	
College of Du Page/ Glen Ellyn IL	April 1985 to Oct. 1994
Nursing Instructor	
Triton College/ River Grove IL	Sept. 1970 to Sept 1985

The word processors for this thesis were Nancy Spaulding and Christine Kuropas.