EXPERIENCE EXCHANGE

"They can crush you": Nursing students' experiences of bullying and the role of faculty

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ABSTRACT

This paper will explore the faculty role when nursing students experience bullying, and what teaching practices best support student confidence and learning. Failure to address the issue of bullying in nursing education contributes to bullying in the profession, and creates an atmosphere of distrust between students and faculty. Nursing students have reported that faculty sometimes behave in bullying ways or are ill-prepared to address bullying as it occurs. Faculty may contribute to bullying unknowingly, as students may perceive teaching behaviours, such as giving feedback, as bullying. Giving feedback is a skill in itself, and faculty members should consider factors influencing a student's perception of student/teacher interactions. Having a firm grasp on conflict resolution processes and reviewing related curriculum are responsibilities of post-secondary nurse educators. Faculty also have the responsibility to recognize and address conflict in a timely manner, and turn difficult situations into learning experiences or teachable moments. In order to prevent faculty bullying of students, faculty members should acknowledge the inherent vulnerability of learners, and also reflect on their own communication practices and their potential impact on learners.

Key Words: Bullying, Nursing students, Nursing education, Faculty role, Conflict resolution

1. INTRODUCTION

In schools of nursing, we are losing students to the phenomenon of bullying. This article is a focused literature review and discussion on the nursing students' experience of bullying and the role of faculty within that dynamic, by two educators who have conducted a pilot study on a bullying intervention in order to promote student success. The intent of this article is to raise faculty awareness about the effect of bullying on students and provide a critical reflection on contributing factors and areas for consideration. Part of the faculty role is to provide safe and positive learning environments and influence students to be skilled and caring practitioners. When faculty don't role model zero tolerance to bullying, we send the message that it is accepted. In conflictual situations, individuals can perceive another's behaviour as bullying, and yet the two phenomenon are distinctly different. Faculty members should have the skill to help students differentiate between the two types of events. While bullying represents inappropriate behaviour, conflict is simply tension created by difference and represents an opportunity for growth in a way the bullying doesn't.

Cognitive Rehearsal Training (CRT) is a strategy based in cognitive behavioural therapy for negotiating difficult or emotional situations. "The core elements of CRT include knowledge and best practices, personal perceptions and recognizing bullying behaviour, managing personal reactions, rehearsing responses in a safe and collaborative environment, and increasing skill and confidence".[1] We used CRT with third-

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year nursing student participants who took part in a two-hour workshop in a campus classroom that included a didactic presentation on bullying in nursing and a role-play activity in which scenes of bullying were portrayed. The scenes were devised with the help of the research assistant (a senior student) and reflected bullying situations involving students, nurses, and clients in practice settings. The students also answered semi-structured questions in group and individual formats. One of the individual questions was: "Are there any changes [to the workshop] or strategies that you suggest to assist student nurses with bullying experiences?" Many participants used this question, at least in part, to advise faculty members on their role in addressing bullying when students were involved. It is this written data and the transcripts of the discussion that followed, which become the basis for this article. As part of the informed consent process, participants gave permission to use the pilot study data in subsequent journal articles, presentations, and for teaching purposes.

The study participants gave us significant feedback about wanting faculty to play a stronger role in the prevention of and intervention with bullying on campus and in the clinical setting. The participants identified gaps in faculty action, knowledge and understanding about bullying. They also reported being bullied by faculty and were deeply disappointed in this. They expected the opposite and had high expectations of faculty as role-models for conflict resolution and protectors of student learning. One of the participants stated, "The response of faculty is so important – they need to know that they can crush you." Throughout the classroom, other participants nodded in agreement, and that moment became the basis of subsequent discussion of the role of nursing faculty in supporting students through experiences of bullying, and what practices best support student confidence and learning. While bullying can be experienced during interactions with various individuals (clients, family members, or health care staff), the focus of this article will be on the interface between the student experience of bullying and the role of faculty to address this dynamic. Current nursing and educational literature will be explored, and other student voices from the pilot study interjected where appropriate.

2. Background literature

Bullying in nursing is an apparent contradiction in a profession where the importance of caring is considered to be absolute, as cited in seminal work by Benner and Wrubel.[2] However, bullying does occur in nursing and nursing education at all levels and in all contexts. Since bullying negatively impacts the workplace and nurse retention, a focus on how to best support students is both relevant and important.[3–5] The discussion about bullying is fraught with inconsistent language, policies, and practices in both class-room and clinical placement settings. Bullying is a form of interpersonal violence or personal harassment and can be defined as "acts or behaviours… directed at someone who finds it difficult to defend him/herself because of a relationship with the bully that is characterized by an imbalance of power"[6] and is repetitive. Synonyms for and subtypes of bullying include abuse,[7] incivility,[8] harassment,[9] mobbing,[10] horizontal and lateral violence,[11] and disruptive behaviours.[12] This multiplicity of terms results in semantic confusion, in which researchers use different language to describe similar phenomena, all of which include inappropriate behaviour that causes harm to another.

Attempts to quantify the prevalence of bullying in nursing have been conducted using various measures including reporting experiences over the last five shifts[13] to cumulative career experiences[14] and everything in between. Other variabilities among studies measuring prevalence include the level of experience of the participants, contexts, and directionality of the bullying (i.e., faculty to student, staff to student, etc.). Prevalence statistics vary, with 24%[3] to 43%[14] to 65%[13] of nurses reporting experiencing some form of bullying on the job. This wide range can be accounted for in how the terms are defined and measured, as well as influences associated with variations among clinical settings. The bullying experience of nursing students is similar statistically to that of working nurses, although it should be noted that while working nurses report experiencing bullying more from external forces (clients, relatives, etc.), nursing students are more likely to describe being victimized by internal forces (fellow students, nurses, colleagues, or nursing instructors).[14] Additionally, students have lower levels of social support and higher psychological demand due to being in the learning role and having only temporary bonds with specific nursing units' work and staff.

The net effect of bullying in healthcare is the creation of an unwelcoming, if not hostile work environment, which in turn negatively affects work satisfaction and retention of nurses, as well as patient care outcomes.[3,4,13] These negative behaviours have been shown to contribute to a plethora of physical, social, professional, and mental health sequelae for individuals who are targeted.[15,16]

It should be noted that the impact on victims of bullying cannot be predicted based on the severity of the received behaviour. Flannery, Hanson, and Penk[14] argued that the effects of non-physical abuse "can produce the same degree of psychological distress for victims as physical abuse" (p. 204). Magnavita and Heponiemi[14] studied nursing students in the workplace and found that the effects of non-physical

abuse are more severe than physical abuse and have longer lasting psychological impacts.

2.1 Bullying in academia

A recent stream of literature focused on bullying in academia highlights that students and faculty can both be subject to bullying behaviours.[5,8,17,18] Cleary, Walter, Horsfall, and Jackson[19] stated, "competiveness, autocratic managers, rigid rule-bound hierarchal organizations, and environments with poor–top-down–communication practices" (p. 266) are factors that contribute to bullying in post-secondary settings. Differing perceptions and interpretations of policy, procedures, and other work-related expectations can lead to behaviours that can be described as bullying.[9] In this sense, bullying can be viewed as a symptom of organizational dysfunction, where the culture of the organization and the behaviour of indiviuals co-create an environment prone to bullying.

In the academic setting, students can also be viewed as bullies. Subordinate-style bullying (e.g., student to faculty) also exists, as students view themselves as consumers of education rather than subjugated to the authority of faculty or institutions.[20] This challenges the traditional view of the learner as being inherently vulnerable. Institutional policies that address bullying often neglect to address bottom-up behaviours, making them more difficult to address.[9] However, aspects of power are still intrinsic in the faculty-student relationship and students often represent a high number of risk factors for being bullied such as inexperience and age.[21,22] Marraccini's[5] study examined multidisciplinary student reporting of professor bullying; 51% of the participants witnessed a peer being bullied and 18% felt they were personally bullied by a professor.

One cannot discuss bullying in academia without including how the increasing use of electronic media contributes to this phenomenon. Cyberbullying in the academic setting can be defined as: conveying language or images through information or communication technology that can "defame, threaten, harass, bully, exclude, discriminate, stalk, disclose personal information or contain offensive, vulgar, or derogatory comments".[23] Although cyberbullying is a relatively recent phenomenon, it is considered to be the most prevalent form of bullying and interpersonal intimidation in academic settings.[17] Slonje, Smith, and Frisén[24] proposed that this type of bullying meets the criteria of being repetitive through its relative permanence and that multiple viewings of the medium are likely to occur. Electronic bullying is difficult to collect evidence for or prove intent to harm, and power imbalances may also exist between the victim and the perpetrator.[25]

Post-secondary campuses are increasingly developing social media policies and enforcing them. Such policies exist specifically within some schools of nursing as a reflection of the professional behaviour that is expected of faculty and students. However, Faucher et al.[23] stated, "the university policy environment is not current with the information and communication technologies that permeate the daily lives of university students and faculty" (p. 102). Further, policies reflect values that may be at odds with the protection of individuals in the name of freedom of expression and are not evenly enforced. Policies do not carry the weight of law when behaviour escalates to criminal status, and it should be noted that there have been "no cases where a cyberbully has been banished from a university [in Canada] for his or her behaviour".[23]

2.2 Bullying in schools of nursing

Research that explores bullying specifically in schools of nursing is substantive, with most discussions referring to definition, prevalence, contributing factors, and the impact of the phenomenon.[5,11,26] Some students report leaving nursing school as a result of bullying.[21] Many types of bullying occur in class or clinical settings within and between student and faculty groups.[3,4] Rudeness, yelling, and making disparaging remarks are the most frequent types of bullying reported by students during nursing school.[11] Studies have produced mixed reports regarding the sources of bullying for students; some report that nurse-to-student bullying is most prevalent,[27] others cite faculty-to-student bullying as the most problematic,[28] and yet others claim that classmates can be very unkind to each other.[29]

Clark and Springer[30] surveyed students and faculty in one school of nursing and found that both groups noted uncivil and/or bullying behaviours in the other group, and that, "stress, disrespect, faculty arrogance and sense of student entitlement contribute to incivility in nursing education" (p. 97). Significantly, female students experience more bullying from all sources than male students, and younger students are victimized much more often than older students.[31]

In schools in nursing, administrators and senior faculty are more likely to be perpetrators of faculty-to-faculty bullying than new or contract faculty.[32] Administrators who value mentorship, collegiality, transparency, and address workplace conflict in a timely manner will develop and influence healthier workplace relationships and thus decrease the incidence of bullying in their areas.[33] An unhealthy working environment may contribute to the nursing faculty shortage,[32] poor program delivery and training,[20] and ultimately, student learning suffers, and most importantly, patient care is compromised[13] when students are distracted or distressed

by interpersonal dynamics they are experiencing.

Faculty bullying of others is seen as a reflection of ego where expertise and status are used as currency and an excuse for insensitive behaviour.[34] Birks et al.[9] postulated that some academics bully through disruptive and passive behaviours, such as spreading malicious gossip, going over management heads, or using power from organizations, such as unions, to exert pressure on managers. Students are at risk of becoming pawns or collateral damage in this context, and also learn to repeat bullying behaviours. The "perpetrators of bullying are teaching those who will soon enter our hospitals, clinical, healthcare services and educational institutions",[9] which may result in costly human resource and legal consequences.[20]

Faculty bullying of students reveals inconsistencies or biases in teaching practices. Forbes[35] described faculty members' idealistic archetypes about what nurses are and the image they should portray. These constructs can contribute to faculty bias and potentially evaluating students unfairly. If, for example the faculty member highly values a certain characteristic and the student doesn't clearly display that characteristic, the student could be appraised negatively.[35] In addition, clinical faculty may experience role confusion regarding their duties to students, staff, and clients, which can result in unsupportive responses to students. As a result, faculty can have difficulty negotiating "territory, competing priorities and varying expectations".[36] A lack of teaching experience contributes not only to this role confusion, but overall stress, which has been linked to bullying.[37] Clinical faculty may also have experienced bullying as a student or as a nurse and responded to it by either accepting it as standard practice or were traumatized by it. Either outcome diminishes the possibility of that faculty member developing a constructive approach to bullying.

Differences between people of different age cohorts can increase tension and contribute to the perception of bullying. Worldviews, values, and priorities differ among workers (and by extension, students) according to age cohort cultures. This may contribute to the perception of bullying between instructors and students.[38] Typically, these cohorts are described by terms such as Baby Boomers, Generations X, Y (also known as Millennials), and Z (also known as the iGeneration).[39] It is important to note that these proposed groups are not developmental in nature, but rather are shaped by sociological phenomena occurring during formative years. Parry and Urwin[40] suggested that work is still needed to demonstrate the validity of claims around generational theories, but that notable differences in attitudes and behaviours in the workplace have been substantiated. In terms of applicability of these theories to the topic of bullying, it is not difficult to see how personal values and characteristics can be viewed as good or bad; for example, one generation's self-reliance is another's arrogance; job mobility can be viewed as a lack of loyalty; and differing views of work as job versus vocation can cause distrust.[38]

2.3 Best practices in giving feedback

Faculty members are obligated to provide students feedback, which the literature identifies as essential to the educational process and for student personal and professional growth.[41–43] However, students may perceive feedback as a threat (a.k.a. bullying).[1] The bullying described from faculty-to-student often occurs in situations where feedback or evaluation have taken place, or a student is under the supervision of a teacher and feels targeted by them.[21] Individual student perception of feedback varies; giving the same feedback to two different students can leave one feeling crushed and wanting to quit school while the other reflects on the feedback, incorporates it, and flourishes.[1]

Providing student feedback is a skill in itself, and the faculty member should consider factors influencing the student's perception of both interactions and feedback. These would include level of confidence, complex clinical learning environments, and adoption of unacceptable behaviours that are modelled by members of the interdisciplinary healthcare team.[42] Plakht et al.[43] proposed that high quality feedback (both positive and negative) contributes to realistic student self-evaluation. Del Prato[22] described the importance of providing balanced feedback that includes positive comments and suggestions for improvement and "conveys a belief in students' ability to learn and become successful nurses" (p. 211). Nursing faculty members can obtain information on giving and receiving feedback through the educational literature and resources found on the websites of nursing education and regulatory organizations.[44,45]

The literature recognizes the instructor role as possessing power–faculty are the evaluators of student performance, have knowledge of best practices, and influence learner success.[36,46] Even though a teacher may do everything right, they cannot always control a student's reception or perception of feedback. Students should also be encouraged to provide feedback to instructors related to learner needs. Reciprocal feedback between instructors and students is essential to the process of graduating safe and professional nurses.[41] Receptiveness and response to feedback has been shown to be correlated to emotional intelligence and also to personality.[47] Higher degrees of emotional intelligence are also associated with more positive conflict management styles, and lower emotional intelligence with less productive be-

haviours such as avoiding.[47]

2.4 Faculty conflict management skills

Conflict can escalate to bullying. Faculty members are responsible to recognize and address conflict in a timely manner and turn difficult situations into learning experiences or teachable moments. Liddell[48] proposed that conflict results when an experience does not fit within the individual's cognitive schema, resulting in tension where either beliefs or behaviours must change to relieve the tension. While most people dislike conflict, leaning into the discomfort and asking "[w]hat can I learn from this?" (p. 19) not only urges learners to resist the urge to flee from the discomfort, but can result in deep and transformational learning. The instructor facilitates this learning through discussion and by promoting reflection.

Nursing faculty members have varying levels of training, skill, and experience to approach negative behaviours constructively.[20] Faculty who witness bullying by others may not want to stand up to the perpetrator due to lack of tenure or job security, fear of compromising the school's relationship with the clinical placement site, or fear of becoming targets themselves.[8] Unaddressed bullying can lead to deeper issues such as entrenched negative behaviour, and a culture of permissiveness and distrust.[49] The Canadian Association of Schools of Nursing's [CASN][44] guiding principles for generalist nurse preparation include a directive to prepare students with "[k]nowledge regarding healthy work environments including collaborative skills, leadership theories, and effective team functioning and conflict resolution" (p.10). This puts the onus on schools of nursing to include curriculum to deliver this core educational competency. School of nursing faculty and leadership are responsible to have a firm grasp on conflict resolution processes and be aware of and follow due process to address bullying constructively. Faculty should review related curriculum to ensure students are prepared for practice. In addition, educational institutions as employers are responsible to educate and enforce zero tolerance to bullying with all members of the campus environment (staff, faculty, administrators and students).[50]

3. Discussion and recommendations

Students and new graduates leave the profession due to bullying, making this discussion relevant and timely for nursing educators.[51] While the phenomenon of bullying is unfortunate and uncomfortable, faculty should acknowledge its existence, reflect on their own behaviour, and take responsibility to learn how to address bullying constructively. Otherwise, they unwittingly contribute to the dynamic by taking a passive bystander role, or actively engaging in bullying behaviours themselves. It is not fair or ethical to leave students to negotiate this dynamic on their own.

Several participants in our pilot study[1] felt that faculty members were often oblivious to situations of bullying, did not respond adequately or supportively, and left students feeling betrayed. As one participant stated: *You guys are the mentors, you have got to display a positive role-model for them and bullying is not part of that.*

3.1 Higher education and bullying

In British Columbia, bullying that produces sustained psychological symptoms is now a compensable workplace injury,[52] and employers have been charged to "inform, instruct, train and supervise workers to ensure health and safety" (p. 2). Under this legislation, employers now have a vested interest and legal obligation to provide training to educate employees on internal bullying policies as well as related legislation. Anti-bullying legislation varies across the Canadian provinces, but federal Occupational Health and Safety Regulations, which acknowledge bullying as a cause of workplace violence, govern all Canadian workplaces.[52] Internationally, there is a trend towards legislation to address toxic workplace dynamics such as bullying.[20] For instance the United Kingdom, Sweden and France have anti-bullying law under their occupational health and safety-related legislation which hold employers liable for victimization of employees.[52] Australia and the United States have varied legislation across provinces and states.[52]

Post-secondary institutions should attempt to close the gap between policy and practice regarding bullying and communication technologies and consider how such policies could be enforced. For example, Cassidy et al.[17] in their work on cyber-bullying in academia, suggested a rights-based lens be applied to respond to bullying situations to protect those who are victimized. The rights-based lens emphasizes that members of a university community can reasonably expect an environment free of bullying and other forms of mistreatment. Gilbert et al.[33] acknowledged that organizational culture impacts interpersonal dynamics and improves when employees have the information, support, and resources to do their jobs well. This results in engagement, pride, and employees who go above and beyond work duties for the sake of the organization. When engagement does not exist, the opposite occurs, resulting in a workforce that performs only required tasks, and is prone to conflict that leads to bullying.

3.2 Power dynamics: "They can crush you"

Misawa[53] postulates that bullying from academics has historically been an untouched area of research due to the as-

sumption that scholars and researchers follow high standards of ethics and professionalism. Students who feel abused by a teacher who misuses power will not only lose trust and respect for that faculty member, but may project this experience into other aspects of their learning, and ultimately perpetuate bullying themselves.[54]

Del Prato[22] reported that often "student-teacher relationships [are] a multiple barrier to learning, development, and success in nursing school" (p. 157). Cooper et al.[6] (N = 636) reported that students felt they got a bad grade given as a punishment (88.2%), lacked acknowledgement when making significant clinical research or academic accomplishments (80%), and felt they had an assignment or responsibility made by their teacher "for punishment rather than educational purposes (84%)" (p. 219). Across studies, students identify the relationship with clinical faculty members as a primary source of stress and anxiety.[55–58] Faculty awareness of this reality may inform their decision-making and make them more mindful of the student experience.

While some literature suggests that upward or subordinate bullying is on the rise,[9,59] the sense that students are vulnerable simply by being in the learning role remains the dominant view. This puts the onus on faculty members to create safe and inviting learning environments, whether in the classroom or at clinical sites. Diekelman (as cited in Beck[59]) found that "students were so overwhelmed by all the things they needed to know in their nursing education that it was challenging for them to have a meaningful relationship with faculty that focused on learning" (p. 3). Acknowledging this reality, faculty need to continually be student-centered; bring the focus back to learning, alleviate student anxieties, and acknowledge positive student choices and decision-making.

Regrettably, nurses continue to treat novice nurses and students as inferior in the healthcare hierarchy.[31,60] Power imbalances contribute to victims' feelings of helplessness.[8,61] This is supported by our pilot study as participants stated:

> Especially being a student, you look up to the other nurses on the floor, and so if there is bullying or issues, then we're not confident to speak up, because we're thinking these are our role models, or leaders pretty much within the setting.

> When I am a student nurse in the hospital and I see the nurses, and there is horizontal violence or bullying I am not that competent in standing up because of my power role in that situation.

Clinical education is high-stakes learning, where incorrect decisions can lead to negative or even catastrophic patient outcomes. While some stress aids learning, higher levels can impair cognition and decrease the potential for acquiring new knowledge.[58] Suggestions to alleviate student anxiety and increase confidence are: to introduce problem-based learning strategies into curriculum design,[54] front-load placement information, role-play client care scenarios, promote both group and individual reflection,[56] and teach students assertiveness skills.[58] Nursing regulatory bodies also have expectations and competencies for acceptable and unacceptable behaviours among nurses. All nurses are accountable for their inappropriate actions; additionally, the regulatory bodies[45] recognize the student role in healthcare and the duty of nurses to mentor and treat students and new graduates with respect. Faculty can take a proactive role in this, by establishing clear expectations of clinical staff that support student learning. One pilot study participant suggested,

> They [faculty] should have a meeting with the nurses on the unit. And say "okay look, we have these nursing students coming in"… "you guys are the mentors, you have got to display a positive role model for them and bullying is not part of that."

A United Kingdom study found that students were vulnerable to bullying during clinical rotations due to intensive clinical contact time, the short duration of clinical rotations, and overall inexperience.[62] Sun et al.[56] found that the "longer students were on placement, the less stress they experienced" (p. 25) due to established relationships and increased knowledge. This implies that short clinical rotations do not serve students as well as longer ones in terms of building confidence. Limiting the size of clinical groups may also mediate student stress by increasing individual student-faculty contact time.

Ferns and Meerabeau[62] (2007) also found that students belonging to visible minorities were vulnerable to bullying by patients; "[w]hat is this country coming to? Where is (sic) all the white nurses?" (p. 440). Issues related to diversity were also examined by Arieli[56] who described culturally or racially-based tensions and their resolution as part of the "emotional work" (p. 193) of nursing. The author suggested that cultural safety training for faculty and the intentional hiring of faculty members who represent student and client diversity would help to alleviate these issues. Arieli[56] also suggested that senior faculty members should supervise and mentor newer clinical instructors to promote best teaching practices and consistency.

3.3 Faculty self-reflection

Nursing regulatory bodies require ongoing self-reflection regarding nurses' personal health and ability to conduct them-

selves professionally.[45,63] However, Kinsella[64] described the importance of reflective practice in health and social care professions, and also proposed that the term is both overused and lacks conceptual and procedural clarity. Nurses, nursing instructors and student nurses are all required to reflect on their responses to others. Stress, poor mental health, and feelings of overwork and inadequacy are all factors influencing individuals to behave in a bullying manner.[65] Cangelosi et al.[37] found increased faculty bullying of students occurs due to faculty characteristics such as lack of experience teaching, unfamiliarity with the clinical site, and poor workplace boundaries. In nursing, the goals of reflective practice are to develop critical thinking, critique one's performance or knowledge, highlight learning needs, and develop strategies to meet those needs.[66] In order to prevent faculty bullying of students, faculty members should reflect on their own communication practices and their potential impact on learners.

Foundational to reflection is the ability to perform self-assessment, where the locus of control for evaluation and motivation shifts from an educational, workplace, or regulatory authority to the individual and is intended to contribute to self-regulation.[46] In order to promote self-assessment for clinical nursing instructors, a clear understanding of the goals of clinical teaching are needed, as those who are "prepared to question or reflect on what they know and understand are more likely to seek confirmatory and/or disconfirmatory feedback that allows for the best opportunities for learning" (p. 104). Therefore, clinical leadership in schools of nursing must make the goals of clinical teaching explicit, and assessment of the same should go beyond anecdotal comments, student success rates and evaluation of instruction to include instructor self-assessment. While exploring the goals of clinical teaching are beyond the scope of this article, nursing scholars such as Benner, Sutphen, Leonard, and Day[67] identified supporting learning through Socratic questioning, setting priorities, and giving feedback as essential instructor skills.

3.4 Providing student feedback

Nursing faculty are required to provide learner feedback and evaluation, but sometimes lack the skill or confidence to do so constructively. Providing student feedback is a delicate science, the purpose of which is to "reduce discrepancies between current understandings and performance and a goal".[46] Feedback can enhance or diminish learning, and giving effective feedback requires intentionality, practice, and timing. Faculty giving feedback to students should consider individual student learning needs, learning style, and receptiveness. When feedback is not well received, faculty should resist the impulse to become defensive, and ask themselves: 1) Is the feedback student-centered? 2) Is the feedback intended to enhance the student's confidence and success in the program? and, 3) Does the feedback include specific strategies for improvement? While many models for giving feedback exist, these guiding questions can help to eliminate ineffective feedback.[46] Feedback should not only focus on performance deficits, but also highlight strengths.[46] Balanced feedback preserves the ego of the student and is more likely to result in an open flow of communication between the faculty member and the student. One pilot study participant described the effect of unbalanced feedback:

> It was just like all I heard throughout like the whole thing, was all negative. Like "you didn't do this right" and "you didn't do this right" and "you didn't do this right." And before I felt like a confident nurse, and after that I almost quit nursing. It was like "I suck."

Students may also receive feedback from an array of staff members who may be more or less skilled in providing it, which may increase learner sensitivity to feedback. This highlights the need for clinical faculty to establish and maintain positive and open relationships with staff in the clinical setting, promoting student safety and a sense of belonging.[56] Some faculty members also continue to work as nurses in clinical sites, and while relationships and trust with clinical staff are strengthened by this, it also has the potential to result in alliances and priorities that can be confused and difficult to balance.[36] Faculty should also reflect on their skills and attitudes regarding conflict management, and seek to address gaps in knowledge, skills, and attitudes through research and educational opportunities.

3.5 Faculty role-modeling

Ethically, nursing faculty are compelled to ensure the safety of their students and patients, role-model effective conflict resolution, and resist the tendency to normalize negative behaviours.[27] Faculty who role-model misuse of power, poor feedback delivery, and lack of interest in addressing bullying leave students with the perception that bullying is acceptable.[54] Further, several authors postulate that bullying in nursing originates in nursing school, and students are socialized to accept it.[6,28] Participants in our study who felt supported by faculty reported higher confidence in themselves and competence in their skills.[1] One participant stated,

> Something went wrong, and the instructor backed me so well immediately and was like please don't talk to my student that way–and it

> was like the whole world changed. It was way better.

Clark, Ahten and Macy[68] acknowledged that nursing education content regarding conflict resolution and bullying are minimal in nursing programs and typically consist of just a few hours of instruction. Ross[69] reported that nursing curriculum that related to all forms of violence, including intimate partner, child, and elder abuse was incidental and inadequate. A new review of violence-related content in Canadian nursing curricula, including bullying, is urgently needed, as Ross's work has not been duplicated in fifteen years.

Students in our pilot study wanted more education on the management of bullying and conflict throughout the curriculum.[1] They wanted a safe place to discuss their concerns and a clear process to follow when facing bullying. Additionally, students felt that there were no consequences when bullying occurred. Budden, Birks, Cant, Bagley, and Park[51] found three quarters of bullying experienced by students was not reported either to the instructor or university services. Reasons given for not reporting included fear of further victimization, that nothing would be done, or that it was part of the job. The authors concluded that while "clinical facilitators are expected by universities to be students' advocate, mentor, protector and role-model in healthcare facilities" (p. 6), they frequently failed to meet these expectations, raising concerns about instructor selection and training. Clark, Olender, Cardoni and Kenski[70] stated that "[t]he importance of modeling effective communication and related education to address incivility cannot be underestimated, can reduce its incidence and effects, and can assist in fostering cultures of civility" (p. 325).

3.6 Faculty anti-bullying training

Administration, staff, faculty, and students should be offered training on how to address bullying in the professional environment. However, faculty play a key role in addressing relational practice challenges and need education and support to improve their conflict resolution skills in order to address bullying effectively. Role-play activities provided through CRT can be taught to faculty, serving as a method to promote dialogue and teach techniques to recognize, defuse and resolve conflict and prevent bullying.[26] Stagg and Sheridan[7] did a review of bullying prevention initiatives and found that although several of the interventions studied produced improved knowledge and attitudes toward addressing bullying, only CRT[71] resulted in elimination of the bullying behaviour once addressed. Individuals who participated in CRT gained insight about their own bullying behaviours and expressed the desire to change them. Clark, Ahten, and Macy[68] also used CRT in their study. In a ten-month follow-up, participants reported that the strategies presented continued to be effective in their practice, indicating that the CRT training had lasting effects.

Thomas[11] noted that the continuing education nurse role in the practice setting is vital to ensure educational consistency and progression as students move into the workforce. Therefore, interventions at the post-secondary level need to be understood, reinforced, and built upon in the practice setting.

Other educational strategies to diminish or address bullying include techniques that structure and reinforce professional communication such as standardized communication tools,[72] having students complete clinical site evaluations as a means of feedback to practice sites, sessions that focus on institutional bullying policies,[11] and carefronting.[38] Carefronting is a communication technique that focuses on expressing care and respect for the individual receiving feedback, and maintaining a positive relationship.[38]

4. Conclusion

Student confidence is highly influenced by teacher interaction, feedback and perception of support. The role of nursing faculty is to model and aid in the development of healthcare professionals. Relational skills curricula should include how to confront bullying in a professional way. Faculty should reflect on their own communication practices, and seek to increase their conflict management skills in order to support student learning. This would have a positive impact on the learning environment and the nursing profession as a whole.

4.1 Limitations of the study

The original pilot study[1] represents a small number of nursing students (N = 58) from a specific school in Canada. Further research on other cohorts and larger groups of students is strongly recommended.

4.2 Future considerations

Longitudinal studies are needed to understand if the changes in knowledge, skills and attitudes noted in the CRT pilot study[1] are sustainable over time. Increasing faculty knowledge about bullying intervention techniques, such as CRT, would likely improve student, faculty, and staff bullying outcomes. A review of bullying content in Canadian nursing curricula is also needed, as it has been fifteen years since Ross[69] was commissioned by Health Canada for her review of violence-related content in nursing education. The phenomenon of bullying was not explicitly discussed in that document. Interdisciplinary applications of the CRT strategy also need to be tested and could facilitate interdisciplinary

education and the development of standards for bullying prevention. To facilitate the discussion between students, faculty, and other stakeholders in nursing education, brokered dialogue is a promising and innovative research method[73] that could assist in better understanding the phenomenon of bullying and the perspectives of those involved.

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CONFLICTS OF INTEREST DISCLOSURE

No conflict of interest is declared by the authors.

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