Bullying in the Health Sector: A Study of Bullying of Nursing Students

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Abstract

Workplace bullying is a phenomenon that, although it has existed for decades, has only recently begun to be studied and understood. Although the international literature points towards a strong occurrence of bullying amongst nurses, there is very little New Zealand-based research. This article, therefore, examines the prevalence of bullying of nursing students while on their clinical placement from their tertiary institution and documents the experiences and perceptions of those nursing students who have been bullied. It also gauges the perceptions of students who have never experienced bullying. The results of the study outlined in the article clearly show that bullying is a problem for nursing students and that a high percentage of the bullies were senior nurses. Most disturbing was that most nursing students were aware of the patterns and implications of bullying.

Introduction

Bullying is a phenomenon that, although it has existed for decades, has only recently begun to be studied and understood. Overseas literature indicates that bullying in schools and workplaces is common. There is growing academic interest and recognition that bullying is prevalent in the health sector, particularly amongst nurses. However, until recently in New Zealand, the research on bullying and how to counteract the behaviour have been embedded in childhood education programmes. As a result there is little New Zealand research regarding the incidence and nature of workplace bullying in general and even less written on bullying in the health sector.

The primary purpose of this paper is to contribute to the small pool of academic knowledge concerning the prevalence and nature of bullying in New Zealand workplaces. This paper is of particular interest as it reports a survey of student nurses who straddle the work-study divide and investigates their experiences and perceptions of bullying while on clinical placements from their New Zealand tertiary institutions. Based on a survey of student nurses about their experiences of bullying while on their clinical placements, it is argued that bullying of current student nurses rests on a long tradition of such

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behaviour, is frequently committed by senior female nurses and is endemic in the nursing profession. However, as the students become more experienced, the bullying declines. It is also suggested that the acceptance of bullying has in turn perpetuated the situation and retarded efforts to correct this significant problem for nursing students.

Review of the Literature

Stressful working conditions, continuous restructuring, poor pay rates and inadequate staffing levels have had little impact on individuals wishing to become nurses and enrolments for nursing training have remained the same. However, one aspect of nursing that could severely affect the recruitment and retention of nurses is bullying in the workplace. As stated previously, there is growing evidence that workplace bullying of nurses is a significant problem. For example, UK studies show that nurses are in the top three most bullied groups in the National Health Service and that qualified nurses were more likely to be subjected to bullying than any other medical staff in the UK (Dowd, 1996; Quine, 2001). It was found that managers, fellow staff (particularly senior nurses) and the public were their biggest bullies and that younger nurses faired worst than most (Quine, 2001). One in two nurses reported being subjected to bullying, compared with one in three amongst other staff categories. Another British study concluded that 25% of nurses reported verbal abuse and 75% of nurses surveyed received unfair criticisms regarding work performance (McMillan, 1991). US studies also indicate that registered nurses regularly experienced verbal abuse, and a nationwide survey revealed as many as 97% experienced some type of verbal abuse on the job (Cox, 1987). The most common forms of bullying reported by nurses included serious slander, being met with silence, having information systematically withheld, being ignored and excluded as well as being teased or ridiculed (Einarsen, Matthiesen and Skogstad, 1998). Wilson (2000: 24) also notes that “horizontal violence” (a nursing term used to describe workplace bullying) means that nurses are frequently exposed to negativity and professional jealously in a so-called “healing and caring environment” (Wilson, 2000: 24). Hadikin and O’Driscoll (1996), based on their study of 462 midwifes, noted that one-quarter of all victims reported that their health had been affected by bullying, while 8% reported having to take time off work.

In New Zealand, the problem of students being bullied whilst on their clinical placements has become more recognized than was previously the case (Adler, 2002). Lucia Fell (2000), the NZ National Student Unit Chairperson, not only highlighted the fact that nursing students were being bullied but she also noted that there were a variety of sources of bullying in the New Zealand health sector. These sources included tutors, clinical placement buddy nurses, charge nurses and other senior nurses, both enrolled and registered (Fell, 2000). She argued that bullying was not a good management of people, was not conducive to learning, created a stressful working environment and the costs incurred to the organization if not controlled were considerable (Fell, 2000). However, the issue is being confronted head-on at a few tertiary institutions. For example,

in one tertiary institution, first year students are given a two-hour education programme on bullying in which they are told that it is unacceptable and are informed of the avenues for confronting bullies in the workplace (Fraser, 2002).

It has also been suggested by Hadikin and O'Driscoll (1996) that the culture of hospitals has a great deal to do with the high level of bullying, particularly of junior nurses. Smith, Droppleman and Thomas (1996) suggest that anger amongst nurses can be used as both a weapon and as a shield in a hostile environment, and that this anger may be directed more at junior nurses than other senior nurses.

Thus, while nurses face many challenges, such as constant changes, reviews and restructuring, one of the most significant problems comes from working with their colleagues (Wilson, 2000). Moreover, the literature indicates a culture of bullying is more prevalent than the profession may care to admit (Stevens, 2002). This includes an entrenched view that it is necessary for younger nurses to endure the harsh regime that previous generations of nurses have also endured, particularly with regards to training, thus maintaining the cycle of bullying. Indeed, O'Connor (1998) argues that the acceptance of bullying behaviour is at odds with nursing as a profession; there is a contradiction between this behaviour and the public perception of caring and kind nurses.

The Working Life of Student Nurses

Part of every nursing programme is the clinical component; in New Zealand this requires 1500 hours of clinical placement over three years of training (Holland, 2002). Dunn and Hansford (1997) state that clinical education is a major component of the undergraduate nursing curriculum and is important as student nurses develop not only theoretical knowledge but also the practical application of skills. The development of a student's attitudes, psychomotor skills, knowledge and clinical problem solving skills are all largely influenced during clinical placement (Dunn and Hansford, 1997). However, problems of bullying appear to arise during clinical placements where students seem to become the losers in the faculty-staff-student triad. Assessment of clinical performance is a major issue in relation to this triad. Studies have shown that problems often occur when students are asked to take on clinical placements in the first year of study. It has been noted that trying to adjust to tertiary education as well as a ward environment causes a great deal of stress for students (Gwele and Uys, 1998). This, combined with busy and frazzled senior nurses who do not necessarily have time to assist the students, can lead to a very unpleasant learning experience for most student nurses (Fell, 2000).

In addition, timing of clinical placements, which are usually towards the end of the year when students are also studying for final examinations, is often an added source of stress (Holland, 2002). Conflicting relationships between students and the nurses they are assigned to, merely adds to this stress. Research has revealed that some registered

nurses lack the willingness and encouragement to assist training the students (Dunn and Hansford, 1997, Stevens, 2002). This becomes a major problem particularly as there is a power imbalance inherent in the "trainer-trainee" relationship (Garrett, 1997). In this context, Garrett (1997) notes that power has the capacity to produce a change as the trainer has greater knowledge, greater objectivity and status, and therefore has the power to produce change (positive or negative) in the trainee.

Garrett (1997) argues that those "buddy" nurses who lack the willingness to encourage students could be described as "bad supervisors". Specifically, bad supervision involves the absence of effective teaching strategies, role modelling and enthusiasm. This combination often results in having trainers who are disinterested and/or inept, are authoritarian and exploitative, encourage conformity and may punish those who do not conform (Garrett, 1997). These traits have also been reported in other studies (O'Connor, 1998) and by the nursing students surveyed whilst on their clinical placement (as outlined below).

In order to try and overcome the problems associated with clinical placements, in particular the problems involving the trainee and the trainer relationship, one tertiary institution has introduced an incentive programme. This programme involves clinical study scholarships given to registered nurses who "guide, mentor and instruct student nurses" ("Boost for", 2002: 11). These scholarships enable recipients to continue their professional development and further learning in their clinical specialty. It is hoped that the scholarships will encourage a high level of clinical support and partnership between the tertiary institution and its clinical placement organizations and its staff.

However, there is increasing research that shows that such incentive programmes do not necessarily provide an antidote to the entrenched organisational culture that fosters bullying. As one commentator stated:

> "Although a tough competitive environment doesn't create bullies, it may aggravate their behaviour". (Financial Times, 1996 cited in Savva and Alexandrou, 1998)

This quote concurs with research that suggests that while an organisation's culture may not create bullies, it can foster and encourage their behaviour. Cowie et al (2002) asserts that the values and norms of a workplace strongly influence how bullying is viewed, how employees interpret situations and whether bullying is recognised as a problem. Lee (2002) found that annual staff performance-related pay and promotions are occasions where line managers can bully their subordinates. Beasley and Rayner (1997) add that where bullying does occur in organisations, it usually filters down from the top management to the supervisors, and therefore it is seen as an acceptable way to manage staff, and a behaviour that may even assist people getting promotion. Furthermore, O'Moore et al (1998) found that the majority of victims in their study reported that organisational factors, such as autocratic management and a competitive and stressful work environment,

contributed to the prevalence of bullying.

Rayner and Hoel (1997) and Sheehan (1998) support this view by stating that insufficient control of certain behaviours and high levels of conflict resulting from excessive workloads and unreasonable expectations by supervisors, are often precursors to bullying of subordinates. Crawford (1997) also points to the economy that has generated high levels of unemployment and the commercial trend towards downsizing, thus increasing the employees' anxiety and vulnerability and contributing to a climate of fear and bullying. Because there is a managerial expectation that their employees will be loyal to the company (even though this loyalty is not reciprocal) and that dissent is not tolerated, bullying can often remain hidden as employees are too scared to speak out for fear of being portrayed as disloyal or as a trouble-maker (Crawford, 1997).

In summary, as a group, nurses seem to be vulnerable to bullying at work, whether it is inflicted by their peers or their managers. Because of the vulnerable nature of student nurses, as outlined above, it is important to determine the prevalence of bullying of these students whilst on clinical placement, and to ascertain if any characteristics are more dominant in either bullies or their victims.

Methodology

The main objectives of the study reported in this paper was to establish a case study investigating workplace bullying in nursing students in New Zealand, using a lower North Island tertiary institution as the sample population. Given the current limited understanding of the topic, this study took an exploratory approach for which case study methodologies are well suited. Nonetheless, the extant literature indicated that there was a likelihood that:

1) A high percentage of nursing students will report some level of bullying whilst on clinical placement, as proven by international research.

2) Students in later years of study may interpret characteristics and behaviours of bullies differently (with greater knowledge of the role of nurses) than those beginning study.

3) As previous research has shown, characteristics imagined by those who have never experienced bullying will differ greatly from those who have experienced bullying.

4) Students subjected to the harassment education programme (3rd years in 2003) will report substantially less bullying, and more positive action taken to report bullying than other students.

The study was divided into two main parts: part (a) for those who reported being bullied and part (b) for those who had not experienced bullying. The characteristics researched

included general demographics, such as age group, gender, year of study, as well as a list of commonly reported forms of bullying and symptoms associated with workplace bullying. The study involved a mixed qualitative and quantitative survey analysis within a singular New Zealand industry, the nursing sector (Yin, 1989).

As no existing questionnaire was available for use for this particular project, it was necessary to develop one. The questionnaire was divided into three main sections. Section 1 of the questionnaire gathered demographic information from the participants. This section then gave a broad definition of bullying and gave a list of commonly reported forms of bullying. These forms of bullying were taken from the State Services Commission, (2002) study of career progression, which reported up to 16% of employees had experienced a number for forms of bullying and that some types of bullying were more serious than others. Respondents were asked to identify which of these types of bullying they had experienced.

Section 2 of the questionnaire was used to determine similar information about the bully. Participants were asked to identify the perpetrators age range (approximate), gender and job type (position). Respondents also were asked to concentrate on the behaviours associated with the 'worst' incident. Finally awareness of anti-bullying programmes was canvassed.

The third section was completed by those participants who had not experienced any bullying while on clinical placement in order to gauge their perceptions. In an open-ended question, they were asked to imagine what a typical bullied person would be like and describe the average age range, gender and position (job type) of the victim. They were also given a range of symptoms and asked to identify what symptoms the imagined victim would suffer as a result of being bullied and the level of frequency the symptoms would occur. In another open-ended question, the respondents were also asked to imagine what the bully would be like and describe their demographics; this is, age range (approximate), gender and job type. The respondents were also asked if they were aware of any anti-bullying programmes, and if so what were the programmes as well as what actions they would take if they were bullied.

While a detailed description of "bullying" evolved from this study, it should be noted that such a description was reliant on the participants "schema" of its constructs. Participants made their own judgments on what it meant to them to be defenceless, humiliated, stressed or undermined. Therefore, as Cowie et al (2002) stated, a comprehensive understanding of the imbalance of power criterion is never actually satisfied. The one-sided nature of the questionnaire also makes it impossible to accurately gauge the characteristics and the reasons why bullies act as they do and who would no doubt see themselves and their behaviours very differently from the victim.

Given that there was a small number of responses, generalisations cannot be made on the basis of this data. However, the case study data does point to some disturbing trends and further research using a much larger pool of participants from various tertiary institutions would be advantageous.

Results

Of the 75 questionnaires deposited at the tertiary institution's Student Resource Centre, 40 were completed and returned, giving a response rate of 53%. The results presented below follow the phases of the study and questionnaire format.

Demographics of the Interviewees

The majority of participants in this study were aged between 18 and 40, with only 2 participants (5%) older than 40 years of age. The sample consisted of 4 males and 36 females. The majority of participants were in their third year of study (65%), with second year yielding 25% and first year contributing to only 10% of participants. No participants reported being in more than their third year of study. A break down of participants by age and year of enrolment is illustrated in Table 1 below.

TABLE 1: Participants by age group and year of study, (note % are given in brackets)

Age range	1st year	2nd year	3rd year	TOTAL
18-20		2	7	9 (22.5%)
21-25	3	2	8	13 (32.5%)
26-30		4	1	5 (12.5%)
31-35		1	5	6 (15%)
41-45		1		1 (2.5%)
46+	1			1 (2.5%)
TOTAL	4 (10%)	10 (25%)	26 (65%)	**40**

Victim Characteristics

Ninety per cent of participants (or 36 out of 40) reported that they had experienced some form of bullying while on clinical placement. As seen in Table 2, the majority of participants were under 20 years of age (18 or 55.5%) when they were first subjected to bullying behaviour. Another 15 (41%) were aged between 21 and 30, and 3 (or 27%) were aged between 31 and 40. No participants aged 41 or over reported being subjected to the bullying behaviour. Also, as outlined in Table 3, all the male participants stated that they had been bullied at some time during their placements (see below for more discussion).

The majority of participants reported being enrolled in their second year of study when the (worst case) behaviour took place (61 %). Ten participants, (27.7%) reported being in their first year of study and only four (11 %) experienced the behaviour in their third year. Table 2 summarises participants by age and year of study when the behaviour occurred.

TABLE 2: Age and year of study when bullying took place (worst case)

Age	Year 1	Year 2	Year 3	Total
18 -20	4	7		11
21-25	3	5	1	9
26-30	2	2	2	6
31-35		6	1	7
36-40	1	2		3
41-45				
46+				
Total	10	22	4	**36**

TABLE 3: Gender of participants who report being bullied.

	Male	Female	Total
Yes	4	32	36
No	0	4	4
Total	4	36	**40**

Forms of bullying and the worst form of bullying

Over half of the participants experienced ignoring/excluding (70%), intimidation (60%) and belittling remarks (55%). At least 2 of participants (or (10%) had been the victim of all the forms of bullying as outlined below in Table 4, which also summarises the frequency it occurred.

TABLE 4: Forms of bullying and the worst form of bullying experienced

Age	Year 1	Year 2	Year 3	Total
18 -20	4	7		11
21-25	3	5	1	9
26-30	2	2	2	6
31-35		6	1	7
36-40	1	2		3
41-45				
46+				
Total	10	22	4	**36**

The first question of part (a) asked participants to identify the worst form of bullying from the list of the most commonly reported behaviours outlined in the question above. This question was asked in order to assess: 1) if a participant had been bullied on more than one occasion, and 2) which of the forms of bullying they were subjected to, did they find the worst. As illustrated in Table 4, ignoring/excluding was reported as the worst behaviour experienced by 14 participants (38.8%). Intimidation was next with 6 (16.6%), followed closely by being set up to fail (5/36 or 13.8%) and belittling remarks (4/36 or 11 %).

The type of symptoms and frequency experienced

Participants were then given a list of commonly reported symptoms and asked to state whether they had experienced these symptoms as a result of being bullied, and how frequently they experienced these symptoms, as seen in Table 5. Anxiety was the most commonly reported symptom with over 75% of participants experiencing it at some level of frequency (52% once or twice; 22% frequently and 2.7% for prolonged periods). Participants reported shattered self-confidence (69%) and low self-esteem (66%) as the next most commonly reported symptom. At least one participant reported experiencing each of the symptoms, except sleeplessness, at a prolonged frequency. At least 35% of respondents reported experiencing some type of symptom as a result of being bullied.

TABLE 5: Type of and frequency of symptoms experienced.

Symptom		Frequency		
	Never	Once/twice	Frequently	Prolonged
Sleeplessness	19	15	2	
Depression	23	8	4	1
Anxiety	8	19	8	1
Poor concentration	21	9	5	1
Shattered self-confidence	11	20	4	1
Low self-esteem	12	19	3	2

Awareness of anti-harassment policies and reporting behaviours

Anti-harassment policies are commonplace in most organisations and the next question required participants to report if they were aware of anti-bullying programmes in their clinical placement organisation. Only 19% of respondents stated that they were aware of any such a policy.

Respondents were questioned as to whether or not they talked to anyone regarding the alleged behaviour and 86% stated that they had talked to someone. The most commonly reported confidant was their lecturer/tutor (44%) while confiding in classmates came a close second (33%). When asked, however, if any actions were taken against the person bullying them as a consequence of talking to someone about the problem, only five (13.8%) reported that some action was taken to mitigate the problem.

Characteristics of bullies

Questions then focused on the perpetrator of the bullying behaviour. Twenty-nine of the respondents (80%) stated that people who bullied them were aged over 31 years of age. More specifically, the most reported age group of bullies was between 31-40 years of age (47%), followed by the age group between 41-50 years of age (30.5%). Table 6 below summarises the age of bullies in relation to their victims. It is interesting to note also that almost no respondents were bullied by someone of a noticeably younger age group (2.7%).

TABLE 6: Age of bullies in relation to their victims.

Age of Victim	Age of Bully					
	18.20	21-30	31-40	41-50	51+	**Total**
16-20	1	1	7	4		13
21-25		4	1	2		7
26-30			4	2		6
31-35			4	2	1	7
36-40		1	1	1		3
41-45						
Total	1	6	17	11	1	36

The majority of respondents also identified that the perpetrators were mostly female (86%), with only 3 respondents (8.3%) identifying males. Results also indicate that the 3 respondents who reported male bullies were also male themselves.

When asked to identify the bully's occupation or position in the organisation, the majority of respondents indicated that the bully was a nurse of some description (88%), with only 4 respondents stating that the person bullying them was not a nurse. Within the nursing occupation, the most commonly reported bullies were registered nurses (38%) with "buddy" nurses being the second most commonly reported bullies (36%). Table 7 below summarises the gender, occupation and organisational position of the reported bullies.

TABLE 7: Gender, occupation and organisational position

Position	Male	Female	Total
Buddy nurse	2	11	13
Registered nurse		14	14
Enrolled nurse		2	2
Nurse aid			0
Charge nurse		3	3
Doctor	1		1
Specialist			0
Other student		2	2
Other…Tutor		1	1
Total	3	33	**36**

Respondents were then asked if it was always the same person who bullied them. The results were virtually split down the middle, with 44% stating that it was always the same person and 47% stating it was not. Three respondents (8%) did not complete this question. When asked to specify the occupation of the serial bully, again most were nurses, in which 33% of the respondents stated that the person continuously bullying them was a registered nurse and 8.3% respondents stated that it was another "buddy" nurse.

In order to establish if the victims had any preconceived views of the person who bullied them, the final question for this section asked respondents to indicate whether or not they had any suspicions in the beginning that the perpetrator would subsequently bully them. Again results were almost evenly split with 52% indicating they had expected that the person would bully them and 47% indicating they had not.

Perceptions of respondents who not experienced bullying

Of the four respondents who had not experienced any bullying, two of them believed that the victims would be aged between 18-20 while the other two respondents thought that typically the victims would be aged between 21-25 and between 26-30 respectively. All respondents thought that the victims would be female. In relation to the victim's occupation, three of the respondents thought that nursing students would be most vulnerable to bullying and the other respondent thought that the victim would most likely be a nurse aid.

When asked to imagine the type of symptoms that victims of bullying might experience and the frequency of these symptoms, all respondents thought that the victims would experience some level of shattered self confidence (50% frequently; 50% prolonged) and also low self-esteem (25% once/twice; 25% frequently; 50% prolonged). In addition, 3 (75%) of the respondents thought that the victims of bullying would suffer from anxiety. Table 8 illustrates the respondent's perceptions of the victim's symptoms and the frequency of the symptoms.

TABLE 8: The perceived symptoms and the frequency of the symptoms

Symptom	Frequency			
	Never	Once/twice	Frequently	Prolonged
Sleeplessness	3	1		
Depression	2	1		1
Anxiety	1	1	2	
Poor concentration	2		2	
Shattered self-confidence			2	2
Low self-esteem		1	1	2

With regard to the characteristics of bullies, two of the respondents imagined the bullies to be aged between 36-40; while the other respondent thought the age to be between 36-45 and remaining respondent believed the age to be between 41-45. Three respondents (75%) thought that the perpetrator would be a woman while one respondent thought that the bully would be a man. With the exception of one respondent, who thought that the bully could either be a charge nurse or a doctor, all the respondents thought that the occupation of the bully would typically be a registered nurse, enrolled nurse or a charge nurse.

All four of the respondents stated not only were they aware of an anti-bullying programmes in their clinical placement organisation but that they would also tell their lecturer if they were subjected to bullying.

Discussion

The results from the study show that that 90% of the student nurses surveyed had experienced some form of bullying while on clinical placement. Although the results are more extreme than those reported by Quine (2001) and Einarsen, Matthiesen and Skogstad (1998), (who reported that one in every two students was bullied and that 8.4% were bullied respectively), this study indicates that there is an increasing trend towards student and junior nurses being bullied. However, as noted earlier, Garrett, (1997) argues that the power imbalance between a trainer and trainee can lead to harassment

and bullying. Therefore, the reason for the high number of nursing students being bullied could be because the victims are *students* as well as nurses (also refer to see Alder, 2002, Anonymous, 2002, Fell, 2000).

Over half of the student nurses surveyed noted that the most frequent forms of bullying that they had experienced were ignoring/excluding, intimidation and belittling remarks. It is interesting to note that these forms of bullying involve *social aspects of the job* (being ignored/excluded, etc.) rather than the tasks themselves. It could be argued that wanting to fit into the social fabric of the workplace and not being able to readily achieving this may in itself cause as much distress for nursing students as the action of bullying.

The age of the participants who reported being bullied was diverse. Although just over half were 20 years of age or under, the other half were fairly evenly spread between 21 and 40 years of age. None of the participants over the age of 40 reported being bullied, however this may be because there were only two (5%) in the study. Therefore, it could be concluded that while the very young student nurses (under 20) are most prone to being bullied whilst on clinical placement, there is no age that can be deemed "safe". This finding is supported by the literature (Rayner, 1997, Rayner, 1998b and Rayner and Hoel, 1997) in which there is general consensus that bullying can happen to anyone at any age.

There also appears to be a correlation between the year in which students are enrolled in study and when they are bullied. The majority of respondents reported being bullied in their first year (27.7%) and second year (61 %) of study, while only 11 % of the respondents reported being bullied in their third year. In addition, because students only have one week of placement at the end of their first year, the inexperience may make some nurses more vulnerable and thus more prone to bullying. As they enter the second year of clinical placement, they gain more exposure to the working environment and gain more knowledge of their profession; they become more socialised into their groups and more aware of the mores and norms of their occupation; and therefore become more confident. Moreover, the more experience they gain, the more they become aware of what behaviour is tolerated and not tolerated and how to counteract inappropriate behaviour.

However, the results show that a number of students nurses experience symptoms of bullying (such as low self-esteem, etc) for prolonged periods of time. These symptoms of bullying are a direct cost to the organisation in terms of high rates of sickness and absenteeism, low morale, mental and physical illnesses and high staff turnover (also refer to Beasley and Rayner, 1997; Douglas, 2001).

Although most of the student nurses surveyed had been bullied, a high percentage of them (86%) were able to talk to someone about it and that this confidant was usually a lecturer/tutor or classmate. O'Moore et al (1998) found a similar number of respondents

(over 70%) had also sought advice and support by talking to someone else about their experiences. Sheehan (1998) cited that one-quarter of victims sought help from family doctors and counsellors after being bullied. While a high percentage reported the incident to others, only a small percentage of confidants took any action against the perpetrator. Liefooghe and Davey (2001) state that if there is a lack of procedures to deal with bullies and there is a propensity for bullying and harassment to be condoned, then these behaviours will continue unchecked and even increase.

Furthermore, this study supports other research in that the bully is frequently older than their victim (Rayner, 1997; Rayner, 1998a; Rayner, 1998b and Quine, 2001). However, one reason for this could be that the majority of respondents (and indeed students in general) are in the young age group (61 % in this study under the age of 25) and therefore, it is likely that senior staff will be older than them.

The respondents also stated that almost all the bullies were women (86%). However, this is not surprising as nursing is a female dominated profession. Therefore, bullying amongst nurses is more often than not perpetrated by women, most of whom will be older than the victim, as mention above (Stevens, 2002; Einarsen, Matthiesen and Skogstad, 1998). It is also interesting to note that the three male respondents stated that they were bullied by men. There is some research that supports this finding which suggests that on one hand women are bullied by men and women, while on the other hand men are more likely to be bullied by other men and unlikely to be bullied by women (Rayner and Hoel, 1997; Rayner, 1997). There is debate, however, as to whether or not this is an accurate claim. It could be argued that men are bullied by women but are too embarrassed to disclose it (Rayner, 1997). However, as one of the male respondents stated that he had been bullied by a senior female nurse, this assertion may also be flawed. Moreover, in an industry dominated by women, perhaps the notion of a man being bullied by a woman is not remarkable or embarrassing as would be the case if the man worked in a male (macho) dominated industry.

Not only were the bullies predominately women, but also 88% of the respondents noted that most of the bullies were nurses; the most commonly reported bullies were registered nurses (38%) and buddy nurses (36%). Only four respondents were bullied by an individual who was not a nurse.

This indicates that the bullying is occurring *within* the nursing profession rather than outside it. O'Connor (1998) points to a vicious cycle where a nurse is bullied by another colleague, who is often more senior, they then lose confidence and become a victim. As a way of diminishing the victim's role they have assumed and to make themselves feel better, they in turn bully another more vulnerable colleague. Stevens (2002) argues that the cycle is perpetuated by senior nurses who believe that because they had to endure a rigorous and often tyrannical training in which bullying was part of the system, their juniors should also have to put up with it. Thus, the cycle continues on.

Almost half of the respondents in this study had been bullied by more than one person and nearly all had been nurses. Moreover, nursing students are not only bullied by their own buddy nurse on more than one occasion, but also by other nurses in the same department (33% identified other registered nurses). There was also evidence that the respondents were being bullied by different buddy nurses (8.3% identified other buddy nurses), i.e. two different placements with different buddy nurses but the same bullying behaviour. To make matters worse, 52% of the respondents expected to be bullied while on clinical placement. The question, therefore, is: "Why are students going out on these learning expeditions and expecting to be bullied?" And "If students are expecting to be bullied, why does the profession seem to be ignoring the problem?"

The perceptions of those respondents who had not been bullied and those who had were similar. However, when the respondents who had not been bullied were asked to envisage what symptoms victims would experience, they perceived the symptoms to be worse and last longer than was actually experienced by the student nurses who had been bullied. An explanation for the differences between what was perceived and what was experienced by the nurses could be that the non-bullied respondents may have previously witnessed someone being bullied at work. This assertion is supported by Rayner (1997) who found that 77% of individuals had at sometime witnessed bullying at work and Quine (2001) revealed that nurses were more likely to witness bullying than any other health-care providers.

Further Research

Although it is acknowledged that the number of responses (40) were too few to provide any conclusive statements or to apply any generalisations, the findings do highlight a number of directions for further research. One such area that requires further investigation is whether or nor student nurses have an expectation and acceptance that they will experience a level of bullying while on clinical placements. The results from this study, which are somewhat disturbing, suggest that this may be the case but other similar studies are required to test this hypothesis.

Another possible area for investigation is the affects of bullying on student nurses, and in particular the impact of bullying on the recruitment and retention of nurses. For example, studies that link the levels absenteeism, withdrawals from courses and resignations with the affects of bullying could provide the basis of useful arguments to fund comprehensive programmes to counteract bullying behaviour. Research in other sectors shows that victims of bullying invariably leave their positions and seek employment elsewhere. However, given that there is a chronic nursing shortage, it may be useful to address issues, such as bullying, that detract from the nursing profession.

Conclusions

The results of this study clearly indicate that bullying is occurring to the majority of students whilst on clinical placement. Targets of such behaviour do not fall within a specific age group and can be either gender suggesting that bullying can happen to anyone. The more advanced the student is in their training, the less likely they are to suffer bullying, suggesting that as they become more experienced and confident, the incidence of bullying also decreases. The majority of respondents reported some form of psychological effects associated with being bullied. A high percentage of the bullies are nurses, suggesting that bullying comes from within the profession, rather than from outside it (e.g., doctors, specialists). Bullies in this study were most likely to be older than their victims, and are typically female. While the perceptions of the non-bullied respondents did not necessarily match those had experiences of being bullied, the findings indicate that even the non-bullied respondents were aware of the patterns, forms and implications of bullying.

Although the findings from overseas research on bullying has implications for New Zealanders, further research is still required in order to assess the prevalence and wider affects of this harmful behaviour amongst vulnerable workers in New Zealand. While bullying is often trivialised and condoned, the long-term negative impact it has on the victims, the colleagues, the families and the organisation deems that it should no longer be ignored. Furthermore, studies that reveal better ways of predicting and preventing bullying behaviour should be encouraged and organisations and government enforcement agencies need to be more proactive to end this damaging behaviour that occurs in the “sanctity” of the workplace.

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