Examining Bullying, Harassment, and Horizontal Violence (BHHV) in Student Nurses.

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Bullying, harassment, and horizontal violence (BHHV) is commonly reported by student nurses during their clinical education. Despite decades of mention in the literature, no instrument is available to specifically measure the student nurse’s experience of BHHV during clinical education. **Purpose:** The purpose of this dissertation is to examine the experience of BHHV in a population of student nurses matriculating during their clinical education in New York. The experience of BHHV is measured with the BEHAVE Survey, the instrument developed and tested for this purpose. **Methods:** This dissertation is presented in three-manuscripts: (1) a comprehensive review of the literature using The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement as the methodological guide, (2) the initial psychometric testing of BEHAVE (Bulling, harassment, and Horizontal Violence) for validity and reliability at a university-based school of nursing in New York, and (3) a descriptive, quantitative survey of baccalaureate nursing students at a university-based school of nursing in New York completed as a field test of the BEHAVE. **Results:** Despite variations in methodology, measurement, terms, definitions, and coding of behaviors and sources of BHHV, the findings of this literature review indicate that student nurses are common targets of BHHV during clinical education, regardless of demographic characteristics, disability, sexual orientation, geography location, academic institution or program type. Psychometric testing indicated: scale-level content validity index among experts 0.89, $r = 0.97$, a Cronbach’s $\alpha$ 0.94, and percent agreement 93% in test-retest reliability. BEHAVE was administered to a total of 32 participants (96.7% participation rate). Approximately 72% reporting current experienced or observed BHHV with 46.8% (36/77) of incidents originated from a nurse. **Conclusions:** The
evidence from both the literature and this field trial suggests that BHHV is a common experience among nursing students. This is significant because student nurses are vulnerable to BHHV and studies including students have been limited to date. Therefore, it behooves the research community to continue to explore the impact of BHHV on the student nurse’s socialization into the professional nursing role. Further knowledge may inform targeted interventions to reduce BHHV and improve the ability of nursing students to minimize the impact of BHHV should it occur.
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voor mijn Anemo
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CHAPTER ONE

In this chapter, I provide an introduction to the dissertation topic, a definition of bullying, harassment, and horizontal violence (BHHV), and a model for examining the concepts of BHHV. The chapter continues with background and significance, a theoretical model, problem statement, and concludes with the aims of this dissertation and an explanation of the forthcoming papers reporting the results from each of the three studies.
On March 10, 2011, the President hosted The White House Conference on Bullying Prevention and noted: “…because [bullying is] something that happens a lot, and it’s something that’s always been around, sometimes we’ve turned a blind eye to the problem” (Henderson, 2011). Responding to the long-standing presence of bullying and other disruptive workplace behaviors in the nation’s hospitals, The Joint Commission published recommendations to prevent their impact and suggests: “To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten performance of the health care team” (The Joint Commission Sentinel Event Alert Issue 40, 2008).

Bullying has been a longstanding concern among nurses but has received limited empirical attention (Longo, 2010). Those disruptive behaviors that comprise bullying have received attention nationally and internationally in the nursing literature for some time (Johnson & Rhea, 2009) ever since their initial symbolic description as “nurses eating their young” by Jarratt in 1981. A recent conceptual analysis of these disruptive behaviors in the nursing literature concluded that individual descriptive terms overlap and can be examined as a single construct (Vessey, DeMarco, & DiFazio, 2011).

As a result of the analysis, the authors determined that BHHV can be examined as a unitary construct consisting of the individual concepts of bullying, harassment, and horizontal violence. The construct of BHHV describes a behavior set characterized by “repeated, offensive, abusive, intimidating or insulting behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence” (Ibid., pp. 136), see Figure 1.1.
Figure 1.1 depicts a circle inscribed in an equilateral triangle. The circle encloses the behavior set of the BHHV construct contained in each individual concept. Each of the individual concepts, bullying, harassment, and horizontal violence, is separated and inhabits a corner. The separation of concepts represents the fact that each one contains a distinctive difference from the other, such as: bullying requires a power gradient between the target and instigator(s), horizontal violence occurs between and/or among peers, and harassment occurs when the target is different from the normed group (Ibid., p. 136). Due to the novelty of the concept and exploratory nature of this work, this model represents the examination of BHHV as one construct, comprised of three concepts. Future inquiry and testing of this model will be necessary to validate it and to articulate the relationship(s) between the three concepts.

Figure 1.1

Model of the individual concepts underpinning the bullying, harassment, and horizontal violence (BHHV) construct based on Vessey, DeMarco, & DiFazio, (2011).
Background and Significance

With approximately 45% of currently employed nurses (Health Resources and Services Administration, 2010) approaching retirement age at the same time as the health care system needs are burgeoning and the elderly population is reaching its peak, greater access to nurses and nursing care will be needed. The nursing workforce supply is further impacted by the regular attrition of new nurses, with BHHV emerging as an important factor influencing the organizational and/or professional retention of new nurses (Smith, Andrusyszyn, & Laschinger, 2010; Rowell, 2009; Johnson, & Rhea, 2009; Simmons, 2008; Daiski, 2004; McKenna, Smith, Poole, & Coverdale, 2003). BHHV influences attrition by having negative effects on the emotional and physical well-being of staff (Einarsen, Hoel, & Notelaers, 2003), quality of care and patient safety (Lashinger, Finegan, & Wilk, 2009; Farrell, Bobrowski, & Bobrowski, 2006; Rowe & Sherlock, 2005; Randle, 2003), decreased staff productivity (Berry, Gillespie, Gates, & Schafer, 2012), and has been reported as a major obstacle in the recruitment and retention of nurses (Jackson, Clare, & Mannix, 2002).

Similar to newly graduated nurses, student nurses are also considered to be a vulnerable subgroup for experiencing BHHV (Longo, J., 2007; Cooper, et al., 2009; Magnavita, & Heponiemi, 2011; Curtis, Bowen, & Reid, 2007; Randle, 2003). Yet, research on any form of violence involving nurses generally excludes or has not sufficiently studied student nurses (Hinchberger, 2009; Ferns & Meerabeau, 2007; Thomas & Burke, 2009). Between 2000 and 2012, 15 quantitative and seven qualitative BHHV studies were identified that included student nurses (Geller & Larson, In Review), with only five of these studies (27.8%) conducted in the United States (US) (Anthony, & Yastick, 2011; Cooper, et al., 2009; Hinchberger, 2009; Longo, 2009; Thomas & Burk, 2009).
In one southern US state, the majority (95.6%) of 636 student nurses reported experiencing at least one of twelve behaviors categorized as bullying (Cooper, et al., 2009). In Florida, out of 47 students surveyed, 53% reported being ‘put down’ by a nurse, 40% heard a sarcastic comment being made about them, and 26% reported being talked about behind their back (Longo, 2007). Notably, in Southern California, 100% of 126 student nurses reported experiencing or observing violence, primarily from staff members, directed toward student nurses during their clinical placement (Hinchberger, 2009).

BHHV experienced by student nurses has also been studied in Italy, Jordan, Turkey, the United Kingdom, Canada, and Australia (Magnavita & Heponiemi, 2011; Al-Hussain, et al., 2008; Celebioglu, Akpinar, Kucukoglu, & Engin, 2010; Celik & Bayraktar, 2004; Stevenson, Randle, & Grayling, 2006; Clarke, Kane, Rajacich, & Lafreniere, 2012; Ferns & Meerabeau, 2007). Researchers have not yet examined student nurse populations in the US sufficiently to determine whether students in various educational settings experience BHHV at a different rate from their international colleagues or if the different tools and cultural variations in professional behavior have any impact on the reported prevalence of BHHV in student nurses.

Based on the available information on the rate and impact of BHHV experienced in the student nurse population, it has been proposed that BHHV has a significant effect on student career trajectories (Curtis, Bowen, & Reid, 2006; Randle, 2003; Deary, Watson, & Hogston, 2003). Because clinical experiences and placements are presumed to influence post-graduate employment (Andrews, et al., 2005; Curtis, et al., 2006), reliable and valid measures on the impact of BHHV on student nurses during their clinical nursing education remains a gap in the current literature.
Theoretical Framework

One of the earliest and frequently referenced explanations for BHHV appears in Roberts’ adaptation of Paolo Freire’s 1971 book *Pedagogy of the Oppressed*. Roberts adapted Freire’s theory to explain the evolution of leadership style within nursing and to offer strategies in the development of more effective professional leadership (Roberts, 1983). Further adapted by DeMarco and Roberts (2003) to explain negative behaviors that impact the nursing workforce and again by Martin, Stanley, Dulaney, and Pehrson (2008) for explanation of lateral violence in nursing, a cyclical model is proposed to explicate the manifestations of Oppressed Group Behaviors (OGB) in nursing, see Figure 1.2.

Negative behaviors within nursing are congruent with those of an oppressed group because the profession is at least partially controlled by external sources that are “…dominated by physicians, administrators, and marginalized [by] nurse managers…” (Griffin, 2004), and lacks autonomy, accountability, and control over nursing professional activities (Woelfle & McCaffrey, 2007; Roberts, 1983). In response to the work environment and its professional socialization, nurses learn negative behaviors that occur in this cycle (DeMarco & Roberts, 2003) which are maintained by the inequities of power inherent in the nursing workplace (Roberts, DeMarco, & Griffin, 2009). Thus, OGB may describe nursing’s negative behaviors, such as those in BHHV, as resulting from nursing’s relative institutional powerlessness and the workplace’s hierarchy and its power differentials (Ibid.).

Nursing students or new graduates are particularly vulnerable when entering this kind of workplace because they are often younger, have less clinical and life experience, fewer acquired coping skills, minimal power in the environment’s hierarchy (Vessey, et al., 2009; Dellasega,
2009; Griffin, 2004) and are unfamiliar with the environment and its standards (Andrews, et al., 2005). These factors expose the student nurse to marginalization and targeting of BHHV because the student is on the fringes of the dominant group and unable to be a full member (Roberts, 1983).

Figure 1.2

The Stanley/Martin Applied Model of Oppressed Group Behavior (OGB)* to Explain Lateral Violence in Nursing.

Decision to leave work group

- Low self-esteem
- Low group morale

→ Unable to effect meaningful change

Unable to trust coworkers

→ Self-reliance

Tension in work relationships; conflict-charged environment

Powerlessness and frustration

→ Unable to assert self; “silencing of voice”

Unable to support one another; dissatisfaction directed toward peers

*Applied Model of Oppressed Group Behavior (OGB), using concepts proposed by DeMarco and Roberts (2003).
Problem Statement

Although studies of BHHV among practicing nurses have been published for several decades, data have lacked methodological rigor and remain sparse in reporting the incidence and prevalence of BHHV in the US nursing workforce (Vessey, DeMarco, & DiFazio, 2010). Considering that the student nurse is thought to be in one of the most vulnerable groups for targeting of BHHV (Longo, 2007; Cooper, et al., 2009; Magnavita, & Heponiemi, 2011; Curtis, et al., 2007; Randle, 2003) and research on any form of violence involving nurses often excludes student nurses (Hinchberger, 2009; Ferns & Meerabeau, 2007; Thomas & Burke, 2009), examination of the student nurse’s experience of BHHV is essential to understanding its professional impact. Further, the recent development of a cadre of instruments to measure the presence of BHHV in nursing presents an opportunity to study and accurately report on its incidence, severity, and impact on student nurses in the US. The timely measurement of BHHV in student nurses will provide the necessary information to fill the gap in the literature.

Therefore, the research question guiding this dissertation is: What is the experience of BHHV in a population of student nurses matriculating during their clinical education in New York?

**Aim I:** To develop and test the psychometric properties of the BEHAVE Survey (Bulling, harassment, and Horizontal Violence) to assess bullying, harassment, and horizontal violence (BHHV) in student nurses.

**Aim II:** To examine the proportion of bullying, harassment, and horizontal violence (BHHV) in a sample of student nurses in New York during the clinical portion of their nursing education.
This dissertation includes three papers that have been or will be submitted to peer reviewed journals: two submitted manuscripts which are being peer reviewed (Chapters 2 and 3). The third paper will be submitted in the Fall of 2013 (Chapter 3).

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CHAPTER TWO

In this chapter, I present the results of the comprehensive review of the literature from a manuscript, “Comprehensive Review of Student Nurse Bullying, Harassment, and Horizontal Violence”, under review in the *Journal of Nursing Education*. 
Abstract

**Purpose:** This review summarizes the state of the science on the experience of student nurses as targets of bullying, harassment, and horizontal violence (BHHV) during their clinical education.

**Design:** A comprehensive review of the literature published between January 1, 2000 and December 31, 2012. **Methods:** The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement was used as the methodological guide for literature accessed across six data bases linking the word ‘nurse’ with a series of seventeen key words.

**Findings:** A total of 22 articles met inclusion criteria: fifteen quantitative and seven qualitative designs. BHHV was frequently described in various behavioral terms and measured with author-developed surveys. **Conclusions:** Although the overall quantity and quality of this body of literature are limited, the findings indicate that student nurses are common targets of BHHV during clinical education, regardless of demographic characteristics, disability, sexual orientation, geography location, academic institution or program type.

Statement of clinical relevance: The study is relevant to teachers and learners of nursing and to those working with students in the clinical educational environment.

**Key words:** bullying, harassment, horizontal violence, student nurses, comprehensive review.
Comprehensive Review of Student Nurse Bullying, Harassment, and Horizontal Violence

The clinical component of a nursing educational program has been identified as the most important area for learning and socialization to the profession (Atack, Comacu, Kenny, LaBelle, & Miller, 2000), in part because staff-student relationships have been reported as being of most influence on student’s sense of belonging and learning (Levett-Jones, Lathlean, Higgins, & McMillan, 2008). When staff-student relationships are successful, socialization of students to the professional nursing role allows for development and refinement of the knowledge and skills necessary to manage care as part of a team (American Association of Colleges of Nursing, 2008).

On the contrary, when students experience negative relationships with staff, they report feeling inhibited (Vallant & Neville, 2006), undervalued (Wakefield, 2000), intrusive, uncomfortable, and unwelcome (Jackson & Mannix, 2001). Students report feelings of anxiety during clinical rotation, which affects performance (Moscaritolo, 2009). Students also expect hostility and communication difficulties in their clinical areas and the interpersonal relationships (Vallant & Neville, 2006) because of the potential negative attitudes of the staff to their limited skill sets (Cooke, 1996). Difficulty with interpersonal relationships was found to affect the student’s overall perception of their clinical placement because of the stress it generated (Timmins & Kaliszer, 2002). Further, the student nurse’s socialization to challenging interpersonal relationships may continue as they enter into the nursing workforce, negatively impacting work relationships and decreasing the quality of patient care (Luparell, 2011).

One category of potential negative clinical interactions includes bullying, harassment, and horizontal violence (BHHV). BHHV has long been referred to as the phenomenon of “nurses eating their young” (Jarratt, 1981), and student nurses are thought to be at greatest risk for being targets (Beech, 2001).
BHHV is a set of overlapping behaviors defined as: “repeated, offensive, abusive, intimidatory or insulting behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence”, (Vessey, DeMarco, & DiFazio, 2010, pp. 136), see Figure 1. Specifically, bullying requires a power gradient between the target and instigator(s), horizontal violence occurs between and/or among peers, and harassment occurs when the target is different from the normed group (Ibid.).

To date, there has been no published comprehensive review or meta-analysis conducted on BHHV in student nurses. In an effort to understand the experience of BHHV in student nurses, a comprehensive review of the literature published between January 1, 2000 and December 31, 2012 was completed in January of 2013. The purpose of this review was to critique the current state of the science on the experience of student nurses as targets of BHHV during their clinical education and focuses on the following questions:

How has BHHV experienced by student nurses in clinical education been studied and measured?

What are the terms used to define BHHV, frequency, types, and sources of BHHV experienced by student nurses in clinical education?

**Method**

For a comprehensive search of the articles that were published between January 1, 2000, and December 31, 2012, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement was used as the methodological guide (Moher, Liberati, Tetzlaff, & Altman, 2009). Literature was accessed from six data bases by the first author reviewer: CINAHL, PubMed, Web of Science, ERIC, The Cochrane Library, and PsycInfo. Key words

To meet the inclusion criteria for this comprehensive review, studies had to: (1) be written in English, (2) include student nurses in the sampled population, (3) be published in a peer-reviewed journal, (4) mention any form of BHHV in the title, and (5) use a quantitative, qualitative, or a mixed-method study design. All included studies defined their phenomenon congruent with the Vessey, et al. (2010) definition of BHHV as behaviors of repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions that make recipients upset, feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence. Exclusion criteria included (1) duplicate publications, (2) case studies, (3) publications available as abstracts or posters only, (4) editorials or opinions, and (5) doctoral dissertations and Master’s theses.

First, titles were scanned for including terms associated with BHHV in student nurses. Then, individual abstracts were read to confirm eligibility for full-text review. During full-text review inclusion criteria were confirmed for the individual studies. If studies met criteria, their reference lists were subsequently reviewed for additional related articles. Following the screening process, the studies were sorted by study design and analyzed according to the components of interest, including: (1) methodology and instrumentation, (2) terminology, constructs, and associated behaviors, (3) frequency and sources, and (4) study location and sample characteristics. To assess quantitative studies, principles of qualitative rigor were used and applied to each of the studies.
Results

The flow diagram in Figure 2 documents the selection and review process of included articles. Initially, a total of 3791 records were identified from the six databases. A duplication rate of 36% resulted in the removal of 1366 titles, leaving 2425 records eligible for review at title. Sixty-four abstracts from these 2425 articles mentioned some form of BHHV in student nurses, 35 then met eligibility for full-text evaluation. After review of the full texts of these 35 articles, 22 met all inclusion criteria. No additional articles were identified from the hand searches of reference lists from these articles.

Nomenclature and definition

BHHV nomenclature used in these studies, see Tables 1a and 1b, included the terms: bullying (7/22, 31.8%), harassment (2/22, 9%), violence (7/22, 31.8%), or other terminology (6/22, 27.3%). Bullying was used as an independent term to describe a specific behavior set, whereas harassment was linked with a sexual component (2/2, 100%). Further, violence was described as: horizontal or vertical (57.1%, 4/7), workplace related (1/7, 14.3%), verbal (1/7, 14.3%), and generalized (1/7, 14.3%). Other terms used to report BHHV in student nurses included: abuse (3/22, 13.6%), and aggression, incivility, or mistreatment (1/22, 9%, each).

Nomenclature used to describe the same BHHV phenomenon was inconsistent across studies, but each individual study included more than one of the components of BHHV’s conceptual definition (Vessey, et. al., 2010).

Designs, locations, and response rates of studies

The 22 articles included fifteen which used a quantitative design (68.2%) and seven used a qualitative design (31.8%). Surveys were used in all fifteen of the quantitative studies, with content analysis conducted on open-ended questions in two of the studies (Ferns, & Meerabeau,
In the qualitative studies, designs included focus groups (Anthony & Yastick, 2008; Hoel, Giga, & Davidson, 2007), thematic content analyses (Curtis, Bowen, & Reid, 2007; Jackson et al., 2011), phenomenology (Lash, Kulakac, Buldugoglu, & Kukulu, 2006), grounded theory (Randle, 2003), and narration (Thomas & Burk, 2009). Studies were conducted in ten countries: the United States (5/22, 22.7%), the United Kingdom (5/22, 22.7%), Turkey (4/22, 18.2%), Australia (2/22, 9.1%), Canada, Israel, Italy, Jordan, New Zealand, Italy, and Korea (each 1/22, 4.5%). Recruitment of nursing students occurred in a university setting/school of nursing (17/22, 77.4%), a free-standing school of nursing (3/22, 13.6%), and online (2/22, 9%). Response and/or participation rates were reported in 77.3% (17/22) of the studies and ranged from 53% to 99%.

**Measurement, frequency, and behavior types**

BHHV was measured with fourteen separate instruments, five of which were author-developed (Cooper & Curzio, 2012; Unal, Hisar, & Gorgulu, 2012; Celebioglu, Akpinnar, Kucukoglu, & Engin, 2010; Longo, 2007; Bronner, Peretz, & Ehrenfeld, 2004). In eight studies, existing surveys on similar topics were adapted to the student nurse population (Clarke, Kane, Rajacich, & Lafreniere, 2012; Lee, Song, & Kim, 2011; Magnavita & Hiponemi, 2011; Hinchberger, 2009; Al-Hussain et al., 2008; Stevenson, Randle, & Grayling, 2006; Celik & Bayraktar, 2004). One study used the Bullying in Nursing Education Questionnaire (BNEQ) (Cooper et al., 2009). There was no description of how two of the instruments were developed (Ferns et al., 2007; Foster et al., 2004).

BHHV was reported by a wide range of the participating students across the studies, ranging from ≤8% to 100%, with two studies reporting frequencies of 100% (Celik et al., 2004; Hinchberger, 2009). There was some suggestion that students may experience BHHV at varied
rates depending on the year of their matriculation, rather than the cumulative experience. Yet, Clarke, et al. (2012) found no statistically significant difference in mean rates of bullying by year spent matriculating in a Canadian sample of student nurses. Celik et al. (2004) concluded that spending more years in nursing school increases the likelihood of experiencing BHHV as a student nurse. Yet, Cooper et al. (2012) found that reporting of non-verbal peer bullying occurred more frequently in older students, attributing the difference to the expectation of different age cohorts.

In greater than half of the articles, BHHV included belittling, blaming and undermining students and humiliation, teasing, and use of sarcasm, see Table 2 (Al-Hussein et al., 2008; Anthony et al., 2011; Bronner et al., 2003; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2012; Cooper et al., 2009; Curtis et al., 2006; Foster et al., 2004; Lee et al., 2011; Longo, 2007; Hoel et al., 2007; Jackson et al., 2009; Stevenson et al., 2006; Thomas et al., 2009; Unal et al., 2012). In half of the studies, students reported experiencing slurs, jokes, or comments based on age, race, ethnicity, religion, gender, disability, or sexual orientation (Al-Hussain et al., 2008; Bronner et al., 2003; Celebioglu et al., 2010; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2012; Ferns et al., 2007; Jackson et al., 2009; Lash et al., 2006; Lee et al., 2011; Stevenson et al., 2006). Neglect, exclusion, isolation, ignoring the student, or the threat or actual performance of physical or sexual harm was also reported as a frequent form of BHHV (Al-Hussein et al., 2008; Anthony et al., 2011; Bronner et al., 2003; Celebioglu et al., 2010; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2012; Cooper et al., 2009; Curtis et al., 2006; Ferns et al., 2007; Foster et al., 2004; Hinchberger, 2009; Hoel et al., 2007; Jackson et al., 2011; Lee et al., 2011; Longo, 2009; Magnavita et al., 2011; Stevenson et al., 2006; Thomas et al., 2009.)

Sources of BHHV
A variety of disciplines and individuals were reported as the perpetrators or sources of BHHV towards student nurses. In six studies, sources were not reported or specifically described in terms of discipline or role (Cooper et al., 2009; Curtis et al., 2007; Hoel et al., 2007; Jackson et al., 2011; Lee et al., 2011; Stevenson et al., 2006). When reported, sources of BHHV included classmates, nurses and physicians, and patients and their families or visitors (Al-Hussein et al., 2008; Anthony et al., 2011; Bronner et al., 2003; Celebioglu et al., 2010; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2012; Ferns et al., 2007; Foster et al., 2004; Hinchberger, 2009; Lash et al., 2006; Longo, 2007; Magnavita et al., 2011; Randle et al., 2003; Thomas et al., 2009; Unal et al., 2012).

Classmates, or fellow students, were reported as sources of BHHV in five of the studies (Al-Hussain et al., 2008; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2012; Foster et al., 2004), ranging from 10% to 100%, yet only one study focused solely on peer-bullying, reporting frequencies of verbal bullying of 24 to 42%, non-verbal 17 to 45%, and physical bullying ≤8% (Cooper et al., 2012). In 80% of the studies, nurses practicing in some capacity were reported as engaging in BHHV toward student nurses at a rate of 18.5 to 53%. Clinical nursing faculty were reported as the source of BHHV in four studies (Clarke et al., 2012; Unal et al., 2012; Celik et al., 2004; Foster et al., 2004), with a rate of 3% to 41.3%.

Physicians were cited as sources of BHHV at a rate of 3 to 31.6% (Celebioglu et al., 2010; Unal et al., 2012; Celik et al., 2004; Foster et al., 2004; Bronner et al., 2003). In multiple studies, patients, their families and visitors were cited as common sources of BHHV towards student nurses. In two of these studies (Celebioglu et al., 2010; Ferns et al., 2007), patients and/or families and/or visitors were the most common sources, reported between 53.4 to 80.4%.
In two studies 80% of the sexual component of BHHV (Lee et al., 2011; Bronner et al., 2003) was initiated by male physicians and patients.

**Qualitative themes**

In the qualitative studies, varying methodologies produced a series of themes related to BHHV. Use of the principles for qualitative rigor was described by the authors of most of the seven studies, see Table 1b. When unreported, three studies excluded credibility (Hoel et al., 2007; Lash et al., 2006; Thomas et al., 2009), and one study, Curtis et al. (2007), did not describe any methods to maximize design rigor.

Authors focused predominantly on describing and explaining the students’ experiences with BHHV as feeling invisible and unwelcome. Most often, students reported their experience as being treated with dismissiveness and being distrusted for their work. Hostility, rudeness, blaming, and public or private humiliation were also common expressions of BHHV towards students as well as feeling marginalized and treated as ‘ignorant outsiders’ (Lash et al., 2006).

Coping behaviors, such as internalization and rationalization, were described by students as a way to secure their legitimate identity and professional role by resisting the occurrences and impact of BHHV. Students expressed the opinion that the institutional hierarchy promoted aggression as legitimate behavior (Jackson et al., 2011). Three of the studies explored how students objectively explained the origin of the behaviors attributed to a relative lack of experience and institutional power, predisposing them to being targets for the staff’s negative behavior. Further contributing to BHHV was the students’ feeling that the practicing nurses and instructors had varying expectations of their skill set. Lastly, students felt that these experiences would have an impact on their future professional lives by informing their expectations of their work environments (Curtis et al., 2007).
Discussion

Across the studies, there was variation in methodology, measurement, terminology, frequency, behavioral types, and reported sources of BBHV. Lack of consistency in study design and methods may have contributed to the variations in the frequencies of BHHV rates reported in these studies, making it difficult to compare the experiences and frequencies of BHHV across studies.

Although a common perception of BHHV is the phenomenon of “nurses eating their young”, common sources of BHHV reported by students in these studies were patients and their visitors and classmates rather than solely practicing nurses. However, because the sources of BHHV were reported differently across the studies it was not possible to make accurate comparisons. Differences in reporting across studies included (1) reporting on patients and their family members as a single group, (2) lack of differentiation between individual disciplines, and/or (3) not reporting frequencies of BHHV from the clinical instructor and/or faculty and/or preceptor across the studies.

Another source of the variation in reported frequencies of BHHV, types, and sources reported by the students was the use of predominantly author-developed instruments and those with minimal reporting of psychometric properties. None of the studies in which an instrument was developed by the author included explicit information regarding how the instrument was created and tested. Even in studies using instruments adapted from other sources, there was little or no reporting of instrument reliability and validity. Adequate comparison between individual studies is, at this time, challenged by the current state of the science.

Based on this review, it is clear that there is no ‘gold standard’ for methods and measures to assess BHHV, as none of the instruments available in the literature measured the full range of
behaviors associated with BHHV (Vessey, et al., 2010). Further, variations in cultural, generational, and geographical norms that constitute appropriate professional communication may differ, posing a challenge in the development of a tool for application and measurement of BHHV across countries. Cooper, et al. (2012), suggested that behaviors attributable to BHHV remain difficult to define because their recognition is dependent on the individual’s perception and emotional health at that time. Further, in Maganvita, et al. (2011), their survey was limited to experiencing threats, physical assaults, and sexual harassment, while student participants in Ferns, et al., (2007) reported on having witnessed other students experiencing verbal abuse. Finally, variations in time frames surveyed, such as past year of matriculation versus cumulative experience, limited description of BHHV over the course of a student’s clinical education. These examples demonstrate how study design and BHHV terminology impact study results and interpretation, and may not be universally understood or applicable.

Further, Griffin (2004) published a list of the ten most frequent categories of behaviors associated with BHHV that were derived from the literature in practicing nurses and from interviews of newly licensed nurses. The behaviors described by Griffin are included in the 20 categories of BHHV behaviors in this review with minor variations. Thus, there is a consensus in the literature regarding the constellation of behaviors associated with BHHV, despite the variations in descriptive terminology. Consistent, standardized measurement and identification of BHHV will be possible as these categories will allow further exploration into a more universal theoretical and operational definition of BHHV.

**Limitations**

This review has several limitations. Articles could have been missed because of limitations in the databases searched, use of varied terms for the same construct, and because
searches and analyses were conducted by a single individual and only in English. Further, the pool of articles was not sufficiently large to make generalizations across the student nurse population.

**Conclusion**

Although the overall quantity and quality of this body of literature are limited, the findings of this analysis indicate that student nurses are common targets of BHHV during clinical education, regardless of demographic characteristics, disability, sexual orientation, geography location, academic institution or program type. Limitations in the published research are due to variations in methodology, measurement, terms, definitions, and coding of behaviors and sources of BHHV, all of which likely contribute to the wide range in frequencies reported. Further, studies had limited external validity because they were conducted in various settings in which geographical or cultural expectations of professional behavior may differ. Future research will need to focus on standardization of nomenclature and definitions, conducting validity studies of behaviors associated with BHHV, and the development of psychometrically robust measurement tools to accurately examine BHHV experienced in the student nurse population.
References


Beech, B. (2001). Sign of the times or the shape of things to come. A three day unit on aggression and violence in health care settings for all students during pre-registration nurse training. *Accident and Emergency Nursing, 9*, 204-211.


Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An


**List of Clinical Resources:**


Figure 1.

*Model of the individual concepts underpinning the bullying, harassment, and horizontal violence (BHHV) construct based on Vessey, DeMarco, & DiFazio, (2010).*
Figure 2.

Flow diagram for the comprehensive review of the literature on bullying, harassment, and horizontal violence (BHHV) in student nurses*. 

Table 1a.

Summary of 15 quantitative bullying, harassment, and horizontal violence (BHHV) studies included in the synthesis.

<table>
<thead>
<tr>
<th>First author, (year), sample size, &amp; location</th>
<th>BHHV construct, term, and definition</th>
<th>Research method &amp; statistics (if applicable)</th>
<th>Frequencies of experiences, types, and sources of BHHV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke (2012) n= 674 Canada</td>
<td>Bullying = Acts of bullying defined as a series of terms that encompass negative and unwanted acts toward others. Bullying acts were operationalized into 25 statements.</td>
<td>Descriptive, cross-sectional survey produced descriptive statistics and a Chi-square</td>
<td>Frequency: 88.7% respondents experienced bullying. Types: 60.2% undervaluing of efforts, 45.2% negative remarks about nursing, 43.0% impossible expectations set, 42.1% treated with hostility, 41.8% undue pressure to produce work, 41.54% being ignored/excluded, and 40.36% unjustly criticized. Sources: 30.2% clinical instructors, 25.5% nurses, 15% classmates, and 14% patients/families.</td>
</tr>
<tr>
<td>Cooper (2012) n= 165 UK</td>
<td>Bullying = Acts which are intended to hurt or intimidate a weaker individual. Bullying was described in relation to peers and further subdivided into: verbal, non-verbal, and physical</td>
<td>Author-developed, based on the literature and Oppeheim (2003)</td>
<td>Frequency: 24-42% verbal, 17-45% non-verbal, and ≤8% physical bullying. Types: Verbal bullying included: peer pressure, group targeting for difference, exclusion, humiliation, rudeness, teasing, slurs, jokes, sarcasm, threats; non-verbal bullying included: withholding, ignoring, and sabotage; physical bullying included:</td>
</tr>
<tr>
<td>Study</td>
<td>Violence Definition</td>
<td>Methodology</td>
<td>Frequency for Source of Violence</td>
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<td>------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Unal (2012)</td>
<td>“Any incidence of threatening behavior, verbal threat, physical assault and sexual</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics</td>
<td>Teacher 16.6-65%, nurse 8.7-55.5%, doctor 11.4-26.1%, and patient 10.3-36.1%.</td>
</tr>
<tr>
<td>n= 274 Turkey</td>
<td>assault inflicted by the patient, the patient’s relatives or any other individual,</td>
<td>Author-developed, based on the literature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>which constitutes a risk for the health staff.” (Saines, 1999).</td>
<td>No psychometrics available for the verbal violence portion of this study</td>
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<tr>
<td></td>
<td>Verbal violence operationalized as:</td>
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<td></td>
<td>humiliating and degrading speech, shouting, threats, humiliation, snapping, use of</td>
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<td></td>
<td>undesirable nickname, making false allegations, assignment sabotage, and questioning</td>
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<td></td>
<td>honesty and reliability.</td>
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<tr>
<td>Lee (2011)</td>
<td>Harassment (sexual) = “…repeated and unwelcome sexual comments, looks, or physical</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics</td>
<td>Frequency of experiencing sexual harassment in clinical: 17.9% definitely, 6.6% not sure, and 75.5% did not; Of the sexually harassed students: 55.8% experienced once, 29.5% twice, and 4.2% more than six experiences of sexual</td>
</tr>
<tr>
<td>n= 542 Korea</td>
<td>contact at workplaces or other places.</td>
<td>Used instrument from: Lee &amp; Lee (2001); a Korean 18-item checklist measuring</td>
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<td></td>
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<td>experience of sexual</td>
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</table>
and is related to not only sexuality but also uneven power (Chen, et al. 2009; King, 1995).

Acts of sexual harassment were operationalized into 18 statements.

harassment

Internal consistency reliability: Cronbach’s alpha 0.80; content validity reported

Types: 52% experienced at least one of the 18 items; 40.9% verbal, 26.1% physical, 13.0% gender-related demands, and 11.5% visual; 23% comments related to sexually evaluating appearance, 16.7% having intended physical contact, and 16.5% dirty remarks or sexual talk in [student’s] presence.

Sources: 97.9% males, 96.9% patients, and 41.2% aged 40 and above.

<table>
<thead>
<tr>
<th>Magnavita (2011)</th>
<th>Violence (workplace) = Violent acts directed toward workers, includes physical assault, the threat of assault, and verbal abuse.</th>
<th>Descriptive, cross-sectional survey, produced: descriptive statistics, Chi-square, and t-tests, Mann-Whitney U, multivariate logistic regression and linear regression</th>
<th>Frequency: 34% experienced workplace violence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>n= 346 Italy</td>
<td>Internal violence: violence source is colleagues, staff, and others.</td>
<td>Italian version of the Violent Incidents Form</td>
<td>Types: 6.6% physical assault, 7.5% threats, and 5.8% sexual harassment.</td>
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<td>External violence: violence source is patients, patient relatives, and friends.</td>
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<td>Sources:</td>
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<td></td>
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<td></td>
<td>Physical assault</td>
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<td>70.4% male, 29.6% female</td>
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<td></td>
<td>55.6% patient, 3.7% patient’s relative/friend</td>
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<td>18.5% colleague or staff, and 22.2% other people.</td>
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<td>Non-physical assault</td>
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<td></td>
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<td>59.8% male, 40.2% female</td>
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<td></td>
<td>19.6% colleague or staff, 23.5% superior, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>27.4% other people.</td>
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</tbody>
</table>

Celebioglu       Violence = “Any incidence Descriptive, cross-sectional survey, Frequency: 50.3% students were subjected
<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Country</th>
<th>Sample Size</th>
<th>Sample Demographics</th>
<th>Description of Violence</th>
<th>Methodology</th>
<th>Types</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saines (1999)</td>
<td>Turkey</td>
<td>$n=380$</td>
<td></td>
<td>“of threatening behavior, verbal threat, physical assault and sexual assault inflicted by the patient, the patient’s relatives or any other individual, which constitutes a risk for the health staff.”</td>
<td>Author-developed, based on the literature</td>
<td>$91.6%$ verbal violence, $4.2%$ physical violence, and $4.2%$ sexual violence; $9%$ cursing and swearing, $5.4%$ unmanageable workloads or unrealistic deadlines, $5.2%$ being ignored or physically isolated, $4.8%$ inappropriate, nasty, rude, or hostile behavior, and $4.2%$ spreading malicious rumors or gossip.</td>
<td>$53.4%$ patient/family, $21.5%$ nurses, $19.9%$ physicians, and $5.2%$ other staff.</td>
</tr>
<tr>
<td>Cooper (2009)</td>
<td>USA: Southeast</td>
<td>$n=665$</td>
<td></td>
<td>Bullying = “Persistent, demeaning, and downgrading acts…use of vicious words and cruel acts that gradually undermine the victim’s confidence and self-esteem.”</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics</td>
<td>$95.6%$ reported experiencing bullying in the past year.</td>
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<tr>
<td>Hinchberger (2009)</td>
<td>USA</td>
<td>$n=126$</td>
<td></td>
<td>Violence (horizontal) and Bullying = “Horizontal violence is a consistent (hidden) pattern of behaviors designed to control, diminish, or devalue another peer (or group) that creates a risk to health and/or safety.”</td>
<td>Author-adapted: Violence Against Student Nurses in the Wkplace, adapted from the Metropolitan Chicago Healthcare Council (MCHC) survey</td>
<td>$69%$ verbal abuse, $21%$ bullying acts, and $10%$ physical abuse.</td>
<td>$50%$ staff members, $25%$ patients, and $25%$ visitors/others.</td>
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<thead>
<tr>
<th>Author</th>
<th>Study Title</th>
<th>Methodology</th>
<th>Operational Definition</th>
<th>Frequency</th>
<th>Types</th>
<th>Sources</th>
</tr>
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<tr>
<td>Al-Hussain (2008)</td>
<td>Mistreatment = Forms and sources of mistreatment: psychological, physical, religious, appearance, sexual harassment, specialty, and sources.</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics and a Chi-square</td>
<td>No conceptual or operational definition offered by authors.</td>
<td>63% student nurses reported mistreatment.</td>
<td>50% psychological mistreatment (shouting and humiliation), 34% physical harm, 40% religious discrimination, 36% external appearance, 38% sexual harassment, and 44% specialty-related.</td>
<td>44% fellow students, 37% professors, and 19% technicians.</td>
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<tr>
<td>Jordan</td>
<td>n= 100</td>
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<tr>
<td>Ferns (2007)</td>
<td>Abuse (verbal) = “The use of inappropriate words…causing distress.” (United Kingdom National Health Services, 2003).</td>
<td>Descriptive, with thematic content analysis to open-ended questions, produced descriptive statistics</td>
<td>Operationalized in survey with 35 questions relating to verbal abuse.</td>
<td>45.1% experienced verbal abuse, 34.5% witnessed other students experiencing verbal abuse, and 65.5% were aware of others having experienced verbal abuse.</td>
<td>Verbal abuse involved threats to kill, racial and sexually oriented verbal abuse, and swearing. No further frequencies were reported.</td>
<td>62% female abusers and 37.4%</td>
</tr>
<tr>
<td>UK: England</td>
<td>n= 114</td>
<td>Author-developed</td>
<td>Face and content validity; no reliability testing reported</td>
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<tr>
<td>Author</td>
<td>Study Details</td>
<td>Methodology</td>
<td>Findings</td>
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<tr>
<td>Longo (2007)</td>
<td>Violence (horizontal) = An act of subtle or overt aggression perpetuated by one colleague toward another; the aggressive act may be physical, verbal or emotional. Examples include: belittling words or gestures, sarcastic comments, faultfinding, and ignoring or minimizing another’s concerns (Conti-O’Hare and O’Hare, 2003; Hastie, 2002).</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics</td>
<td>Male abusers; 64.7% patients, 15.7% relatives/visitors, 19.6% other health care workers. Frequency: Overall frequency not reported. Types: 53% being put down, 40% humiliated, 32% sarcastic comment being made about them, 26% talked about behind their backs, 2% being pushed or shoved; 34% observed between staff and a classmate. Sources: 53% staff nurse.</td>
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<tr>
<td>Stevenson (2006)</td>
<td>Bullying = “A person is bullied or harassed when he or she is repeatedly subjected to negative acts in a situation where the victim finds it difficult to defend himself/herself.” (Einarsen &amp; Skogstad, 1996). Bullying was operationalized into 25</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics</td>
<td>Frequency: 53% experienced bullying. Types: 34% exclusion, 29.7% innuendo and criticism, 29.1% resentment, 28.8% humiliation, 28% undervaluing, and 26.6% teasing. Sources: Physicians and non-nurse trained health care assistants were most often reported as sources; no frequencies reported.</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>n</td>
<td>Country</td>
<td>Description</td>
<td>Methodology</td>
<td>Psychometrics</td>
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<tr>
<td>Celik</td>
<td>2004</td>
<td>225</td>
<td>Turkey</td>
<td>Abuse (verbal, academic, sexual, and physical) = “A traumatic experience...can have long-lasting physical and psychological effects.”</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics and ANOVA</td>
<td>No psychometrics reported</td>
</tr>
<tr>
<td>Foster</td>
<td>2004</td>
<td>40</td>
<td>New Zealand</td>
<td>Bullying = Bullying included serious slander, being met with silence, having information systematically withheld, being ignored and excluded as well as being teased or ridiculed. (Einarsen, et al., 1998).</td>
<td>Descriptive, with content analysis, produced descriptive statistics</td>
<td>Author-developed, similar instrument used by American Medical Association</td>
</tr>
<tr>
<td>Bronner</td>
<td>2003</td>
<td>280</td>
<td>Israel</td>
<td>Harassment (sexual) = “Behavior that is sexual in nature and directly or indirectly adversely affects or threatens to affect a person’s job security,”</td>
<td>Descriptive, cross-sectional survey, produced descriptive statistics and a Chi-square</td>
<td>Author-developed, based on ten years of data collection</td>
</tr>
</tbody>
</table>
prospects of promotion or earning, working conditions, or opportunity to secure a job, living accommodation, or any kind of public service.” (Knox, 1995).

Seven types of sexual harassment were defined and orders according to severity: dirty sex jokes, teasing sexual remarks related to appearance, attempts to initiate romantic relationships, physical touch, forcing intimate touch unrelated to nursing care, intimate touch, and attempts to have sexual relationships.

Content validity; no reliability testing reported

frequency of sexual harassment decreased as behavior became more intimate and offensive; 51.2% reported ‘mild’; 36.7 ‘moderate’, and 11.9% ‘severe’.

Types: 78.8% teasing remarks, 55.2% attempt to initiate romantic relations, 48.5% sexual joke telling, 45.8% physical touch, 20.8% intimate touch, 10% forced intimate touch, and 6.6% suggestions and/or attempts to have sex.

Sources: 75% men harassing women; when males were harassed, the perpetrators were women.

Most common sources: male patients (18-38%), male physicians (10-30%), and male nurses (15-22%); Men initiated twice as many (80%) ‘mild’ behaviors of sexual harassment as women (40%); Female patients initiated ‘severe’ types of sexual harassment (10-15%), female nurses initiated ‘mild’ harassment (12-14%).
Table 1b.

Summary of 7 qualitative bullying, harassment, and horizontal violence (BHHV) studies included in the synthesis.

<table>
<thead>
<tr>
<th>First author, (year), sample size, &amp; location</th>
<th>BHHV construct, term, and definition</th>
<th>Research method and rigor*</th>
<th>Qualitative themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthony (2011) n= 21 USA: Midwest</td>
<td>Incivility = “Low-intensity deviant behavior with ambiguous intent to harm the target, in violation of…norms for mutual respect.” (Andersson &amp; Pearson, 1999)</td>
<td>Focus group with thematic content analysis</td>
<td>Three themes emerged: Exclusionary “We’re in the way”, hostile or rude “We’re always in tears”, and dismissive “They just walk away”.</td>
</tr>
<tr>
<td>Jackson (2011) n= 103 Australia</td>
<td>Aggression (organizational) = A form of hostility arising from fellow nurses, nursing managers, other medical and administrative staff, or patients/clients and their families.</td>
<td>Descriptive, qualitative questionnaire with thematic content analysis of open-ended questions</td>
<td>Three themes emerged: Students as ‘other’ (outsiders or marginalized), aggression is a legitimate device, and resistance and securing a legitimate identity.</td>
</tr>
<tr>
<td>Thomas (2009) n= 221 USA: Southeast</td>
<td>Violence (vertical) = Deliberate, unwanted or unwarranted behavior bestowed by one nurse coworker towards another in a subordinate position with the intent to hurt, manipulate, degrade, sabotage, or isolate. (Thomas, 2004; Hutchinson, et al., 2006; Jackson, et al. 2002; Bubak,</td>
<td>Narratives with thematic content analysis</td>
<td>Four themes emerged: “We were unwanted and ignored”, “Our assessments were distrusted and disbelieved”, “We were unfairly blamed”, and “I was publicly humiliated”.</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Sample Size</td>
<td>Methodology</td>
</tr>
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<tr>
<td>Curtis (2007)</td>
<td>Australia</td>
<td>n= 152</td>
<td>Descriptive, with thematic content analysis of open-ended items on questionnaire</td>
</tr>
<tr>
<td>Hoel (2007)</td>
<td>UK: England</td>
<td>n= 48</td>
<td>Focus group with thematic content analysis, and two follow up interviews</td>
</tr>
<tr>
<td>Lash (2006)</td>
<td>Turkey</td>
<td>n= 66</td>
<td>Phenomenology</td>
</tr>
</tbody>
</table>
Randle (2003) | Bullying = “The persistent, demeaning, and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem.” (Adams, 2002). | Grounded theory | One theme emerged related to students: Nurses have power over students and use it during clinical education. | *The four components of rigor were used to assess research validity.*
Table 2.

Summary of 20 bullying, harassment, and horizontal violence (BHHV) behaviors derived from the literature.

<table>
<thead>
<tr>
<th>Reported experienced/observed behavior</th>
<th>First author (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal affront or verbal violence and/or</td>
<td>Al-Hussain (2008), Celebioglu (2010),</td>
</tr>
<tr>
<td>Expression/Behavior</td>
<td>References</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
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<tr>
<td>Gossiping and/or rumors spread about the student(s)</td>
<td>Celik (2004), Cooper (2009), Clarke (2012), Longo (2007), Lash (2006)</td>
</tr>
<tr>
<td>Sabotage (or set up for failure) and/or withholding information and/or with inequity in assignments</td>
<td>Cooper (2012), Unal (2012), Celik (2004), Clarke (2012), Cooper (2009), Curtis (2006), Foster (2004)</td>
</tr>
<tr>
<td>Actual or threat of punishment through grading and/or assignments</td>
<td>Celik (2004), Clarke (2012), Cooper (2009), Lash (2006)</td>
</tr>
<tr>
<td>Verbal or non-verbal sexual behaviors or behaviors related to being asked out on a date</td>
<td>Bronner (2003), Celik (2004), Lash (2006), Lee (2011), Magnavita (2011)</td>
</tr>
<tr>
<td>Criticism (excessive and/or destructive)</td>
<td>Unal (2012), Clarke (2012), Stevenson (2006)</td>
</tr>
<tr>
<td>Slurs or jokes or comments based on external appearance</td>
<td>Cooper (2012), Al-Hussain (2008), Bronner (2003), Clarke (2012), Lee (2011)</td>
</tr>
</tbody>
</table>
CHAPTER THREE

In this chapter, I present the results of the psychometric pilot testing of the BEHAVE Survey from a manuscript, “Development of the BEHAVE Survey to Measure Bullying, Harassment, and Horizontal Violence in Student Nurses”, under review in Nursing Education Perspectives.
Abstract

**Background:** Bullying, harassment, and horizontal violence (BHHV) has raised concerns among nurses for decades, receiving considerable attention in the literature.

**Significance:** Although student nurses are considered among the most vulnerable to BHHV, there is a paucity of studies in this population. Further, there has been no instrument designed to measure BHHV in student nurses during their clinical experiences. **Purpose:** This article describes the development and initial psychometric testing of the BEHAVE Survey (Bulling, harassmEnt, and HorizontAl ViolencE) designed to measure BHHV experienced by student nurses during their clinical education. **Methods:** Face and content validity and test-retest reliability of BEHAVE were examined among a group of content experts and nursing students. **Results:** Scale-level content validity index among experts was 0.89; Pearson’s correlation coefficient was 0.97 and percent agreement was 93% in test-retest reliability. **Conclusion:** The BEHAVE Survey appears to be psychometrically sound and warrants further use and testing in a larger, more diverse sample of student nurses.

*Key words:* bullying, harassment, horizontal violence, student nurses, clinical education, pilot, psychometrics.
Development of the BEHAVE Survey to Measure Bullying, Harassment, and Horizontal Violence in Student Nurses

While long being a concern among nurses as “…eating [our] young” (Jarratt, 1981), and going unchecked or accepted as part of the system (Longo, 2010), bullying, harassment, and horizontal violence (BHHV) have received attention nationally and internationally in the nursing literature (Johnson & Rhea, 2009). BHHV has been studied under various terms and has been defined as: “repeated, offensive, abusive, intimidating or insulting behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence” (Vessey, DeMarco, & DiFazio, 2010, pp.136).

BHHV is an important factor influencing the professional and/or organizational retention of nurses (Smith, Andrusyszyn, & Laschinger, 2010; Rowell, 2009; Johnson, & Rhea, 2009; Simmons, 2008; Daiski, 2004; McKenna, Smith, Poole, & Coverdale, 2003) by: (1) having negative effects on the emotional and physical well-being of staff (Einarsen, Hoel, & Notelaers, 2003), (2) reducing the quality of care and patient safety (Lashinger, Finegan, & Wilk, 2009; Farrell, Bobrowski, & Bobrowski, 2006; Rowe & Sherlock, 2005; Randle, 2003), (3) decreasing productivity (Berry, Gillespie, Gates, & Schafer, 2012), and (4) as a major obstacle in the recruitment and retention of nurses (Jackson, Clare, & Mannix, 2002).

The student nurse is considered among those most vulnerable for experiencing BHHV (Longo, 2007; Cooper, et al., 2009; Magnavita, & Heponiemi, 2011; Curtis, Bowen, & Reid, 2007; Randle, 2003). Despite BHHV being proposed as having a significant effect on the student’s career trajectory (Curtis, et al., 2007; Randle, 2003;
Deary, Watson, & Hogston, 2003), research on any form of violence involving nurses generally excludes or has not sufficiently studied student nurses (Hinchberger, 2009; Ferns & Meerabeau, 2007; Thomas & Burk, 2009), in part because few tools have been published in the literature to measure BHHV in nursing education (Clarke, et al., 2012).

Cooper & Curzio (2012) have suggested that BHHV behaviors are difficult to capture because their recognition is dependent on the individual’s perception. Yet, a consensus exists in the literature regarding the constellation of behaviors associated with BHHV even though there is no ‘gold standard’ capturing the full range of BHHV behaviors (Vessey, DeMarco, & DiFazio, 2010). Further, the existing literature has not yet examined whether variations in reported rates of BHHV among student nurses are due to different behavioral norms or measurement issues. Therefore, the purpose of this study is to describe the initial development and assessment of psychometric properties of a new instrument to evaluate BHHV in nursing students during their clinical education, called the BEHAVE Survey (Bullying, harassment, and Horizontal Violence).

**Initial Instrument Development**

Initially, a comprehensive literature review was conducted to identify available instruments to measure BHHV and to identify and categorize the terminology and variety of behaviors reported to be components of BHHV. Two published instruments measuring BHHV were identified: the Bullying Acts Inventory for the Nursing Workplace (BAINW) and the Lateral and Vertical Violence in Nursing Survey (LVNS+V), both described below. While these two instruments captured the key components associated with BHHV reported in the literature, neither included the entire spectrum of behaviors described in the definition of BHHV, nor met expectations derived
from the review of the literature, nor were normed on student nurses. Thus, to include a larger spectrum of the experience of BHHV in student nurses and answer the posed research question, we combined elements of both of these instruments, see Table 1.

**Bullying Acts Inventory for the Nursing Workplace**

The Bullying Acts Inventory for the Nursing Workplace (BAINW) is a survey comprised of a 17-item, seven-point Likert scale (0='never’ to ‘7’=constantly) to assess bullying acts in the previous twelve months. Bullying is operationalized by the authors as “…a range of behaviours that are often hidden and difficult to prove….aim to harm their target through relentless barrage of behaviours that may escalate over time and include being harassed, tormented, ignored, sabotaged, put down, insulted, ganged-up on, humiliated and daily work life made difficult” (Hutchinson, Wilkes, Vickers, & Jackson, 2008). This survey was tested for content and face validity and sent to a group of 500 Australian nurses, with a 20.4% return rate (n=102). Each of the item-total correlations had a discrimination score above 0.30, suggesting use of these items in one scale as appropriate and providing good discrimination. Factor analysis identified three factors: (1) ‘attack upon competence’ ($\alpha=0.93$), (2) ‘personal attack’ ($\alpha=0.89$), and (3) ‘attack through work tasks’ ($\alpha=0.88$). The Cronbach’s alpha for the entire instrument was 0.83. Overall, the authors report robust psychometric data for this instrument.

**Lateral and Vertical Violence in Nursing Survey (LVNS+V)**

The LVNS+V is a survey comprised of a 23-item, four-point Likert scale, and is organized by perceived seriousness, oppressors, mediators, and open-ended questions related to the respondent’s experience of lateral and/or vertical violence. The authors define these as forms of “nurse-on-nurse aggression and inter-group conflict expressed as
abusive verbal and nonverbal behavior intended to inflict psychological pain”, with lateral violence occurring between nurses at the same level within nursing and vertical violence between nurses at different levels within nursing (Stanley, Martin, Nemeth, Michel, & Welton, 2007). The LVNS+V was tested on 663 nurses and ancillary nursing staff in the southeastern United States, with a Cronbach’s alpha of 0.74 on the ‘self’ prevalence/severity and 0.85 on the ‘other’ prevalence/severity subscales. The ‘causes’ subscale yielded ‘lower correlations’. Construct validity was tested with a two-factor solution and the developers are currently using the two-factor solution in the most recent revision of the instrument (L. Nemeth, personal communication, February 27, 2013). However, the psychometric properties of this instrument have not yet been published.

In the combined survey instrument, we removed items irrelevant to the student population, adjusted the wording of items to address the student experience, i.e., using “classmates” instead of “colleagues”, using “during clinical” in place of “at work” or “on your unit,” and consolidated the demographic items to avoid duplication. The resulting 17-item instrument, the BEHAVE Survey, contained five demographic questions, two open-ended questions, and ten questions with set choices asking participants about their prior or current histories with BHHV, their perceptions of the behaviors, location, frequency, seriousness, source(s) of the BHHV experience, as well as their reporting behaviors. These ten questions contain: two 3-point Likert scales, four items requesting the participant to check all that apply, and four items for dichotomous response with ‘yes’ and ‘no’ on a total of 25 options, see Table 1. The BEHAVE survey was designed to more accurately capture the experience of student nurses with BHHV while matriculating through clinical education.
Sources for each individual item in the BEHAVE Survey are summarized in Table 2. A total of ten questions capturing the experience of BHHV in student nurses during clinical education are presented. To apply the most current, scientific definition and confirm the experience of BHHV, two questions were created embedding the Vessey, Demarco, & DiFazio (2010) definition of BHHV. An item containing the most common behavioral manifestations of BHHV was derived from both a review of the literature and the two combined instruments. Most of the remaining items are represented in either or the BAINW and the LVNS+V. Of the ten questions asking participants about their specific experiences with BHHV, the item capturing location of BHHV experience was not derived from either of the two instruments. On completion of combining and adapting the two instruments, psychometric testing commenced.

Validity Testing

Following approval from the Columbia University Medical Center Institutional Review Board, content validity was initially examined by a panel of four content experts, recruited by email from a pool of authors of BHHV studies published in the peer-reviewed literature but not affiliated with the two combined instruments used to create the BEHAVE Survey. Each content expert was introduced to the objectives of the survey and asked to rate each item for relevance, clarity, simplicity, and ambiguity on a four-point scale adapted from Yaghmaie (2003).

Content validity was estimated with the Content Validity Index (CVI) to quantify experts’ agreement regarding each item’s content relevance. Each item’s rating by the content expert was assigned a value of either 0 or 1 for each of the four categories (relevance, clarity, simplicity, and ambiguity). These assigned ratings were summarized
for each item and for the entire scale. The CVIs for the individual items (I-CVI) ranged from 0.5 to 1, while the scale level CVI (S-CVI) was 0.89. An S-CVI of 0.80 is considered as an acceptable lower limit for agreement between raters (Polit & Beck, 2007). Items with an I-CVI less than 1 were examined and reworded for clarity, as items with an I-CVI or greater for three or more experts are considered evidence of content validity (Polit, Beck, & Owen, 2006). Based on the comments of the content experts, no items were deleted or added to this initial pool.

Face validity was then tested to determine if the survey measured BHHV in the opinion of a panel of six non-experts recruited by email from a pool of available nursing doctoral students. In face-to-face and phone interviews, participants were asked to carefully examine each item, identify items which were unclear or ambiguous, record how long it took them to complete the survey and describe what the survey was intending to measure. All six participants reported that each individual item, as well as the entire survey, was straightforward, easily understood, and that the survey seemed to measure what it was intended to measure. They were able to complete the survey in an average of fifteen minutes (range: 7 to 30 minutes). Items were re-ordered and re-worded based on the suggestions of this panel.

**Reliability**

To assess the stability of the survey responses over time, test-retest reliability was then examined among volunteers in master’s level nursing courses. To be eligible, the student had to have been within six months of graduation, not currently engaged in clinical work, and willing to complete the survey twice, with one week between administrations. The survey was distributed in an unsealed envelope to students at the
end of a class. Students willing to participate completed the survey and returned it in the same envelope. Participants were instructed to use an identifier known only to them, such as the street where they spent their childhood or their pet’s name, seal the envelope with the completed survey and deposit it in a box at the exit. On the second administration, students were asked to mark the second survey with the same identifier and return it using the same procedures. The matched surveys were tested for test-retest reliability with a Pearson’s correlation ($r$) statistic and a Spearman’s rho. The percent agreement for each item between the first and second survey was also calculated.

Twelve students completed both surveys for test-retest reliability. Their mean age was 24.7 years (range: 22 to 26 years), all were female graduates of an accelerated nursing program, and 75% were Caucasian, 16.7% Asian, and 8.3% Black. The overall Pearson’s correlation statistic for the overall instrument was 0.97 between the first and the second administration. Due to the variation in items types in BEHAVE, ie. Likert, ‘check all that apply’, and dichotomous, a sub-analysis of the items was conducted. Pearson’s $r$ on dichotomous items 0.93, whereas the Spearman’s rho conducted on both the Likert and ‘check all that apply’ items were 0.96 and 0.94, respectively. Cronbach’s alpha was calculated on both administrations to students resulting in 0.94 for both administrations.

Across all respondents, the percent agreement was 93%; the individual participants’ percent agreement for the whole survey ranged from 67 to 100%, see Appendix M. Four items on the survey had <100% agreement on test-retest. These items asked about current experience, behavioral manifestations, perceived severity, and
Discussion and Conclusions

The purpose of this study, therefore, was to describe the initial development and assessment of psychometric properties of the BEHAVE Survey. BEHAVE is a new instrument to evaluate BHHV in nursing students during their clinical education. This avenue of inquiry is essential to determine whether reported variations in experiences among nursing students are due to actual differences across settings or simply to measurement issues.

The psychometric properties of BEHAVE were explored, and demonstrated high levels of construct, content and face validity as well as internal consistency and test-retest reliability. This indicates that the instrument shows promise for future use. The four items asking about BHHV experience, behavioral manifestations, perceived severity, and location had lower percent agreement on test-retest reliability. Perhaps these items may have provoked reflection or re-thinking of their answers and changing them in the second administration. Further testing is needed to validate the findings of this study in other populations of nursing students. In this study, the application of the Pearson’s correlation coefficient (r) was based on the assumption of BHHV being a single construct. In subsequent larger studies, examination of the construct of BHHV will aid in understanding if multiple constructs versus a singular one exists. Concurrently, examination with factor analysis will aid in the elimination of redundancies and identify whether potential subscales exist in the instrument. We recommend further examination and use of this BEHAVE Survey.
References


Stevenson, K., Randle, & Grayling, I. (May 31, 2006). Inter-group conflict in health
care: UK students’ experiences of bullying and the need for organizational solutions.

*OJN: The Online Journal of Issues in Nursing, 11*(2), manuscript5.

doi:10.3912/OJIN.Vol11No02Man05


doi:10.1016/j.outlook.2008.08.004


Table 1.

The final BEHAVE Survey items.

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you in a previous environment experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions?</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>If yes, did this make you feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your self-confidence?</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Which of the following describes your experience:</td>
<td></td>
</tr>
<tr>
<td>During your clinical education, have you ever experienced:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>During your clinical education, have you seen anyone experience:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making her/him feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining her/his self-confidence?</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Which of the following describes what you saw happen or personally experienced in clinical education? Check all that apply.</td>
<td></td>
</tr>
<tr>
<td>You saw or experienced...</td>
<td></td>
</tr>
<tr>
<td>Rude behavior towards a student.</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Personality clashes between students.</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Power or control issues among students.</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Inadequate resources to handle the student’s clinical workload.</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Loss of control over behavior in clinical related to school stress.</td>
<td>___yes   ___no</td>
</tr>
<tr>
<td>Misunderstandings related to gender of a student.</td>
<td>___yes   ___no</td>
</tr>
</tbody>
</table>
Misunderstandings related to cultural differences of student.  
Targeted student not willing to stand up to the source/perpetrator.  
Clinical instructor not willing to intervene on behalf of the student.  
Classmates not willing to intervene on behalf of the student.  
Blaming of a student.  
Questioning of abilities of the student.  
Excessive scrutiny of work of the student.  
Exclusion of student from information.  
Public humiliation of a student.  
Belittling of a student.  
Threats towards a student.  
A student being ignored.  
Denial of learning opportunities to a student.  
Work organized to be inconvenient for a student.

If you have experienced or seen repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making you or someone feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your or her/his self-confidence, what would you like to say about it?

When during clinical education did this happen? Check all that apply.

How often in clinical education did this happen?

How serious did it feel to you?

If you were the one experiencing or witnessing these behaviors, which one(s) best describes the source of these behaviors? Check all that apply.
Have you ever reported any of these behaviors?

If you did report the incident, then to whom? Check all that apply.

If you did not report the incident, please provide the reason? Check all that apply.

Is there anything you would like to add?
What is your age?
What is your gender?
What is your race?
Native
____Black or African American
____Native American or other Pacific Islander
____White or Caucasian
____Other: Please specify:

What is your ethnicity?
____Hispanic or Latino
____Not Hispanic or Latino

I am:
____an accelerated student nurse
____a traditional BSN student nurse
Table 2.

Sources for BEHAVE Survey items.

<table>
<thead>
<tr>
<th>BEHAVE item</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you in a previous environment experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions?</td>
<td>Applied definition of BHHV by Vessey, DeMarco, &amp; DiFazio (2010). Both BAINW and LVNS+V contain an explanation of the definition in the introduction to their instrument.</td>
</tr>
<tr>
<td>If yes, did this make you feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your self-confidence?</td>
<td></td>
</tr>
<tr>
<td>Which of the following describes your experience:</td>
<td>As above.</td>
</tr>
<tr>
<td>During your clinical education, have you ever experienced:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?</td>
<td></td>
</tr>
<tr>
<td>During your clinical education, have you seen anyone experience:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?</td>
<td></td>
</tr>
<tr>
<td>Which of the following describes what you saw happen or personally experienced in clinical education? Check all that apply.</td>
<td>Derived from items: BAINW 15 &amp; LVNS+V 1-10.</td>
</tr>
<tr>
<td>Rude behavior towards a student.</td>
<td>These items were adapted to the student nurse population from a review of the literature.</td>
</tr>
<tr>
<td>Personality clashes between students.</td>
<td>The items express the twenty most common forms of BHHV.</td>
</tr>
<tr>
<td>Power or control issues among students.</td>
<td></td>
</tr>
<tr>
<td>Inadequate resources to handle the student’s clinical workload.</td>
<td></td>
</tr>
<tr>
<td>Loss of control over behavior in clinical related to school stress.</td>
<td></td>
</tr>
<tr>
<td>Misunderstandings related to gender of a student.</td>
<td></td>
</tr>
<tr>
<td>Misunderstandings related to cultural differences of student.</td>
<td></td>
</tr>
<tr>
<td>Targeted student not willing to stand up to the source/perpetrator.</td>
<td></td>
</tr>
<tr>
<td>Clinical instructor not willing to intervene on behalf of the student.</td>
<td>experienced by student nurses, as summarized in a review of the literature. A comprehensive list with references is presented in Chapter 2, Table 2.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Classmates not willing to intervene on behalf of the student.</td>
<td></td>
</tr>
<tr>
<td>Blaming of a student.</td>
<td></td>
</tr>
<tr>
<td>Questioning of abilities of the student.</td>
<td></td>
</tr>
<tr>
<td>Excessive scrutiny of work of the student.</td>
<td></td>
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<tr>
<td>Exclusion of student from information.</td>
<td></td>
</tr>
<tr>
<td>Public humiliation of a student.</td>
<td></td>
</tr>
<tr>
<td>Belittling of a student.</td>
<td></td>
</tr>
<tr>
<td>Threats towards a student.</td>
<td></td>
</tr>
<tr>
<td>A student being ignored.</td>
<td></td>
</tr>
<tr>
<td>Denial of learning opportunities to a student.</td>
<td></td>
</tr>
<tr>
<td>Work organized to be inconvenient for a student.</td>
<td></td>
</tr>
</tbody>
</table>

When **during clinical education** did this happen? *Check all that apply.*

- During conference or report.
- While giving patient care.
- During another time in your clinical experience that is not mentioned here.
- Please specify:

How **often** in clinical education did this happen? Derived from item: BAINW 13.

- Rarely, i.e. only once or twice.
- Sometimes, i.e. every few clinical days.
- Regularly, i.e. with every clinical day.

How **serious** did it feel to you? Derived from items: LVNS+V 20-21.

- Not serious.
- Somewhat serious.
- Very serious.

If you were the one experiencing or witnessing these behaviors, which one (s) best describes the source of these behaviors? *Check all that apply.* Derived from items: BAINW 14 & LVNS+V 11-19.

- A classmate.
- A clinical instructor.
- A nurse preceptor.
- The nurse assigned.
- Other nurse(s).
The nurse manager.
A physician, resident, or medical student.
Ancillary personnel, such as a unit secretary, aide, tech, or other person with whom you interacted.

Have you ever reported any of these behaviors? Derived from item: BAINW 16.

If you did report the incident, then to whom? Check all that apply. Derived from item: BAINW 18.
Another student.
A clinical instructor.
A didactic faculty member.
Another faculty member.
A school administrator, e.g. Dean.
Other. Please specify:

If you did not report the incident, please provide the reason? Check all that apply. Derived from items: BAINW 17 & 21, & LVNS+V 26-28.
"I did not know how to report it."
"I did not know to whom to report it."
"I did not think it was serious enough."
"I was afraid of reprisal."
"It was the end of clinical."
"I didn’t think I could prove it."
"I would be labeled a trouble maker."
"Nothing would have been done."
"The process was too complicated."
"It would have affected my career."
"It would have affected my grade."
Other reason not mentioned above. Please comment below:
CHAPTER FOUR

In this chapter, I present the results of the field test of the BEHAVE (Bullying, harassment, and Horizontal Violence) Survey, “Measuring the Prevalence and Characteristics of Bullying, Harassment and Horizontal Violence in Nursing Students”, to be submitted for review in the Fall of 2013.
Abstract

**Purpose:** This field test measured bullying, harassment, and horizontal violence (BHHV) using the BEHAVE Survey in a sample of student nurses in New York. **Aims:** To examine the proportion of (BHHV) during the clinical portion of their nursing education and the rates of prior experience with BHHV; perceptions of the frequency, seriousness, source(s), and locations; and the reporting behaviors of student nurses while engaging in clinical education.

**Method:** This descriptive, quantitative survey of baccalaureate nursing students at a university-based school of nursing was conducted to field test the BEHAVE Survey. **Results:** A total of 32 participants (96.7% participation rate) completed this survey, with 71.9% reporting current experienced or observed BHHV and 46.8% (36/77) of incidents originated from a nurse.

**Discussion:** These results of the BEHAVE Survey confirmed the high prevalence of BHHV experienced in the student clinical learning environment and is consistent with prior studies in both American and international studies. **Conclusions:** Further research is warranted to continue the development and testing of the BEHAVE Survey and its application to a larger sample of students to inform policy and education on ways to include student nurses in programs addressing and preventing BHHV.

*Key words:* bullying, harassment, horizontal violence, student nurses, comprehensive review.
Measuring the Prevalence and Characteristics of Bullying, Harassment and Horizontal Violence in Nursing Students.

Bullying, harassment, and horizontal violence (BHHV) is a common occurrence during the clinical education of student nurses. The proportion of student nurses who report experiencing or witnessing another student experience BHHV during clinical education is between 50 and 100% (Al-Hussain et al., 2008; Bronner, Peretz, & Ehrenfeld, 2004; Celebioglu, Akpinnar, Kucukoglu, & Engin, 2010; Celik & Bayraktar, 2004; Clarke, Kane, Rajacich, & Lafreniere, 2012; Cooper et al., 2009; Ferns et al., 2007; Foster, Mackie, & Barnett, 2004; Hinchberger, 2009; Longo, 2007; Stevenson, Randle, & Grayling, 2006).

Although BHHV has been reported in student nurses for decades, there has been no ‘gold standard’ or universally applied instrument for its measurement. The surveys that have been used are either author-derived (Cooper & Curzio, 2012; Unal, Hisar, & Gorgulu, 2012; Celebioglu, Akpinnar, Kucukoglu, & Engin, 2010; Longo, 2007; Bronner, Peretz, & Ehrenfeld, 2004), adaptations of existing surveys from similar constructs or populations (Clarke, Kane, Rajacich, & Lafreniere, 2012; Lee, Song, & Kim, 2011; Magnavita & Hiponemi, 2011; Hinchberger, 2009; Al-Hussain et al., 2008; Stevenson, Randle, & Grayling, 2006; Celik & Bayraktar, 2004), or not specifically capturing BHHV during clinical education (Cooper et al., 2009). Furthermore, published literature has provided minimal information on procedures and psychometric evaluation of survey instruments. Hence, adequate assessment of reliability and validity of measurements of BHHV remains a missing yet necessary component of the literature. As a result, the BEHAVE Survey (Bullying, harassment, and Horizontal Violence) was developed and is further described in the proceeding methods section.
The purpose of this field test was to measure BHHV using the BEHAVE Survey in a sample of student nurses in New York. The research question guiding this study was: “What is the experience of BHHV in a population of student nurses?” Specific aims of the study were to (a) examine the proportion of experiencing bullying, harassment, and horizontal violence (BHHV) in a sample of student nurses during the clinical portion of their nursing education and (b) examine the rates of prior experience with BHHV; perceptions of the frequency, seriousness, source(s), and locations; and the reporting behaviors of student nurses while engaging in clinical education.

**Methods**

This descriptive, quantitative survey of baccalaureate nursing students in a school in New York was conducted to field test the BEHAVE Survey. Prior to data collection, institutional board approval was obtained from the human subjects’ review boards from the investigators’ institution and from the institution where data were collected. A waiver of documentation of consent was granted by both boards and completion and return of the survey was assumed as consent for participation.

**Instrumentation**

The BEHAVE Survey used in this study was developed by combining and adapting two published instruments measuring BHHV to capture the experience of student nurses during clinical education. The two published instruments, The Bullying Acts Inventory for the Nursing Workplace (BAINW) and the Lateral and Vertical Violence in Nursing Survey (LVNS+V), were adapted to the student experience and underwent psychometric evaluation in a pilot study (Hutchinson, Wilkes, Vickers, & Jackson, 2008; Stanley, Martin, Nemeth, Michel, & Welton, 2007).
**Bullying Acts Inventory for the Nursing Workplace.** The Bullying Acts Inventory for the Nursing Workplace (BAINW) is a survey designed to assess bullying acts in the previous twelve months (Hutchinson et al., 2008). This survey was tested for content and face validity and sent to a group of 500 Australian nurses, with a 20.4% return rate (n=102). Each of the item-total correlations had a discrimination score above 0.30, suggesting use of these items in one scale as appropriate and providing good discrimination. Factor analysis produced three factors: (1) ‘attack upon competence’ (α=0.93), (2) ‘personal attack’ (α=0.89), and (3) ‘attack through work tasks’ (α=0.88). The Cronbach’s alpha for the entire instrument was 0.83. Overall, the authors report robust psychometric data for this instrument.

**Lateral and Vertical Violence in Nursing Survey (LVNS+V).** The LVNS+V is designed to measure the respondent’s experience of lateral and/or vertical violence in areas such as: perceived seriousness, oppressors, and mediators (Stanley et al., 2007). The LVNS+V was tested on 663 nurses and ancillary nursing staff in the southeastern United States, with a Cronbach’s alpha of 0.74 on the ‘self’ prevalence/severity and 0.85 on the ‘other’ prevalence/severity subscales. The ‘causes’ subscale yielded ‘lower correlations’. Construct validity was tested with a two-factor solution and the developers are currently using the two-factor solution in the most recent revision of the instrument (L. Nemeth, personal communication, February 27, 2013). However, the psychometric properties of this instrument have not yet been published.

**The BEHAVE Survey.** The BEHAVE Survey comprises a 17-item instrument containing five demographic questions, two open-ended questions, and ten questions with set choices asking participants about their prior or current experience with BHHV, their perceptions on the behaviors, location, frequency, seriousness, source(s) of the BHHV experience, as well as their
reporting behaviors. Initial psychometric testing of BEHAVE demonstrated high levels of construct, content and face validity as well as internal consistency and test-retest reliability (Geller & Larson, In Review).

Setting, sample, and recruitment

Data were collected on the main campus of a university-based school of nursing in Westchester County, New York. All students were full-time matriculates in a traditional four-year baccalaureate program.

Student participants were enrolled during a didactic course in their fourth year and final semester of clinical experience, having completed clinical experiences in general medicine, surgery, obstetrics, mental health, pediatrics, and community health. This didactic course accompanies the final clinical experience and provides the student with an opportunity to synthesize the acquired knowledge and skills in clinical education. Both career and clinical scenarios are reviewed in a faculty-led seminar that emphasizes preparation for the professional nursing practice and employment as a professional nurse.

Data collection procedure

Data were collected on one day in March 2013. The researcher was introduced to the students by the faculty member. First, an overview of the study was provided, including: (1) instructions for completion and return of the survey, (2) uncompensated and voluntary participation, (3) use confidential envelopes, and (4) ways to contact the researcher. Following a question period, the researcher distributed confidential envelopes containing the survey instrument and a pencil, and then exited the classroom with the faculty member for 30 minutes. Students completed the surveys, returned them in the confidential envelope, and placed them in a box at the front of the room.
**Data analysis.** Data were entered Microsoft Excel 2010 and screened for missing data. Missing data were imputed into the spreadsheet with a separate code for missing rather than a ‘no’ response. Descriptive information including frequencies and percentages were calculated. Associations between demographic variables and prior history of BHHV with current experience of BHHV were tested for significance using the Fischer’s exact test. With the race variable, the data was collapsed into ‘white’ and ‘non-white’ for the computation of significance for the Fisher’s exact test.

**Results**

Of 33 eligible students, 32 (96.7%) completed the survey. The mean age of participants was 22 years, with a range of 20 to 28 years old. Table 1 summarizes the demographics of the participants. Participants identified themselves as: 90.6% female (29/32); 50% (16/32) Caucasian or White, 18.8% (6/32) African American or Black, 15.6% (5/32), Asian American, 9.4% (3/32) and 9.5% (3/32) Latino and/or Hispanic. Of the respondents, 40.6% (13/32) reported a prior experience with BHHV.

The majority of students (71.9%, 23/32) reported currently experienced or observed BHHV. Among those reporting BHHV, 77 different source(s) were named; 46.8% (36/77) of incidents originated from a nurse, such as a preceptor, assigned nurse, nurse manager, or ‘other nurse, and 19.5% (15/77) originated from a clinical instructor, see Table 2. BHHV was reported to occur while giving patient care 47.3% (18/38) of the time. The majority (52.3%, 12/23) reported the frequency as sometimes or every few clinical days, and the severity of the BHHV was perceived by 73.9% (17/23) as somewhat serious.

When BHHV was observed or experienced, only 34.8% (8/23) of students reported the behavior. When it was reported, it was most often to their clinical instructor(s) and another
student 62.5% (5/8); one of the eight also reported to the didactic faculty member or the clinical instructor or the didactic faculty member and a preceptor. The students who did not report BHHV (15/23) provided 57 reasons for not reporting. Almost three-fourths of these participants who did not report BHHV stated that the reason for not reporting was that nothing would have been done, almost half did not know how to report BHHV, did not think there was proof, or did not know to whom to report the BHHV, see Table 3.

BHHV was experienced as rudeness, questioning their abilities and excluding them from clinical information. Being ignored, belittling, exposure to excessive scrutiny, and blaming were also commonly reported as perceived BHHV by the students, Table 4.

Due to the small sample sizes and the desire to apply inferential statistics, variables were combined into two categories, such as female and non-female, white and non-white, Latino and non-Latino, prior BHHV and no prior BHHV. Fisher’s exact test demonstrated that there was a statistically significant association ($p = 0.005$, $n = 32$) in prior life experience with BHHV. In participants who reported prior life experience with BHHV (40.6% or 13/32), 92.3% or 12/13 also reported experiencing BHHV in clinical education. All other variables tested with the Fisher’s exact showed no statistically significant association.

Discussion

These field test results confirmed the high prevalence (71.9%) of BHHV experienced in the student clinical learning environment. This prevalence is consistent with prior studies conducted in both American and international student nurse populations (Al-Hussain et al., 2008; Bronner, Peretz, & Ehrenfeld, 2004; Celebioglu, Akpinnar, Kucukoglu, & Engin, 2010; Celik & Bayraktar, 2004; Clarke, Kane, Rajacich, & Lafreniere, 2012; Cooper et al., 2009; Ferns et al., 2007; Foster et al., 2004; Hinchberger, 2009; Longo, 2007; Stevenson, Randle, & Grayling,
2006). Similarly, in this study nurses were reported as the most common originating source of BHHV. These results are also consistent with other studies in which respondents were asked about individual disciplines in their list of sources (Clarke et al., 2012; Longo, 2007; Unal et al., 2012). Thus, experiencing BHHV during clinical education and having it originate from a nurse can be said to be a common occurrence among student nurses.

The BEHAVE Survey results were consistent with the literature except in the area of student reporting behaviors. In this study, when BHHV was reported or experienced, most students (65.2%) did not report the incident(s). Conversely, in Ferns & Meerabeau (2009), most students (62.7%) did report their experiences of BHHV. These authors suggested that students are reluctant to report BHHV originating from colleagues due to factors associated with being vulnerable in the clinical area. In our sample, students gave various reasons for not reporting, such as: nothing would have been done (73.3%), not knowing how (46.7%) and to whom to report (40%), and not thinking they could prove the BHHV incident(s) (46.7%), see Table 3. This discrepancy highlights the need for future studies focusing, in part, on reporting behaviors.

In this study, students with a prior life experience of BHHV reported a high prevalence and statistically significant association with a current experience of BHHV. Reasons for this relationship may be associated with factors of vulnerability to BHHV, such as gender, generational cohort, educational program type, race and ethnicity, or their heightened sensitivity to perception of BHHV based in their prior life experiences. Further studies examining the association of prior experience of BHHV and factors related to vulnerability are necessary to consider why a prior history could increase the prevalence of experiencing BHHV during matriculation in nursing school.
Although previously published research has described BHHV experienced by student nurses (Al-Hussain et al., 2008; Bronner et al., 2004; Celebioglu et al., 2010; Celik et al., 2004; Clarke et al., 2012; Cooper et al., 2009; Ferns et al., 2007; Foster et al., 2004; Hinchberger, 2009; Longo, 2007; Stevenson, et al., 2006) this current study was the first to use a psychometrically sound instrument developed specifically for use with nursing students. Further adaptation, testing, and application of the BEHAVE can assist the science of BHHV in student nurses by validating specific behaviors, sources, and their frequencies, as well as demographic variables that predispose a student to the experience. This information, in turn, will inform the targeted interventions that allow student nurses the opportunity to develop and create strategies to counter the impact of experiencing BHHV.

The results of three interventions have been published to help clinical nurses and graduate nursing student adjust their behavioral and cognitive reactions to ‘real-time’ BHHV experiences (DeMarco, Roberts, & Chandler, 2005; Griffin, 2004; Barret, Piatek, Korber, & Padula, 2009). These interventions included cognitive reappraisal or shielding (Griffin, 2004), narrative writing (DeMarco, et al., 2005), and team building (Barret, et al., 2009), but none of these studies included undergraduate nursing students. Consequently, with inclusion of student nurses in research on BHHV interventions and the further testing and application of BEHAVE, tailored interventions designed to the student’s experience of BHHV will generate the tertiary prevention interventions necessary yet missing in the literature.

Current efforts directed at the development of policy and prevention programs in the health care workplace include a call for education, development of an organizational culture with zero tolerance and non-punitive reporting for BHHV (Center for American Nurses, 2008; The Joint Commission, 2008; Occupational Safety & Health Administration, 2011; American Nurses
Association, 2013). Future research including the application of the BEHAVE Survey to a larger sample of student nurses will potentially inform policy on ways to include student nurses in programs addressing and preventing BHHV.

**Limitations**

This study has several limitations. Students were recruited at a single time from one program, and hence the sample size was small and potentially not generalizable to other types of programs, geographic regions, or student populations. This is the first field trial of the BEHAVE Survey using the BHHV definition by Vessey et al. (2010) and further testing in subsequent studies with larger samples of student nurses is needed. Since the BEHAVE Survey did not offer the student opportunity to assign patient, patient’s family, or visitor as one source of BHHV, this might be added in future uses. As with any self-report survey, there is potential for misunderstanding of items as well as over- or under-reporting experiences.

**Conclusions**

The findings of this analysis are similar to those of prior studies in the student nurse population, confirming that BHHV in student nurses matriculating in New York for their clinical nursing education are common targets for BHHV. Further research is warranted to: (1) continue to validate the construct and definition of BHHV, (2) further investigate a typology of behavioral manifestations associated with BHHV, (3) compare the findings in a larger pool of equally diverse participants, and (4) continue the development and psychometric evaluation of the BEHAVE Survey. Ultimately, the goal would be to identify interventions to reduce BHHV in the educational and clinical settings and also to prepare nursing students with skills needed to deal with BHHV should it occur.
References


The Joint Commission. (July 9, 2008). Behaviors that undermine a culture of safety. Accessed


Table 1.

Summary of demographics of participants (n = 32).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample size</th>
<th>Experienced BHHV</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean is 22 years old)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>90.6% (29/32)</td>
<td>72.4% (21/29)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6.3% (2/32)</td>
<td>50% (1/2)</td>
<td>0.5</td>
</tr>
<tr>
<td>Missing</td>
<td>3.1% (1/32)</td>
<td>100% (1/1)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>50% (16/32)</td>
<td>68.8% (11/16)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>15.6% (5/32)</td>
<td>40% (2/5)</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>18.8% (6/32)</td>
<td>100% (6/6)</td>
<td>0.47</td>
</tr>
<tr>
<td>Other</td>
<td>6.2% (2/32)</td>
<td>100% (2/2)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>9.4% (3/32)</td>
<td>66.7% (2/3)</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino or Hispanic</td>
<td>9.3% (3/32)</td>
<td>66.7% (2/3)</td>
<td>0.66</td>
</tr>
<tr>
<td>Not Latino or not</td>
<td>68.8% (22/32)</td>
<td>68.2% (15/22)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>21.9% (7/32)</td>
<td>85.7% (6/7)</td>
<td></td>
</tr>
<tr>
<td>Prior life experience with BHHV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>40.6% (13/32)</td>
<td>92.3% (12/13)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

*Fisher’s Exact Test; test for significance computed without missing values. Variable of race was collapsed into ‘white’ and ‘non-white’ for the computation of the p-value.
Table 2.

*Reported rates for frequency, perceived seriousness, source, and location of BHHV (n = 23 respondents).*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Seriousness</th>
<th>Source(s)</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>52.3% (12/23) Sometimes, i.e., every few clinical days</td>
<td>73.9% (17/23) Somewhat serious</td>
<td>46.8% (36/77) Nurse(s)</td>
<td>47.4% (18/38) While giving patient care</td>
</tr>
<tr>
<td>43.5% (10/23) Rarely, i.e. only once or twice</td>
<td>21.7% (5/23) Very serious</td>
<td>19.5% (15/77) Clinical instructor</td>
<td>28.9% (11/38) During conference or report</td>
</tr>
<tr>
<td>0% (0/23) Regularly, i.e. with every clinical day</td>
<td>4.4% (1/23) Both somewhat serious and very serious</td>
<td>16.9% (13/77) Ancillary personnel</td>
<td>23.7% (9/38) During another time in clinical experience</td>
</tr>
<tr>
<td>0% (0/10) Not serious</td>
<td>0% (0/10) Not serious</td>
<td>7.8% (6/77) Classmate(s)</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.

*Students’ reporting of BHHV.*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Students’ reporting behaviors of BHHV (n = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported 34.8% (8/23)</td>
<td><em>To whom:</em></td>
</tr>
<tr>
<td></td>
<td>62.5% (5/8) another student and a clinical instructor</td>
</tr>
<tr>
<td></td>
<td>12.5% (1/8) didactic faculty member</td>
</tr>
<tr>
<td></td>
<td>12.5% (1/8) clinical instructor only</td>
</tr>
<tr>
<td></td>
<td>12.5% (1/8) didactic faculty member and preceptor</td>
</tr>
<tr>
<td>Did not report 65.2% (15/23)</td>
<td><em>Reasons for not reporting in n = 15 respondents:</em></td>
</tr>
<tr>
<td></td>
<td>73.3% (11/15) “Nothing would have been done.”</td>
</tr>
<tr>
<td></td>
<td>46.7% (7/15) “I did not know how to report it.”</td>
</tr>
<tr>
<td></td>
<td>46.7% (7/15) “I didn’t think I could prove it.”</td>
</tr>
<tr>
<td></td>
<td>40% (6/15) “I did not know to whom to report it.”</td>
</tr>
<tr>
<td></td>
<td>33.3% (5/15) “I would be labeled a trouble maker.”</td>
</tr>
<tr>
<td></td>
<td>33.3% (5/15) “I was afraid of reprisal.”</td>
</tr>
<tr>
<td></td>
<td>33.3% (5/15) “It would have affected my grade.”</td>
</tr>
<tr>
<td></td>
<td>26.7% (4/15) “I did not think it was serious enough.”</td>
</tr>
<tr>
<td></td>
<td>20% (3/15) “The process was too complicated.”</td>
</tr>
<tr>
<td></td>
<td>13.3% (2/15) “It would have affected my career.”</td>
</tr>
<tr>
<td></td>
<td>13.3% (2/15) Other reason not mentioned above.</td>
</tr>
<tr>
<td></td>
<td>6.7% (1/15) “It was the end of clinical.”</td>
</tr>
</tbody>
</table>

*Total number of responses from 8 participants = 13.*

*Total number of responses from 15 participants = 58.*
Table 4.

Reported frequency of listed behaviors when students experienced or observed BHHV ($n = 23$).

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Overt behaviors:</strong></td>
</tr>
<tr>
<td>100% (23/23)</td>
<td>Rude behavior</td>
</tr>
<tr>
<td>95.7% (22/23)</td>
<td>Questioning abilities</td>
</tr>
<tr>
<td>95.7% (22/23)</td>
<td>Exclusion from information</td>
</tr>
<tr>
<td>87% (20/23)</td>
<td>Being ignored</td>
</tr>
<tr>
<td>82.6% (19/23)</td>
<td>Being belittled</td>
</tr>
<tr>
<td>69.6% (16/23)</td>
<td>Excessive scrutiny</td>
</tr>
<tr>
<td>60.9% (14/23)</td>
<td>Blaming</td>
</tr>
<tr>
<td>52.2% (12/23)</td>
<td>Denial of learning opportunities</td>
</tr>
<tr>
<td>26.1% (6/23)</td>
<td>Public humiliation</td>
</tr>
<tr>
<td>13% (3/23)</td>
<td>Threats</td>
</tr>
<tr>
<td></td>
<td><strong>Other associated behaviors:</strong></td>
</tr>
<tr>
<td>73.9% (17/23)</td>
<td>Target not willing to stand up to the source/perpetrator</td>
</tr>
<tr>
<td>60.9% (14/23)</td>
<td>Work organized to be inconvenient</td>
</tr>
<tr>
<td>47.8% (11/23)</td>
<td>Personality clashes</td>
</tr>
<tr>
<td>43.5% (10/23)</td>
<td>Power or control issues</td>
</tr>
<tr>
<td>43.5% (10/23)</td>
<td>Classmates not willing to intervene</td>
</tr>
<tr>
<td>43.5% (10/23)</td>
<td>Loss of control over behavior in clinical related to school stress</td>
</tr>
<tr>
<td>34.9% (8/23)</td>
<td>Inadequate resources to handle the clinical workload</td>
</tr>
<tr>
<td>34.9% (8/23)</td>
<td>Clinical instructor not willing to intervene</td>
</tr>
<tr>
<td>30.4% (7/23)</td>
<td>Misunderstandings related to gender</td>
</tr>
<tr>
<td>30.4% (7/23)</td>
<td>Misunderstandings related to cultural differences</td>
</tr>
</tbody>
</table>

On average, students reported experiencing BHHV, they indicated 10.7 of the 20 behaviors (54%) as part of the experience of BHHV.
CHAPTER FIVE

The purpose of this chapter is to synthesize the findings of the three studies which comprise this dissertation and to summarize this body of research and future directions. This chapter begins with a summary of the rationale for studying bullying, harassment, and horizontal violence (BHHV) in student nurses, followed by a synopsis of the comprehensive literature review and the limitations of the current state of the science. Next, the pilot study, the field test results, and the strengths and limitations of the entire dissertation are summarized. The chapter ends with recommendations for future research, education, and practice.
The student nurse is considered to be in a vulnerable subgroup for experiencing bullying, harassment, and horizontal violence (BHHV) (Longo, 2007; Cooper, et al., 2009; Magnavita, & Heponiemi, 2011; Curtis, Bowen, & Reid, 2007; Randle, 2003); however, this group has not been sufficiently studied (Hinchberger, 2009; Ferns & Meerabeau, 2007; Thomas & Burke, 2009). The study of BHHV in student nurses is timely in order to improve attrition, retention, emotional and physical well-being of students, quality and patient safety, productivity, and professional socialization to nursing.

**Summary of the comprehensive review on BHHV in student nurses**

Many researchers have studied the presence and impact of BHHV in the nursing profession, and a recent state of the science review of the topic suggested use of the term and definition for BHHV based on a conceptual analysis (Vessey, DeMarco, & DiFazio, 2010). These authors suggested that a standardized term, BHHV, be used for such disruptive behaviors, and concluded that individual descriptive terms overlapped and could be examined as a single construct (Ibid.). This comprehensive review of the literature was the first to use BHHV and its definition in reviewing studies for inclusion.

Based on the findings of the comprehensive review, there is strong evidence to support that student nurses are common targets of BHHV during clinical education, regardless of their demographic characteristics, disability, sexual orientation, geography location, academic institution or program type. However, due to variations in methodology, measurement, terms, definitions, coding of behaviors, and reporting sources of BHHV, the current literature did not provide information to enable accurate conclusions.
Furthermore, these variations limited external validity and highlighted a set of opportunities for future research. As the studies were conducted in various settings with different geographical or cultural expectations of professional behavior, future research will need to focus on the standardization of nomenclature and definitions, validation studies of behaviors associated with BHHV, and the development of psychometrically robust measurement tools to critically examine BHHV experienced in the student nurse population.

**Summary of the pilot study of BEHAVE**

Based on this comprehensive review of the literature, it was clear that a major gap was the lack of standardized valid and reliable tools to measure BHHV. Therefore, the next step in this research program was to develop and test a measurement tool, the BEHAVE Survey (Bullying, harassment, and Horizontal Violence). BEHAVE was developed using the most recent nomenclature and definition, and adapted two previously tested instruments to the student nurse population. The psychometric testing of BEHAVE, summarized in Chapter 3, demonstrated high levels of construct, content and face validity as well as internal consistency and test-retest reliability. The next step, summarized in Chapter 4, was to conduct a field trial of the tool.

**Summary of the field test of BEHAVE**

The field trial of the BEHAVE Survey was then conducted to examine the phenomenon of BHHV in a population of student nurses from a university-affiliated baccalaureate nursing program in New York’s Westchester County. The study employed a descriptive survey design of 32 student nurses to examine the prior or current experience with BHHV; perceptions on the
frequency, seriousness, source(s), and locations; and the reporting behaviors of student nurses while engaging in clinical education.

BHHV was reported by 71.9% of the students. Among those who had experienced BHHV, it was categorized as rudeness (100%), questioning of their abilities, and excluding them from clinical information (95.7% each). A total of 46.8% of the incidents originated from a nurse, 73.9% were considered to be somewhat serious, 47.3% occurred while giving patient care, and 52.3% reported that this occurred every few clinical sessions or sometimes. Most often (65.2%), students did not report the experience of BHHV. Almost three-fourths of these participants stated that they did not report the behavior because nothing would have been done.

These field trial results confirmed that BHHV is a common experience in student nurses.

**Strengths of the dissertation**

The findings of the three studies make several important and new contributions to the body of knowledge regarding BHHV experienced by student nurses during their clinical education. In the comprehensive review, 22 studies were evaluated but synthesizing the evidence proved challenging. Despite the variety of methodologies, terminology and definitions, the review was able to harness the key elements required to move the science further. This is, to my knowledge, the first review of the literature on BHHV in student nurses.

Second, the development and testing of the BEHAVE Survey, the only available instrument for measurement of BHHV in student nurses during their clinical education, produced results consistent with those from the comprehensive review of the literature. These consistent results elicited from the field study further highlight the appropriateness of BEHAVE’s measurement of BHHV in student nurses.
Third, the application of the newest term and definition for BHHV elicited similar results when applying the BEHAVE Survey as compared to the studies included in the comprehensive review of the literature. As a result, the use of BHHV as the newest construct for measurement was further validated by these studies. Again, this is the first study known to me that uses the construct of BHHV in relation to student nurses. Subsequent testing of the BEHAVE Survey will continue to validate the use and the definition for BHHV in the student nurse population.

Finally, to my knowledge, this is the first study of BHHV including student nurses from the New York Metropolitan Area. Although BHHV has been studied in the US, no publications were found including this specific population of nursing students. Inclusion of New York students in both the pilot study and field trial allowed the expansion of our knowledge of the BHHV phenomenon to an additional setting within the US.

Challenges and Limitations of the dissertation

In addition to the strengths, there were some limitations to this dissertation. In the comprehensive review of the literature, articles could have been missed because of limitations in the databases searched, use of varied terms for the same construct, and because searches and analyses were conducted by a single individual and only in English. Further, the pool of articles was not sufficiently large to make generalizations across all student nurse populations.

The BEHAVE Survey is a new instrument developed for this study. While psychometric testing results indicate promise for future application, exploratory factor analysis was not possible due to the small size of the sample. Thus, additional piloting of BEHAVE is necessary in future research to determine whether subscales and redundancies exist. BEHAVE will also require expansion of the item capturing the source(s) of BHHV and clarification of the individual
items that describe the experienced behaviors during clinical education to convey universal understanding. Thus, additional content validity studies and psychometric testing should be completed in a larger sample of students.

Finally, the field trial included a sample of 32 senior student nurses from a traditional program at a university-based school of nursing in New York. Hence, generalizing these results to other nursing student populations or geographic areas should be done with caution. Hypothesis testing in other settings to examine demographic variables and other factors that may predispose individual student nurses to experiencing BHHV are needed to complete the examination of BHHV in student nurses.

Summary of recommendations for research, education, and practice

There are several future research opportunities to continue to study and develop the science, education, and reduce the impact of BHHV in the clinical education and practice of student nurses. First, the BEHAVE instrument will require further testing. Testing should include the application of BEHAVE to other, larger and less homogeneous populations of nursing students in an effort to isolate which variables impact the student’s potential for experiencing BHHV. Multivariable analyses including variables such as demographic characteristics, disability, sexual orientation, geography location, a prior history of BHHV, and academic institution or program type will allow for hypothesis testing and identification of risk factors for experiencing BHHV.

Second, increased student nurse participation and ownership of BHHV research will facilitate the development and testing of interventions. These interventions can be targeted toward improving the student’s specific experiences of BHHV. As a result, nursing students
would have an opportunity to gain the skills needed to improve their responses to BHHV in their current and future professional practice.

Third, the National Student Nurses’ Association (NSNA) passed a resolution in support of policy development and increased funding for research on BHHV (NSNA, 2010). The NSNA acknowledges the major impact of BHHV and resolves to educate its constituents, a national membership of approximately 60,000 student nurses (NSNA, 2013). Nevertheless, despite national attention placed on the development of programs addressing BHHV in the health care workplace, such programs have not generally included student nurses (Center for American Nurses, 2008; The Joint Commission, 2008; Occupational Safety & Health Administration, 2011; American Nurses Association, 2013). Future studies of BHHV that include student nurses are therefore a priority, providing researchers with an unprecedented opportunity to join forces with NSNA and other national groups concerned with the culture of the health care workplace.

Finally, based on the overall findings of this dissertation, nurse educators and administrators are well positioned to address BHHV in their clinical areas. Educators and administrators play a crucial role in the inclusion of student nurses as members of a clinical team. With their leadership through role modeling, intervention, and constructive, positive communication, this collegial working environment will promote “a culture and environment based on cooperation, support, and mutual enrichment that fulfills the educational goals of a program of learning” (National League for Nursing, 2012).

Conclusions

To my knowledge, this is the first study to develop and test an instrument to measure BHHV experienced in student nurses during clinical and to characterize their experience in the
New York Metropolitan area. Given the evidence suggesting that BHHV is frequently encountered during the student’s clinical education, it behooves the research community to continue to investigate its valid and reliable measurement in order to understand the impact of BHHV on the student nurse’s socialization into the professional nursing role.

Further knowledge will pave the way to develop scientifically tested, theoretically sound interventions to improve both the student’s experience of preparation for professional clinical practice as well as their care of the patient. Prior research has linked BHHV to a series of factors that impact this area. Thus, the knowledge gleaned from further study will enhance the nursing care of patients.
References


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professional practice environment, workplace civility, and empowerment. *Nursing Economic* $, 27(6), 377-383.


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doi:10.3912/OJIN.Vol11No02Man05

doi:10.1016/j.outlook.2008.08.004


Irb Correspondence for Protocol IRB-AAAK3059

From: IRB Office   To: Researcher   Notified: 08/30/2012 at 13:22:23
Subject: RASCAL IRB Protocol IRB-AAAK3059 (Protocol Header)

On August 23, 2012, the above-mentioned study was reviewed and approved by the Chair or Designee of Columbia University Medical Center Institutional Review Board (IRB) Exp. It met the regulatory guidelines for expedited review, category 7. You may now begin human research for this study.

Please note:
- Be reminded that IRB approval from Pace University must be obtained prior to the initiation of study activities at that site.
- At the time of the next submission, please add additional details to the Subjects section to include the 20 non-expert consultants who will also be recruited as study subjects.

During the approval period, all subjects enrolled must provide voluntary informed consent to participate in the study. The requirement to obtain written informed consent has been waived in accordance with 45 CFR 46.117(c).

The following study-related materials were approved:
- BHHV Information Sheet Face Validity Final, attached 08/08/2012
- BHHV Information Sheet Students Final, attached 08/08/2012
- BEHAVE Survey, attached 08/08/2012
- Content validity data collection sheet, attached 08/08/2012

Any proposed changes in the protocol must be immediately submitted to the IRB for review and approval prior to implementation, unless such a change is necessary to avoid immediate harm to the participants. Additionally, any unanticipated problems that involve risks to subjects must be reported to the IRB in accordance with the CUMC Unanticipated Problems: Reporting to the IRB of Unanticipated Problems Involving Risks policy, dated January 24, 2008. All submissions for modifications and unanticipated problems must be submitted through RASCAL.

Renewal applications should be submitted 60 days before the expiration date of this study through RASCAL. Failure to obtain renewal of your study prior to the expiration date will require discontinuance of all research activities for this study, including enrollment of new subjects. You must inform the IRB in writing when your study has been completed.

If you have any questions regarding this approval, please contact Susie Kim at (212) 342-3058 or sjk2142@columbia.edu.

Columbia University appreciates your commitment towards the ethical conduct of human research.
Appendix B.

Pace University Institutional Review Board Approval letter.

One Pace Plaza New York, NY, 10038

**PACE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) NOTIFICATION OF APPROVAL.**

Date: November 20, 2012 IRB Code #: 12-66

Nicole Geller Mail Code 6, 630 West 168th Street New York, NY 10032

Nicole:

Please be advised that the Institutional Review Board, “Examining Bullying, Harassment, and Horizontal Violence (BHHV) in a sample of Student Nurses from New York City: The BEHAVE Study.” has approved the proposal you submitted, for the period of November 20, 2012 to November 19, 2013 for your Pace University Interns. After that date, and annually thereafter, if the proposal continues to enroll subjects, the IRB is required to review its implementation. Your method of data collection and assurance of confidentiality are consistent with minimal to low risk, make this an expedited review. If you receive any more Pace Interns please have them take the NIH training and submit their certificates to the IRB.

Please advise Pace University Institutional Review Board when participants are first enrolled. A final report to the IRB should be submitted within 60 days of the conclusion of the research. A form for this purpose is available from the Office of Sponsored Research and Economic Development and can be obtained at that time.

Please remember your obligation to notify the IRB of any deviation from your proposal, however slight, since any change requires IRB review and approval. In addition, please notify the IRB of the occurrence of any adverse outcomes or effects, whether or not anticipated. If interim data suggest that it may be ethically problematic to continue the research because of risks to participants, the IRB must be advised.

Thank you for your continuing cooperation, and best of luck with your research.

Sincerely,

Brian Evans, Ed.D. Co-Chair Institutional Review Board

Copy: Office of Sponsored Research and Economic Development
Hello Nicole

I would be happy to provide you with access to the instrument and further details.

I will forward the material through to you within the next few days.

Regards

Marie

----- Original Message -----  
From: Nicole Geller <nfg2103@columbia.edu>  
Date: Thursday, December 15, 2011 10:09 am  
Subject: Request for permission to use the BAINW  
To: marie.hutchinson@scu.edu.au

> Dear Dr. Hutchinson:
> 
> My name is Nicole Geller and I am a current PhD candidate at
> the Columbia University School of Nursing in New York City.
> 
> I am writing to obtain a copy of your instrument, the Bullying
> Acts Inventory for the Nursing Workplace (BAINW), and your permission
> to use it for my dissertation.
> 
> I plan on further adapting it for use in the student nurse
> population to measure student's experiences with bullying, harassment,
> and horizontal violence during his/her clinical education. I
> am hoping to first run a pilot study to test the psychometric properties of
> the BAINW after its adaptation to students, and then apply it along
> with two others to a population of student nurses.
>
> I am hoping I have provided you with the necessary information
> you will need. If not, I will be glad to provide you with the necessary documentation as soon as I know what that is.
>
> I thank you in advance for your consideration of this request
> and will keep you posted on this project as it evolves.
>
> Best wishes for the holiday season,
>
> Nicole Geller, RN, MS, CNM
> PhD candidate, Columbia University School of Nursing
Appendix D.

Permission for use of LVNS+V.

Date: Mon, 13 Jun 2011 14:37:26 -0400 [Monday June 13, 2011 02:37:26 PM EDT]
From: Karen Stanley <karen.stanley1988@comcast.net>
To: Nicole Geller <nfg2103@columbia.edu>
Cc: Elaine Larson <ell23@columbia.edu>
Subject: Re: The Lateral Violence in Nursing Survey

Dear Nicole,

I hope that your comprehensive exams are over by now -- or soon will be. I wanted to let you know that we are now ready to share the revised LVNS instrument with you. We are renaming it the LVNS+V since it will deal with both lateral and vertical violence in nursing. I have attached an agreement for you to sign electronically and return to me. Once that is done, I will forward the LVNS+V to you for your use in your study.

I think that I also told you that we have been working on an article about the psychometric testing that Dr. Richard Faldowski did on the LVNS. It has been a painfully slow process, but I think we are ready to submit the article for publication very soon. It may be a while before we know if it is accepted and when it will be published, but I will also keep you informed about this since Dr. Faldowski's findings and recommendations were key to the revisions we made in the instrument.

I look forward to hearing back from you soon.

Karen

June 13, 2011

Nicole Geller, RN, MS, CNM
PhD Student, Columbia University School of Nursing

Dear Nicole

You have requested a copy of the Lateral Violence in Nursing Survey (LVNS). The Lateral and Vertical Violence in Nursing Survey (LVNS+V) will be provided to you as requested for use in your research project. This tool is a revision of the original LVNS and is designed to identify the prevalence and severity of both lateral and vertical violence in nursing. We are asking that you acknowledge and cite us in any presentations or publications related to the use of this instrument in your work. We further ask that you provide us with any data you acquire using the LVNS+V or adaptations of it.
Please contact Karen Stanley to indicate your agreement with these stipulations, and she will forward to you a copy of the LVNS+V.

Karen Stanley, MS, RN, PMHCNS-BC  
Mary Martin, DNSc, ARNP, FNAP  
Lynne Nemeth, PhD, RN  
Martina Meuller, PhD  
Richard Faldowski, PhD

Please direct correspondence to:

Karen Stanley  
916 Trowman Lane  
Mount Pleasant, SC 29464-3585  
karen.stanley1988@comcast.net  
(843) 849-7715

I agree to the stipulations outlined in the above letter.

Date: June 15, 2011.  
Electronic signature:
Appendix E.

Psychometric information provided on the LVNS+V.

June 1, 2012

Information shared with Nicole Geller, RN, MS, CNM; PhD Student, Columbia University School of Nursing

The following is information regarding reliability and validity of the Lateral Violence in Nursing Survey (LVNS) questionnaire that is as yet unpublished.

Methods A principal components analysis was used with survey data including the responses of 663 registered nurses and ancillary nursing staff in a southeastern tertiary care medical center. Using SAS version 9.1 and MPlus exploratory factor analysis, Cronbach’s alpha and bivariate correlations were performed to evaluate validity and reliability of the LVNS.

Results Exploratory factor analysis yielded two factors within the prevalence/severity subscale (self and other) with Cronbach’s α at .74 and .85. The causes subscale yielded lower correlations.

Conclusions Additional psychometric evaluation of the LVNS demonstrated a two-factor solution for validity and will be used to guide the revision of the LVNS for future use.

©Nemeth L, Stanley K, Faldowski R, Mueller M, & Martin M.
Appendix F.

Email communication on LVNS+V.

Date: Tue, 26 Feb 2013 16:53:36 -0500 [Tuesday February 26, 2013 04:53:36 PM EDT]
From: "Nemeth, Lynne S." <nemethl@musc.edu>
To: Nicole Geller <nfg2103@columbia.edu>, Karen Stanley <karen.stanley1988@comcast.net>
Subject: Re: Quick question

Nicole, I am glad to hear that your work is going well. We found two factors in the original survey. But due to our inability to get the statistician to work with us on the manuscript, (he is not with our university) we have been hung up a long time on this analysis and are not comfortable reporting on the psychometrics based on his analysis. I will discuss this again in our group and hope we can provide something more substantial soon before your defense/manuscript.

I apologize for not being able to provide anything more detailed than this at this time.

Best,

Lynne

---

Lynne S. Nemeth, PhD, RN
Associate Professor
College of Nursing
Medical University of South Carolina

MUSC Nurses Change Lives!

On 2/26/13 4:21 PM, "Nicole Geller" <nfg2103@columbia.edu> wrote:
Thank you for the speedy reply!

I look forward to accurately quoting your psychometrics. Mostly, to show you the impact of your hard work and your contribution to the science.

Nicole Geller

Quoting Karen Stanley <karen.stanley1988@comcast.net>:

Congratulations on the progress on your study -- and the positive indication that the adapted tool is reliable and valid.

As you can see, I have cc'd Dr. Lynne Nemeth on this email, because I would like to ask her advise you regarding the reporting of the psychometric results of our study. Unfortunately, our paper with that information has not been submitted for publication.

Karen

On Tue, Feb 26, 2013 at 1:48 PM, Nicole Geller <nfg2103@columbia.edu> wrote:

Dear Professor Stanley:

Reaching out to let you know that I am getting ready to complete data collection with the adaptation of the LVNS+V. So far, my pilot data suggests that the adapted tool is reliable and valid.

As a result of completing the pilot, I am writing up the psychometric conclusions. I was wondering if you had published the results you conveyed to me in email so that I can quote you.

In the meantime, once I have finished this portion of the research, I will send you the results.

And, again, thank you for everything thus far,

Nicole Geller, PhD candidate at Columbia University
Appendix G.

Recruitment email to content experts.

Dear XXXX:

My name is Nicole Geller and I am a PhD candidate at Columbia University School of Nursing. I am contacting you because of your expertise in bullying, harassment, and horizontal violence in nursing.

As a component of my dissertation research, I am requesting your participation in the content validity assessment of the BEHAVE Survey.

• The BEHAVE survey is the combination of the Lateral and Vertical Violence in Nursing Survey (LVNS+V) and the Bullying Acts Inventory for the Nursing Workplace (BAINW). It has been adapted to measure bullying, harassment, and horizontal violence (BHHV) in a sample of student nurses in the New York City metro area.

• Your participation will be limited to the completion of an answer sheet which will take 15-20 minutes.

• I have attached: the BEHAVE survey answer sheet to record your responses. If you are willing, please complete the answer sheet and email it back to Nicole Geller, nfg2103@columbia.edu by September 21, 2012. If you are unwilling or unable, please respond to this as soon as possible so that I will not contact you again.

• This study and the materials have been approved by the Columbia University Medical Center IRB under protocol number AAAK3059 until August 22, 2013.

Thank you, in advance,
Nicole F. Geller, MPhil, MS, CNM
PhD Candidate
Columbia University School of Nursing
617 West 168th Street Mail Code 6
New York, NY 10032
Phone: 646-341-1421
Nfg2103@columbia.edu
Appendix H.

Answer sheet for content validity attached to email to content experts.

**The BEHAVE Survey:** Student nurse’s experience during clinical education in New York City

Adapted from the LVNS+V and BAINW Surveys

The purpose of this answer sheet is to learn more about your opinion of the BEHAVE Survey. Please **bold** or **highlight** your opinion of each item on the BEHAVE survey in the four categories provided. For feedback on the item not captured in the categories, please comment in the last column. *Please email the completed answer sheet to Nicole Geller (nfg2103@columbia.edu) by September 21, 2012.*


<table>
<thead>
<tr>
<th>Item</th>
<th>Relevance</th>
<th>Clarity</th>
<th>Simplicity</th>
<th>Ambiguity</th>
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<tbody>
<tr>
<td>Have you in a previous workplace experienced repeated, offensive,</td>
<td>1=not relevant</td>
<td>1=not clear</td>
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<td>abusive, intimidating, or insulting behavior, abuse of power, or</td>
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<td>unfair sanctions making you feel upset, humiliated, vulnerable, or</td>
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<td>threatened, creating stress and undermining your self-confidence?</td>
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<td>Which of the following describes your clinical education?</td>
<td>1=not relevant</td>
<td>1=not clear</td>
<td>1=not simple</td>
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<td>&quot;During clinical, I currently experience repeated, offensive,</td>
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<td>unfair sanctions making me feel upset, humiliated, vulnerable, or</td>
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<td>clear</td>
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threatened, creating stress and undermining my self-confidence.” (Y/N)

"In previous clinical education, I experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and undermining my self-confidence.” (Y/N)

"In clinical education, I have seen or currently see a classmate experience repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making her/him feel upset, humiliated, vulnerable, or threatened, creating stress and undermining her/his self-confidence.” (Y/N)

"In clinical education, I have never experienced or seen a classmate experience repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me or another feel upset,
humiliated, vulnerable, or threatened, creating stress and undermining my or someone else’s self-confidence.” (Y/N)

| If you have experienced or seen repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making you or someone feel upset, humiliated, vulnerable, or threatened, creating stress and undermining your or her/his self-confidence, what would you like to say about it? | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant |
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| | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant | 1=not relevant | 2=not clear | 3=not simple | 4=very relevant |

Which of the following describes what you saw happen or personally experienced in clinical education? *Check all that apply.*

**You saw or experienced...**

Rude behavior towards a student. (Y/N)

Personality clashes between students. (Y/N)

Power or control issues among students. (Y/N)

Inadequate student resources to handle the clinical workload. (Y/N)

School stress related to loss of control over behavior in...
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<th>Event</th>
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<th>2=it needs some revision</th>
<th>3=clear but needs</th>
<th>1=doubtful</th>
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<td>Clinical misunderstandings related to gender.  (Y/N)</td>
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<td>Misunderstandings related to cultural differences. (Y/N)</td>
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<td>Targeted student not willing to stand up to the source/perpetrator. (Y/N)</td>
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<td>Clinical instructor not willing to intervene on behalf of the student. (Y/N)</td>
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<td>Classmates not willing to intervene on behalf of the student. (Y/N)</td>
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<td>Blaming of a student. (Y/N)</td>
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<td>Questioning of abilities of the student. (Y/N)</td>
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<td>Excessive scrutiny of work of the student. (Y/N)</td>
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<td>Exclusion from information. (Y/N)</td>
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<td>Public humiliation of a student. (Y/N)</td>
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<td>Belittling of a student. (Y/N)</td>
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<td>Threats towards a student. (Y/N)</td>
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<td>A student being ignored. (Y/N)</td>
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<td>Denial of learning opportunities to a student. (Y/N)</td>
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<td>Work organized to be inconvenient for a student. (Y/N)</td>
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When during clinical education did this happen?

___During pre- or post-conference or any other meetings with my clinical
During the clinical experience, i.e. during patient care.

During another time in your clinical experience that is not mentioned here.

Please specify:

<table>
<thead>
<tr>
<th>How often in clinical education did this happen?</th>
<th>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</th>
<th>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</th>
<th>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</th>
<th>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely, i.e. only once or twice.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
<td>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</td>
</tr>
<tr>
<td>Sometimes, i.e. every few clinical days.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
<td>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</td>
</tr>
<tr>
<td>Regularly, i.e. with every clinical day.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
<td>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</td>
</tr>
</tbody>
</table>

How serious did it feel to you?

<table>
<thead>
<tr>
<th>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</th>
<th>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</th>
<th>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</th>
<th>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not serious.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>Minor seriousness.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>Somewhat serious.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>Serious.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>Very serious.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
</tbody>
</table>

If you were the one experiencing or witnessing these behaviors, which one best describes the source?

<table>
<thead>
<tr>
<th>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</th>
<th>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</th>
<th>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</th>
<th>1=doubtful 2=item needs some revision 3=simple but needs some revision 4=meaning is clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>A classmate.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>A clinical instructor.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>A preceptor.</td>
<td>1=not relevant 2=item needs some revision 3=relevant but needs some revision 4=very relevant</td>
<td>1=not clear 2=item needs some revision 3=clear but needs minor revision 4=very clear</td>
<td>1=not simple 2=item needs some revision 3= simple but needs some minor revision 4=very simple</td>
</tr>
<tr>
<td>Have you ever reported any of these behaviors? (Y/N)</td>
<td>relevant</td>
<td>clear</td>
<td>some minor revision</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------</td>
<td>-------</td>
<td>---------------------</td>
</tr>
<tr>
<td>1=not relevant</td>
<td>1=not clear</td>
<td>1=not simple</td>
<td>1=doubtful</td>
</tr>
<tr>
<td>2=needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
</tr>
<tr>
<td>3=relevant but needs some revision</td>
<td>3=clear but needs minor revision</td>
<td>3=simple but needs some revision</td>
<td>3=simple but needs some revision</td>
</tr>
<tr>
<td>4=very relevant</td>
<td>4=very clear</td>
<td>4=very simple</td>
<td>4=very simple</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you did report the incident, then to whom? Check all that apply.</th>
<th>relevant</th>
<th>clear</th>
<th>some minor revision</th>
<th>is clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=not relevant</td>
<td>1=not clear</td>
<td>1=not simple</td>
<td>1=doubtful</td>
<td></td>
</tr>
<tr>
<td>2=needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
<td></td>
</tr>
<tr>
<td>3=relevant but needs some revision</td>
<td>3=clear but needs minor revision</td>
<td>3=simple but needs some revision</td>
<td>3=simple but needs some revision</td>
<td></td>
</tr>
<tr>
<td>4=very relevant</td>
<td>4=very clear</td>
<td>4=very simple</td>
<td>4=very simple</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you did not report the incident, please provide the reason? Check all that apply.</th>
<th>relevant</th>
<th>clear</th>
<th>some minor revision</th>
<th>is clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=not relevant</td>
<td>1=not clear</td>
<td>1=not simple</td>
<td>1=doubtful</td>
<td></td>
</tr>
<tr>
<td>2=needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
<td>2=item needs some revision</td>
<td></td>
</tr>
<tr>
<td>3=relevant but needs some revision</td>
<td>3=clear but needs minor revision</td>
<td>3=simple but needs some revision</td>
<td>3=simple but needs some revision</td>
<td></td>
</tr>
<tr>
<td>4=very relevant</td>
<td>4=very clear</td>
<td>4=very simple</td>
<td>4=very simple</td>
<td></td>
</tr>
</tbody>
</table>
to whom to report it.”

1. “I did not think it was serious enough.”
2. “I was afraid of reprisal.”
3. “It was the end of clinical.”
4. “I didn’t think I could prove it.”
5. “I would be labeled a trouble maker.”
6. “Nothing would have been done.”
7. “The process was too complicated.”
8. “It would have affected my career.”
9. “It would have affected my grade.”
10. Other reason not mentioned above. Please comment below.

<table>
<thead>
<tr>
<th>Is there anything you would like to add?</th>
<th>some revision</th>
<th>minor revision</th>
<th>simple but needs some minor revision</th>
<th>some revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=not relevant</td>
<td>4=very relevant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2=item needs some revision</td>
<td>3=clear but needs minor revision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3=relevant but needs some revision</td>
<td>2=item needs some revision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4=very relevant</td>
<td>1=not clear</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please email the completed answer sheet to Nicole Geller (nfg2103@columbia.edu) by September 21, 2012.
Appendix I.

Recruitment email to non-experts.

Dear classmates:

My name is Nicole Geller and I am your fellow PhD candidate at Columbia University School of Nursing. I am emailing you to request your participation on a study I am conducting.

I am doing a research survey to learn more about the types of experiences students have had during clinical rotations. I am asking if you would be willing to complete this survey and give me feedback on its ease of use. Your participation will be used to evaluate both its face validity and the amount of time required for its completion.

If you are interested in participating, please respond to this email by September 21, 2012 by saying yes. I will find a mutually convenient time for us to meet.

If you are not interested, you do not have to respond to this email.

Your decision to participate is entirely voluntary. If you choose to participate, your answers will be confidential and your name will not be written down anywhere.

If you have any questions or concerns about the study, you may contact me, Nicole Geller by phone (646) 341-1241 or email nfg2103@columbia.edu.

If you have any questions about your rights as a participant, you may contact:

Institutional Review Board
Columbia University Medical Center
722 West 168th Street, 4th Floor
New York, NY 10032
Telephone: (212) 305-5883

An Institutional Review Board is a committee organized to protect the rights and welfare of human subjects involved in research. This study has been approved by the above IRB under protocol number AAAK3059.

Thank you, in advance, for considering participation in this study,

Nicole F. Geller, MPhil, MS, CNM
Appendix J.

The BEHAVE Survey.

The BEHAVE Survey
Student nurse’s experience during clinical education in New York City
Adapted from the LVNS+V and BAINW Surveys

Introduction: The purpose of this questionnaire is to learn more about your experience during clinical this past year.

Section I: In the first section, I am asking you about your experience in a previous environment, NOT related to nursing school, with any of the following:

1. Have you in a previous environment experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions?
   ____yes ____no

   If yes, did this make you feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your self-confidence?
   ____yes ____no
Section II: In this section, I will be asking you about your nursing school clinical education:

2. Which of the following describes your experience:

During your clinical education, have you ever experienced:

repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?

_____yes _____no

During your clinical education, have you seen anyone experience:

repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making her/him feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining her/his self-confidence?

_____yes _____no

If you answered yes to either option, please continue taking this survey.

If you answered no to both, go to page 8 and complete the questions.
Thank you for your participation.
3. Which of the following describes what you saw happen or personally experienced in clinical education? *Check all that apply.*

**You saw or experienced…**

Rude behavior towards a student.  
_____yes _____no

Personality clashes between students.  
_____yes _____no

Power or control issues among students.  
_____yes _____no

Inadequate resources to handle the student’s clinical workload.  
_____yes _____no

Loss of control over behavior in clinical related to school stress.  
_____yes _____no

Misunderstandings related to gender of a student.  
_____yes _____no

Misunderstandings related to cultural differences of student.  
_____yes _____no

Targeted student not willing to stand up to the source/perpetrator.  
_____yes _____no

Clinical instructor not willing to intervene on behalf of the student.  
_____yes _____no

Classmates not willing to intervene on behalf of the student.  
_____yes _____no

Blaming of a student.  
_____yes _____no
Questioning of abilities of the student.
_____yes _____no

Excessive scrutiny of work of the student.
_____yes _____no

Exclusion of student from information.
_____yes _____no

Public humiliation of a student.
_____yes _____no

Belittling of a student.
_____yes _____no

Threats towards a student.
_____yes _____no

A student being ignored.
_____yes _____no

Denial of learning opportunities to a student.
_____yes _____no

Work organized to be inconvenient for a student.
_____yes _____no

4. If you have experienced or seen repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making you or someone feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your or her/his self-confidence, what would you like to say about it?

Comment below:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
5. When during clinical education did this happen? *Check all that apply.*

____ During conference or report.
____ While giving patient care.
____ During another time in your clinical experience that is not mentioned here.

Please specify: ________________________________________________________________.

6. How often in clinical education did this happen?

____ Rarely, i.e. only once or twice.
____ Sometimes, i.e. every few clinical days.
____ Regularly, i.e. with every clinical day.

7. How serious did it feel to you?

____ Not serious.
____ Somewhat serious.
____ Very serious.

8. If you were the one experiencing or witnessing these behaviors, which one (s) best describes the source of these behaviors? *Check all that apply.*

____ A classmate.
____ A clinical instructor.
____ A nurse preceptor.
____ The nurse assigned.
____ Other nurse(s).
____ The nurse manager.
____ A physician, resident, or medical student.
____ Ancillary personnel, such as a unit secretary, aide, tech, or other person with whom you interacted.
9. Have you ever reported any of these behaviors?  
____yes  ____no

10. If you did report the incident, then to whom? Check all that apply.  
____Another student.
____A clinical instructor.
____A didactic faculty member.
____Another faculty member.
____A school administrator, e.g. Dean.
____Other. Please specify:  
__________________________________________________________________________

11. If you did not report the incident, please provide the reason? Check all that apply.  
____"I did not know how to report it."
____"I did not know to whom to report it."
____"I did not think it was serious enough."
____"I was afraid of reprisal."
____"It was the end of clinical."
____"I didn’t think I could prove it."
____"I would be labeled a trouble maker."
____"Nothing would have been done."
____"The process was too complicated."
____"It would have affected my career."
____"It would have affected my grade."
____Other reason not mentioned above. Please comment below:  
__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
12. Is there anything you would like to add?
Section III: In this last section, I will be asking you how you identify yourself:

13. What is your age? ____years

14. What is your gender? ____female ____male

15. What is your race?
   _____Asian ____American Indian or Alaskan Native
   _____Black or African American ____Native American or other Pacific Islander
   _____White or Caucasian ____Other: Please specify: ____________________

16. What is your ethnicity?
   _____Hispanic or Latino ____Not Hispanic or Latino

17. I am:
   _____an accelerated student nurse _____a traditional BSN student nurse

Please place completed survey in the envelope and return to the crate provided in your classroom.

Thank you very much for your participation.
I wish you success in all of your future nursing endeavors.
Appendix K.

Cover sheet for Columbia University recruitment.

BHHV Information Sheet

Protocol: CUMC, IRB-AAA3059

Student nurses have a variety of clinical experiences during their time in nursing school. I am doing a research survey to learn more about the types of experiences you have had during clinical rotations. Specifically, I am interested in finding out if you have had any negative experiences during clinical, what happened, and how you responded.

Today, I am asking if you would be willing to complete this survey. I will be asking students from both Columbia University and Pace University's Lienhard School of Nursing to participate in this study.

This is an eight page survey that should not take more than 15 or 20 minutes to complete.

Your decision to participate is entirely voluntary. You are not obligated to complete this survey and you will not receive anything for doing it. If you choose to participate, your answers will be confidential and your name will not be written down anywhere. If you choose to not participate and would like to remain in the room, you are welcome to stay in the classroom and do something else, including doodle across the survey's pages.

I plan to summarize my results from the survey and share the information with other students, nurses, and educators so that we can better understand what your experiences are like during clinical rotations. There is no direct benefit to you for completing the survey, but the information we collect may help us to develop better interventions during clinical rotations for student nurses in the future. To the best of my knowledge, there are no risks associated with this study.

If you have any questions or concerns about the study, you may contact me, Nicole Geller, at 646.341.1241 or at nfg2103@columbia.edu.

If this study has brought up any issues you would like to address, please contact student health services.

Columbia University Student Health Services
60 Haven Ave
212.305.3400

Pace University Student Health Care
Pleasantville: 861 Bedford Road
212.346.1700

If you have any questions about your rights as a participant, you may contact:

Institutional Review Board
Columbia University Medical Center
722 West 168th Street, 4th Floor
New York, NY 10032
Telephone: (212) 305-5883

An Institutional Review Board is a committee organized to protect the rights and welfare of human subjects involved in research.

Thank you, in advance, for considering participation in this study,

Nicole F. Geller, MPhil, MS, CNM
Appendix L

Cover sheet for Pace University recruitment.

BEHAVE Study Information Sheet:

Student nurses have a variety of clinical experiences during their time in nursing school. I am doing a research survey to learn more about the types of experiences you have had during clinical rotations. Specifically, I am interested in finding out if you have had any negative experiences during clinical, what happened, and how you responded.

I am asking if you would be willing to complete this survey.

I will need you to open up the envelope, complete the survey, and return the survey to the envelope. You will deposit the envelope in this black filing cabinet by the door on your way out. You will not need to write your name or any other identifying information on the survey. This way, your answers remain confidential and known only to you. This is an eight page survey that should not take more than 15 or 20 minutes to complete. You do not have to complete any questions if you do not wish to do so and your participation is completely voluntary. You are welcome to remain in the classroom during administration of the survey when the rest of the class is participating, even if you choose not to participate. You can spend the time doing anything they choose as long as it is quiet. You can return the envelope without completing the survey in the same way as the rest of the class is doing. You can keep this information sheet.

Your decision to participate is entirely voluntary. You are not obligated to complete this survey and you will not receive anything for doing it.

If you choose to participate, your answers will be confidential and your name will not be written down anywhere. If you choose to not participate and would like to remain in the room, you are welcome to stay and do something else, including doodle across the survey’s pages. Your choice to participate is entirely voluntary and has no bearing on any part of your studies here. I am not affiliated with Pace University or Lienhard School of Nursing in any way. Further, because you will not be using any information to identify yourself, we will not know who has or has not chosen to participate.

There is no direct benefit to you for completing the survey, but the information we collect may help us to develop better interventions during clinical rotations for future student nurses.

I plan to summarize my results from the survey and share the information with other students, nurses, and educators so that we can better understand what your experiences are like during clinical rotations.

I do not anticipate any risks to completing the survey, although some respondents may find the questions disturbing if they have experienced bullying, harassment, or horizontal violence.

If this study has brought up any issues you would like to address, please contact your student health services:

Pleasantville: 861 Bedford Road, 914.773.3760
Manhattan: 551 5th Ave # 8, 212.346.1700

If you have any questions or concerns about the study, you may contact me, Nicole Geller, at 646.341.1241 or at nfg2103@columbia.edu. I will answer each of your questions to the best of my abilities.

The Institutional Review Board (IRB) at Pace University has approved the solicitation of subjects for this study. If you have any questions or concerns, please contact the Office of Sponsored Research at 212.346.1273.

An Institutional Review Board is a committee organized to protect the rights and welfare of human subjects involved in research.

Thank you, in advance, for considering participation in this study,

Nicole F. Geller, MPhil, MS, CNM
Appendix M.

Results of percent agreement for reliability study on BEHAVE.

<table>
<thead>
<tr>
<th>Item</th>
<th>Item agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you in a previous environment experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions?</td>
<td>100%</td>
</tr>
<tr>
<td>If yes, did this make you feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your self-confidence?</td>
<td></td>
</tr>
</tbody>
</table>

Which of the following describes your experience:

During your clinical education, have you ever experienced:

repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence? 100%

During your clinical education, have you seen anyone experience:

repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence? 100%

Which of the following describes what you saw happen or personally experienced in clinical education? Check all that apply.

Rude behavior towards a student.
Personality clashes between students.
Power or control issues among students.
Inadequate resources to handle the student’s clinical workload.
Loss of control over behavior in clinical related to school stress.
Misunderstandings related to gender of a student.
Misunderstandings related to cultural differences of student.
Targeted student not willing to stand up to the source/perpetrator.
Clinical instructor not willing to intervene on behalf of the student.
Classmates not willing to intervene on behalf of the student.
Blaming of a student.
Questioning of abilities of the student.
Excessive scrutiny of work of the student. 76%
Exclusion of student from information.  
Public humiliation of a student.  
Belittling of a student.  
Threats towards a student.  
A student being ignored.  
Denial of learning opportunities to a student.  
Work organized to be inconvenient for a student.

When during clinical education did this happen?  *Check all that apply.*

- During conference or report.  
- While giving patient care.  
- During another time in your clinical experience that is not mentioned here.  
  Please specify:  

- How often in clinical education did this happen?  
  - Rarely, i.e. only once or twice.  
  - Sometimes, i.e. every few clinical days.  
  - Regularly, i.e. with every clinical day.  

- How serious did it feel to you?  
  - Not serious.  
  - Somewhat serious.  
  - Very serious.  

If you were the one experiencing or witnessing these behaviors, which one(s) best describes the source of these behaviors?  *Check all that apply.*

- A classmate.  
- A clinical instructor.  
- A nurse preceptor.  
- The nurse assigned.  
- Other nurse(s).  
- The nurse manager.  
- A physician, resident, or medical student.  
- Ancillary personnel, such as a unit secretary, aide, tech, or other person with whom you interacted.  

- Have you ever reported any of these behaviors?  

| 84% |
If you did report the incident, then to whom? Check all that apply.

Another student.  
A clinical instructor.  
A didactic faculty member.  
Another faculty member.  
A school administrator, e.g. Dean.  
Other. Please specify:  

92%  

If you did not report the incident, please provide the reason? Check all that apply.

”I did not know how to report it.”  
”I did not know to whom to report it.”  
”I did not think it was serious enough.”  
”I was afraid of reprisal.”  
”It was the end of clinical.”  
”I didn’t think I could prove it.”  
”I would be labeled a trouble maker.”  
”Nothing would have been done.”  
”The process was too complicated.”  
”It would have affected my career.”  
”It would have affected my grade.”  
Other reason not mentioned above. Please comment below:  

83%
Appendix N.

Results of correlation coefficient sub-analysis from the reliability study on BEHAVE.

<table>
<thead>
<tr>
<th>Item</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dichotomous items</strong></td>
<td></td>
</tr>
<tr>
<td>Have you in a previous environment experienced repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions?</td>
<td></td>
</tr>
<tr>
<td>If yes, did this make you feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining your self-confidence?</td>
<td></td>
</tr>
<tr>
<td>Which of the following describes your experience:</td>
<td>Pearson’s 0.93</td>
</tr>
<tr>
<td>During your clinical education, have you ever experienced:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?</td>
<td></td>
</tr>
<tr>
<td>During your clinical education, have you seen anyone experience:</td>
<td></td>
</tr>
<tr>
<td>repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions making me feel upset, humiliated, vulnerable, or threatened, creating stress and under-mining my self-confidence?</td>
<td></td>
</tr>
<tr>
<td>Have you ever reported any of these behaviors?</td>
<td></td>
</tr>
<tr>
<td><strong>Likert items</strong></td>
<td></td>
</tr>
<tr>
<td>How often in clinical education did this happen?</td>
<td>Pearson’s 0.9</td>
</tr>
<tr>
<td>Rarely, i.e. only once or twice.</td>
<td></td>
</tr>
<tr>
<td>Sometimes, i.e. every few clinical days.</td>
<td>Spearman’s 0.96</td>
</tr>
<tr>
<td>Regularly, i.e. with every clinical day.</td>
<td></td>
</tr>
<tr>
<td>How serious did it feel to you?</td>
<td></td>
</tr>
<tr>
<td>Not serious.</td>
<td></td>
</tr>
<tr>
<td>Somewhat serious.</td>
<td></td>
</tr>
<tr>
<td>Very serious.</td>
<td></td>
</tr>
</tbody>
</table>
Check all that apply

Which of the following describes what you saw happen or personally experienced in clinical education? Check all that apply.

Rude behavior towards a student.
Personality clashes between students.
Power or control issues among students.
Inadequate resources to handle the student’s clinical workload.
Loss of control over behavior in clinical related to school stress.
Misunderstandings related to gender of a student.
Misunderstandings related to cultural differences of student.
Targeted student not willing to stand up to the source/perpetrator.
Clinical instructor not willing to intervene on behalf of the student.
Classmates not willing to intervene on behalf of the student.
Blaming of a student.
Questioning of abilities of the student.
Excessive scrutiny of work of the student.
Exclusion of student from information.
Public humiliation of a student.
Belittling of a student.
Threats towards a student.
A student being ignored.
Denial of learning opportunities to a student.
Work organized to be inconvenient for a student.

When during clinical education did this happen? Check all that apply.

During conference or report.
While giving patient care.
During another time in your clinical experience that is not mentioned here.
Please specify:
If you were the one experiencing or witnessing these behaviors, which one(s) best describes the source of these behaviors? Check all that apply.

A classmate.
A clinical instructor.
A nurse preceptor.
The nurse assigned.
Other nurse(s).
The nurse manager.
A physician, resident, or medical student.
Ancillary personnel, such as a unit secretary, aide, tech, or other
person with whom you interacted.

If you did report the incident, then to whom? Check all that apply.

Another student.
A clinical instructor.
A didactic faculty member.
Another faculty member.
A school administrator, e.g. Dean.
Other. Please specify:

If you did not report the incident, please provide the reason? Check all that apply.

"I did not know how to report it."
"I did not know to whom to report it."
"I did not think it was serious enough."
"I was afraid of reprisal."
"It was the end of clinical."
"I didn’t think I could prove it."
"I would be labeled a trouble maker."
"Nothing would have been done."
"The process was too complicated."
"It would have affected my career."
"It would have affected my grade."
Other reason not mentioned above. Please comment below: