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Research Brief

Reflective Responses Following a Role-play Simulation of Nurse Bullying

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Abstract

A qualitative exploratory design was used for this study to evaluate role-play simulation as an active learning strategy. The context for the role-play was bullying in nursing practice. Following a simulation, 333 students from five college campuses of three universities completed a reflection worksheet. Qualitative thematic findings were personal responses, nonverbal communications exhibited, actions taken by participants, and the perceived impact of bullying during the simulation. Role-play simulation was a highly effective pedagogy, eliciting learning at both the cognitive and affective domains.

KEY WORDS Active Learning – Aggression – Bullying – Nursing Students – Role Play – Violence

Nurses are expected to adhere to the American Nurses Association (2015) Code of Ethics for Nurses and integrate ethical behaviors into their professional practice. An essential function for nurse educators is to instill these professional nursing values, morals, and ethics in students as they develop into professional nurses. Although the affective domain of learning is best suited for developing professional values in students, the measurement of effectiveness is often difficult (McArthur, Burch, Moore, & Hodges, 2016). The purpose of this study was to evaluate role-play simulation as an active learning strategy to address the problem of bullying in nursing.

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BACKGROUND

A growing body of literature describes teaching activities that incorporate affective learning. Neville, Petro, Mitchell, and Brady (2013) discussed undergraduate health science students observing an interprofessional health care team meeting and then reflecting on and documenting their perceptions of team member roles. McArthur et al. (2016) described an activity where undergraduate nursing students portrayed the life of a person with a physical disability with the aim of better understanding environmental limitations to live independently. However, although the body of literature is growing, there remains a dearth of published strategies focused on the affective domain of learning to assess student emotions, beliefs, attitudes, values, and moral behaviors.

Role-play can be used to simulate current practice problems in multiple settings. A contemporary and pervasive problem for nurses in practice settings and students and faculty in academic settings is bullying (Berry, Gillespie, Gates, & Schafer, 2012; Clarke, Kane, Rajacich, & Lafreniere, 2012). Bullying can take a variety of forms, from nonverbal intimidation through exclusion and other means, to overt aggression (Hutchinson, 2013). Given this pervasiveness, role-play simulations developed to address bullying can educate students about this significant clinical problem while facilitating discourse on ethical behaviors in response to bullying.

METHOD

A qualitative exploratory design was used for this study to evaluate role-play simulation as an active learning strategy. This design was selected based on the researchers' belief in the existence of multiple realities consistent within a naturalistic paradigm (Lincoln & Guba, 1985). The context for the role-play was bullying in nursing practice. This study was approved by the institutional review boards of three participating universities.

The research intervention took place in fall 2013 at five college campuses from three universities in the Midwest. Faculty at these colleges were trained by the study's principal investigator to deliver the educational intervention. These faculty coordinated the collection of student-level data to prevent the potential for coercion to participate.

The sample was drawn from all senior-level nursing students enrolled in a community health or leadership didactic course at the five college campuses. Students were permitted to observe and not actively participate in the session if the simulation was perceived as potentially too upsetting. In addition, students were informed that their information would be used for research; they were instructed to write "Do Not Use" if they wanted to opt out.

At the start of a classroom-based simulation, students were instructed on the learning outcome for the role-play: examine the experience and outcomes of simulated bullying. The intervention itself was developed based on prior work in affective learning (e.g., Clarke et al., 2012; Neville et al., 2013). Students, assigned to groups of four, randomly drew a role card with instructions from an envelope: aggressor, target, nurse bystander, or patient. Details about the role-play instructions and simulation were previously reported (Gillespie, Brown, Grubb, Shay, & Montoya, 2015).

Immediately following the role-play, students completed an individual reflection worksheet responding to questions about personal responses, nonverbal communications, actions taken, and potential impact to employees and patients. Then the faculty member facilitated a large-group debriefing to explore student responses to the simulation and discuss professional mitigation strategies for future events in health care settings. Examples of strategies included calling for assistance, showing support for the target, and relocating the confrontation to a different location.

Worksheet narratives were transcribed and analyzed by the researchers to determine important units of information based on naturalistic coding as described by Lincoln and Guba (1985). The researchers then met to discuss their respective units of information and cluster the units into respective categories; they then discussed individual coding and came to consensus on the coding for each unit. Coded data were extracted into Microsoft Word documents according to their respective categories and verified for accuracy and consistency.

The rigor or trustworthiness of the data was assured through the components of credibility, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was achieved by triangulating the data across participants and reaching agreement on the categories and units of information. Dependability was achieved by maintaining an audit trail documenting coding decisions. Investigator triangulation and the audit trail helped achieve confirmability.

FINDINGS

Reflection worksheets were received from all but one of the 334 senior-level nursing students portraying the roles of aggressor ($n = 91$), target ($n = 83$), nurse bystander ($n = 81$), and patient ($n = 78$). Data were categorized according to personal responses, nonverbal communications exhibited, actions taken by participants, and perceived impact of bullying.

Personal responses simulated by participants varied by student role. Students portraying aggressors reported difficulty demonstrating bullying behaviors, such as one student who wrote, "It was awkward. I was uncomfortable but I knew my 'role' was to beat the nurse into submission." Students also reported feelings of negative behavior and guilt, such as "I felt uncomfortable with being so aggressive and unhelpful." Students portraying targets most commonly reported feeling bullied, uncomfortable, or overwhelmed, including this response by a student: "I felt like I was being bullied by the nurse and I felt like I was being forced to do the wrong thing." Students portraying nurse bystanders frequently felt helpless and unable to stop the bullying. For example, a student wrote: "I felt a little helpless. By interjecting, I felt that I could have overstepped boundaries and possibly ruin a relationship with at least one of my coworkers by taking sides."

Only 16 students intervened to stop the bullying. A high number of students portraying patients reported feeling helpless, losing trust, and feeling neglected. One student wrote, "It felt like [if] I were a patient, I would trust my nurses less in providing care for me [when I] see that they are distracted/busy [and] arguing."

Nonverbal communications were both exhibited and witnessed. Students portraying aggressors used aggressive gestures, such as pointing fingers, and facial communications, such as rolling eyes. One student portraying the role of novice nurse wrote, "Expression of annoyance. Flailing arms and negative body posturing." Students portraying targets used nonaggressive facial communications, opening their mouths in surprise, and nonaggressive body posture, such as leaning away from the aggressor. Students portraying nurse bystanders used nonaggressive facial communications and body posture, such as backing away from the conflict. Students portraying patients used both nonaggressive (e.g., sad facial expressions, scared facial expressions) and aggressive facial communications (e.g., eye-rolling).

Actions taken by the participants were categorized as aggressive, proactive, or passive. Aggressive actions were predominantly used by students portraying aggressors. Examples include yelling and stating, "Figure it out on your own." Proactive actions were predominantly used by students portraying targets and nurse bystanders. Examples include attempting compromise, suggesting that both parties take a break, and, as one student wrote, "I tried to explore the alternative possibilities." Passive actions were predominantly used by students portraying patients. Examples include "watching the incident transpire" and "retreated to the room."

The perceived impact of bullying was assessed for employees and patients. For employees, the perceived impact was a negative team/working environment with negative emotions and increased risk for legal consultation. Negative team/working environment was described as tension and conflict between employees and decreased morale and cohesion. This finding was reflected by the comment that bullying "causes a break in unity and teamwork on unit and causes worker dissatisfaction." Negative emotions included anxiety, fear, anger, loss of confidence, disgruntlement, and confusion, as well as feeling "nervous, threatened, scared, angry, revenge, back talk, mistrust, [and] resentment." Legal risk was described as loss of licensure (e.g., "Could have lost license if given [medication] without order"), risk for malpractice claim, and employee discipline.

The perceived impact to patients was negative organizational perception (e.g., loss of trust, not returning for future care). Personal emotions included fear, guilt, and neglect; and patient outcomes included delayed care and poor care.

DISCUSSION

The role-play activity evoked authentic affective responses from participants, grounded in the affective domain of learning, similar to research reported by McArthur et al. (2016). The responses and

perceived impact of students playing the roles of target and nurse bystander were similar to those exhibited in real-life bullying situations (Berry et al., 2012). This alone points to role-play simulating real life, allowing participants to feel the emotions they might experience should they encounter bullying in the future.

Participants also exhibited verbal and nonverbal communications, as well as other physical actions of aggression and passivity in response to the role-play. Body language, facial expressions, arm gestures, and other proactive, aggressive, and passive actions were noted by participants. Again, affective responses demonstrated that participants were reacting in much the same manner as someone actually experiencing bullying.

These responses and actions can be leveraged during a critical debriefing facilitated by the nurse faculty member. Debriefings can include a discussion on how to stand up for oneself, physically support targets, call for help, and maintain professionalism (Gillespie et al., 2015; Murray, 2009).

In order for role-play to be effective in evoking similar responses to real-life encounters, the faculty member needs to set the stage with a realistic and relevant scenario based in reality (Gillespie et al., 2015; McArthur et al., 2016). In this way, students can experience stressful situations in a safe learning environment prior to experiencing them in nursing practice. This allows students to practice different ways of reacting and learning how to best deal with a professional practice issue.

This study was limited by a lack of geographical variability in the participating nursing schools. In addition, students' knowledge and experiences with bullying were not measured. Student backgrounds could have had an impact on their participation and engagement in the role-play simulation, ultimately impacting their affective responses documented on the reflection worksheets.

CONCLUSION

As costs associated with nursing education rise, the need for low-cost educational activities becomes paramount. The role-play simulation discussed here was conducted without costs to students or faculty members. More importantly, the desired student learning outcome, to examine the experience and outcomes of simulated bullying, was achieved. Students described a multitude of responses and actions reflecting affective learning, an area often not addressed in nursing education.

Given the credence of bullying as a practice problem, education about bullying prevention and mitigation needs to be incorporated into nursing curricula. Role-play simulations can serve as effective strategies to deliver this content. Students reported aggressive behaviors including eye-rolling, standing with hands on hips, and crossed arms. These gestures, even if not intended to be aggressive, were deemed as such. Therefore, students need to be educated as to how their nonverbal behaviors could be interpreted as aggression.

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