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Qualitative Evaluation of a Role Play Bullying Simulation

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Abstract

Bullying against nurses is becoming a pervasive problem. In this article, a role play simulation designed for undergraduate nursing students is described. In addition, the evaluation findings from a subsample of students who participated in a role play simulation addressing bullying behaviors are reported. Focus group sessions were completed with a subset of eight students who participated in the intervention. Sessions were audiorecorded, transcribed verbatim, and analyzed using Colaizzi's procedural steps for qualitative analysis. Themes derived from the data were "The Experience of Being Bullied", "Implementation of the Program", "Desired Outcome of the Program", and "Context of Bullying in the Nursing Profession". Role play simulation was an effective and active learning strategy to diffuse education on bullying in nursing practice. Bullying in nursing was identified as a problem worthy of incorporation into the undergraduate nursing curriculum. To further enhance the learning experience with role play simulation, adequate briefing instructions, opportunity to opt out of the role play, and comprehensive debriefing are essential.

Keywords

qualitative research; role playing; nursing students; bullying; active learning; simulation

1. Introduction

Novice nurses are at high risk of bullying victimization within two years of starting nursing practice.[1] Examples of bullying behaviors are ridiculing, undermining, micromanaging, gossiping, assigning an unreasonable workload, invading personal space, making allegations, encouraging to quit, shouting, and threatening the novice nurse.[2–3] These behaviors negatively impact novice nurses' ability to practice safely and productively;[1] therefore, efforts need to be enacted to reduce the adverse impact these negative behaviors have on novice nurses. The purpose of this study was to examine a novel role play

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simulation designed to prepare nursing students to manage the bullying behaviors they will encounter as novice nurses.

1.1 Bullying as a Practice Problem

Bullying against nurses is becoming a pervasive problem. Berry et al. studied workplace bullying in a sample of United States' novice nurses from Ohio, Kentucky, and Indiana finding that 21% (n=43) were exposed to daily bullying.[1] Dellasega[2] and Hutchinson, Wilkes, Jackson, and Vickers[4] both discussed that bullying has become such a norm in nursing settings that the acceptance of bullying now starts in nursing schools. Clarke, Kane, Rajacich, and Lafreniere explained that 89% (n=598) of nursing students experienced at least one bullying behavior.[5] The primary source of bullying was from their nursing faculty (n=181, 30%). A secondary source was staff nurses (n=152, 25%) at the clinical agency. The bullying behaviors from staff nurses caused the nursing students to work faster than what they believed was safe and led many of them to consider quitting the nursing program.

One explanation for the pervasiveness of bullying in nursing is that persons exhibiting bullying behaviors are often rewarded, receive promotions, and get special treatment because of their clinical expertise and ability to manipulate work situations.[4] As the targets witness the response to the bullying they receive, they begin to have self-doubt in their competence. Over time, targets begin using self-deprecating language which reinforces the negative comments made by the persons using bullying behaviors.[2]

Another explanation for the pervasiveness of bullying is reflected in the findings of Lindy and Schaefer's qualitative study.[6] In this study, the researchers interviewed 20 nurse leaders from the South Central United States about their experiences with employees who bullied others. The common themes related to bullying were: (1) that was just how the bully is, (2) the targets just take the bullying, (3) there were a lot of competing priorities demanding the leaders' time, (4) there were other interpersonal reasons for the bullying, (5) there are three sides to every story, and (6) the manager's own perspective about the bullying. Fundamental to these themes is that the bully is commonly an asset to the department possessing extensive clinical expertise, the persons using bullying behaviors could justify the bullying, and the target didn't speak up for him or herself. Given that bullying represents a power gradient with the bully in control, targets may not perceive that they have the right to speak up for themselves or notify the department manager that the bullying is occurring.

Recommended strategies to counteract bullying include modeling appropriate behavior; not playing favorites; providing education on bullying, prevention, conflict resolution, and communication skills; adopting a zero tolerance policy; and not allowing bullying behaviors to go unaddressed by promptly addressing the bullying actions.[4,7–11] Interventions to mitigate nurse bullying are scarce. One study that discussed an intervention with promise used cognitive rehearsal.[12] In this study, Griffin taught novice nurses how to rehearse their response to persons using bullying behaviors.[12] The nurses in their sample reported that they were able to confront the aggressor. While the experience was problematic for the novice nurses, the bullying behaviors did stop. Findings from this study reflect the importance of using simulations to prepare nurses on how to effectively handle bullying.

The purpose of this paper is to describe the role play simulation and report the evaluation findings from a subsample of students who participated in a role play simulation addressing bullying behaviors.

2. Methods

A qualitative descriptive design was used to evaluate the bullying intervention depicted in this study. Institutional Review Board approval was granted prior to the initiation of the study. The investigators implemented the intervention at two college campuses, one situated on the academic medical center of an urban-based university and the other situated on a regional campus in a rural setting. Both campuses were affiliated with the same university in the Midwest United States.

2.1 Procedures

The role play simulation intervention was delivered to one class of senior nursing students from each college campus during Spring and Summer semesters 2013. Sixty-five full-time pre-licensure baccalaureate of science nursing students participated in the role play simulation intervention. After delivering the intervention, all students who participated in the simulation were invited to participate in a focus group session to discuss their experiences as learners during the simulation. There were no exclusion criteria. Eight students agreed to participate in a focus group session. Exactly one and two weeks after the intervention was delivered, a session was held on each campus for a total of four sessions. Due to low response by students, two sessions were conducted as one-on-one interviews between the researcher and student, one session had two students, and one session had four students. Each session was audio-recorded and transcribed verbatim by a professional transcriptionist. Each transcription was audited for accuracy by simultaneously listening to the audio-recording and reading the transcript. Any errors were corrected before starting data analysis.

2.2 Role Play Simulation Intervention

The first and second authors, serving as guest lecturers, began the intervention with a discussion of the desired learning outcomes and purpose of the role play simulation during the student's nursing leadership or community health nursing course. Next, students were clustered into groups of four. Due to class sizes, some groups had three students instead of four. Each group then received an envelope with descriptions of four different roles to play: novice nurse who was the target of the aggression, senior nurse who was the aggressor or bully, a nurse observing the bullying situation, and a patient witnessing the bullying situation. The two observer roles were included to allow an opportunity for targets to solicit support from observers or for observers to intervene during the bullying simulation. Students randomly drew their role from the envelope. Three students between the two classes opted to not participate in the role play simulation and left the classroom just prior to the start of the simulation. All three students returned to participate in the simulation debriefing.

An example of the instructions for each role was:

Role 1 – Novice Nurse: A patient was admitted during night shift for possible appendicitis. His temperature is quickly rising from 100'F (37.8'C) one hour ago to a current temperature of 102'F (38.9'C). The patient is requesting acetaminophen for his fever and severe headache/abdominal pain. It is now 0800 and the surgeon that admitted the patient does not make rounds until noon. Efforts to contact the surgeon are unsuccessful. An appropriate behavior in this situation is to contact the surgeon for an acetaminophen order. However, in this simulation, your objective is to wait until the surgeon arrives at noon to obtain an acetaminophen order.

Role 2 – Experienced Nurse: A patient was admitted during night shift for possible appendicitis. His temperature is quickly rising from 100'F (37.8'C) one hour ago to a current temperature of 102'F (38.9'C). The patient is requesting acetaminophen for his fever and severe headache/abdominal pain. It is now 0800 and the surgeon that admitted the patient does not make rounds until noon. Efforts to contact the surgeon are unsuccessful. An appropriate behavior in this situation is to contact the surgeon for an acetaminophen order. However, in this situation you are to demonstrate aggressive bullying behaviors. Your aim in this simulation is to say or do what you need to in order for the novice nurse to administer acetaminophen to the patient. You can explain that this specific surgeon prefers you administer over-the-counter medications and notify him of the administration when he makes rounds. He willingly writes orders for these medications. Remember to demonstrate bullying behaviors such as the use of condescending words, insults, and intimidation. For example, "I can't believe you would actually call and bother the surgeon to ask for an over-the-counter medicine. That's so stupid and wastes the surgeon's time." Then exhale loudly to demonstrate irritation.

Role 3 –Nurse: Your responsibility is to observe the interaction between the students performing the role of Novice Nurse and Experienced Nurse.

Role 4 – Patient: Your responsibility is to observe the interaction between the students performing the role of Novice Nurse and Experienced Nurse.

Only students playing the roles of novice and experienced nurse were aware of the clinical situation as depicted on their role play cards, although all students made aware that the role play was to simulation a workplace bullying incident. Students then portrayed their respective roles for a five minute period. The two researchers delivering the intervention walked about the classroom assuring that all students were actively involved in the role play simulation and not distracted with personal electronic devices.

The classroom in the urban-based campus was squared-shaped and set up with four rectangular tables that seated 10 students per table. The classroom in the rural-based campus was rectangular-shaped with two columns of tables with seating for four students per table. In both classrooms, students were able to cluster into their groups; however, noise was notable once the students started their role play simulation.

At the close of the role play simulation, all students in the classroom reflected individually on their experiences using a reflection guide designed to accompany the intervention. Next, students were brought back together to reflect on their common experiences during the

simulation using a group reflection guide. Finally, a class debriefing took place with students from each respective role coming to the front of the classroom and sharing their experiences. Students were asked to come to the front of the classroom, because this was a norm used with team-based learning activities. This presentation style also gave students additional experience with presenting to an "audience", a skill necessary locally where nurses will present to physicians and nurses during patient rounds. Students playing the role of the experienced nurses were asked to discuss their experiences as an aggressor and their perceived motivation for the aggression that occurred. Students playing the role of novice nurses were asked to discuss their experiences as the targets of aggression. Students playing the role of the nurse witnessing the event were asked to discuss their experiences as observers of the aggressive events. They also were asked if any of them intervened during the scenario, describe what they did, and what they could have done. Students playing the role of patients were asked to discuss their perceptions of the event and discuss any fears they may have had as a patient during the simulation. Finally, the researchers summarized key points learned during the simulation and verbally assessed students by asking them to describe specific actions they can take for bullying events that they may experience as novice nurses. The researchers provided additional recommendations based on student responses. For example, the researchers encouraged students to relocate aggressors and targets to a private room or different location if already in a private setting with the assumption that the act of relocation would dissipate some of the aggression and tension.

2.3 Human Subject Protections

Perceived coercion is a risk for research involving undergraduate students. Students were not required to remain in the room during the role play simulation. The three students who left during the simulation were permitted to do so without reprisal from their course faculty members. Additional efforts to prevent coercion in this study were (1) the researchers recruiting and enrolling students or facilitating data collection did not teach senior level nursing courses, (2) the names of students who participated in the focus group sessions were not shared with the students' faculty members, and (3) participation or non-participation in the simulation or the research did not affect students' grades. Focus group participants signed an informed consent document which explained their rights as research participants. Finally, all data were deidentified prior to analysis.

2.4 Data Analysis

Transcripts were analyzed using Colaizzi's procedural steps in phenomenological data analysis including reading each transcript multiple times for general essence followed by line-by-line coding, clustering significant statements into themes, and confirming findings with some of the study participants.[13] During line-by-line coding, each successive interview and focus group was analyzed and compared to previously analyzed and coded data in order to develop a consistent coding schema that by the end of data analysis represented composite themes of the qualitative data. In order to increase the trustworthiness of data analysis, four researchers simultaneously analyzed and coded the qualitative data. The researchers then met to determine consistency in units of information. Disagreements in the coding of a particular unit of information were settled by the researchers reading the content preceding and following the unit of information in situ to the transcript and discussing the

rationale for the coding and/or lack of coding. Consensus was achieved in all instances. The data were managed using NVivo 10 (QSR International, Burlington, MA). NVivo outputs of the coded data were then distributed to each researcher. The unit of information in each output was assessed for accuracy and suitability to its subtheme. Each researcher recommended changes. A summary of recommendations was reviewed and discussed by the researchers until agreement on the coding schema, names of themes and subthemes, and units of information were settled.

2.5 Trustworthiness

Qualitative rigor or the determination of trustworthiness (comparable to validity and reliability in quantitative studies) was performed as described by Lincoln and Guba.[14] The components of trustworthiness are credibility, dependability, confirmability, and transferability. Credibility of the findings was enhanced by cross analyzing the transcripts for consistent themes and subthemes as well as the researchers coming to consensus on the coding schema. Dependability was achieved through the generation of an audit trail to explain coding decisions. Confirmability occurred through the audit trail, investigator triangulation, and several participants agreeing to the "validity" of the study findings. Transferability happened by providing a rich description of the findings with supporting exemplar statements.

3. Findings

Two students participated in a one-on-one interview and six students participated in a focus group. Seven participants were White and one was African-American. The primary language for all participants was English. The mean age of students was 35 years of age and ranged from 23 to 45 years.

Fifteen subthemes were derived from the data and clustered within four themes. The themes were *The Experience of Being Bullied* (two subthemes), *Implementation of the Program* (seven subthemes), *Desired Outcome of the Program* (three subthemes), and *Context of Bullying in the Nursing Profession* (three subthemes).

3.1 The Experience of Being Bullied

There were two subthemes to this theme reflecting the bullying the participants experienced during their lives (see Table 1). The first subtheme, *Previous experience with bullying*, represented the personal reflections and responses of being bullied or observing bullying as a child, adult, or nursing student. Personal accounts included having flashbacks, memories, and negative emotions about the previous bullying events. The second subtheme, *"Why am I so stupid?"*, included self-blaming and rationalizing for why they were targeted for bullying by others. At times participants asked themselves "Why me?" and justified the reason for being a target for bullying because they were "stupid".

3.2 Implementation of the Program

There were seven subthemes to this theme reflecting the effectiveness or recommendations for improvement of role play simulation (see Table 2). The first subtheme, *Role play*

instructions, denoted participants' desire for the role play scenarios and process to be concrete. All participants suggested that additional instructions and briefing at the start of the exercise as well as additional scripting on the role play cards so that the process would be easier to initiate. The second subtheme, *Can't act like a bully*, signified that acting like a bully was unnatural, awkward, strange, terrifying, silly, or weird for the participants. While most participants reported difficulty acting like a bully, a few participants reported that some students in the groups easily adopted the role of bully particularly referring to the male nursing students. The third subtheme, *Role of the observer*, represented the participants' interpreting their roles as watching only and not intervening during the role play simulation. This subtheme reflected the need for further clarity in the simulation roles. The fourth subtheme, *Realism vs. fake*, represented the scenarios and role play experience being very realistic and true to life. Other comments referred to the simulation scenarios being fake or not rational for what would occur in real student practicums or nursing practice. The fifth subtheme, *Debriefing and discussion*, represented the value of and recommendations for improving the discussion and debriefing at the end of the role play simulation. The sixth subtheme, *The learning space*, analyzed specific aspects of the learning environment (e.g., room design, furniture, acoustics) where the role play simulations took place. Some specific recommendations to improve upon the simulation environment were performing the simulation in the hallway or adjacent classrooms and having the students who assume the role of target and bully stand during the simulation. The seventh subtheme, *Courses for program adoption*, provided the recommendations for specific nursing courses and similar class simulation exercises where the bullying program content could be incorporated for future intervention delivery.

3.3 Desired Outcome of the Program

There were three subthemes to this theme reflecting the knowledge attained from the intervention (see Table 3). The first subtheme, *Now aware of bullying in nursing*, illuminated participants' shock that bullying occurred in nursing practice while now being aware of the impact of bullying, its presence in nursing, and that "there's more than *one way* to bully." The second subtheme, *Teach the tools to help with bullying*, embodied the need for students and nurses to be prepared to deal with workplace bullying by having an arsenal of tools. Some recommendations to prepare for bullying were conflict resolution and the ability to compromise and negotiate. The third subtheme offered by participants, *Stand in support*, symbolized a memorable recommendation of the role play simulation where students were encouraged to show support by standing next to or just behind someone being targeted for bullying.

3.4 Context of Bullying in the Nursing Profession

There were three subthemes to this theme reflecting the dichotomy of being victimized vs. advocating for their future patients as practicing nurses (see Table 4). The first subtheme, *Submissive role*, represented the submissive, powerless positions and at times, perceptions of weakness experienced or witnessed by the participants. The second subtheme, *Don't rock the boat vs. confronting the problem*, indicated that participants avoided conflict and aggressive situations and just "took it", especially when the situation involved a peer as opposed to a physician. Four participants stated the need to stand up for themselves and not

avoid, accept, or tolerate the negative behaviors. The third subtheme, *Do the right thing*, exemplified participants' beliefs that as long as they did the right thing, their license would be protected, they would be serving as a patient advocate, and would be altruistic. The ability to do the right thing would be complemented by having clinical competence and the confidence that their actions were the best thing for their patients despite the presence of bullying.

4. Discussion

The theme of *Experience of Being Bullied* represented a pervasive rationale for why bullying occurs in nursing – the perception that victims are legitimately targeted for victimization. Szutenbach explained in her literature review that low self-esteem was a common rationale for why victims "accept" the bully behaviors they experience.[15] This commentary mirrors the findings in the current study where participants expressed feeling stupid and had they been more clinically astute the bullying would not have occurred. Some participants in the current study expressed their belief that once they became confident in their clinical competence, their risk of bullying would be less likely to happen. However, Hutchinson[7] and Murray[10] discussed that even when nurses are highly competent, aggressors would still accuse others of being incompetent. The experiences of being bullied described in this study reflect the need for novice nurses to learn that the actions and words of aggressors are not always legitimate. Novice nurses need to seek out mentors who will provide legitimate feedback on their clinical competence while providing constructive, professional, and supportive comments as they develop into expert nurses.

Lehr and Kaplan declared that the learning experience during simulations is the same for observers watching a simulation as it is for learners actively participating in a simulation.[16] While this declaration reflects the experience of the participants in the current study based on their ability to reflect on their learning regardless their role as active participant versus observer, the experience of the observers was inhibited. The purpose of the program was to allow for a learning situation where all students would actively participate during the simulation. Unbeknownst to the researchers during the intervention design and deployment, the participants in this study had undergone numerous high fidelity simulations where students in the roles of observer were prohibited from speaking or actively engaging during a simulation. This interpretation of the role of observer is common with nursing students.[17] In the situation of workplace bullying, Hutchinson reports that the victimization may be worsened with the presence of passive observers, because targets and aggressors could perceive the observers to be indirectly supporting the bullying behaviors.[7] In this study, some participants said they wanted to intervene during the bullying scenario but did not. Had the observers intervened, they would have modeled one of two strategies recommended by Murray: calling for help or directly intervening to mitigate the bullying they will likely experience in the future.[10] The attempt to intervene then could be further discussed and evaluated during the full class debriefing. In order for the learning experience to be maximized based on the study findings, revisions to the intervention were made, particularly with increased instructions, more specific scripting for each of the four roles, and enhanced debriefing after the simulation. The verbiage in the novice nurse instructions for "appropriate behavior" was revised to "You need to decide whether to administer

acetaminophen for the quickly elevating temperature or wait until the surgeon makes rounds in 4 hours." This change now requires students to think critically about guidelines for patient care while being confronted with a bullying situation. References to "appropriate behavior" also were removed from the experienced nurse instructions. The instructions now focus exclusively on the behaviors needed for this role. In addition, students assuming the role of the experienced nurse are briefed by the researchers or faculty educators on how to exhibit bullying behaviors in addition to the role play instructions (e.g., stand during the role play, point finger at the student playing the novice nurse; however do not curse, use racial slurs, or touch the student acting as the novice nurse). This briefing assists those students who do not believe they can demonstrate bullying behaviors. Most importantly, the instructions for the two observers were revised to allow students to intervene during the role play simulation. For example, the wording for the nurse observer was amended to: "You notice that two of your colleagues seem to be in a heated disagreement. Do whatever, if anything, that seems natural for you."

Murray further recommends persons witnessing bullying behaviors support the target.[10] A specific supportive strategy was to "stare silently at the individual bullying the nurse" (p. 275).[10] Three participants in the current study each discussed that the single most memorable component of the role play simulation was the strategy of standing in support of the target. Given the powerlessness perceived by novice nurses and student nurses as well as fear of retaliation by an aggressor,[18] it is understandable that the participants would remember this approach as an initial strategy to deal with bullying in the workplace.

Standing up for oneself can be daunting when paired against an aggressive person. Murray's approach for dealing with persons demonstrating bullying behaviors was to call for help.[10] Optimally any person available to respond would do so. This physical show of support to the target may be enough for the target to not think negative self-thoughts about his or her competence and blame him or herself for the bullying behaviors.[10,15] Despite the bullying behaviors that may occur, the participants in this study expounded that they would overcome their negative self-thoughts and insecurities related to competence when a patient's needs warranted their advocacy. This finding warrants inclusion during the briefing of the role play simulation to address patient advocacy as a rationale to overcome a bullying situation.

4.1 Limitations

The findings from this study are limited due to the small sample size (n=8), predominantly female sample, and participants being drawn from a single university; although participants were recruited from two geographically dissimilar campuses. While the homogeneity of the sample limits generalizability, the sample being predominantly female is representative of the overall Unites States' nursing population. While the sample size and single institution are additional limitations to generalizability, the rich, descriptive exemplars may allow transferability of the study findings to similar nursing school populations.

5. Conclusion

Role play simulation was an effective and active learning strategy to diffuse education on bullying in nursing practice. Bullying in nursing was identified as a problem worthy of

incorporation into the undergraduate nursing curriculum. To further enhance the learning experience with role play simulation, adequate briefing instructions, opportunity to opt out of the role play, and comprehensive debriefing are essential. Further research is needed to correlate the knowledge of managing incidents of bullying to the application of this knowledge in nursing practice with novice nurses.

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References

1. Berry PA, Gillespie GL, Gates D, Schafer J. Novice nurse productivity following workplace bullying. J Nurs Scholarship. 2012; 44(1):80–87.
2. Dellasega, C. When nurses hurt nurses: Recognizing and overcoming the cycle of bullying. Indianapolis, IN: Sigma Theta Tau International; 2011.
3. Einarsen S, Hoel H, Notelaers G. Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire—Revised. Work & Stress. 2009; 23(1):24–44.
4. Hutchinson M, Wilkes L, Jackson D, Vickers MH. Integrating individual, work group and organizational factors: Testing a multidimensional model of bullying in the nursing workplace. J Nurs Management. 2010; 18:173–181.
5. Clarke CM, Kane DJ, Rajacich DL, Lafreniere KD. Bullying in undergraduate clinical nursing education. J Nurs Educ. 2012; 51(5):269–276. [PubMed: 22495922]
6. Lindy C, Schaefer F. Negative workplace behaviours: An ethical dilemma for nurse managers. J Nurs Management. 2010; 18:285–292.
7. Hutchinson M. Bullying as workgroup manipulation: A model for understanding patterns of victimization and contagion within the workgroup. J Nurs Management. 2013; 21:563–571.
8. Laschinger HKS, Grau AL, Finegan J, Wilk P. New graduate nurses' experiences of bullying and burnout in hospital settings. J Advanced Nurs. 2010; 66(12):2732–2742.
9. McNamara SA. Incivility in nursing: Unsafe nurse, unsafe patients. AORN J. 2012; 95(4):535–540. [PubMed: 22464626]
10. Murray JS. Workplace bullying in nursing: A problem that can't be ignored. MEDSURG Nurs. 2009; 18(5):273–276. [PubMed: 19927962]
11. Schoonbeek S, Henderson A. Shifting workplace behavior to inspire learning: A journey to building a learning culture. J Continuing Educ Nurs. 2011; 42(1):43–48.
12. Griffin M. Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. J Continuing Educ Nurs. 2004; 35(6):257–263.
13. Sanders C. Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. Contemporary Nurs. 2003; 14:292–302.
14. Lincoln, YS.; Guba, EG. Naturalistic inquiry. Newbury Park, CA: SAGE Publications; 1985.
15. Szutenbach MP. Bullying in nursing: Roots, rationales, and remedies. J Christian Nurs. 2013; 30(1):16–23.
16. Lehr ST, Kaplan B. A mental health simulation experience for baccalaureate student nurses. Clinical Simulation Nurs. 2013; 9:e425–e431.
17. Harder N, Ross CJM, Paul P. Student perspective of roles assignment in high-fidelity simulation: An ethnographic study. Clinical Simulation Nurs. 2013; 9:e329–e334.
18. Embree JL, White AH. Concept analysis: Nurse-to-nurse lateral violence. Nurs Forum. 2010; 45(3):166–173. [PubMed: 20690992]

Table 1

Subthemes and Exemplars for Theme 1: *The Experience of Being Bullied*.

Subthemes	Exemplars
Previous experience with bullying	"But it did bring back some things of times when I was bullied, so I was a little uncomfortable in that respect. And I think we've all probably—at least the majority of us have experienced that, somewhat. So that may have been what was hard in the beginning to kind of get it going."
"Why am I so stupid?"	"I mean it's one thing like if you're in a situation, you know, because a lot of time then it's a gut reaction that's going on, you known, when someone's like, you know, 'Are you stupid?!?!' It's like, 'I don't think so! But right now I'm not sure.'"

Table 2

Subthemes and Exemplars for Theme 2: *Implementation of the Program*.

Subthemes	Exemplars
Role play instructions	"Yeah, more instruction at the beginning. Even if you were pulling aside, like, the bullies in just a small group with more detailed instruction of 'This is your scenario,' this is what—yeah. More instruction on what you could do to get the process rolling and more realistic instead of oh, I think we're supposed to do this, so here's some mean stuff I can say to you."
Can't act like a bully	"Two of the nurses were having a *hard time* being a bully because they're just—they're not like that. You know? They're just, they couldn't event fake it well, you know? They couldn't really come up with—I mean that probably took like the first 10 minutes of—you know—well, what are you gonna say? And just like, 'I don't know what I'm gonna say.' It's just like, 'I don't know how to be mean.'"
Role of the observer	"When we do scenarios here, our observers do not interact with what's going on. They critique us afterwards…So that's why you probably did not get the feedback from the observer…"
Realism vs. fake	"Well, in real life I would have walked away. You know, obviously in a classroom setting I couldn't just walk away from her. But I could—I would have walked away."
Debriefing and discussion	"And I think, you know, hearing as many perspectives on that as you can and—knowing signs to kind of look for, you know, and just even hearing, you know, our classmates' kind of reactions to the whole concept of bullying was very enlightening to me. Because I know if [I] have *feelings* about it but I come from my place, and, you know, knowing how other people might *feel* about it, or, you know, approach situations, so—just airing it out more."
The learning space	"Unfortunately, with the room we were in, the way everything was set up, nobody could really like stand up and act it out. It was a room full of people and it may have been better if we could have either split up into separate rooms and have the chance to get up and act it out. That might have helped."
Courses for program adoption	"Some of your scenarios, it's an ethical problem if you're debating whether or not would your patient—if it's the health of the patient that kind of thing and you're being told something else…I think this would follow into it because bullying isn't necessarily a black and white thing."

Table 3

Subthemes and Exemplars for Theme 3: *Desired Outcome of the Program*.

Subthemes	Exemplars
Now aware of bullying in nursing	"And for me, that was very, um, like I had asked you, two weeks ago after work why? Why is bullying so prevalent in nursing? and I admit that I'm a naïve person. I think that everyone's out to do good and be kind to each other and life is, you know, rainbows and butterflies. But I—it's very disheartening. I remember in socialization [course]…she said the old eat their young in nursing. and I just remember like my heart sank."
Teach the tools to help with bullying	"…you're not sure of what you can and cannot do in order to protect yourself, and having some sort of—I hate to say it—arsenal, because everybody's up in arms with guns and stuff, but if you have like simple things that you can remember to say to someone, you know, to try to get them to *not* talk to you that way, you know?"
Stand in support	"I like how [you] talked about diffusing the situation and bringing just, you know, one person standing up by the person being bullied and the other—another person standing up. And I think you—you know, that's important to know that you've got someone that has got your back and that is going to stand there and support you without saying anything—you know, at first, at least—to know that we support each other."

Table 4

Subthemes and Exemplars for Theme 4: *Context of Bullying in the Nursing Profession*.

Subthemes	Exemplars
Submissive role	"One of the major problems with bullying in the work force is that a younger nurse, a younger student any not recognize that that's bullying. They may think, again, 'I am in a submissive position. That is my-my-my charge nurse.' Or 'That nurse has been working here for 15 years.' Or—you know what I mean? And they kind of assume that it is *okay* for somebody to, you know, boss them around or talk to them a certain way—or to make them feel stupid or to make them feel incompetent."
Don't rock the boat vs. confronting the problem	"It's hard when somebody's being mean or being condescending or being nasty to you, when you are asking for information. And you do. You kind of shrink in on yourself because you're just like, 'Well, okay, maybe I should be able to do this,' you know, when, in my head, I'm like, 'Man, I really want someone here to be doing this with me because I've never ambulated this person before.'"
Do the right thing	"A lot of this stuff is a lot easier to stick up for yourself depending on where you're at in a situation. If it involves the patient, I feel like it's really easy to just say, 'No, this is my evidence and if you don't like it, tough.'"