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Reflective Responses Following a Role Play Simulation of Nurse Bullying

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Abstract

The affective domain of learning can be used with role play simulation to develop professional values in nursing students. 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. Three hundred thirty-three senior nursing students from five college campuses participated. Following the role play simulation students completed a reflection worksheet. The worksheet data were qualitatively coded into themes. Thematic findings were personal responses during the simulation, nonverbal communications exhibited during the simulation, actions taken by participants during the simulation, and the perceived impact of bullying. Role play simulation was a highly effective pedagogy requiring no technology, was free, and elicited learning at both the cognitive and affective domains of learning.

Keywords

violence; aggression; students; active learning; nursing schools

Nurses are expected to adhere to the American Nurses Association (ANA, 2015) Code of Ethics for Nurses and integrate ethical behaviors into their professional practice (Fowler,

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2008). An essential function for nurse educators is to instill these professional nursing values, morals, and ethics in students as the students develop and mature into professional nurses. Nurse educators can accomplish this education by designing learning opportunities that encompass the three categories or domains of learning commonly used in nursing academia: cognitive, psychomotor, and affective (Shultz, 2009). The affective domain of learning is best suited for developing professional values and invokes feelings and emotions in students which is often difficult to teach as well as difficult to measure (Brown, Holt-Macey, Martin, Skau, & Vogt, 2015; Cazzell & Howe, 2012; McArthur, Burch, Moore, & Hodges, 2015). Developing and evaluating active learning strategies incorporating the affective domain of learning are needed in nursing education to transform how nursing students are taught (Valiga, 2014). The purpose of this study was to evaluate role play simulation as an active learning strategy to address the problem of bullying in nursing.

Background

There is a growing body of literature describing teaching activities incorporating affective learning in nursing and/or interprofessional education (e.g., Cazzell & Howe, 2012; McArthur, Birch, Moore, & Hodges, 2015; Neville, Petro, Mitchell, & Brady, 2013; Rees, 2013). Neville et al. (2013) discussed undergraduate health science students observing an interprofessional healthcare team meeting and then reflecting and documenting their perceptions on the team member roles. McArthur et al. (2015) 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. While the body of literature is growing, there remains a dearth of published strategies focused to the affective domain of learning assessing student emotions, beliefs, attitudes, values, and moral behaviors.

Role play is an experiential learning strategy where learners take an active part in an imaginary scenario to provide targeted practice and receive feedback to enhance their skills all within a safe learning environment (Wheeler & McNelis, 2014). The students figuratively place themselves in another person’s shoes so as to experience what that person is experiencing, while empathizing and understanding that person’s motivations (McArthur et al., 2015). Role play provides the opportunity for students to explore the affective domain of emotions and values, although it also can provide cognitive learning as students analyze the situation they find themselves in as they experience the activity. The physical aspect of role play touches on the psychomotor domain, another domain of learning. Role play also provides a forum for students to make mistakes and try a variety of approaches to mitigate a difficult situation or problem. In this way, learners gain a repertoire of responses available for their future use when they encounter a similar situation (Murphy, Yaruss, & Quesal, 2007). Debriefing after role play is a key to learning. Allowing students to discuss how they feel, why they respond as they do, how they might do something different the next time, and what they learned from the experience, the faculty member creates an interactive and inclusive environment where learning occurs. It helps students understand and accept their feelings and those of others as genuine and real, as well as develop competence in interacting in difficult circumstances.

An advantage to role play is simulating current practice problems with minimal requirement for technology leading to an inexpensive active learning strategy that can be implemented in multiple settings. A contemporary and pervasive problem for nurses in practice settings and students and faculty members in academic settings is bullying (Berry, Gillespie, Gates, & Schafer, 2012; Clarke, Kane, Rajacich, & Lafreniere, 2012; Hutchinson, Wilkes, Jackson, & Vickers, 2010). Bullying can take a variety of forms from nonverbal intimidation such as ignoring or excluding a target to overt aggression (Hutchinson, 2012). Given this pervasiveness, role play simulations developed to address bullying can educate students about this significant clinical problem, as well as facilitate discourse on ethical behaviors in response to bullying. In the current study, it was anticipated the student participants would experience affective domain of learning, identify strategies to address bullying professionally, and self-manage personal responses while adhering to the ANA's Code of Ethics for Nurses.

Methods

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. This study was by approved the Institutional Review Boards of three participating universities.

Setting and Sample

The research intervention took place at five college campuses from three universities in the Midwest United States. The sample was drawn from all senior level nursing students enrolled in a community health or leadership didactic course at one of the five college campuses.

Role Play Simulation

Three simulation scenarios were developed by faculty researchers. Each scenario was reviewed for content by expert faculty members, a graduate student, and an undergraduate student. After changes were made to the scenarios, the scenarios were pilot tested and further revised. The final version of the scenarios was used for this study.

At the start of the simulation, students were instructed on the learning outcome for the role play: examine the experience and outcomes of simulated bullying. Students were assigned to groups of four students per group. Students randomly drew a role card with instructions from an envelope: aggressor, target, nurse bystander, or patient. Aggressor and target role cards explained the simulation and provided instructions. The nurse bystander and patient role cards informed the students to act as they normally would once the simulation starts. Further, details about the role play instructions and simulation were previously reported (author information removed for anonymity). The role play simulation for all groups continued simultaneously for about five minutes and then was halted by the nursing faculty member.

Immediately following the role play, students completed an individual reflection worksheet developed by the researchers for use in this study. Questions on the worksheet included:

- What did it feel like to be in the role you played during the simulation?
- What nonverbal communication did you exhibit and see in others during the simulation?
- What actions were taken or attempted in order to resolve the issue?
- What impact to employees did the issue cause or may cause had the simulation been a real experience?
- What impact to patients did the issue cause or may cause had the simulation been a real experience?

Next, students reflected on the role play experience in their groups. Finally the faculty member facilitated a large group debriefing to explore their responses to the simulation and discuss professional mitigation strategies for future events in healthcare settings. The findings in this paper will focus on the individual self-reflection responses.

Procedures

Faculty members teaching the role play simulation informed students that their role play worksheets would be used for research. Students declining their data to be used for research were instructed to write “Do Not Use” on the top of their worksheet. Worksheets were provided to the principal investigator and transcribed verbatim by a research assistant into a database.

Data Analysis

The data were independently reviewed by four researchers to determine important units of information based on naturalistic coding described by Lincoln and Guba (1985). The research team then met to discuss their respective units of information and cluster the units of information into themes. Next, the data were independently analyzed and coded to themes. The team met to discuss their individual coding and came to consensus on the final thematic coding for each unit of information. The coded data then were extracted into Microsoft Word documents according to their respective themes and verified for accuracy and consistency by the research team.

Trustworthiness

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 the research team coming to agreement on the themes and coding of units of information. Dependability was achieved by maintaining an audit trail documenting coding decisions made by the research team further increasing the consistency of data coding. Confirmability was achieved through investigator triangulation and an audit trail.

Findings

Reflection worksheets were received by 333 senior level nursing students portraying the roles of aggressor (n=91), target (n=83), nurse bystander (n=81), and patient (n=78). Themes

were categorized according to personal responses during the simulation, nonverbal communications exhibited during the simulation, actions taken by participants during the simulation, and the perceived impact of bullying.

The personal responses simulated by the participants varied by student role (see Table 1). Students portraying the role of aggressor reported difficulty demonstrating bullying behaviors. They also reported having feelings of negative behavior and guilt. Students portraying the role of target most commonly reported feeling bullied, uncomfortable, or overwhelmed. Students portraying the role of the nurse bystander frequently felt helpless and unable to stop the bullying. Only 16 students intervened to stop the bullying. A high number of students portraying the role of patient reported feeling helpless and would likely lose trust in the healthcare team and/or feel neglected.

Nonverbal communications were both exhibited and witnessed by the study participants (see Table 2). Nonverbal communications of students portraying the role of aggressors included aggressive arm gestures such as pointing fingers and flailing arms and facial communications such as rolling eyes and grimacing. Nonverbal communications of students portraying the role of targets included non-aggressive facial communications such as opening mouth in surprise and non-aggressive body posture such as leaning away from aggressor. Nonverbal communications of students portraying the role of nurse bystanders included non-aggressive facial communications and body posture such as backing away from the conflict. Nonverbal communications of students portraying the role of patients included both non-aggressive and aggressive facial communications.

Actions taken by the study participants were categorized as proactive, passive, or aggressive (see Table 2). Aggressive actions were predominantly used by students portraying the role of aggressor. Examples include yelling and stating “Figure it out on your own.” Proactive actions were predominantly used by students portraying the roles of target and nurse bystanders. Examples include attempting compromise, suggesting that both parties take a break, and expressing their feelings. Passive actions were predominantly used by students portraying the role of patient. Examples include watching the incident transpire and doing nothing.

The perceived impact of bullying was assessed by the study participants (see Table 3). The perceived impact for employees resulting in adverse effects for following bullying incidents was the team/working environment, onset of negative emotions, and increased risk for legal consultation. Team/working environment impact was described as increased tension and conflict between employees and decreased morale and cohesion. Negative emotions included descriptors such as anxiety, fear, worry, anger, loss of confidence, disgruntlement, and confusion. Legal risk impact was described as loss of licensure, risk for malpractice claim, and employee discipline. The perceived impact to patients was negative organizational perception, personal emotions, and patient outcomes. Examples of negative organizational perceptions were loss of trust in care delivery and lack to return to that organization for future healthcare encounters. Examples of negative personal emotions for patients were feeling uncomfortable, afraid, confused, guilty, disrespected, neglected, and

traumatized. Examples of negative patient outcomes were delays in care, poor patient care, lack of patient-centered care, and fragmented care.

Discussion

The role play activity evoked authentic affective responses from the participants, similar to research reported by McArthur et al. (2015). The responses and perceived impact of the students playing the roles of target and nurse bystander were similar to those exhibited in real life bullying situations (Berry et al., 2012; Reknes, Pallesen, Magerøy, Moen, Bjorvatn, & Einarsen, 2014; Vogelpohl, Rice, Edwards, & Bork, 2013). This alone points to the fact that role play can simulate real life to a great extent, allowing participants to actually feel the emotions and feelings they might experience should they encounter a similar situation 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 in the role play activity. Again, affective responses demonstrated that the participants were reacting in much the same manner as someone who would actually experience bullying. These responses and actions then can be leveraged during a critical debriefing facilitated by the nurse faculty member.

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 (Anonymous – reference blinded for peer review; McArthur et al., 2015). In this way, students can experience these 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.

Debriefing after role play is a major component of the role play activity and is seen by most to be more important than the role play scenario itself. Allowing students to discuss the situation they found themselves in, the way they responded and alternative responses for effective mitigation, and how others felt and responded will aide students to learn new ways to react, redirect, and hopefully halt bullying behaviors. Although debriefing is a huge part of the learning process, role play scenarios need to serve as the crux of the debriefing component. Role play must be realistic and relevant to practice if it is to evoke genuine feelings and emotions. Without a solid scenario for the role play, debriefing would not be as effective or lead to maximum learning. As evidenced by our findings, the role play simulation was realistic and evoked genuine feelings and emotions that were later leveraged in discussion/debriefing to plan professional mitigation strategies.

Role play also can address and lead to critical conversations about healthcare organizations. Students can relate the content of the scenario to their perceptions about how it could impact the organization and how a single bullying incident can spread quickly to affect the entire organization. In the bullying scenario, students reflected on the impact that bullying had for employees, patients, and the working environment of the healthcare team. They were able to grasp the enormity of the problem of bullying and see the problem from the viewpoints of all of the players: aggressors, targets, nurse bystanders, and patients. They noted the

organizational impact, which expanded the learning and allowed the learners to see the cumulative impact of bullying.

Limitations

Three limitations were noted to this study. First, student knowledge about and experiences with bullying were not measured. This student background could have impacted student participation and engagement in the role play simulation and ultimately their affective responses documented on the reflection data collection tool. Second, fidelity to the implementation of the role play simulation was not measured by the research team. This limitation was minimized by the researchers providing 1:1 training to faculty members who implemented the simulation prior to deploying the intervention in the classroom. In addition, a detailed instructional guide was provided to faculty members to use during implementation to promote fidelity across classrooms. Third, the research was conducted with students who attended nursing schools in close geographic proximity, although the programs do enroll students who are not local to their campuses. This geography as well as the qualitative nature of the study design limit the generalizability of the study findings.

Implications for Nurse Educators

Bullying as a clinically significant practice problem recently garnered national attention when the ANA (2015) published the position statement “Incivility, Bullying, and Workplace Violence” which recognizes the magnitude and importance of bullying. 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 such as the one conducted in this study can serve as an effective strategy to deliver this course content.

As the costs associated with nursing education for books, tuition, and other fees continue to rise, the need for low cost or free educational activities becomes more important. The role play simulation discussed in this paper 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 with students describing a multitude of responses and actions reflecting their learning at the affective domain, an area often not addressed in nursing education.

The planned debriefing for this role play simulation could be extended to other professional behaviors and discussed in multiple courses. For example, students can discuss not only how to respond professionally to colleagues, but to patients and patients’ visitors demonstrating stress or agitation. Students in this study reported exhibiting behaviors deemed as aggressive including eye rolling, standing with their hands on their 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 manifest or be interpreted as aggression. Some students in this study who portrayed the role of targets were perceived as aggressive, likely a manifestation of their stress response to receiving bullying behaviors. These responses when witnessed by patients or visitors could lead to reduced patient satisfaction scores or an increase in patient complaints to healthcare administrators. Providing students multiple opportunities to practice their response and management to

difficult situations using realistic scenarios related to current clinical problems and allowing a through debriefing can provide a mechanism for optimal student learning.

Conclusion

Role play simulation was a highly effective pedagogy requiring no technology, was free, and yet elicited learning at both the cognitive and affective domains of learning. Well written scenarios that are realistic and relevant to current nursing practice are excellent mechanisms to help students experience difficult issues and situations in safe supportive environments, while gaining new insights into best practices for handling difficult people, situations, and problems common to nursing practice. Future research is needed to evaluate students' adoption and effective use of the education taught during this role play simulation.

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References

American Nurses Association. Code of ethics for nurses with interpretive statements. Silver Spring, MD: Author; 2015.

Berry PA, Gillespie GL, Gates D, Schafer J. Novice nurse productivity following workplace bullying. Journal of Nursing Scholarship. 2012; 44(1):80–87. DOI: 10.1111/j.1547-5069.2011.01436.x [PubMed: 22339938]

Brown B, Holt-Macey S, Martin B, Skau K, Vogt EM. Developing the reflective practitioner: What, so what, now what. Currents in Pharmacy Teaching and Learning. 2015; 7(5):705–715. DOI: 10.1016/j.cptl.2015.06.014

Cazzell M, Howe C. Using objective structured clinical evaluation for simulation evaluation: Checklist considerations for interrater reliability. Clinical Simulation in Nursing. 2012; 8(6):e219–e225. DOI: 10.1016/j.ecns.2011.10.004

Clarke CM, Kane, Rajacich DL, Lafreniere KD. Bullying in undergraduate clinical nursing education. Journal of Nursing Education. 2012; 51(5):269–276. DOI: 10.3928/01484834-20120409-01 [PubMed: 22495922]

Fowler, M. Guide to the Code of Ethics for Nurses: Interpretation and Application. Silver Springs MD: American Nurses Association; 2008.

Gillespie GL, Brown K, Grubb P, Shay A, Montoya K. Qualitative evaluation of a role play bullying simulation. Journal of Nursing Education and Practice. 2015; 5(6):73–80. DOI: 10.5430/jnep.v5n6p73 [PubMed: 26504502]

Hutchinson M. Bullying as workgroup manipulation: A model for understanding patterns of victimization and contagion within the workgroup. Journal of Nursing Management. 2012; :1–8. DOI: 10.1111/j.1365-2834.2012.01390.x [PubMed: 22229895]

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. Journal of Nursing Management. 2010; 18:173–181. DOI: 10.1111/j.1365-2834.2009.01035.x [PubMed: 20465745]

Lincoln, YS., Guba, EG. Naturalistic inquiry. Newbury Park, CA: SAGE Publications; 1985.

Maier-Lorentz M. Writing objectives and evaluating learning in the affective domain. Journal for Nurses in Staff Development. 1999; 15(4):167–171. [PubMed: 10745786]

McArthur P, Burch L, Moore K, Hodges MS. Novel active learning experiences for students to identify barriers to independent living for people with disabilities. Rehabilitation Nursing. 2015; in press. doi: 10.1002/rnj.208

Murphy W, Yaruss J, Quesal R. Enhancing treatment for school-age children who studder II. Reducing bullying through role-playing and self-disclosure. Journal of Fluency Disorders. 2007; 32:139–162. [PubMed: 17499126]

Neville CC, Petro R, Mitchell GK, Brady S. Team decision making: Design, implementation and evaluation of an interprofessional education activity for undergraduate health science students. Journal of Interprofessional Care. 2013; 27(6):523–525. DOI: 10.3109/13561820.2013.784731 [PubMed: 23683060]

Rees KL. The role of reflective practices in enabling final year nursing students to respond to the distressing emotional challenges of nursing work. Nurse Education in Practice. 2013; 13(1):48–52. DOI: 10.1016/j.nepr.2012.07.003 [PubMed: 22854313]

Reknes I, Pallesen S, Magerøy N, Moen BE, Bjorvatn B, Einarsen S. Exposure to bullying behaviors as a predictor of mental health problems among Norwegian nurses: Results from the prospective SUSSH-survey. International Journal of Nursing Studies. 2014; 51(3):479–487. DOI: 10.1016/j.ijnurstu.2013.06.017 [PubMed: 23891534]

Schultz, CM. Building a Science of Nursing Education: Foundation for Evidence-Based Teaching-Learning. New York, NY: National League of Nursing; 2009.

Valiga TM. Attending to affective domain learning: Essential to prepare the kind of graduates the public needs. Journal of Nursing Education. 2014; 53(5):247.doi: 10.3928/01484834-20140422-10 [PubMed: 24802228]

Vogelpohl DA, Rice SK, Edwards ME, Bork CE. New graduate nurses' perception of the workplace: Have they experienced bullying? Journal of Professional Nursing. 2013; 29(6):414–422. DOI: 10.1016/j.profnurs.2012.10.008 [PubMed: 24267937]

Wheeler CA, McNelis AM. Nursing student perceptions of a community-based home visit experienced by a role-play simulation. Nursing Education Perspectives. 2014; 36(4):259–261. DOI: 10.5480/12-932.1

Woods JH. Affective learning: One door to critical thinking. Holistic Nursing Practice. 1993; 7(3):67–70.

Zimmerman BJ, Phillips CY. Affective learning: Stimulus to critical thinking caring practice. Journal of Nursing Education. 2000; 39(9):422–425. [PubMed: 11138750]

Table 1

Students' personal responses while simulating the roles of aggressor, target, nurse bystander, and patient.

Personal responses	N (%)
Personal responses of students simulating the role of aggressor	
Not able to be the bully	51 (56.0%)
Feelings of negative behavior	29 (31.9%)
Guilt	22 (24.2%)
Motivation to bully	11 (12.1%)
Personal responses of students simulating the role of target	
Bullied	27 (32.5%)
Uncomfortable	18 (21.7%)
Overwhelmed	16 (19.3%)
Inferior	14 (16.9%)
Personal responses of students simulating the role of nurse bystander	
Helpless/couldn't stop the bullying	36 (44.4%)
Took action	16 (19.8%)
Internal conflict of allegiance	15 (18.5%)
Emotional responses of self and others	10 (12.3%)
Personal responses of students simulating the role of patient	
Helpless	47 (60.3%)
Loss of trust	19 (24.4%)
Neglected	16 (20.5%)
Upsetting	12 (15.4%)

Table 2

Nonverbal communications exhibited and actions taken by students during the simulation as perceived by themselves and other students.

	Aggressor (N)	Target (N)	Nurse bystander (N)	Patient (N)
Nonverbal communications				
Verbal language responses	42	10	3	6
Aggressive body posture	52	6	5	0
Non-aggressive body posture	0	54	24	9
Aggressive facial communications	90	21	12	12
Non-aggressive facial communications	4	70	43	45
Aggressive arm gestures	100	16	4	2
Non-aggressive arm gestures	0	0	6	2
Actions taken				
Proactive actions	40	195	194	35
Passive actions	13	24	37	77
Aggressive actions	126	8	5	1

Table 3

Perceived impact of bullying in the workplace.

	N (%)
Employee impact	
Team/working environment	236 (70.9%)
Personal/emotional impact	141 (42.3%)
Legal impact	15 (4.5%)
Patient impact	
Organizational perceptions	153 (45.9%)
Patient emotions	147 (44.1%)
Patient outcomes	103 (30.9%)