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Coping Strategies of Prelicensure Registered Nursing Students Experiencing Student-to-Student Incivility

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Abstract

Incivility is rude or discourteous behavior that demonstrates a lack of respect for others. Some nurses purposefully target each other with uncivil behaviors. Incivility has invaded the nursing educational environment with deleterious results. Uncivil behaviors perpetrated by nursing students against other nursing students cause psychological and physiological distress for victims and witnesses. The purposes of this study were to identify the behaviors that constituted lateral student-to-student incivility, determine the frequency of experienced student-to-student incivility, and describe the coping strategies employed by prelicensure registered nursing students experiencing lateral student-to-student incivility. This quantitative descriptive study recruited prelicensure registered nursing students in associate degree, baccalaureate degree, and diploma programs using non-probability convenience sampling through the email member list of a national student nursing organization. Critical Social Theory was the study framework. Participants completed the Ways of Coping (Revised)* survey and the Incivility in Nursing Education Revised (INE-R) Survey anonymously online. Data was analyzed comparing nursing program levels, ages, genders, and ethnicities using descriptive statistics and Kruskal-Wallis analyses. Recommendation for a universally accepted definition of academic incivility within the discipline of nursing is promoted so civil behavior can be modeled by educators and taught to students

Keywords: Coping; Coping Strategy; Critical Social Theory; Incivility; Nursing Student; Stress

Introduction

Incivility is rude or discourteous behavior that demonstrates a lack of regard or respect for others [1,2]. Incivility behaviors can be overt or covert, occurring blatantly out in the open where victims can easily identify the perpetrator or in secret where the perpetrator is hidden. Behaviors can be verbal (hurtful words, sighing, and sounds) or non-verbal body language (eye rolling, toe tapping, and finger pointing). Incivility is purposeful. One person intends to upset, psychologically hurt, or demean another person. Academic incivility is not a new phenomenon within higher education. Institutions of higher learning have been confronting academic incivility since the United States experienced societal unrest in the 1960's and 1970's [3]. Incivility occurs vertically among the differing higher education strata: faculty-to-student; administration-to-faculty; and administration-to-student [4]. Incivility occurs laterally between institutional members of equal status: faculty-to-faculty and student-to-student [5].

Incivility has invaded nursing academia [5-15] with deleterious effects. Academic nursing incivility between faculty and students has been studied and reported in the literature [5,6,9,14,16-20]. The phenomenon of lateral nursing student-to-student incivility in the academic environment has not been well researched. Articles containing personal exemplars of or anecdotal references to nursing student-to-student incivility have been published [5,8,10,12,17,19,21-27]. Few studies have systematically examined nursing student-to-student incivility. This study investigated incivility between registered nursing students in the classroom and clinical areas. A nursing student is an incivility victim if he or she receives direct uncivility behaviors from a student peer. A nursing student is an incivility witness if incivility behaviors are seen being perpetrated against another

nursing student peer or classmate and the student does not know what to do to aid the victimized peer. Both the direct and vicarious victimization cause the same deleterious effects.

Academic incivility inhibits collegiality, prevents optimum learning, decreases academic motivation, creates a negative educational atmosphere, thwarts assimilation of positive professional nursing behaviors, and propagates a milieu of fear and anxiety [8,12,28,29]. Repeated exposure of nursing students to incivility can breed acceptance embedding these behaviors in the academic nursing environment [19,26]. Nursing student concerns, faculty concerns, frequency of occurrences, and types of incivility behaviors are reported in the literature to be increasing [5-8,10,12,14,15,30]. These studies do not offer an exact percentage of incivility increase, but do identify a significant number of students affected by academic incivility in a variety of educational environments in various geographical locales since 1995. Lashley and De Meneses [30] surveyed 409 Nursing Program Directors about problematic student behaviors.

All of the participants identified classroom inattentiveness as problematic. Clark and Springer [5] distributed surveys to 15 nursing faculty and 186 nursing students in one public university in 2004. Talking in class was identified as the most frequently occurring form of student incivility. Luparell [14] interviewed 21 nursing faculty members in 2004. Participants reported 36 separate critical incidences of student incivility. Academic incivility is perceived to be a moderate to severe problem by 194 faculty and 306 student participants in a 2006 national study [8]. Clark and Springer [10] surveyed 32 nursing faculty and 324 nursing students in one university to obtain perceptions about incivility occurrences. Cheating on assessments was identified as always uncivil by 82% of participants. Anthony and Yastik [7] conducted focus groups with 21 nursing students in a private university. Students promote adding incivility awareness education to the nursing curriculum due to the prevalence of academic and professional incivility. Altmiller [6] conducted focus groups with 24 nursing students who identified the increasing frequency of incivility occurrences as problematic in the nursing classroom. Incivility is an unwelcome dimension of the nursing profession pervading all areas of education and practice [31].

Incivility occurs when nurses are rude, disrespectful, or purposefully unkind to one another displaying a lack of esteem and collegial professionalism [2,32]. Incivility in nursing has been studied under the names of: lateral violence; horizontal violence; bullying; mobbing; and harassment [28,32,33]. Nursing schools are not able to prepare enough registered nurses to fill current vacancies or projected employment needs [34]. Nursing schools turned away 79,659 qualified applicants in 2012 for lack of faculty, clinical preceptors, classroom space, and clinical placements [34]. The Bureau of Labor Statistics projects 1.2 million additional registered nurses will be needed in the healthcare workforce by 2020 [34]. This professional nursing shortage cannot be addressed if nursing students leave school or newly graduated nurses change career choices because of incivility.

The nursing shortage can be perpetuated as nursing students replicate the uncivil behavior that is seen and experienced in academic and clinical settings. Students begin to learn professional nursing culture in prelicensure registered nursing programs. Positive collegiality and negative incivility are learned from teachers and preceptors [35,36]. Witnessed and experienced behavior becomes the enculturated norm [19]. Acceptance and tolerance of incivility by the nursing profession has created a self-perpetuating culture of rude, disrespectful, unkind behaviors [19,35,37]. The American Nurses Association (ANA) proposes a "No Tolerance" stance against incivility in professional nursing to break this cycle [38]. The theoretical framework for this study was the Transactional Model of Stress and Coping [39]. The three main concepts of this model are transaction, stress, and coping [40]. Transaction addresses the basic psychological human need for positive interpersonal relatedness. This study explored the phenomenon of nursing students not meeting the psychological need for positive interpersonal relatedness to academic peers when experiencing student-to- student incivility [40].

Oppressed group behavior theory is one explanation for the incivility that exists within professional and academic nursing [22, 31,32,36,41-47]. Oppression is defined as exploitation of a less powerful group by a dominant group [32]. The less powerful group perceives a state of exclusion from the total group power structure [36,43,47]. Feeling oppressed in the workplace can lead to self-doubt, a state of vulnerability, untoward behavioral changes [48], and low self-esteem [32,37,47,49]. Incivility is manifested as untoward behaviors directed at professional peers and colleagues on an equal, lateral plane [36,37,42,43,46,50].

Critical Social Theory was the study framework to explore the meaning of civil and uncivil student-to-student interactions and behaviors in daily academic life. Critical Social Theory (CST) links nursing practice with nursing theory [51] through the reflective lens of a politically engaged nurse [52]. CST as a study framework can be used to study the opportunities for human growth and change in response to society's institutional structures and power hierarchies [51]. Nursing knowledge acquisition and nursing science advancement are guided by the relationship between the society of nurses working to form a caring human science discipline and the philosophical assumptions of CST. Opportunities for positive nursing student-to-student behavioral change and the decrease of student-to-student incivility are possible outcomes of exploring student-to-student incivility using CST.

The lack of knowledge about student coping strategies employed in response to student-to-student incivility was addressed in this study. Jenkins, et al. [53] used the Ways of Coping

Questionnaire to identify the coping strategies employed by 25 prelicensure registered nursing students experiencing student-to-student incivility. Social capital building with written journals as an alternative to student engagement in incivility behavior was the main focus of this study.

Materials and Methods

The aims of this quantitative non-experimental descriptive study were: (1) explore specific behaviors prelicensure registered nursing students report constitute student-to-student incivility; (2) determine the frequency of experienced student-to-student incivility; and (3) describe the coping strategies employed by prelicensure registered nursing students experiencing student-to-student incivility in nursing classroom and clinical settings.

The research questions were: 1. What behaviors do prelicensure registered nursing students identify as student-to-student incivility as measured by the INE-R [16]? 2. With what frequency do prelicensure registered nursing students experience perceived student-to-student incivility in nursing classroom and clinical settings? 3. Do perceptions of student-to-student incivility vary by program type, age, gender, or race/ethnicity? 4. What coping strategies do prelicensure registered nursing students employ when experiencing student-to-student incivility in nursing classroom and clinical settings as measured by the Ways of Coping (Revised)* Questionnaire [54]? 5. Do coping strategies vary by program type, age, gender, or race/ethnicity?

Participants were prelicensure registered nursing students from seven types of programs: associate degree (n=130), baccalaureate degree (n=183), diploma program (n=14), LPN to ADN (n=6), LPN to BSN (n=4), BA or BS to BSN (n=28), and BA or BS to MSN (n=7). Students were recruited using nonprobability convenience sampling with the email member list of a national student nursing organization. This national sample contained 337 females, 31 males, and 5 who preferred not to respond, for a total of 373 participants. The age groups of the participants were: 18 - 24 (n = 130), 25 - 34 (n = 122), 35 - 44 (n = 70), 45 - 54 (n = 39), 55 - 64 (n = 10), and 65 and over (n = 1). The racial/ethnicity demographic of the sample was: Arab or Arab American (n = 3), Asian or Asian American (n = 16), Black, Afro-Caribbean, or African American (n = 21),

Caucasian, Non-Hispanic White, or Euro-American (n = 261), Latino or Hispanic American (n =32), Multiracial (n = 23), Native American or Alaskan Native (n = 4), Native Hawaiian or Pacific Islander (n = 3), Another race or ethnicity (n = 1), and Prefer not to respond (n = 9). Participants have not passed the NCLEX examination, have completed at least one semester of nursing school, are 18 years of age, or older, and can speak and read the English language. Participants received the electronic survey in their national student nurses' association email inbox. Participants completed the survey on their own computers without meeting the Primary Investigator. The study purpose was explained in an introductory letter that accompanied the Informed Consent form in the email. Informed Consent was assumed when the participants entered the electronic survey. Participants could exit the survey at any time. No incentive was offered for participation. No penalty was imposed for choosing not to participate. The survey was completely anonymous. No IP addresses were attached to the returned surveys, so the participants could not be identified.

Institutional Review Board (IRB) approval was obtained from East Tennessee State University. Anonymity was maintained because the PI did not have access to the respondents' email addresses or meet the participants in person. Participation was voluntary. Students chose to enroll in the study by completing the online survey. Participants were able to withdraw from the study at any time by exiting the online survey without clicking the submit icon. Nurses are considered an oppressed group due to their long history of perceived and actual subjugation to the male dominated medical profession, historically marginalized nurse managers, and lower power status in the health care hierarchy [2,32,43]. Oppression and powerlessness can lead to inter-group violence and aggression manifesting itself as displacement of personal anger, an attempt to gain control over another individual perceived to be of lesser status, or a coping mechanism to elevate poor self-esteem and self-worth [22,28,36,43,46,47,50].

Nursing students, as a subset of the entire nursing profession, may be considered an oppressed group due to their lack of control over their academic environment and the uncivil behaviors received from faculty and peers [22]. Clinical nursing students may be blamed falsely for untoward events, belittled, or humiliated by unit staff nurses [19]. Reciprocated incivility may be an attempt of nursing students to regain control of the academic environment [22].

The original Incivility in Nursing Education (INE) Survey [12] was the first mixed-method tool developed to study academic incivility from the perspective of both nursing faculty and nursing students. The tool consists of three parts. Part I is demographic data. Part II contains two lists of uncivil behaviors. One list of 16 student behaviors is considered potentially uncivil. The second list of 13 behaviors is considered definitely threatening. Participants identify which behaviors are perceived to be uncivil and indicate the frequency of experienced incivility over the past 12 months. Cronbach's alpha for the 16 student behaviors listed in Part II showed good inter-item reliability. The level of student incivility was 0.848 and the frequency of incivility occurrence was 0.808 [12]. Part III contains qualitative open-ended items soliciting narrative responses describing personal experiences with academic nursing incivility and suggestions for future change to reduce academic incivility. Participants should be able to complete the

survey in approximately 10 minutes, but no time limit is imposed on this survey.

The INE was revised to the INE-R [16]. The revised INE-R tool also measures faculty and student perceptions of incivility behaviors. Like the INE, the INE-R can be used to study the perceptions of both groups simultaneously, or either group independently [16]. Clark, et al. [16] calculated reliability using 310 students and 182 faculties from 20 nursing schools in the United States. Cronbach's alpha for the total student behavior was 0.96 and the total faculty behavior was 0.98. The proposed study will use only the student portion of the INE-R as the concept of interest is student-to-student incivility. The INE-R will be used to identify behaviors that student nurses consider constitute student-to-student incivility and quantify the frequency of experienced student-to-student incivility. Perceptions of incivility specifically occurring among nursing students in academic and clinical settings will be obtained without reference to the nursing faculty. Nurse faculty perceptions of incivility are not germane to this study.

The INE-R consists of the same three parts as the INE. Part I is demographic data. In the INE-R, the study investigator identifies the demographic data to collect. The proposed study will ask participants to supply: registered nursing program type; gender; age; and race/ethnicity. Participants still identify which behaviors are perceived to be uncivil and indicate the frequency of experienced incivility over the past 12 months in Part II, but the list of uncivil behaviors has been revised. Part II now contains one list of 24 behaviors derived from the original two lists in the INE. Participants will rate the level of incivility for each of the 24 behaviors on a four-point Likert-type scale as: not uncivil; somewhat uncivil; moderately uncivil; or highly uncivil. Participants will indicate the frequency of experienced or witnessed incivility behaviors on a four-point Likert-type scale as: never; rarely; sometimes; or often. The four qualitative items in Part III have been moderately revised. Participants may include a narrative description of one episode of student-to-student incivility witnessed or experienced during the past 12 months. Two items solicit participant views of the main cause and main consequence of academic incivility. The fourth item asks participants to describe a way to promote academic civility. Part III will be included in the proposed study as elective items. Participants may choose to complete or omit the narrative qualitative items without adversely affecting the collection of the quantitative data item responses which are germane to this study.

The Ways of Coping (Revised)* [54] contains 66 items describing actions and thoughts a person may perform or think during a stressful situation. Eight factors emerge from the 66 items through factor analysis: Confrontive Coping (CC) [6 items]; Distancing (D) [6 items]; Self-Controlling (SC) [7 items]; Seeking Social Support (SS) [6 items]; Accepting Responsibility (AR) [4 items]; Planful Problem Solving (PP) [6 items]; Escape-Avoidance (EA) [8 items]; and Positive Reappraisal (PA) [7 items] [54,55]. The survey is self-scored using a four-point Likert scale: Not Used = 0; Used Somewhat = 1; Used Quite a Bit = 2; and Used a Great Deal = 3. Participants are asked to think about one specific stressful incident while completing the survey. There is no designated time frame for completion of the survey. Participants should be able to complete the survey in approximately 15 minutes. The survey can be administered over several time points to analyze coping styles using intraindividual analyses [54]. Cronbach's alpha for the eight coping subscales of the Ways of Coping (Revised)* tool show moderate to acceptable reliability [55]. The alphas are: PA = 0.79; SS =0.76; EA = 0.72; CC = 0.70; SC = 0.70; PP = 0.68; AR = 0.66; and D = 0.61.

The Ways of Coping (Revised)* instrument [54] was used to answer Research Question # 3: What coping strategies do prelicensure registered nursing students employ when experiencing student-to-student incivility in the nursing classroom and clinical setting? Participants were asked to complete the Ways of Coping (Revised)* while recalling an incident perceived to be uncivil occurring among nursing students in the classroom or clinical setting within the past 12 months. The participant completed the survey from the aspect of an incivility victim experiencing direct uncivil behaviors or as an incivility witness observing a peer receive uncivil behavior from another nursing student. The data collected was used to identify coping strategies employed by nursing students experiencing student-to-student incivility. This study used a single-time point response about a single uncivil encounter. The identified coping strategies were compared to other participant responses to assess any existing commonalities and differences among nursing student responses to experiencing student-to-student incivility.

The Ways of Coping (Revised)* 1985 version of the instrument was used for this study. The 1985 version is in the public domain and can be used without obtaining any special permission. An open email communication from Susan Folkman (n.d.), who developed the Ways of Coping (Revised)* with Richard Lazarus, explains that the 1985 version varies insignificantly from the copyrighted 1988 version [56]. The Four-point Likert Scale is the same in both versions: 0 = Not used; 1 = Used somewhat; 2 = Used quite a bit; and 3 = Used a great deal. The 1988 version includes the pronoun "I" at the beginning of every statement. Using the free public domain 1985 version rather than the copyrighted 1988 version will not affect the results of this study. In all probability, the validity and reliability of both instrument versions are the same.

The data analysis was completed using SPSS software Version 23. Descriptive statistics were used to analyze and describe the survey data [57]. Three measures of central tendency, mean, median, and mode, and a variability index, standard deviation [57],

were calculated for participant identification of the 24 incivility behaviors in the INE-R [16], frequency of experienced and witnessed incivility behaviors in the INE-R [16], and employed coping strategies in the Ways of Coping (Revised)* [54,55]. A frequency distribution table was developed for the descriptive statistics for each prelicensure nursing school type, gender, age, and race/ethnicity group. The study used descriptive statistics, so a power analysis to estimate sample size was not needed.

Registered nursing students can matriculate in seven different program types. The study participants were recruited using nonprobability convenience sampling from all seven program types using the email addresses from a national student nurse membership list. The number of participants recruited from each program type could not be guaranteed to be equal as participants self-enrolled online in response to the email invitation. The Kruskal-Wallis Test (K-W) is useful for nonparametric testing of one-way ordinal rank assignment of an independent variable for more than two groups of unequal size [57,58]. K-W was used to compare student perceptions of the 24 incivility behaviors in the INE-R [16], frequency of the 24 experienced and witnessed incivility behaviors in the INE-R [16], and employed coping strategies in the Ways of Coping (Revised)* Survey [54,55] across the seven registered nursing program types.

Results

Four student behaviors were identified as highly uncivil: threats about weapons; threats of physical harm; property damage; and discriminating comments toward others. This is a positive finding as civil society consider these activities unacceptable, and often illegal. No participant self-identified as a perpetrator of these four behaviors. The most frequently occurring student behavior participants identified as incivility was the use of media devices during class for purposes unrelated to the current educational task. Students consider using computers, iPads, cell phones, and iWatches for non-academic purposes as incivility.

Planful Problem-Solving (PP) was the coping strategy most often employed by participants. Most students "Concentrated on what I had to do next" (n =153). Students ignored the incivility and thought about a future activity rather than confront the uncivil peer or address the behavior. Students used the coping skill labeled "Escape-Avoidance" to deal with incivility. These activities include: hoping a miracle would take place; hypersomnia; over eating; alcohol use; increased tobacco use; illicit drug use; isolation; wishing the situation would go away; fantasizing about a pleasant end to the situation; and taking out the anxiety and anger on other people not related to the incivility [54]. This last activity leads to increased incivility.

Discussion

Anxiety, depression, somatic symptoms, poor sleep hygiene, powerlessness, and feeling judged are negative consequences of students witnessing peers and faculty engaging in incivility [19,32,42,59]. Victims of repeated incivility may also experience post-traumatic stress disorder [29,42,60]. Students need to be educated about the existence of incivility, the frequency of experienced incivility, and the propensity to witness uncivil behaviors or personally experience incivility as a victim. Educational programs need to be developed to teach students about the behaviors that constitute incivility and how to prevent replication of these behaviors. Education is needed to specifically address the problem of academic student-to-student incivility during nursing school. Educated nursing students will become educated nursing professionals. The study identified coping strategies employed by prelicensure registered nursing students who experienced student-to-student incivility. This knowledge can guide the development of educational programs about coping strategy employment for all nursing students. Cognitive rehearsal [43] has been successful in preparing nursing students to engage workplace incivility after graduation. Programs are needed to model civil attitudes and behaviors beginning with the first day of nursing school.

Conclusion

Research focusing on the specific concept of prelicensure registered nursing student-to-student incivility in the academic setting is needed to increase our understanding of this phenomenon. At the present time, there is insufficient knowledge of student-to-student incivility other than our knowledge that it exists. Accurate description of the phenomenon and its extent is necessary to take the next steps of education and intervention. In order to develop greater knowledge about student-to-student incivility, it is important to understand how prelicensure registered nursing students view incivility. The study addressed two research gaps. The Incivility in Nursing Education Revised Survey [16] helped to identify student behaviors considered to be incivility and the frequency of the occurrence of these behaviors. The Transactional Model of Stress and Coping [39] helped to identify coping strategies employed by prelicensure registered nursing students who experience lateral nursing student-to-student incivility. This theory postulates that problem-based and emotion-based coping strategies are employed by people when faced with a stressor helping them to appraise the relevance of the stressor to personal goal attainment and one's ability to cope. Knowledge about the phenomenon of student-to-student incivility in the prelicensure registered nursing student population was gained. Educational tools about incivility,

interpersonal interaction, professional comportment, stress, coping, and coping strategies can be developed to help students understand incivility, how to address it, and how to work to eliminate it.

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