Bullying in the nursing profession

Jacqueline Randle BA MSc PhD RN

Lecturer, School of Nursing, Medical School, Faculty of Medicine and Health Sciences, Queen's Medical Centre, Nottingham, UK

Correspondence:
Jacqueline Randle,
Room 59a,
School of Nursing,
Medical School,
Faculty of Medicine and Health Sciences,
Queen's Medical Centre,
Nottingham NG7 2UH,
UK.
E-mail: jacqueline.randle@nottingham.ac.uk

RANDLE J. (2003) *Journal of Advanced Nursing* **43**(4), 395–401
Bullying in the nursing profession

Background. Self-esteem is a major predictor of behaviour. Nurses with healthy self-esteem are likely to deliver therapeutic patient care, while those with low self-esteem are less likely to do so.

Aim. The aim of the 3-year study discussed here was to explore students' self-esteem and how their experiences of preregistration education influenced its development over the period of the programme.

Research methods. Students participated in unstructured qualitative interviews at the beginning and end of their 3-year preregistration course and a grounded theory approach was used for data collection and analysis.

Findings. Bullying was found to be commonplace in the transition to becoming a nurse. Students were bullied and also witnessed patients being bullied by qualified nurses. The internalization of nursing norms meant that students then bullied others. Students' self-esteem was low.

Conclusion. Bullying, and its effects on self-esteem, are perpetuated by practices within nursing. This situation will only be changed if nurses and educators transform their practice and the context in which bullying occurs. Otherwise, each new generation of nurses will continue to be socialized into negative practices which undermine both their own feelings of self-worth and standards of nursing care.

Keywords: bullying, horizontal violence, preregistration students, socialization, power, nursing, self-esteem

Introduction

Self-esteem theory is complex, but the major strands evident in the literature are that self-esteem is generally understood to be a major predictor of behaviour, both privately and publicly, that it is not a polarized entity, but rather occurs along a continuum, and that it consists of different 'selves', in that an individual can feel differently about themselves as a nurse, than they do as a parent. Self-esteem is built up or damaged in social interaction, as people receive feedback about how others view and judge their behaviour. In nursing, previous work on professional socialization and horizontal violence has focused on this and related issues (see for example, Freire 1972, Roberts 1983, Freshwater 1998). The data discussed in this article are drawn from a 3-year longitudinal study of a cohort of preregistration nursing students in England. The study used mixed methods to study self-esteem, and bullying emerged as an important theme in the qualitative interviews conducted. This forms the focus of the present paper. However, the quantitative data, collected using the Professional Self-Concept Nursing Inventory (Arthur 1992) and Tennessee Self-Concept Scale (Roid & Fitts 1988) produced results which corroborate the qualitative findings, in that deteriorations in both general and professional self-esteem were found. The quantitative findings are reported elsewhere (Randle 2003a).

Self-esteem

Self-esteem is considered to be a major predictor of human behaviour. The term self-concept is often used interchangeably with self-esteem and is an umbrella term for words

prefixed with 'self'. Self-esteem refers to self-evaluative attitudes that are integral to the individual. In its most simple form, self-esteem refers to the individual's perception of themselves. Kavanagh (1992, p. 177) presents a client scenario which exemplifies the issues apparent in this complex area:

I am totally hopeless. I'm no good at anything. I can't get any good ideas for my project, I keep saying dumb things when I'm around other people. I look at my friend – she has a great job, she's popular, she always seems to know what to say. I'm never going to be like her. There's no point in trying.

It is apparent that the woman in this scenario does not like herself. She makes a direct comparison between how she feels about herself with her friend's supposed positive characteristics. The woman appears to compound further her low self-esteem, as she feels powerless to change her situation. There are two important issues evident here: the first is that self-esteem is subjectively evaluated (self-evaluatory) and in part is socially constructed (comparative) (Reeve 2000). Rogers (1991) proposes that self-esteem is based on life experiences and self-perception is reflected in the attitudes of others.

Having healthy self-esteem means that people feel good about themselves and as people become more positive about themselves, they become more positive about others (Andersson 1993). Characteristics of healthy self-esteem include the use of the authentic-self, empathy, the delivery of individualized, holistic care and continuing in the face of adversity. In health care, this generally results in facilitation of sound, interpersonal relationships not only with patients, but also with carers and colleagues. Reynolds and Scott (2000) emphasize the importance of relationship development and therapeutic communication in nursing practice. To be able to value patients and clients, students and nurses have to be able to value themselves first and part of this process is being self-aware (Cook 1999). Theorists suggest that nurses with healthy self-esteem are able to share some of themselves with colleagues and subsequently affect care in a positive direction (Olsen 1995, Carson *et al.* 1997, Arthur & Thorne 1998, Freshwater 1998, Reeve 2000, Randle 2001b).

Professional self-esteem refers to the self-evaluative beliefs that nurses hold about themselves as nurses. The professional socialization process affects professional self-esteem through the assimilation of professional norms. The context in which students begin to identify with and develop their professional self-esteem is central to any developments in self-esteem. Also fundamental to any such developments is the notion that self-esteem is largely, if not entirely, constructed through interaction with and feedback from significant others (Terry *et al.* 1999). Theorists also argue that the self has its genesis within

social groups (Hogg & Abrams 1990, Meeres & Grant 1999). The desire for consistency is a central motivator of human conduct (Cialdini *et al.* 1999), and richness in feedback from the wider social context makes it virtually impossible not to self-compare. Social comparison plays a central role in developing and maintaining professional self-esteem and, in order to enhance their own self-esteem in the eyes of other nurses, it is likely that students and nurses will conform to the roles and standards that seem to be expected of them.

The study

Aims

The aim of this paper is to discuss one major theme emerging from qualitative data in a larger mixed methods study of self-esteem in a cohort preregistration nursing students in England.

Sample

A convenience sample of students in all four branches (adult, child, mental health and learning disability) of one preregistration nursing programme in the United Kingdom (UK) was studied. By choosing two cohorts of students, all branches of nursing were represented; students were studying the same curriculum and had clinical placements in similar geographical localities. At the start of the course, 43 students were aged between 20 and 24 years, 18 were between 25 and 29 years, 13 were between 30 and 34 years and four were between 40 and 50 years of age. A minority of the sample was male (eight students). In the adult branch there were 56 students, 10 in the mental health branch, seven in the child branch and five in the learning disability branch. At the beginning of the course 56 students participated in interviews, and 39 participated at the end. The reduced numbers were a consequence of theoretical sampling.

Methods

Grounded theory was used as the framework for collecting and analysing the qualitative data because it focuses on description and the generation of theory. Furthermore, it is an inductive approach, and is thus likely to identify the concerns of those involved in the study rather than reflecting researcher interests.

Data were collected using unstructured, qualitative interviews, which are akin to everyday conversations. A request to 'Tell me how your course is going' started the interviews,

which were conducted in clinical areas, tape recorded and lasted between 20 and 90 minutes, with the average being 30 minutes. I was known to students because I was a lectrer on their programme of study.

Ethical considerations

Permission for the study was granted from the Local Research Ethics Committee. I met with students in a classroom session, and informed them of the study aims and invited them to participate. Participation was voluntary and students were told at both phases of data collection that they could withdraw from the study at any point. Pseudonyms and codes were used in order to ensure confidentiality.

Data analysis

Interviews and accompanying field notes were fully transcribed. All transcripts were intensely and repeatedly scrutinized in order to gain theoretical sensitivity, and codes and properties were linked with data as they emerged. A substantial number of codes and theoretical memos resulted, some of which could be linked with each other into categories and some which stood in isolation. These were substantiated or modified by comparing them to parts of the data where there were differences or similarities. Two independent researchers coded the same set of data and arrived at consensus via discussion and analysis. These categories were then tested out in subsequent interviews, which in turn informed future interviews.

Findings

Two categories related to self-esteem arose from the data and showed how participants' self-esteem as would be nurses originated and developed. Becoming a nurse and subsequent feelings associated with the trajectory from student to nurse were greatly influenced by how students were treated by nurses in clinical areas. Social control was imposed through largely negative experiences for both students and the patients they cared for. Bullying was a common theme in the students' narratives. A hierarchy existed in that having power over someone or something became integral to their self-esteem.

Nurse power over students

The process of becoming a nurse was a distressing and psychologically damaging one for the students who participated in the study. Their experiences were often negative and

had repercussions for how they felt about themselves as student nurses and as individuals. An adult branch student at the end of the course exemplified this:

You were a waste of time as far as the staff were concerned…I had a few problems getting on with staff. I didn't think they could be all that bad, but then I realised what they were like. That's what worries me about going up to X, it's the staff that have the problems, not the patients. I'm the kind of person who'd like to say something but I don't think you can…I can't go to bed annoyed cos (sic) I can't sleep and then I wake up even more annoyed. So I think I'd have to go and speak to someone, someone above them without sounding too much as if I'm telling tales.

This description shows an undermining of self-esteem, and all students provided examples where they felt that some of the nurses with whom they worked had used their positions and power to bully 'subordinates'. Being on the receiving end of such tactics appeared to render students powerless, and their reactions were to work hard at fitting in and to maintain the status quo in order to make other nurses more positively responsive to them. A child branch student at the beginning of the course stated:

The Sister said really loudly, 'Does this student have a name then?' (belittling her) And that was that for the day. So a few of us have met the dreaded Sister. So they (lecturers) tell you that if you don't want to do something because its wrong, then don't do it, but we're afraid it will go against us and that's one of my worries if I say I don't want to do something, how is that going to affect my reference. Are we there to be slaves? You tend to fall in and do whatever.

Similarly, a student from the same branch said:

I think I've learnt when to speak and when not to, when to ask questions and also the sort of questions you do ask. I think it's alright, it's like speaking when you're spoken to.

Towards the end of the course, when students were able to reflect on their experiences, there was a greater awareness that nurses exercised power over them, as illustrated by this adult branch student:

I wouldn't do it over again, no, not this. If I knew what it was going to be, I don't know, but I definitely wouldn't do this again. I never thought nurses could be so bitchy, I'm a grown woman and they've made my life hell, really. My daughter's at school and she's had less bullying than me. They're just bullies, to other nurses and to the patients as well. They ought to be sacked.

A child branch student continued this theme:

I had a problem with regards to working every single weekend for the 3 months I was down there, apart from one, and the fact I got

treated…mainly by the Sister, but some of the staff nurses as well, as if I was something that had crawled out of underneath a stone. And you know like, all the placements you talk about other things apart from work, but at X they never really spoke to you except, 'Can you go and do this?' and 'Do that'.

Similarly, a learning disability branch student reflected:

Some of the staff nurses there do have problems, I think it is just one of them wards. It's not very good to go to…If I'd had another placement as bad as X, I think I would have packed my bags.

Students spoke of nurses with whom they worked as being harsh to them because of their perceived lack of practical experience or apparent lack of knowledge. Such insults were a threat to their future professional standing. An adult branch student reflected on her first placement:

I think the first placement up here, they were, they expected more of you. I had sort of occasions when people would turn around and say, 'Well, don't you know this' and I would think, 'Well no, I don't', and they would be, like, off and I would think, 'Well you've never shown me.' That makes us feel really stupid but what can you do? If you haven't done it, then you haven't done it – they shouldn't blame us.

These reflections demonstrate how many students experienced negative situations that affected how they felt about themselves. For some, the fact that they had not taken any action to protect themselves or those who were in a more vulnerable position resulted in negative emotions such as anger, anxiety and stress. One student stated that she did not like herself much, a theme expressed throughout the interviews. For instance, an adult branch student stated that:

I'm so unhappy, it makes me really bad and then I worry about the type of care I'm providing. It's a vicious circle really.

Students identified the presence of a bullying attitude in nurses, and those who were on the receiving end of bullying tactics found this very distressing. However, they appeared to lack the personal and professional resources to challenge such practices, and began to assimilate the same tactics into their everyday working practice. This strategy seemed to be the only one that could ensure that they would continue with the course, which is what the majority were determined to do. However, their participation in bullying meant that patients were potentially placed in a vulnerable position.

Nurse power over patients

All students described events that involved ridicule and personal psychological repercussions. They described numerous scenarios in which nurses used their positions, seemingly intentionally, to humiliate, belittle or isolate patients. This could be subtle or occasionally extreme in its nature, but the nurse commonly worked in ways that placed patients in a vulnerable and precarious position. An adult branch student at the start of the course described a scenario where she felt that the nurse involved used her power to place the client in a position of powerlessness:

The staff nurse on duty asked X (resident with learning disabilities) what she wanted to buy. X had replied and the staff nurse followed by giving (her) the money to meet the cost of what she wanted to buy. X then asked for some more in case she came across anything else she wanted to buy. The staff nurse said no, but wouldn't explain to X why she wouldn't allow her to have more of her own money.

Although students were initially shocked and uncomfortable that patients were not central to all nursing actions, it was evident by the end of the course that those who were interviewed had by then begun to use their own power in the hierarchy of health care, often at the expense of patients. An adult branch student recalled an incident where a patient had medical treatment withdrawn by a doctor because of her deteriorating condition. However, the student was encouraged by nurses to take this opportunity to practise administration of medications. During the interview he realized that his and the nurses' actions put the patient in a very vulnerable position:

I didn't really give a lot of thought to the ethics of the situation, as I was keen to improve my practice skills, i.e. calculating, administering and practising drugs, and it did help that the patient wasn't overtly conscious of what I was doing. I think my confidence and technique improved, though.

The way in which students and nurses talked about patients was also indicative of the type of care they delivered. An adult branch student at the beginning of the course described an older patient who had accidentally spilt a full urinal as:

Absolutely disgusting. He was horrible…I keep avoiding him now. I've asked if I can work within another team and I can't wait for him to be discharged. I spoke to my mentor about it because I don't know whether I should be feeling like this, but she said he was disgusting as well.

Students also spoke of nurses ignoring specific pleas for help from patients, and this resulted in isolation of patients. An adult branch student spoke of how a patient explicitly told the nurse that he could not cope with his wife, who had dementia:

I felt the gentleman was giving a plea for help and it wasn't being addressed. She focussed on asthma management, even though he said he felt anxious about his wife's safety.

A consequence of working in clinical areas was that students had to face the disjuncture of the picture that nurses were caring and supportive professionals with the reality that, in some cases, nurses did not display such characteristics towards patients. Students' inability to handle certain patient situations, and witnessing colleagues handling situations in a seemingly insensitive and detrimental manner, initially caused them conflict and confusion. Later in the course, those who were interviewed described how they adopted ways of working which conformed to those that had initially caused them to be shocked and confused. Their emotional responses and interactions were adjusted as a result of the expectations that the role of nurse placed on them, and they began to identify with the role-models of professional nurses that they experienced in clinical areas.

The impact of this on their personal identity was that they seemed to be blind to the conflicts and anxieties they had at first experienced, and not speaking about their anxieties became part of their repertoire. An adult branch student at the end of the course recalled how she had expressed anxieties about how patients were treated at the start of her course. She went on to say:

You just have to fit in and get on with the work really. The patients don't mind. So long as they're treated, that's all they're bothered about.

Similarly, a learning disability branch student stated that:

I make myself do what basically everybody else does. I do what they do…It's not such a nightmare – you wouldn't do it otherwise.

A mental health branch student confirmed this:

Well, I just think you've got to make that extra bit of effort and you've got to go and do the things that they want you to do, and do it how they want it doing.

For students in this study, the process of becoming a nurse necessitated adjustment and acculturation to a hierarchical system that they maintained to achieve a professional role. Initial notions of their selves, which they described as caring, supportive, kind and being empathetic, appeared to disintegrate as they became aware of and assimilated nursing norms, which then shaped their own actions, attitudes and beliefs. The consequence of this was that patients were displaced from their position of being central to nurses' actions.

Discussion

Strong evidence was found in the data of the continued existence of bullying and horizontal violence, and this aspect of the findings is the focus of this article.

Bullying is the persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem (Adams 1997). Rayner (2002) describes five categories of bullying, including acts such as belittling, professional humiliation, and failure to acknowledge good work. The recipients, commonly referred to as 'victims', usually experience poor psychological health and dissatisfaction with work [Royal College of Nursing (RCN) 2002]. In the RCN report it was found one in six nurses had been subjected to bullying from a colleague in the last year, but only 6% of those who had experienced bullying went on to formally report incidents. This implies that many nurses are victims of bullying practices but remain silent, which is characteristic of being bullied (Reeve 2000). One-third of nurses on long-term sick who have experienced bullying leave the profession, compared with 16% of nurses who have not experienced bullying (RCN 2001). Additionally, one in three of those bullied intend to leave nursing (RCN 2002).

It appears that students begin to assimilate such tactics into their nursing practice, as they identify with becoming a nurse during their education programme. Whilst undergoing professional socialization, students come to adopt the norms, values and rules that characterize their collective working group (Reeve 2000). To gain a sense of belonging to the profession, they may even have to pass a 'tribal test' (Mozingo *et al.* 1995), where they are put through a set of tasks that are difficult or unpleasant in order to gain an identity of belonging. This may not be as extreme as scenarios described in Alavi and Cattoni's (1995) paper, with students being asked to take observations on patients whom the rest of the staff knew were already dead. However, in its most severe form, the socialization process can be akin to brainwashing. Meissner (1986) alleges that nursing departments are guilty of 'insidious cannibalism' because of socialization processes that change students' personalities. Du Toit's (1995) study of first and third year Australian nursing students in two universities found that the majority conformed to such a degree that their nursing identity subsumed how they felt about themselves as female or married, for example.

Nursing literature offers strategies to deal with workplace bullying; these generally involve workers being aware of the characteristics of bullying, documenting events and organizations establishing disciplinary procedures (Nazarko 2001, RCN 2001). However, such strategies do not always account for the historical and contextual factors which shape the nature of bullying. Freshwater (2000) describes how historically nurses have been an oppressed group and are typically seen as subordinate and powerless in the health care system (Roberts 1983). Further, definitions of a 'good nurse' have

What is already known about the topic

- A clear relationship exists between nurses' self-esteem and the delivery of patient care.
- If self-esteem is low, then individuals become powerless to change their situation.
- Nurses have been subjected to bullying in the workplace.

What this paper adds

- In the course of preregistration education, student nurses witness bullying of patients by qualified nurses.
- Students themselves are subject to bullying by qualified nurses.
- As a result, students themselves engage in bullying activities to the detriment of patients.
- Suggestions for tackling these important issues are made, recognizing that radical social structural changes will be needed in order to improve the situation.

focused on female stereotypical attributes, such as compassion and caring, again contributing to nursing's relatively powerless position in comparison with male-dominated professions such as medicine.

Nurses and students appeared to need power to fulfil their professional role and they exerted this over others; however, because this was a destructive power, limited in its capacity, negative feelings resulted. Freire (1972) describes how oppressed groups tend to become like their oppressors because the way that they think becomes distorted. As a result they unconsciously identify with the oppressors and, in the process, become oppressive themselves. Similarly, internalized oppression makes nurses doubt that there is any alternative to the status quo (Roberts 1983, Hedin 1986). It is likely that when individuals lose their identity because of compliance to organizational needs, they generally occur in an unrecognizable manner and most people are unaware of the fact that they may be contributing to this process (Reeve 2000). Freshwater's (2000) work contributes to our understanding of this process, suggesting that when nurses feel themselves oppressed or ridiculed, they keep themselves protected from the public view of shame.

Controlling, coercive and rigid behaviour is typical of leaders in oppressed groups (Roberts 1983). Lacking power as professionals, except over helpless patients, students and the nurses they described were wielding oppressive power. This is characteristic of bullying and horizontal violence. Horizontal violence in this context refers to symptoms of violence that move horizontally between people in oppressed groups (Freire 1972). Here nurses attack one another in order to vent their frustration and anger with the system they find themselves in. Ironically, it is contended that nurses have encouraged this hierarchical system in order to maintain nursing's status (Street 1992). Horizontal violence includes an understanding of why oppressed groups, such as nurses, direct bullying behaviours inwards. Although students experienced conflict and anxiety at the start of the course and can be described as being dissatisfied with the system they found themselves in, by the end of the course they were venting their frustrations towards those who were in a subordinate position.

Towards the end of the course all students were silent about their anxieties and failed to recognize that the ways of working that they were describing were the same as those they had initially been shocked at. They faced many scenarios and experiences that challenged their previous perceptions about the type of individual that they were. If students come to see themselves as oppressors or bullies, this may incur psychological distress as they come to internalize their inferiority.

Implications for nursing practice and research

Learning from a role model is not always beneficial, as nurses' attitudes towards colleagues are often followed from expediency. It would be easy to criticize students in these situations, yet the context in which learning occurs may define their relative powerlessness. Students who offered their stories were under great pressure to comply with the norms of the nursing staff. They were also aware that staff had to complete a practice assessment document that would affect their progression on the course.

The findings from this study suggest that, in addition to looking at localized and individual strategies in dealing with bullying such as the RCN's (2001) Dealing with Bullying and Harassment at Work initiative, the context of health care delivery requires scrutiny.

Nurses operate collectively in an interactive social system, rather than as isolates; therefore, bullying should be considered from a socio-cultural perspective, and cannot be isolated from the social relations in which it is embedded or from its social consequences. Contexts where nurses collectively judge themselves as powerless convey a sense of group futility that can pervade the entire nursing profession (Reeve 2000). Remedies must involve eradication of negative institutionalized behaviours, such as focussing on routines and procedures, as these diminish educational and vocational aspirations and erect barriers to occupational opportunities.

Dealing with these issues requires continuing awareness of the power structures that perpetuate such social situations (Freire 1972). It also needs to take account of the pressures exerted by the social context in transforming the 'self' of all those involved. A critical social theory approach, which focuses on oppressed and disenfranchised people and identifies factors that can liberate them from their past and current circumstances, may be useful for this (Morrow 1994). Bullying cannot be understood unless it is related to the historical and social structure from which it is derived. If priority is not given to reforming the context in which bullies operate, then these practices will be perpetuated, and could become even more widespread in a health care environment under pressure to meet tight outcome targets in the face of limited resources.

References

Adams A. (1997) *Bullying at Work – How to Confront and Overcome It*. Virago Press, London.

Alavi C. & Cattoni J. (1995) Good nurse, bad nurse. *Journal of Advanced Nursing* 21, 344–349.

Anderson E.P. (1993) The perceptions of student nurses and their perceptions of professional nursing during the nurse training programme. *Journal of Advanced Nursing* 18, 808–815.

Arthur D. (1992) Measuring the professional self-concept of nurses: a critical review. *Journal of Advanced Nursing* 17, 712–719.

Arthur D. & Thorne S. (1998) Professional self-concept of nurses: a comparative study of four strata of nursing students in a Canadian university. *Nurse Education Today* 18, 380–388.

Carson J., Fagin L., Brown D., Leary J. & Bartlett H. (1997) Self-esteem in mental health nurses; its relationship to stress, coping and burnout. *Nursing Times Research* 2, 361–370.

Cialdini R.B., Wosinska W., Barrett D.W. & Gornik-Durose M. (1999) Compliance with a request in two cultures: the differential influence of social proof and commitment/consistency on collectivists and individualists. *Personality and Social Psychology Bulletin* 25, 1242–1253.

Cook S. (1999) The self in self-awareness. *Journal of Advanced Nursing* 29, 1291–1299.

Du Toit D. (1995) A sociological analysis of the extent and influence of professional socialisation on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing* 21, 164–171.

Freire P. (1972) *Pedagogy of the Oppressed*. Continuum, New York.

Freshwater D. (1998) Transformatory learning in nurse education. Unpublished PhD Thesis. University of Nottingham, Nottingham.

Freshwater D. (2000) Crosscurrents: against cultural narration in nursing. *Journal of Advanced Nursing* 32, 481–484.

Hedin B.A. (1986) A case study of oppressed group behaviour in nurses. *Image: Journal of Nursing Scholarship* 18, 53–57.

Hogg M.A. & Abrams D. (1990) Social motivation, self-esteem and social identity. In *Social identity theory: Constructive and critical advances* (Abrams D. & Hogg M.A., eds), Springer-Verlag, New York, NY, USA, pp. 28–47.

Kavanagh D.J. (1992) Self-efficacy and depression. In *Self-Efficacy: Thought Control of Action* (Schwarzer R., ed), Taylor and Francis, Washington, DC, USA, pp. 177–193.

Meeres S.L. & Grant P.R. (1999) Enhancing collective and personal self-esteem through differentiation: further exploration of Hinkle and Brown's taxonomy. *British Journal of Social Psychology* 38, 21–34.

Meissner J. (1986) Nurses: are we eating our young? *Nursing* 16, 51–53.

Morrow R. (1994) *Critical Theory and Methodology: Contemporary Social Theory*, Vol. 3. Sage Publications, Thousand Oaks, CA.

Mozingo J., Thomas S. & Brooks E. (1995) Factors associated with perceived competency levels of graduating seniors in a baccalaureate nursing program. *Journal of Nursing Education* 34, 115–122.

Nazarko L. (2001) Bullying and harrassment. *Nursing Management* 8, 14–15.

Olsen J.K. (1995) Relationships between nurse expressed empathy, patient perceived empathy and patient distress. *Image* 27, 317–322.

Randle J. (2001a) The effect of a three year pre-registration training course on students' self-esteem. *Journal of Clinical Nursing* 10, 293–300.

Randle J. (2001b) Past Caring: the influence of technology. *Nurse Education in Practice* 1, 157–165.

Randle J. (2003) Changes in self-esteem changes during a 3 year pre-registration Diploma in Higher Education (Nursing) programme. *Journal of Clinical Nursing* 12, 142–143.

Rayner C.H. (2002) *Workplace Bullying*. Taylor and Francis, London.

Reeve J. (2000) *Past Caring?: a longitudinal study of the modes of change in the professional self-concept and global self-concepts of students undertaking a three year diploma in nursing course*. Unpublished PhD dissertation. University of Nottingham, Nottingham.

Reynolds W. & Scott P. (2000) Do nurses and other professional helpers normally display much empathy? *Journal of Advanced Nursing* 31, 226–234.

Roberts S. (1983) Oppressed group behaviour: implications for nursing. *Advances in Nursing Science* 5, 21–30.

Rogers C.R. (1991) *Client-Centred Therapy*. Constable, London.

Roid G.H. & Fitts W.H. (1998) *Tennessee Self-Concept Scale (TSCS). Revised Manual*. Western Psychological Services, Los Angeles, CA.

Royal College of Nursing (2001) *Dealing with Bullying and Harassment at Work: A Guide for RCN Members*. RCN, London.

Royal College of Nursing (2002) *Working Well*. http://www.rcn.org.uk/news/pdfs/1778-Working Well.pdf.

Street A.F. (1992) *Inside Nursing. A Critical Ethnography of Clinical Nursing Practice*. State University of NY Press, Albany, NY.

Terry D.J., Hogg M.A. & White K.M. (1999) The theory of planned behaviour: self identity and group norms. *British Journal of Social Psychology* 38, 225–244.