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

Robin A. Foreman
East Tennessee State University

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by

Robin Ann Foreman

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Dr. Sally Blowers, Chair

Dr. Sharon Loury

Dr. Joellen Edwards

Dr. Jon Ellis

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ABSTRACT

Coping Strategies of Prelicensure Registered Nursing Students

Experiencing Student-to-Student Incivility

by

Robin Ann Foreman

Incivility is rude or discourteous behavior that demonstrates a lack of respect for others. Some nurses ignore the dictates of professionalism and exhibit a total disregard for colleagues and peers by purposefully targeting 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 quantitative descriptive 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. Prelicensure registered nursing students in associate degree, baccalaureate degree, and diploma programs were recruited online using nonprobability convenience sampling through the email member list of a national student nursing organization. Participants completed the Ways of Coping (Revised)* survey and the Incivility in Nursing Education Revised (INE-R) Survey anonymously online via email accounts. The response rate was 38%. Four behaviors are identified as *highly uncivil* by 83.1% to 86.1% of the 373 participants: (1) making threatening statements about weapons; (2) threats of physical harm against others; (3) property damage; and (4) making discriminating comments directed toward others. The most frequently occurring incivility behavior (n = 202; 54.2%) is the use of media devices for purposes unrelated to the

current educational task. Planful problem-solving (PP) is the coping strategy employed by most participants (n = 88, 23.6%). Data was analyzed comparing participants' nursing program levels, ages, genders, and ethnicities using descriptive statistics and Kruskal-Wallis analyses. There were no statistically significant differences across these variables.

DEDICATION

I dedicate this work to my family and my Lord. I would not be here today if the Lord had not brought me to this place. Thank you, my children, Paul Daniel, Charise Nadine and Philip John, Joshua Daniel and Jennifer Michelle, and Jeremiah Daniel and Elena Suzanne, for supporting Moomer 24/7. Thank you, grandchildren, Carla Ann, Caleb Daniel, Ethan Bernard, Andrew John, Jonathan Daniel, Jayson Daniel, and Ava Noelle, for hugging Granny Moo when she could not see through the tears. And thank you to my husband, Rev. Daniel John Foreman, who can only be with us in our hearts. We love you, Pop-Pop, and miss you.

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CHAPTER 1

INTRODUCTION

Incivility is not a new phenomenon in professional nursing. Incivility is defined as rude or discourteous behavior that demonstrates a lack of respect for others (Milam, Spitzmueller, & Penney, 2009; Olender-Russo, 2009). Disrespect can be expressed verbally as insulting remarks, disapproving grunts, and exasperated sighs. Rudeness can be expressed nonverbally in closed body posturing, judgmental facial expressions, and threatening hand gestures. Nursing, as a profession, promotes civility, camaraderie, courtesy, and collegiality. Nurses, as a cohort, are generally caring and helpful. There are exceptions. The exceptions have prompted this study. Some nurses ignore the directives of professionalism by purposefully targeting colleagues and peers with uncivil behaviors. Disrespectful and rude behaviors are used to disintegrate civility, camaraderie, courtesy, and collegiality among nurses.

Disrespectful and rude behaviors are being reported in the nursing classroom and clinical settings. Incivility has invaded nursing academia affecting everyone involved in nursing education. Of particular interest to this study was incivility occurring among prelicensure registered nursing students who have not yet passed the NCLEX-RN or practiced independently. Nursing student-to-student incivility was the dependent variable in this quantitative descriptive study. Participants identified the behaviors they considered to be uncivil and quantified how often the behaviors occur.

Nursing students may experience incivility as victims and witnesses. A nursing student is an incivility victim when he or she experiences the receipt of uncivil behaviors directly from another nursing student. A nursing student witness observes friends, classmates, and peers

receive uncivil behaviors from other students. Identification of the coping strategies employed by nursing student victims and witnesses when experiencing incivility was another study goal.

Research Problem

Incivility is an unwelcomed reality in the nursing classroom and clinical setting (Altmiller, 2012; Anthony & Yastik, 2011; Caza & Cortina, 2007; Clark, 2008a; Clark, 2008b; Clark, Farnsworth, & Landrum, 2009; Clark & Springer, 2007a; Clark & Springer, 2007b; Clark & Springer, 2010; Griffin, 2004; Kolanko et al., 2006; Luparell, 2007; Marchiondo, Marchiondo, & Lasiter, 2010; Robertson, 2012). The phenomenon of student-to-student incivility in the nursing classroom and clinical setting has not been comprehensively studied. The coping strategies employed by prelicensure registered nursing students experiencing student-to-student incivility have not been well researched. Prelicensure registered nursing student participants in this study identified the behaviors they believed constituted student-to-student incivility, quantified the frequency of student-to-student incivility experiences, and described the coping strategies employed when experiencing student-to-student incivility in nursing classroom and clinical settings.

Problem Statement

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 (Bloomberg, 1970). Incivility occurs vertically among the differing higher education strata: faculty-to-student; administration-to-faculty; and administration-to-student (Nordstrom, Bartels, & Bucy, 2009). Incivility occurs laterally between institutional members of equal status: faculty-to-faculty and student-to-student (Clark & Springer, 2007b).

Incivility has invaded nursing academia (Altmiller, 2012; Anthony & Yastik, 2011; Clark, 2008a; Clark, 2008b; Clark & Springer, 2007a; Clark et al, 2009; Clark & Springer, 2007b; Clark & Springer, 2010; Kolanko et al., 2006; Luparell, 2007; Robertson, 2012). Academic nursing incivility between faculty and students has been studied and reported in the literature (Altmiller, 2012; Clark, 2008b; Clark, Barbosa-Leiker, Gill, & Nguyen, 2015; Clark & Springer, 2007b; Cleary & Horsfall 2010; DalPezzo & Jett, 2010; Luparell, 2007; Luparell, 2011; Marchiondo et al., 2010). Studies have identified anxiety, depression, somatic symptoms, poor sleep hygiene, powerlessness, and feeling judged as negative consequences of students witnessing peers and faculty engaging in incivility (Becher & Visovsky, 2012; Lee & Brotheridge, 2006; Luparell, 2011; Sheridan-Leos, 2008). Victims of repeated incivility may also experience post-traumatic stress disorder (Becher & Visovsky, 2012; Child & Mentes, 2010; Suplee, Lachman, Siebert, & Anselmi, 2008).

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 (Clark, 2008b; Clark et al., 2009; Hinchberger, 2009; Suplee et al., 2008). Repeated exposure of nursing students to incivility can breed acceptance, thus embedding these behaviors in the academic nursing environment (Luparell, 2011; Norris, 2010).

Nursing student concerns, faculty concerns, frequency of occurrences, and types of incivility behaviors are reported in the literature to be increasing (Altmiller, 2012; Anthony & Yastik, 2011; Clark, 2008a; Clark et al., 2009; Clark & Springer, 2007a; Clark & Springer, 2007b; Lashley & De Meneses, 2001; Luparell, 2007; Robertson, 2012). These studies do not offer an exact percentage of incivility increase, but since 1995, do identify a significant number

of students affected by academic incivility in a variety of educational environments in various geographical locales. Lashley and De Meneses (2001) surveyed 409 Nursing Program Directors about problematic student behaviors. All of the participants identified classroom inattentiveness as problematic. Clark and Springer (2007b) 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 (2007) 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 (Clark, 2008a; Clark et al., 2009). Clark and Springer (2007a) 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 (2011) conducted focus groups with 21 nursing students in a private university. Students support adding incivility awareness education to the nursing curriculum due to the prevalence of academic and professional incivility. Altmiller (2012) 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 (Hutchinson, Vickers, Jackson, & Wilkes, 2006). Incivility occurs when nurses are rude, disrespectful, or purposefully unkind to one another displaying a lack of esteem and collegial professionalism (Olender-Russo, 2009; Sheridan-Leos, 2008). Incivility in nursing has been studied under the names of: lateral violence; horizontal violence; bullying; mobbing; and harassment (Hinchberger, 2009; Sheridan-Leos, 2008; Simons & Mawn, 2010).

Nursing schools are not able to prepare enough registered nurses to fill current vacancies or projected employment needs (AACN, 2014). Nursing schools turned away 79,659 qualified applicants in 2012 for lack of faculty, clinical preceptors, classroom space, and clinical placements (AACN, 2014). The Bureau of Labor Statistics projects 1.2 million additional registered nurses will be needed in the healthcare workforce by 2020 (AACN, 2014). This professional nursing shortage cannot be addressed if nursing students leave school (Marchiondo et al., 2010) or newly graduated nurses change career choices because of incivility (Embree & White, 2010; Griffin, 2004; Hinchberger, 2009; Luparell, 2011).

The nursing shortage can be perpetuated as nursing students replicate the uncivil behavior that is seen and experienced in the academic and clinical settings of their educational environments. Students begin to learn professional nursing culture in prelicensure registered nursing programs. Positive collegiality and negative incivility are learned from teachers and preceptors (Hutchinson, 2009; Weinand, 2010). Witnessed and experienced behavior becomes the enculturated norm (Luparell, 2011). Acceptance and tolerance of incivility by the nursing profession has created a self-perpetuating culture of rude, disrespectful, unkind behaviors (Hutchinson, 2009; Longo & Sherman, 2007; Luparell, 2011). The American Nurses Association (ANA) proposes a "no tolerance" stance against incivility in professional nursing to break this cycle (Trossman, 2014).

Two gaps in the nursing literature were identified. First, 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 (Ali, 2012; Baker, 2012; Clark, 2008a; Clark, 2012; Clark et al., 2009; Clark et al., 2010; Clark & Springer, 2007a; Clark & Springer, 2007b; Cleary & Horsfall,

2010; Luparell, 2011; Morin, Luparell, Clark, & Heinrich, 2010; Norris, 2010; Stewart, 2012). Few studies have systematically examined nursing student-to-student incivility. In addition, little is known about the differences that gender and type of prelicensure program may have on nursing student-to-student incivility. The second gap is the lack of knowledge about student coping strategies being employed in response to student-to-student incivility. Jenkins, Kerber, and Woith (2013) used the Ways of Coping Questionnaire to identify the coping strategies employed by 25 prelicensure registered nursing students experiencing student-to-student incivility. The main focus of this study was the use of an intervention to build the students' social capital as a specific resource for coping. However, in order to develop greater knowledge about student-to-student incivility, it is important to know how prelicensure registered nursing students respond when experiencing incivility. Interventions can then be developed based on knowledge and evidence.

The results of this study addressed these two research gaps. Knowledge about the specific phenomenon of lateral nursing student-to-student incivility in the academic environment was gained. A nonprobability convenience sample of 373 prelicensure registered nursing student participants identified the classroom and clinical behaviors that constituted incivility and quantified the frequency of those incivility experiences. Knowledge about student coping strategies employed in response to student-to-student incivility was gained. Study participants identified the coping strategies employed when student-to-student incivility was experienced as a victim or witness. The phenomenon of student-to-student incivility was explored in relation to student gender, student age, prelicensure registered nursing program type, and race/ethnicity.

Statement of Purpose

The three main purposes of this study were to identify the behaviors prelicensure registered nursing students believed constituted student-to-student incivility, determine the frequency of student-to-student incivility behaviors experienced in the nursing classroom and clinical setting, and describe the coping strategies employed by prelicensure registered nursing students when student-to-student incivility was experienced.

A national sample of 373 prelicensure registered nursing students completed an anonymous online survey designed to obtain information to fulfill the study's three objectives. The findings suggest that educational programs can be developed to help students learn to identify incivility behaviors and understand the potential to become a victim or witness. Nursing students can also benefit from instruction on effective coping strategies to employ when experiencing academic incivility. Making use of such educational programs beginning on the first day of nursing school has the potential to influence the development of future collegiality, and to support optimum learning and a positive educational atmosphere.

Research Questions

1. What behaviors do prelicensure registered nursing students identify as student-to-student incivility as measured by the INE-R (Clark et al., 2015)?
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 (Folkman & Lazarus, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986)?

5. Do coping strategies vary by program type, age, gender, or race/ethnicity?

Definitions

For the purpose of this study, operational definitions of the following concepts were employed: Coping strategy, Incivility, Prelicensure registered nursing student, Student victim, and Student witness.

Coping strategy: a cognitive and behavioral process of appraising the stressors in a situation that triggers a problem-focused or emotion-focused response (Lazarus & Folkman, 1987).

Incivility: rude or disrespectful behavior that demonstrates a lack of regard or respect for others (Milam et al., 2009; Olender-Russo, 2009).

Prelicensure registered nursing student: any student currently matriculated in an Associate of Science in Nursing (ADN) degree program, a Bachelor of Science in Nursing (BSN) degree program, or a Diploma Nursing program who has not previously passed the NCLEX-RN and is not currently credentialed as a Registered Nurse.

Student victim: a nursing student who experiences the receipt of uncivil behaviors directly from another nursing student.

Student witness: a nursing student who is present and observes academic friends, classmates, or peers experience the receipt of uncivil behaviors from other nursing students.

Summary

This study of nursing student-to-student incivility is significant to nursing academia because of the potential deleterious effect of such behaviors on the nursing profession. Today's nursing students will be tomorrow's nursing professionals. Experiencing and witnessing uncivil

behaviors may impact future professional behavior and the nursing practice environment. Nurses' and students' abilities to cope with incivility within the discipline of nursing may be reflected in the current and future nursing workforce shortage. In addition, incivility negatively affects all aspects of teaching and learning. It is vital that students gain all that they can from their educational experiences. 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.

This study identified behaviors perceived to constitute incivility occurring among prelicensure registered nursing students in the context of nursing academia. The frequency of experienced student-to-student incivility behaviors illuminated the magnitude of the problem. Coping strategies currently employed by nursing students experiencing incivility were identified. The findings can be applied to develop educational programs and intervention strategies with the potential to break the cycle of academic student-to-student incivility.

CHAPTER 2

REVIEW OF THE LITERATURE

Incivility is an interpersonal phenomenon occurring in the workplace, in academia, and within professional disciplines. Five computerized data bases were reviewed to identify literature that studied or discussed incivility and its effects: Cumulative Computerized Index of Nursing and Allied Health Literature (CINAHL); PsycINFO; Journal Storage (JSTOR); PubMED; and Education Resources Information Center (ERIC). The original search terms included nursing incivility, academic incivility, student incivility, nursing student incivility, student-to-student incivility, and peer incivility. This first search identified few articles specifically addressing academic incivility among prelicensure registered nursing students. A second review of the same five data bases used surrogate terms for incivility identified in the reviewed literature: abuse, bullying, workplace bullying, peer bullying, mobbing, lateral violence, horizontal violence, vertical violence, workplace violence, workplace incivility, workplace terror, dysfunctional nurse-nurse relationship, peer-to-peer hostility, and horizontal hostility. The only delimiting parameter was to review articles written in English. Information included in this review is dated 1970 to 2015.

Incivility and Its Forms

Incivility is rude or disrespectful behavior that demonstrates a lack of regard or respect for others (Baker & Boland, 2011; Caza & Cortina, 2007; Clark, 2012; Clark et al., 2009; Clark & Springer, 2007a; Clark & Springer, 2007b; Clark & Springer, 2010; Connelly, 2009; Craig & Kupperschmidt, 2008; Felblinger, 2008b; Ganske, 2010; Harris, 2011; Leiter, Laschinger, Day, & Oore, 2011; Luparell, 2011; Milam et al., 2009; Nordstrom et al., 2009; Olender-Russo, 2009; Sheridan-Leos, 2008; Woelfle & McCaffrey, 2007). Incivility is intentional, purposeful,

maleficent, and unsolicited verbal or nonverbal communication directed overtly or covertly at a coworker, peer, or colleague inflicting psychological, physiological, or social harm (Caza & Cortina, 2007; Clark et al., 2009; Lee & Brotheridge, 2006; Olender-Russo, 2009; Sheridan-Leos, 2009).

Connotative understanding of the phenomenon of incivility is as important as a denotative definition (Clark, 2008a). Incivility is often subjective and experiential. Behaviors can be perceived as uncivil by one person and civil by another person (Clark, 2008a; Nordstrom et al., 2009). Verbal intonation, speed, pitch, and vocal tone can influence a person's reception of the intended meaning of a statement. Facial expressions (eye rolling and teeth clenching), hand gestures (clenched fists or finger pointing), and body postures (arms across a person's chest or hands on both hips) can be perceived to be uncivil or threatening behaviors. The setting in which the behaviors occur, whether academic, professional, workplace, or leisure, will impact the perception of behaviors as civil or uncivil (Clark, 2008a). Racial and ethnic distinctives will also influence a person's perception of uncivil behaviors (Clark & Carnosso, 2008).

Vertical Incivility

Incivility can occur vertically both upward and downward between people of differing levels of authority or status in the workplace and academia (Luparell, 2011). Any behavior from a top-down abuse of power associated with assigned rank that humiliates, exploits, or denigrates a person of lower rank is incivility (Clark & Carnosso, 2008). Bottom-up vertical incivility may be fueled by anger, self-preservation, or retaliation.

In academia, students exhibit incivility to professors, administrators, and institutional personnel, such as departmental secretaries and cafeteria workers (Baker & Boland, 2011; Connelly, 2009; Lampman et al., 2009). In nursing, unit staff may be uncivil to nurse managers

and managers may be uncivil to hospital administrators. Over half of all third and fourth year nursing students in a British survey had been the victims of vertical incivility because they were on the lowest rung of the healthcare ladder (Snow, 2006). Students do not always effectively cope with vertical incivility. Anger and frustration may be displaced laterally between academic peers (Clark & Springer, 2007b). "Same status" student-to-student incivility can negatively impact professional interpersonal behavior development in the nursing classroom and clinical setting (Caza & Cortina, 2007).

Lateral or Horizontal Incivility

Lateral or horizontal violence is incivility directed at people of equal levels of authority or power within the work or academic environment (Baker & Boland, 2011; Connelly, 2009; Dirty Looks, 2006; Embree & White, 2010; Griffin, 2004; Hutchinson et al., 2006; Katrinli, Atabay, Gunay, & Cangarli, 2010; Longo & Sherman, 2007). Workers often target newly hired personnel or people of lowest organizational rank (Griffin, 2004; Longo & Sherman, 2007). The autonomy and dignity of the victims may be damaged (DalPezzo & Jett, 2010; Stokes, 2010). These verbal and nonverbal hostile behavioral manifestations can be isolated incidents (Sincox & Fitzpatrick, 2008), but are usually repeated over time (Becher & Visovsky, 2012).

Student-to-Student Incivility

The phenomenon of incivility among prelicensure registered nursing students is being acknowledged in nursing literature. Two articles contain student reflections of personal experiences with interpersonal academic incivility (Ali, 2012; Clark & Springer, 2007b). Eight articles recognize and discuss student-to-student incivility anecdotally (Baker, 2012; Billings, Kowalski, Cleary, & Horsfall, 2010; Clark, 2008a; Clark et al., 2009; Clark et al., 2010;

Luparell, 2011; Morin et al., 2010; Norris, 2010). None of these 10 articles are research studies exploring the specific phenomenon of nursing student-to-student incivility.

Jenkins et al. (2013) conducted a study of 25 student nurse leaders specifically investigating the concept of academic nursing student-to-student incivility. This exploratory, mixed-methods study investigated the efficacy of social capital building techniques to promote civility rather than incivility among nursing student leaders. Participation in a journaling club did change student attitudes about incivility. These ten students increased peer assistance activities and decreased student-to-student incivility behaviors.

Student-to-student incivility is occurring in nursing academia (Norris, 2010; Stewart, 2012). To date no studies have attempted to determine the prevalence and none have examined nursing student coping strategies. Empirical research is needed to understand this phenomenon and guide development of educational programs and interactional interventions.

Historical Perspective of Incivility

Oppressed Group Behavior Theory

Oppressed group behavior theory is one explanation for the incivility that exists within professional and academic nursing (Baker, 2012; Bartholomew, 2006; Becher & Visovsky, 2012; Griffin, 2004; Hutchinson et al., 2006; King-Jones, 2011; Sheridan-Leos, 2008; Stevens, 2002; Stokes, 2010; Townsend, 2012; Weinand, 2010). Oppression is defined as exploitation of a less powerful group by a dominant group (Sheridan-Leos, 2008). The less powerful group perceives a state of exclusion from the total group power structure (Griffin, 2004; Townsend, 2012; Weinand, 2010). Feeling oppressed in the workplace can lead to self-doubt, a state of vulnerability, untoward behavioral changes (Lapum et al., 2012), and low self-esteem (DeMarco, Roberts, Norris, & McCurry, 2007; Longo & Sherman, 2007; Sheridan-Leos, 2008; Townsend,

2012). Incivility is manifested as untoward behaviors directed at professional peers and colleagues on an equal, lateral plane (Becher & Visovsky, 2012; Griffin, 2004; Longo & Sherman, 2007; Stokes, 2010; Taylor, 2001; Weinand, 2010).

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 (Griffin, 2004; Olender-Russo, 2009; Roberts, DeMarco, & Griffin, 2009; Sheridan-Leos, 2008). 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 (Baker, 2012; Griffin, 2004; Hinchberger, 2009; Stokes, 2010; Taylor, 2001; Townsend, 2012; Weinand, 2010).

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 (Baker, 2012). Clinical nursing students may be blamed falsely for untoward events, belittled, or humiliated by unit staff nurses (Luparell, 2011). Reciprocated incivility may be an attempt of nursing students to regain control of the academic environment (Baker, 2012).

Incivility in the Workplace

Quantitative and qualitative studies have been conducted to explore the phenomenon of workplace incivility in the fields of healthcare, education, counseling, manufacturing, information technology, administration, management, public service, and law enforcement in the countries of Australia (Taylor, 2001; Tuckey, Dollard, Hosking, & Winefield, 2009); Canada (Lee & Brotheridge, 2006); Denmark (Agervold, 2007); Italy (Magnavita & Heponiemi, 2011);

Norway (Nielsen, Matthiesen, & Einarsen, 2008); Portugal (Sa & Fleming, 2008); Singapore (Lim & Lee, 2011); Spain (Escartín, Rodríguez-Carballeira, Zapf, Porrúa, & Martín-Peña, 2009); Sweden (Strandmark & Hallberg, 2007); Turkey (Katrinli et al., 2010; Yildirim, 2009; Yildirim, Yildirim, & Timucim, 2007); the United Kingdom (Lewis, 2006; Lewis & Orford, 2005); and the United States (Child & Mentes, 2010; Craig & Kupperschmidt, 2008; DalPezzo & Jett, 2010; Embree & White, 2010; Hinchberger, 2009; Longo & Sherman, 2007; Milam et al., 2009; Olender-Russo, 2009; Stanley, Martin, Michel, Welton, & Nemeth, 2007; Woelfle & McCaffrey, 2007). The literature shows workplace incivility is a global problem.

One fifth of employees in the United States endure recurrent verbal abuse in the workplace (Lee & Brotheridge, 2006). Uncivil behaviors in the workplace are as in the definition characteristically rude, discourteous, and display a lack of regard for others (Bunk & Magley, 2013; Milam et al., 2009). Employees enduring repeated disrespect from managers and peers are driven to engage in reciprocal incivility (Bunk & Magley, 2013).

Lack of Respect for Female Workers

The healthcare system continues to be a patriarchal system headed by mostly male physicians (Longo & Sherman, 2007) while nurses and nursing students are predominantly female (AACN, 2013). Females are frequently socialized to be care givers and nurturers (Sheridan-Leos, 2008; Taylor, 2001) but are not frequently encouraged to value their professional care giving roles and talents. Female healthcare workers are college educated or professionally trained and competent to perform their assigned duties. Incivility can take the form of disrespect for their training, education, and expertise through verbal intimidation (Becher & Visovsky, 2012). Females are often expected to follow the male leaders, rather than be leaders

themselves (Bartholomew, 2006). Ignoring the leadership potential of female employees is another form of disrespect and incivility.

The Emergence of Incivility in Professional Nursing

The nursing profession has long accepted and tolerated interpersonal incivility (Felblinger, 2008a; Hutchinson, 2009; Lapum et al., 2012). New graduate nurses are enculturated to accept incivility as a professional norm (Hutchinson, 2009) as it is modeled by preceptors and mentors (Harris, 2011; King-Jones, 2011; Townsend, 2012). Nurses are incorrectly told to accept incivility as an expected part of the job (Baker, 2012; Child & Mentes, 2010; Hutchinson, 2009; Magnavita & Heponiemi, 2011; Thomas, 2010). Enduring incivility has become a rite of passage for new nurses to prove they have reached the age of maturity in the proverbial tribe of professional nursing (Baker, 2012; Griffin, 2004; Hinchberger, 2009; Sheridan-Leos, 2008; Sincox & Fitzpatrick, 2010; Thomas, 2010). Nurses accept a helpless and powerless status in the healthcare institution, remain silent, and endure incivility (DeMarco & Roberts, 2003; Taylor, 2001).

The changing demographics of nursing have been postulated to be a cause of incivility (Clark & Springer, 2007b). The generational differences present in the nursing classroom and workforce can create discord (Baltimore, 2006; Suplee et al., 2008). The majority of contemporary nursing students come from three generational cohorts: Baby Boomers, Generation X, and Generation Y. Baby Boomers were born between 1943 and 1960 (Leiter, Price, & Laschinger, 2010) or 1946 and 1964 (Shacklock & Brunetto, 2011) making them a large portion of the current nursing faculty or older student population. Baby Boomers have a strong work ethic, derive self-worth and identity from their occupations, and often become "workaholics" (Billings & Halstead, 2012; Leiter et al., 2010; Shacklock & Brunetto, 2011).

Baby Boomers value loyalty to employers, recognition, position, personal growth, and professionalism (Leiter et al., 2010; Shacklock & Brunetto, 2011). Generation X (GenX) students were born between 1965 and the mid 1970's (Billings & Halstead, 2012), 1965 and 1979 (Shacklock & Brunetto, 2011), or 1961 and 1981 (Leiter et al., 2010). GenX students expect to have a specific purpose delineated for all educational assignments (Billings & Halstead, 2012; Shacklock & Brunetto, 2011). They desire a balance between their work and recreational activities (Leiter et al., 2010; Shacklock & Brunetto, 2011). These students do not value loyalty to employers because they do not believe job security exists (Shacklock & Brunetto, 2011). The Generation Y (GenY) students were born between the mid 1970's to the late 1990's (Billings & Halstead, 2012) or 1980 and 2000 (Shacklock & Brunetto, 2011). GenY students are technologically astute, confident, career-oriented, optimistic, and culturally diverse (Billings & Halstead, 2012; Shacklock & Brunetto, 2011). They have problems with critical thinking and relating to authority figures, especially if the person in authority is older in age (Shacklock & Brunetto, 2011). The differing values placed on loyalty to employers, dedication to work, and professionalism create a foundation for discord among students in the classroom and clinical settings. Student-to-student incivility is increased by competition among the generational student cohorts for the valued few nursing school placements, top grades, best internships, and professor reference letters (Suplee et al., 2008; Young, 2011).

Compromised Safety of Healthcare Workers

Workplace incivility can escalate to workplace violence. Workplace violence is any employee activity or verbalization that disrupts the work environment and threatens, harasses, or intimidates a coworker (OSHA, n.d.). The second leading cause of death in the workplace is violence (Hinchberger, 2009). The third leading cause of female occupational death is workplace

violence (Child & Mentes, 2010). Studying the phenomenon of female workplace violence initiated the body of research on workplace violence (Hinchberger, 2009).

Nursing is considered a dangerous occupation. Nurses are at risk of violence-related incidents in the workplace from patients, peers, and physicians (Felblinger, 2008a; Lapum et al., 2012; Magnavita & Heponiemi, 2011). Female nurses are three times more likely to experience workplace violence than any other professional group (Hinchberger, 2009).

Occupational homicide is an extreme form of workplace violence defined as overt, malicious, intentional harm to a colleague, peer, or coworker resulting in death (MMWR, 1994). Three registered nurses died from workplace violence and one postsecondary health educator death was a homicide in 2013 (Bureau of Labor Statistics, 2014). The annual average of registered nurses murdered in a workplace setting every year is 11 (Siciliano, 2015).

Workplace sabotage is a form of incivility that endangers employees' physical and emotional health (Kerfoot, 2007). Incivility takes the form of withholding and manipulating important information which can compromise the safety of employees (Escartín et al., 2009; Hutchinson, 2009; Kerfoot, 2007; Townsend, 2012). Negligent work practices place coworkers at risk of injury (Escartín et al., 2009). Employees engage in overt incivility by intervening in a peer's work process improperly or at the wrong time, by purposely sabotaging a coworker's assigned job obligations, and disrupting the duties of a colleague (Escartín et al., 2009; Hutchinson, 2009; Kerfoot, 2007). Diverting an employee's attention from designated work duties may endanger everyone in the work environment (Kerfoot, 2007). Peer sabotage in the form of uneven distribution of the workload also constitutes incivility placing the employees at risk of injury (Hutchinson, 2009). Workplace sabotage is very dangerous in the healthcare arena endangering the workers and the patients to whom they deliver care.

Incivility in Higher Education

Incivility is a long standing problem in institutions of higher education (Bloomberg, 1970). Incivility is injurious to the teaching/learning process and faculty/student relationships (Clark, 2008a; Clark & Springer, 2007b; Clark & Springer, 2010; Clark et al., 2009; Connelly, 2009; Nordstrom et al., 2009; Suplee et al., 2008). The health and safety of the institutional staff and students are endangered by incivility (Clark, 2008b; Clark & Springer, 2010). Academic incivility adds the aspect of harming, injuring, damaging, or destroying the teaching-learning environment (Clark, 2008a; Clark, 2008b; Clark et al., 2009). Learning is impeded (Clark & Springer, 2007b; DalPezzo & Jett, 2010). Teaching is interrupted. Students and professors feel angry, lose self-esteem, and experience strained faculty-student relationships (Clark, 2008a).

Nordstrom et al., (2009) surveyed 593 undergraduates for predictors of classroom incivility. Students' attitudes about appropriateness of a behavior predicted engagement in the behavior. Males considered more uncivil behaviors appropriate so males engaged in more uncivil behaviors.

Alkandari (2011) investigated university students' perceptions of student-to-student incivility in Kuwait. The behaviors mirror incivility perpetrated by nursing students against peers: leaving early; arriving late; side conversations; being absent; using cell phones in class; arguing; and displaying anger. Study participants considered intolerance of other students' political and religious ideas incivility. Baker and Boland (2011) investigated students' perceptions of incivility in a small Pennsylvania women's college. Disregard for established classroom procedures, using profanity, and verbal threats were considered uncivil.

Lack of Interpersonal Respect

Incivility has plagued society in general and higher education in particular since the beginning of the Union (Baker & Boland, 2011). The lack of interpersonal respect is increasing in contemporary culture (Clark, 2008a; Connelly, 2009; Hutchinson, 2009) and on today's college campuses (Clark & Springer, 2007a; Clark & Springer, 2007b). Students suffer disrespect from faculty mentors and classroom peers (Luparell, 2011). Nursing students verbally criticize faculty members in the classroom and clinical setting (Luparell, 2007). Nurses endure verbal disrespect from nurse peers and physicians (Felblinger, 2008a). Fostering interpersonal respect is the responsibility of all nursing students and nursing faculty (Clark and Carnosso, 2008). Nursing academia is fast-paced and demanding so interpersonal respect will take purposeful time and effort (Clark, 2012).

Lack of Autonomy

Autonomy is a basic ethical value. People want to have choices and make decisions in all aspects of their lives. College students have the same autonomous desires but are permitted few choices in their educational tracks. The educational institution's core is set. The major courses follow a prescribed Plan of Study. If students want to obtain a college degree, the predetermined course of study must be completed. This lack of autonomy may be manifested as anger and frustration displaced laterally as student-to-student incivility between academic peers of equal status (Hinchberger, 2009; Kafle, 2009; Sheridan-Leos, 2009; Stanhope & Lancaster, 2008).

Perceived Powerlessness

Incivility can follow an actual or perceived power imbalance between professionals, colleagues, peers, or students (Caza & Cortina, 2007; Clark & Carnosso, 2008; Hinchberger, 2009; King-Jones, 2011; Olender-Russo, 2009; Sincox & Fitzpatrick, 2008; Sheridan-Leos,

2008; Stokes, 2010; Taylor, 2001; Townsend, 2012). Nursing students do lack power over the academic environment. The plan of study, classmates, faculty, and clinical assignments are often beyond their control (Hinchberger, 2009; Sheridan-Leos, 2009; Stanhope & Lancaster, 2008). Baltimore (2006) postulates that the hierarchical configuration of nursing school may be a cause of student-to-student incivility. Students accept and replicate the uncivil behaviors they receive or witness peers receiving from professors and administrators (Baker, 2012; Luparell, 2011; Townsend, 2012). This cycle of replication embeds incivility in the nursing academic environment as a cultural norm (Norris, 2010). Vertical incivility perpetrated from faculty to students contributes to stress and perceived student powerlessness (Clark, 2008a; Clark, 2008b).

Students may feel powerless to address professor incivility for fear of academic reprisals in the form of poor grades, program dismissal, and embarrassment (Thomas, 2010). Clark (2008b) used Colaizzi's phenomenological method of qualitative research to interview seven nursing students about their lived experiences with faculty uncivil behaviors. The students felt powerless to confront the faculty members fearing reception of poor grades or dismissal from school. Six of the seven chose to endure the incivility in silence, cry at home, and suffer psychological stress and anxiety. The seventh student withdrew from the nursing program.

Nursing students may perceive powerlessness in the clinical setting. Students lack experience and a license to practice independently fostering a perception of being ranked on the bottom of the healthcare hierarchy (Anthony & Yastik, 2011; Baltimore, 2006; Griffin, 2004; Taylor, 2001). This feeling of powerlessness may be difficult to overcome. The anxiety and distress of feeling disempowered may be manifested in anger displaced laterally at peers (King-Jones, 2011).

Nursing Student-to-Student Incivility

Incivility in Nursing Education-Revised Survey (INE-R)

Students may be exposed to incivility throughout their academic programs (Hutchinson, 2009). Identification and quantification of uncivil academic behaviors through empirical data collection is important for development of prevention education and intervention activities (Clark, 2008a; Clark et al., 2015; Clark et al., 2009; Clark et al., 2010; Clark & Springer, 2007a; Clark & Springer, 2007b). The Incivility in Nursing Education Survey (INE) was developed to measure academic incivility behaviors from the perspective of both nursing faculty and nursing students (Clark et al., 2009). Study participants identify behaviors perceived to constitute incivility from the two lists of potentially uncivil and definitely threatening behaviors provided in the INE. Participants also quantify the frequency of uncivil, disruptive, and threatening behaviors experienced over the previous 12-month period. The INE was revised to the INE-R (Clark et al., 2015) reflecting changes in the Continuum of Incivility framework (Stokowski, 2011). The Continuum of Incivility is an organizing framework of uncivil behaviors along a continuum ranging from disruptive and irritating to threatening and violent (Clark et al., 2011). A unique feature of the INE-R is the flexibility to use the tool with subsets of nursing faculty or nursing students (Clark et al., 2015). Clark et al., (2015) conducted psychometric analyses of each of the 24 student and faculty behaviors contained in the INE-R. Reliability coefficients were considered statistically significant with $p \leq 0.05$. Cronbach's alpha was 0.95 for the lower and 0.99 for the higher level of incivility for student participants. Cronbach's alpha total score for student behaviors was ≥ 0.96 and for faculty behaviors was ≥ 0.98.

Identify Behaviors Perceived to be Uncivil

One standard list of universally accepted incivility behaviors does not currently exist. Billings et al. (2010) identified rudeness, taunts, harassment, threats, standoffishness, intolerance of peers' opinions, tardiness, and arriving unprepared for class as nursing student-to-student incivility behaviors. Classroom disruptions in the form of sarcastic remarks, side conversations, groans, leaving early, arriving late, using cell phones, using computers for non-academic purposes, and sleeping are frequently cited as incivility (Clark, 2008a; Clark et al., 2009; Clark et al., 2010; Clark & Springer, 2007a; Clark & Springer, 2007b; Clark & Springer, 2010; Sincox & Fitzpatrick, 2008; Suplee et al., 2008). Being apathetic about course content, cheating on examinations, demanding special accommodations for assignments, and demanding specific grades are uncivil behaviors contained in the INE-R survey tool (Clark et al., 2015).

Quantify Occurrence of Incivility Behaviors

The INE-R is an empirical tool to measure the frequency of experienced and witnessed academic incivility behaviors (Clark et al., 2015). The original INE Survey contained 16 potentially uncivil and 13 definitely threatening nursing student classroom and clinical behaviors (Clark et al., 2009). The INE-R fused the two lists of 29 total behaviors into a single list of 24 behaviors (Clark et al., 2015).

Untoward Effects of Experiencing Incivility

Uncivil behaviors perpetrated by nursing students against other nursing students cause psychological and physiological distress for students, faculty, institutional staff, and academic administrators (Caza & Cortina, 2007; Clark et al., 2009). Student stress levels increase (Clark, 2012; Clark & Carnosso, 2008). Somatization, anxiety, and depressive symptoms are experienced (Clark, 2012; Becher & Visovsky, 2012; Harris, 2011; Luparell, 2011). Student self-

confidence and self-image are negatively affected (Baker, 2012). Anger and frustration may be displaced between academic nursing peers (Clark & Springer, 2007b). Students have sleep disorders and headaches (Clark, 2012). Academic performance is negatively affected (Caza & Cortina, 2007). Students feel isolated, ostracized, and socially rejected (Caza & Cortina, 2007).

As Victims. Nursing student victims of direct incivility may experience post-traumatic stress disorder (Becher & Visovsky, 2012; Child & Mentes, 2010; Suplee et al., 2008), other anxiety disorders (Clark & Springer, 2007a; Clark & Springer, 2007b; Griffin, 2004; Rowell, 2013), and clinical depression (Rowell, 2013). Repeated exposure to student-to-student uncivil behaviors in the nursing classroom and clinical setting may damage a student's self-esteem, professional nursing self-image, and personal self-image (Rowell, 2013).

As Witnesses. Lim et al. (2008, p. 98) identify incivility witnesses as "co-victims." Vicarious exposure to the trauma of incivility as a "co-victim" can produce the same somatic and psychological responses seen in direct victimization. Students may experience anxiety, depression, somatic symptoms, poor sleep hygiene, powerlessness, and feeling judged as negative consequences of witnessing peers and faculty engaging in incivility (Becher & Visovsky, 2012; Lee & Brotheridge, 2006; Luparell, 2011; Sheridan-Leos, 2008).Witnesses may experience depression (Townsend, 2012), anxiety, sleep disorders, headaches (Clark, 2012), guilt, and fear of reprisal (Hutchinson, 2009). Witnesses dread being labeled a *whistle blower* if they report the incidences (Townsend, 2012).

Theoretical Perspectives

Transactional Model of Stress and Coping

The theoretical framework for this study was the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). The three main concepts of this model are *transaction,*

stress, and *coping* (Spilt, Koomen, & Thijs, 2011). 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 (Spilt et al., 2011). Stress is the physical body's attempt to regain homeostasis after a stressful encounter. Stress increases the extent of the body's negative physiological and psychological response (Nandkeolyar, Shaffer, Li, Ekkirala, & Bagger, 2014). Personal appraisal of an external stressor innervates an emotional response. Coping is an active cognitive appraisal process (Lazarus & Folkman, 1984) employing thoughts and behaviors to manage external stressors (Björklund, Häkkänen-Nyholm, Sheridan, & Roberts, 2010; Nandkeolyar et al., 2014). The intellectual process of evaluating what uncivil behavior was encountered, how the student may respond, when the student should respond, and if the student will, indeed, respond is discussed in the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984).

The Model helps to explain the transactional aspect of human relationships. The affective domain of interpersonal relationships between people or between people and their environments are evaluated (Spilt et al., 2011). The Model facilitates conceptualization of a connection between external stressors and wellbeing. The Model addresses the stress associated with experiencing interpersonal student-to-student incivility as a victim or witness. Coping strategies nursing students employ to cope with the uncivil encounters can be identified (Split et al., 2011). Stress can be described as the physical body's attempt to regain homeostasis after an unwelcomed student-to-student incivility encounter. The nursing student will actively engage a coping strategy through this intellectual reasoning process to help address the stressor. The

Model endorses positive individual effort to attempt to manage the stress without requiring total success in overcoming the stress (Lazarus & Folkman, 1984).

Using the Model

People evaluate the potential impact of stressors using two sequential steps in the Transactional Model of Stress and Coping (Nandkeolyar et al., 2014). The first response to stress is subjective and affective through emotions (Lazarus & Folkman, 1984). This *primary appraisal* step follows a three-tiered hierarchy. Student-to-student incivility can be perceived by victims and witnesses as merely *irrelevant* causing personal positive or negative outcomes. Uncivil behaviors may be labeled *benign-positive* when they indicate a positive outcome is in the immediate future. The student-to-student encounter is appraised *stressful* if a definite negative outcome is anticipated. People use primary appraisal to determine the impact of the stressor on their level of wellness.

Secondary appraisal is the second response to stress using the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). This is an objective intellectual process. A person experiencing a stressor assesses existing coping strategies for the potential to influence a positive change in the present situation. Existing coping strategies may be effective or ineffective with the current stressor. The level of the potential of risk to the person's wellbeing influences the coping strategy choice.

Coping Strategies

The Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) identifies eight coping strategies in three overarching categories. Problem-focused coping is cognitive and objective. Emotion-focused coping is affective and subjective. The third category is a combination of problem-focused and emotion-focused coping.

Student nurses may engage in problem-focused coping when experiencing student-to-student incivility. This active intellectual process includes identification of existing strategies to address student-to-student incivility, identification of the risks and benefits of the various solutions, and selection of which solution on which to act (Lazarus & Folkman, 1984). Folkman and Lazarus (1988a) identified planful problem-solving and confrontive coping as problem-focused coping strategies. Problem-focused coping is a very analytical process. Action plans and possible outcomes are conceptualized.

Nursing students may engage in emotion-focused coping to help reduce the emotional distress induced when experiencing student-to-student incivility. Emotion-focused coping does not entail intellectual planning or consideration of the possible outcomes. Emotion-focused coping strategies are: avoidance, minimization, distancing, selective attention, and positive comparisons (Folkman & Lazarus, 1988a; Folkman & Lazarus, 1988b).

Seeking social support is both a problem-focused and emotion-focused coping strategy (Folkman & Lazarus, 1988a; Folkman & Lazarus, 1988b). Nursing students can be analytical and methodical or spontaneous and reactive when seeking social support. This strategy results in positive and negative coping. Environmental constraints and interpersonal characteristics will influence the specific coping strategies students select (Folkman, 2009). Available social resources may influence coping effectiveness (Shipton, 2002).

The literature indicates incivility victims and witnesses seldom have coping strategies that facilitate positive outcomes (Lee & Brotheridge, 2006). Lewis (2006) used grounded theory to explore the coping strategies of female incivility targets working in public service professions. Coping strategies were ineffective due to the inability to uniformly identify incivility behaviors.

This study addresses both of these areas by identifying behaviors student nurses perceive to be uncivil and identifying coping strategies employed when nursing students experience incivility.

Summary

Incivility is rude or disrespectful behavior that demonstrates a lack of respect for others (Baker & Boland, 2011; Caza & Cortina, 2007; Clark, 2012; Clark et al., 2009; Clark & Springer, 2007a; Clark & Springer, 2007b; Clark & Springer, 2010; Connelly, 2009; Craig & Kupperschmidt, 2008; Felblinger, 2008b; Ganske, 2010; Harris, 2011; Leiter et al., 2011; Luparell, 2011; Milam et al., 2009; Nordstrom et al., 2009; Olender-Russo, 2009; Sheridan-Leos, 2008; Woelfle & McCaffrey, 2007). This literature review identified the negative impact incivility has on interpersonal relationships, employment, healthcare, and education. Several research gaps were identified. Student-to-student incivility has not been thoroughly studied. This study helped fill this gap. There is a need to study the prevalence of lateral student incivility in order to understand its impact on the academic environment and its potential effect on future professional practice. The Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) is appropriate to study the phenomenon of student-to-student incivility. Incivility is an interpersonal interaction that can be perceived as threatening or stressful by some students necessitating some type of coping. TMSC is used to explore how people cope with interpersonal and environmental stressors. Student interaction with incivility initiates the TMSC cascade of appraisal. Students engage in the subjective, emotional, affective process of primary appraisal first to identify any threat to personal wellness. Students assess the uncivil behavior for the possibility of leading to a positive or negative wellness outcome.

This study is significant because the coping strategies of prelicensure registered nursing students experiencing academic student-to-student incivility were explored. Coping strategies of nursing students have not been well researched nor have coping strategies for incivility in general. This study is significant because the coping strategies of prelicensure registered nursing students experiencing academic student-to-student incivility were explored. Coping strategies of nursing students have not been well researched nor have coping strategies for incivility in general. This study helped fill this research gap. Studies are needed that identify the coping strategies employed by nursing students and the impact of the employed effective and ineffective strategies on the academic environment. The Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) is appropriate to study the coping strategies employed by nursing students experiencing student-to-student incivility. Secondary appraisal is a cognitive, intellectual response in which students assess their existing coping strategies in an effort to cause a positive change in their wellness outcome while addressing the current stressing experience.

Female and male nursing students are expected to identify incivility occurrences at different rates (Nordstrom et al., 2009). Females tolerate less disrespect than their male counterparts. Females will label behaviors as rude and impolite that the male students may agree is incivility, may label uncivil depending on the context, or may ignore as acceptable college student behavior (Nordstrom et al., 2009). The Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) is appropriate to study gender differences in employed coping strategies. Incivility is an interpersonal stressor. TMSC addresses the unique affective (primary appraisal) and cognitive (secondary appraisal) aspects of all people.

Reciprocal incivility behaviors, compromised physical health, and impaired emotional health are outcomes of interpersonal stress and ineffective incivility coping strategies (Lee &

Brotheridge, 2006). These three phenomena represent gaps in the literature. Reciprocity of incivility behaviors among nursing students has not been extensively studied. Deleterious physical and emotional health outcomes secondary to incivility experiences are noted in the literature, but need to be studied as separate concepts and outcome phenomenon. The Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) is appropriate to study effective and ineffective coping strategies related to reciprocal incivility behaviors and stress mediated health outcomes. TMSC relates the problem-focused and emotion-focused coping strategies people employ to address interpersonal stressors to positive and negative outcomes (Folkman & Lazarus, 1988a).

This study is one of the first to attempt to identify the prevalence of incivility behaviors in the general student nurse population. The Incivility in Nursing Education (Revised) Survey (INE-R) was used in this study to identify and quantify nursing students' perceptions of incivility behaviors occurring between nursing students. Clark et al. (2015) developed the INE-R and conducted the psychometric analyses for reliability. Chronbach's alpha for the total student score was ≥ 0.96 and ≥ 0.98 for the total faculty score. The overall Chronbach's alpha of ≥ 0.94 is reliable as rated by the faculty and student participants (Clark et al., 2015).

CHAPTER 3

METHODS

Research Design

A quantitative nonexperimental descriptive research design (Polit & Beck, 2012) was used to identify the behaviors prelicensure registered nursing students believed constituted lateral student-to-student incivility, determine the frequency of student-to-student incivility encounters experienced in nursing classroom and clinical settings, and identify the coping strategies employed by prelicensure registered nursing students experiencing lateral student-to-student incivility in didactic and clinical academic settings.

Uncivil behaviors were identified, described, documented, and the prevalence quantified through participant completion of the Incivility in Nursing Education-Revised (INE-R) survey (Clark et al., 2015). Coping strategies were identified through participant completion of the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). The surveys were distributed electronically to the student members of the National Student Nurses' Association (NSNA) via email. Completed surveys were returned electronically and anonymously to the East Tennessee State University (ETSU) Checkbox® Survey system.

Philosophical Assumptions

Critical Social Theory as the Study Framework

Critical Social Theory (CST) links nursing practice with nursing theory (Weaver & Olson, 2006) through the reflective lens of a politically engaged nurse (Carnegie & Kiger, 2009). CST as a theoretical framework can be used to study the opportunities for human growth and change in response to society's institutional structures and power hierarchies (Weaver & Olson, 2006). 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.

Ontological Assertions

Human beings engage in rational self-critique in CST (Campbell & Bunting, 1999). People reflect on their affective dispositions in respect to lived experiences, social interactions, and the political environment (Holter & Kim, 1995). People construct reality from their personal histories (Campbell & Bunting, 1999). Reality is perceived through empowering autonomy, supporting self-esteem, practicing traditions, encouraging critical thinking, and reducing dependence on current power hierarchies (Rodgers, 2005). Reality is the basis of truth in CST (Weaver & Olson, 2006). Community collaboration through reflection and negotiation of social, political, and cultural contexts facilitates knowledge development in CST (Campbell & Bunting, 1999).

Epistemological Assertions

Epistemological development is facilitated through shared meanings of subjective customs, beliefs, and values (Benner, 1999). Human beings are intrinsically involved in knowledge development through their interactional language and shared meanings. Humans are self-interpreting and verbally interactive (Rodgers, 2005). Reality is constructed through human self-interpretation of subjective human social experiences (Benner, 1999; Rodgers, 2005). Truth develops from epistemologically developed shared meanings being interpreted within society, culture, and history (Campbell & Bunting, 1999). Truth is communally constructed and changed through human language in response to power gradients and social processes (Rodgers, 2005).

Methodological Assertions

Critical Social Theory provides a method for uncovering the meaning of human behavior in daily life (Benner, 1999). Human language describes these behaviors and lived experiences in community narratives and personal histories creating the reality and knowledge in CST (Benner, 1999). Reality is reflected in rational actions that identify, analyze, and seek to eliminate social, political, and cultural inequities and problems of communities, societies, and populations (Campbell & Bunting, 1999). Rational actions can be developed through CST guided research. Vulnerable populations can be assisted to attain their highest potential through empowerment, emancipation from oppression, freedom from fear, liberation from domination, and elimination of social classes (Campbell & Bunting, 1999). Knowledge and truth are developed as the researcher and agent (participant) negotiate and interact in CST research methodology (Campbell & Bunting, 1999). Knowledge increases and truth changes as research identifies ways to address existing social, political, and cultural inequalities (Weaver & Olson, 2006).

Framework for This Study

Critical Social Theory supports the purposes of this study to identify incivility behaviors, quantify occurrences of incivility behaviors, and identify coping strategies employed when prelicensure registered nursing students experience student-to-student incivility. CST can help identify the oppressive nature of student-to-student incivility and its deleterious effects on students (Carnegie & Kiger, 2009). Nursing students represent a vulnerable population within the discipline of nursing. Students lack autonomy, have a lower social standing, and have little power within the academic social structure. CST can help nurses address the societal, power hierarchy, and autonomy problems caused by incivility (Carnegie & Kiger, 2009). Nurse educators can empower students through educational programs that describe the reality of

incivility (Carnegie & Kiger, 2009) and describe effective coping strategies to employ when experiencing student-to-student incivility. CST offers a professional and ethical way to expose and resolve the existing pattern of student-to-student incivility (Carnegie & Kiger, 2009). CST philosophical assumptions can help facilitate a nursing discipline-wide shift to a no tolerance stance of incivility.

Sample

The population of interest for this study was prelicensure registered nursing students. A prelicensure registered nursing student is defined as a student who is currently matriculated in an Associate of Science in Nursing (ADN) degree program, a Registered Nurse Diploma program, a Bachelor of Science in Nursing (BSN) degree program, a Licensed Practical Nurse (LPN) to ADN program, an LPN to BSN program, a Second Degree Bachelor of Art (BA) or Bachelor of Science (BS) to BSN program, or Second Degree BA or BS to a Master of Science in Nursing (MSN) program, has not previously passed the NCLEX-RN, and is not currently credentialed as a Registered Nurse. Participants were aged 18 or older, could read and write English, and had been involved in a clinical nursing experience as a nursing student.

Participants were recruited using nonprobability convenience sampling. Student members of the National Student Nurses' Association (NSNA) were invited to participate through their NSNA member email addresses. The PI contacted the NSNA Executive Director, explained the study, and secured permission to have the online survey link distributed to NSNA student members via their email address list. A letter explaining the study accompanied the email invitation.

Institutional Review Board (IRB) approval was obtained from East Tennessee State University where the PI is enrolled as a doctoral candidate. 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.

Setting

This study was conducted online via computerized surveys. The electronic survey was distributed to the email addresses of members. The purpose of the study was explained in an introductory letter included with the online survey. Informed consent was assumed when the student voluntarily completed and submitted the online survey.

Research Methods and Procedures

Instruments

Data was collected using two quantitative data collection instruments: the Incivility in Nursing Education-Revised Survey (INE-R) (Clark et al., 2015) and the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985; Folkman et al., 1986). The INE-R was used to answer Research Questions # 1, 2, and 3.

1. What behaviors do prelicensure registered nursing students identify as student-to-student incivility as measured by the INE-R (Clark et al., 2015)?
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?

Incivility in Nursing Education-Revised Survey (INE-R)

The original Incivility in Nursing Education (INE) Survey (Clark et al., 2009) 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. 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 (Clark et al., 2015). 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 (Clark et al., 2015). This study used only the student portion of the INE-R as the concept of interest is student-to-student incivility. The INE-R was 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 were obtained without reference to the nursing faculty. Nurse faculty perceptions of incivility, while critically important, were not germane to this study of student perceptions.

The INE-R consists of the same three parts as the INE (Clark et al., 2015). Part I is demographic data. In the INE-R, the study investigator identifies the demographic data to collect.

This study asked participants to supply: registered nursing program type; gender; age; and race/ethnicity. Participants identified which behaviors were perceived to be uncivil and indicated the frequency of experienced incivility over the past 12 months in Part II, but the list of uncivil behaviors was revised from the original INE. Part II now contains one list of 24 behaviors derived from the original two lists in the INE. Participants rated 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 indicated 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 were moderately revised from the original INE by the tool developer. Participants included a narrative description of one episode of student-to-student incivility witnessed or experienced during the past 12 months. Two items solicited participant views of the main cause and main consequence of academic incivility. The fourth item asked participants to describe a way to promote academic civility. Part III was included in this study as elective items. Participants chose 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.

Survey participants were assured of anonymity and confidentiality by using the designated online Web-based platform ETSU Checkbox® Survey system for electronic submission. No personally identifiable information was linked to the online survey submission. The returned surveys were numbered for tracking purposes without any attempt to connect the responses to any participant. The electronic survey data was saved in a password protected electronic data base. The password is only known to the PI.

Validity. Instrument validity is the degree to which the data collection instrument actually measures the intended variable or concept (Polit & Beck, 2012). Clark et al. (2009) addressed validity of the INE by analyzing the four qualitative narrative response items in Part III. Themes were extracted from the narratives and validated using peer-review and external debriefing processes. Consistent themes were identified among the researchers and the external reviewers.

The peer review process can also be used to support face validity of the INE. The INE does measure the types and frequency of incivility behaviors occurring in nursing academia (Polit & Beck, 2012). Since 2004, the INE has been translated into Farsi, Hebrew, and Mandarin Chinese for use in empirical studies with non-English speaking participants in several countries (Clark et al., 2009; Clark et al., 2015).

Reliability. Clark and Springer (2007a) piloted the INE in 2004 with a convenience sample of 324 nursing students and 32 nursing faculty members from a Northwest American nursing program. The INE was retested in 2006 with a convenience sample of 504 nursing faculty and students recruited from two different national nursing conferences. Clark et al. (2009) described the development and psychometric testing of the INE using the data from the 2006 study. Good inter-item reliability was supported by the calculated Chronbach's alpha inter-item reliability coefficients for the 16 student behaviors listed in Part II. The inter-item reliability coefficients were 0.848 for the level of student incivility and 0.808 for the frequency of incivility occurrence. Exploratory factor analysis of the 16 student behaviors listed in Part II was calculated using a varimax rotation of the student and faculty responses (Clark et al., 2009). Three factors were identified: distracting and disrespectful classroom behaviors; disrespect or disregard for others; and a general disinterest in class. Adequate reliability was supported by the

calculated Chronbach's alpha inter-item reliability coefficients for the three factors in Part II: Factor 1 = 0.88; Factor 2 = 0.74; and Factor 3 = 0.68.

Psychometric testing results for the INE-R have just been published (Clark et al., 2015). The INE-R was completed by 310 nursing students and 182 nursing faculty members from 20 schools of nursing across the United States. Chronbach's alpha for the total student behavior score was 0.96 and the total faculty behavior score was 0.98.

Ways of Coping (Revised)* Questionnaire

The Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985; Folkman et al., 1986) 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 (6 items); Distancing (6 items); Self-Controlling (7 items); Seeking Social Support (6 items); Accepting Responsibility (4 items); Planful Problem Solving (6 items); Escape-Avoidance (8 items); and Positive Reappraisal (7 items) (Folkman & Lazarus, 1985; Folkman et al., 1986; Folkman & Lazarus, 1988b). 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 (Folkman & Lazarus, 1985).

The Ways of Coping (Revised)* instrument (Folkman & Lazarus, 1985; Folkman et al., 1986) was used to answer Research Questions # 4 and 5.

4. What coping strategies do prelicensure registered nursing students employ when experiencing student-to-student incivility in the nursing classroom and clinical setting?

5. Do coping strategies vary by program type, age, gender, or race/ethnicity?

Participants completed the Ways of Coping (Revised)* while recalling an incident perceived to be uncivil that occurred 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 (Folkman & Lazarus, 2014). 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 did not affect the results of this study. In all probability, the validity and reliability of both instrument versions are the same.

The 1985 version of the Ways of Coping (Revised)* Questionnaire is being used in contemporary research studies in multiple populations and geopolitical environments. It was used to study coping strategies of police officers (Ménard & Arter, 2013), combat veterans (Renshaw & Kiddie, 2012), people experiencing chronic pain (Banerjee, Bhattacharya, & Sanyal, 2014), people experiencing type II diabetes mellitus (Hart & Grindel, 2010), and people experiencing Multiple Sclerosis (Aikens, Fischer, Namey, & Rudick, 1997). The Ways of Coping (Revised)* tool was used with a sample of university students in Turkey (Senol-Durak, Durak, & Elagöz, 2011) and Finland (Björklund et al., 2010). These previous studies of coping strategies using the Ways of Coping (Revised)* 1985 version supported the use of this instrument in this study of prelicensure registered nursing students.

Validity. The Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985) and the copyrighted Ways of Coping Questionnaire (Lazarus & Folkman, 1988) were compared to the newer Multidimensional Coping Inventory (MCI) to help establish construct validity (Endler & Parker, 1990). The correlations covered a spectrum of results. Two high correlations were between the Problem-Focused Ways of Coping subscale and MCI Task subscale (a =.65 for males and .68 for females) and the Wishful Thinking Ways of Coping subscale and MCI Emotion subscale (a = .73 for males and .77 for females). The Seeking Social Support Ways of Coping subscale and the MCI Avoidance subscale had a moderate correlation (a = .30 for males and .41 for females). These coping scales are not totally equivalent, but acceptable construct validity is demonstrated (Endler & Parker, 1990).

Senol-Durak et al. (2011) demonstrated satisfactory structural and concurrent validity of a Turkish translation of the Ways of Coping (Revised)* instrument. Confirmatory factor analyses calculated in two samples demonstrated goodness of fit: (1) university students and (2) adults

aged 18 to 75 with a mean monthly income of $936.74 having completed primary school through college.

Reliability. Coefficient alpha estimates of the Ways of Coping (Revised)* subscales are the most commonly used statistical analyses for reliability (Folkman & Lazarus, 1985). Rexrode, Petersen, and O'Toole (2008) reviewed 92 studies that used the Ways of Coping (Revised)* instrument. The coefficient alpha estimates were: Escape-Avoidance (EA) = 86; Distancing (D) = 83; Self-Controlling (SC) = 83; Planful Problem Solving (PP) = 83; Positive Reappraisal (PA) = 81; Confrontive Coping (CC) = 80; and Accepting Responsibility (AR) = 78. Folkman et al. (1986) calculated alphas for the Ways of Coping (Revised)* scales: PA = .79; SS = .76; EA = .72; CC = .70; SC = .70; PP = .68; AR = .66; and D = .61. Tavakol and Dennick (2011) consider Cronbach alpha scores of .70 to .90 representative of reliability. Four of the listed 16 estimates fall outside the acceptable range indicating moderate to acceptable reliability.

The Ways of Coping (Revised)* has moderate internal consistency reliabilities for the eight subscales: Problem-Focused Coping = .85; Wishful Thinking = .84; SS = .81; Self-Blame = .75; D = .71; Emphasizing the Positive = .65; Self-Isolation = .65; and Tension Reduction = .56 (Folkman & Lazarus, 1985). Discrete internal consistency reliability was calculated for the Ways of Coping (Revised)* that had been translated into Turkish (Senol-Durak et al., 2011). Several survey items were modified for cultural congruency. Alphas ranged from 0.67 to 0.84.

Informed Consent

The purpose of this study was explained in the introductory letter that accompanied the online survey. The introductory letter was written on an eighth grade level. Participation in this research was totally voluntary. No coercion was used to recruit participants. No deceit was used. All potential participants could refuse to participate without fear of reprisal or consequences.

Participants could withdraw at any time without incurring any consequences by exiting the uncompleted electronic survey. Submission of a completed survey constituted Informed Consent. No personal identifiers were attached to the submitted online surveys. Children under the age of 18 were not recruited as participants. All prelicensure registered nursing student members of the NSNA who had not yet passed the NCLEX-RN examination and were not currently credentialed as registered nurses were invited to volitionally participate. Participants were informed that a copy of the completed study report could be obtained by contacting the PI at the email address included in the introductory letter accompanying the online survey.

Specific Risks to Participants

No known risks were associated with this study. Participation should not have posed any risk to participants beyond what might be encountered in a normal day of life. Completing the electronic online survey may have posed a minimal physical risk of eye strain or back strain from sitting at the computer to read and complete the survey. Participants may have become fatigued. Participants were encouraged to stand up, change positions, and close their eyes intermittently during the survey completion to prevent experiencing discomfort.

The Ways of Coping (Revised)* Questionnaire asked participants to think about past interpersonal experiences with academic incivility. Participants were asked to remember incivility behaviors experienced directly as a victim or witnessed as an observer. It was highly unlikely that emotional distress of any nature would have occurred as a result of responding to the items in the Ways of Coping (Revised)* survey. If a participant experienced any distress of any magnitude, the toll-free, 24-hour hotline of the National Suicide Prevention Lifeline of the U.S. Department of Health and Human Services was immediately available for assistance at 1.800.273.8255. The Lifeline is open 24 hours a day; seven days a week; 365 days a year. All

callers are connected with a trained counselor. This crisis service is confidential, anonymous, and provided free of charge. The website may be accessed at: http://www.cdc.goc/aging/mentalhealth/depression.htm

Participants could discontinue completion of the surveys at any time without incurring any consequences. The participant could exit the online survey at any time to discontinue the completion cycle.

Benefits to Participants

No personal fiscal or physical benefits were gained from participation in this study. No financial incentives were provided to the participants. Study participants may have experienced a feeling of personal satisfaction for knowing they added to the body of nursing knowledge.

Participant Privacy and Confidentiality

In order to maintain confidentiality, the online surveys contained no personal identification to link the responses to the participants. Surveys were completed online without the PI being present. Participants determined the level of privacy by selecting the location of the computer on which the surveys were completed. The online survey results were transmitted directly to a password protected electronic database. The aggregate data was collected without any participant identifiers.

Data Collection and Management

Data was collected electronically as the participants completed the online surveys using the ETSU Web-based platform Checkbox® Survey, Inc. The data was exported to SPSS version 23 for analysis. The data was stored in a password protected electronic data base with the password known only to the PI. The PI will maintain the password protected electronic database in a locked safety deposit box for 5 years.

The stored data will be permanently deleted at the end of the 5-year time frame using a data destruction software program. The formal written study report will be maintained by the PI indefinitely. The PI will publish the results of the analyzed aggregate data in professional journals. The aggregate study results will be presented at professional conferences, at nursing faculty meetings, and in the nursing classroom. Survey data does not include any personal identifiers or sensitive information maintaining participant confidentiality.

Data Analysis

All study results were reported as aggregate data to maintain participant confidentiality. The data was analyzed in respect to cohorts of nursing student program types, age groups, self-identified genders, and race/ethnicity groups.

Descriptive Statistics

Descriptive statistics were used to analyze and describe the data obtained from this quantitative nonexperimental descriptive study (Polit & Beck, 2012). Three measures of central tendency, mean, median, and mode, and a variability index, standard deviation (Polit & Beck, 2012), were calculated for participant identification of the 24 incivility behaviors in the INE-R (Clark et al., 2015), frequency of experienced and witnessed incivility behaviors in the INE-R (Clark et al., 2015), and employed coping strategies in the Ways of Coping (Revised)* (Folkman & Lazarus, 1985; Folkman et al., 1986). A frequency distribution table was developed for the descriptive statistics for each prelicensure nursing school type, gender category, age group, and race/ethnicity group.

Kruskal-Wallis Test

Registered nursing students can matriculate in seven different program types: associate degree (ADN), baccalaureate degree (BSN), diploma, Licensed Practical Nurse (LPN) to ADN,

LPN to BSN, second degree bachelor's degree to BSN, and second degree bachelor's to Master of Science in Nursing Degree. The study participants were recruited using nonprobability convenience sampling from all seven program types using the emails from the NSNA membership. 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 (Laerd, 2013; Laerd, 2015; Polit & Beck, 2012). The seven prelicensure registered nursing student program types were the independent variable in this study. K-W was used to compare student perceptions of the 24 incivility behaviors in the INE-R (Clark et al., 2015), frequency of the 24 experienced and witnessed incivility behaviors in the INE-R (Clark et al., 2015), and employed coping strategies in the Ways of Coping (Revised)* Survey (Folkman & Lazarus, 1985; Folkman et al., 1986) across the seven registered nursing program types.

The study data passed the four K-W assumptions to ensure accurate analysis (Laerd, 2015). The INE-R (Clark et al., 2015) and Ways of Coping (Revised)* (Folkman & Lazarus, 1985) both passed the first assumption because the dependent variables in the surveys were measured at the ordinal level in Likert-type scales. The study passed the second assumption because seven independent, categorical groups of participants were compared. Student matriculation in only one of the seven registered nursing program types fulfilled the third assumption that maintains participants can only be part of one group. The fourth assumption was met by analyzing the mean ranks of the analysis of the seven student groups, six age categories, gender categories, and ten race/ethnicity groups against the 24 incivility behaviors and eight coping strategies. Distributions of results were not similar for all groups by visual inspection of

boxplots of the data. The majority of mean ranks were not statistically significantly different between groups.

Ethical Considerations

The study was reviewed and approved by the Institutional Review Board (IRB) of East Tennessee State University. Participant anonymity was protected. No personal identifiers were included in or on any survey responses. No School of Nursing, college, or university name was reported in the study results. Participating student members were reported as a national student nursing organizational sample. All data was reported as aggregate data.

Participants received a thorough explanation of the study purpose, procedure, benefits, and risks in an introductory letter that accompanied the emailed electronic online survey. This introductory letter explained that participation was voluntary through self-enrollment. There was no coercion to participate, no fiscal compensation for participation, and no penalty for declining. Participant anonymity was maintained. Informed consent was obtained electronically when the participant completed and submitted the online survey. Participants were able to withdraw from the study at any time by exiting the online survey without clicking the submit icon.

Limitations of the Study

Using the convenience sampling method to recruit participants was a study limitation. Sample bias was possible because the participants chose to self-enroll in the study. A representative sample of all prelicensure registered nursing students was not ensured due to self-enrollment. Convenience sampling and self-enrollment may simultaneously enhance the study results by reducing researcher bias. The online participants self-enrolled without PI interaction.

The results are not generalizable to the entire population of registered nursing students. The PI did not select or recruit participants who had experienced incivility. Participants from the

national student nursing organization were a nonprobability convenience sample of all prelicensure registered nursing students from across the United States. This national sample was limited by the students who have joined the NSNA. Anonymity was maintained because the PI did not have access to the participants' email addresses or meet the potential participants.

Another limitation was the uniqueness of this study. This study focused specifically on academic incivility occurring among prelicensure registered nursing students in the didactic classroom and clinical setting. Incidental references to student-to-student incivility have been reported in the literature in personal student narratives about academic incivility.

This unique study helped fill two research gaps. This study specifically explored prelicensure registered nursing student perceptions of student-to-student incivility behaviors that occurred in the classroom and clinical setting. This study also explored the coping strategies employed when prelicensure registered nursing students experienced student-to-student incivility in the nursing classroom and clinical setting. Study results have the potential to guide future research, educational programs, and interventional activities that enhance nursing student coping strategies employed when experiencing academic student-to-student incivility.

This study of nursing student-to-student incivility is significant to nursing academia because of the potential deleterious effects incivility has on the nursing profession and nursing professionals. Today's nursing students will be tomorrow's nursing professionals. Incivility negatively affects all aspects of teaching and learning. Experiencing and witnessing uncivil behaviors may impact future professional behavior and the nursing practice environment. Nurses' and students' abilities to cope with incivility within the discipline of nursing may be reflected in the current and future nursing workforce shortage. 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.

CHAPTER 4

RESULTS

Demographic Data

The phenomenon of student-to-student incivility has not been extensively addressed in the nursing literature. This study explored student-to-student incivility experienced by prelicensure registered nursing students. Seven types of registered nursing student programs were identified for this study: Associate of Science in Nursing (ADN) degree; Registered Nurse Diploma; Bachelor of Science in Nursing (BSN) degree; Licensed Practical Nurse (LPN) to ADN degree; LPN to BSN degree; a Second Degree Bachelor of Art (BA) or Bachelor of Science (BS) to BSN degree; or a Second Degree BA or BS to a Master of Science in Nursing (MSN) degree.

Generational differences affect teaching, learning, and interpersonal relationships (Baltimore, 2006; Leiter et al., 2010; Shacklock & Brunetto, 2011; Suplee et al., 2008). Clark and Springer (2007b) studied the impact of generational differences in the student cohort composition in nursing classrooms on the occurrence of academic incivility. Participant ages were germane to this study. All participants were aged 18 or older. This study used the following age categories: 18 to 24; 25 to 34; 35 to 44; 45 to 54; 55 to 64; 65 and over.

Gender influences a person's social and power relationships. The nursing profession has historically been a predominantly female vocation dominated by the historically male medical profession (Griffin, 2004; Olender-Russo, 2009; Roberts et al., 2009; Sheridan-Leos, 2008). Perceived and actual oppression and powerlessness imposed by these power gradients can lead to inter-group incivility as a coping mechanism to deal with a perceived lack of self-esteem and self-worth (Baker, 2012; Griffin, 2004; Hinchberger, 2009; Stokes, 2010; Taylor, 2001;

Townsend, 2012; Weinand, 2010). Exploring the relationship of gender to perceptions of incivility behaviors was germane to this study. Participants self-identified their genders as male, female, or preferred not to respond.

Cultural diversity is encouraged and promoted in nursing academia. Racial and ethnic distinctives as the basis of cultural heritage can influence a person's perceptions of uncivil behaviors. No other research was identified that explored the relationship of race/ethnicity to student-to-student incivility or the coping mechanisms employed when experiencing student-to-student incivility. The race/ethnicity designations in this study were: Arab or Arab American; Asian or Asian American; Black, Afro-Caribbean, or African American; Caucasian, Non-Hispanic White, or Euro-American; Latino or Hispanic American; Multiracial; Native American or Alaskan Native; Native Hawaiian or Pacific Islander; Other race or ethnicity; Prefer not to respond. The demographic data is displayed in Table 1.

Table 1

Demographic Data (n = 373)

Characteristic	Frequency	Percent
Prelicensure RN Program		
ADN	130	34.9
BSN	183	49.1
Diploma	14	3.8
LPN to ADN	6	1.6
LPN to BSN	4	1.1
BA or BS to BSN	28	7.5
BA or BS to MSN	7	1.9

Table 1 (continued)

Gender		
Male	31	8.3
Female	337	90.3
Prefer not to Respond	5	1.3
Age		
18 – 24	130	34.9
25 – 34	122	32.7
35 – 44	70	18.8
45 – 54	39	10.5
55 – 64	10	2.7
65 and Over	1	.3
Race/Ethnicity		
Arab or Arab American	3	.8
Asian or Asian American	16	4.3
Black, Afro-Caribbean, or African American	21	5.6
Caucasian, Non-Hispanic White, or Euro-American	261	70.0
Latino or Hispanic American	32	8.6
Multiracial	23	6.2
Native American or Alaskan Native	4	1.1
Native Hawaiian or Pacific Islander	3	.8
Other Race or Ethnicity	1	.3
Prefer not to Respond	9	2.4

Data Collection Process

Participants received the survey link via email. Study participation was voluntary. Surveys were completed online anonymously and submitted electronically using the web-based platform Checkbox® Survey, Inc. No personally identifiable information was collected. IP addresses were removed. The data was exported to SPSS version 23 for analysis. The data was stored in a password protected electronic data base with the password known only to the PI. The survey link was open for 30 days. Participants were allowed to skip survey items.

The three main purposes of this study were to identify the behaviors prelicensure registered nursing students believed constituted student-to-student incivility, determine the frequency of student-to-student incivility behaviors experienced in the nursing classroom and clinical setting, and describe the coping strategies employed by prelicensure registered nursing students when student-to-student incivility was experienced.

Study participants identified the classroom and clinical behaviors perceived to constitute incivility using the INE-R Survey (Clark et al., 2015). Frequency of incivility experienced over the past 12 months by the participants was also identified using the INE-R Survey. Employed coping strategies were identified using the Ways of Coping (Revised)* Questionnaire (Lazarus & Folkman, 1985). Nine hundred and ninety people responded to the survey. 617 (62%) responses were excluded (n = 2 responded "I do not agree"; n = 615 were incomplete). The final study data analysis included 373 (38%) survey responses. All results were reported as aggregate data.

Data Analysis

Student-to-Student Incivility

The first three research questions pertain to student-to-student incivility:

1. What behaviors do prelicensure registered nursing students identify as student-to-student incivility as measured by the INE-R (Clark et al., 2015)?

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?

This section presents the results of the frequency distributions and K-W calculations for the data obtained in response to these three research questions.

Nursing Student Program Type Differences. The four incivility behaviors considered "highly uncivil" by the largest quantity of prelicensure registered nursing student participants were: making threatening statements about weapons (n = 322; 86.3%); threats of physical harm against others (n = 321; 86.1%); property damage (n = 315; 84.5%); and making discriminating comments (n = 310; 83.1%). Table 2 contains the perceptions of all 24 incivility behaviors as reported by the total nursing student participant sample.

Table 2

Nursing Students' Perceptions of Incivility Behaviors

Student Behaviors	Not Uncivil	Somewhat Uncivil	Moderately Uncivil	Highly Uncivil
Expressing disinterest, boredom, or apathy about course content or subject matter	87 (23.3)	160 (42.9)	88 (23.6)	38 10.2)
Making rude gestures or non-verbal behaviors toward others	21 (5.6)	55 (14.7)	113 (30.3)	183 (49.1)
Sleeping or not paying attention in class	53 (14.2)	123 (33)	106 (28.4)	89 (23.9)
Refusing or reluctant to answer direct questions	81 (21.7)	126 (33.8)	81 (21.7)	83 (22.3)
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes	23 (6.2)	101 (27.1)	126 (33.8)	119 (31.9)

Table 2 (continued)

Arriving late for class or other scheduled activities	33 (8.8)	130 (34.9)	109 (29.2)	99 (26.5)
Leaving class or other scheduled activities early	55 (14.7)	127 (34)	126 (33.8)	60 (16.1)
Being unprepared for class or other scheduled activities	51 (13.7)	147 (39.4)	119 (31.9)	52 (13.9)
Skipping class or other scheduled activities	67 (18)	108 (29)	99 (26.5)	92 (24.7)
Being distant and cold towards others	25 (6.7)	54 (14.5)	116 (31.1)	177 (47.5)
Creating tension by dominating class discussion	28 (7.5)	85 (22.8)	138 (37)	119 (31.9)
Holding side conversations that distract you or others	17 (4.6)	56 (15)	129 (34.6)	170 (45.6)
Cheating on exams or quizzes	36 (9.7)	10 (2.7)	31 (8.3)	292 (78.3)
Making condescending or rude remarks toward others	20 (5.4)	27 (7.2)	50 (13.4)	272 (72.9)
Demanding make-up exams, extensions, or other special flavors	38 (10.2)	59 (15.8)	133 (35.7)	141 (37.8)
Ignoring, failing to address, or encouraging disruptive behaviors by classmates	33 (8.8)	57 (15.3)	116 (31.1)	165 (44.2)
Demanding a passing grade when a passing grade has not been earned	33 (8.8)	28 (7.5)	72 (19.3)	237 (63.5)
Being unresponsive to emails or other communication	29 (7.8)	101 (27.1)	129 (34.6)	111 (29.8)
Sending inappropriate or rude emails to others	34 (9.1)	12 (3.2)	57 (15.3)	266 (71.3)
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others	37 (9.9)	5 (1.3)	20 (5.4)	310 (83.1)
Using profanity (swearing, cussing) directed toward others	34 (9.1)	29 (7.8)	73 (19.6)	235 (63)
Threats of physical harm against others (implied or actual)	37 (9.9)	9 (2.4)	5 (1.3)	321 (86.1)
Property Damage	42 (11.3)	5 (1.3)	10 (2.7)	315 (84.5)
Making threatening statements about weapons	41 (11)	4 (1.1)	5 (1.3)	322 (86.3)

Note. $N = 373$. Percentages are in parentheses. Percentages may not total 100 because not all participants responded to all survey items.

Participants identified the frequency of experiencing these same four behaviors as "never" during the past 12 months. The behavior of "making discriminating comments" is in the fifth place of frequency experiences behind "sending inappropriate or rude emails to others" (n = 249; 66.8%). The perceptions of the behaviors as uncivil closely match the frequency of the experienced behaviors in the total sample. The reported frequency of the 24 incivility behaviors listed in the INE-R (Clark et al., 2015) as experienced by the total nursing student participant sample are contained in Table 3.

Table 3

Frequency of Experienced Incivility Behaviors

Student Behaviors	Never	Rarely	Sometimes	Often
Expressing disinterest, boredom, or apathy about course content or subject matter	23 (6.2)	72 (19.3)	168 (45)	103 (27.6)
Making rude gestures or non-verbal behaviors toward others	62 (16.6)	123 (33)	118 (31.6)	61 (16.4)
Sleeping or not paying attention in class	51 (13.7)	78 (20.9)	135 (36.2)	101 (27.1)
Refusing or reluctant to answer direct questions	126 (33.8)	155 (41.6)	61 (16.4)	23 (6.2)
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes	17 (4.6)	50 (13.4)	95 (25.5)	202 (54.2)
Arriving late for class or other scheduled activities	29 (7.8)	108 (29)	136 (36.5)	94 (25.2)
Leaving class or other scheduled activities early	47 (12.6)	149 (39.9)	112 (30)	52 (13.9)
Being unprepared for class or other scheduled activities	30 (8)	135 (36.2)	131 (35.1)	64 (17.2)
Skipping class or other scheduled activities	69 (18.5)	134 (35.9)	116 (31.1)	43 (11.5)
Being distant and cold towards others	75 (20.1)	144 (38.6)	103 (27.6)	44 (11.8)
Creating tension by dominating class discussion	71 (19)	129 (34.6)	104 (27.9)	61 (16.4)

Table 3 (continued)

Holding side conversations that distract you or others	24 (6.4)	82 (22)	143 (38.3)	115 (30.8)
Cheating on exams or quizzes	183 (49.1)	104 (27.9)	50 (13.4)	28 (7.5)
Making condescending or rude remarks toward others	82 (22)	147 (39.4)	92 (24.7)	44 (11.8)
Demanding make-up exams, extensions, or other special flavors	138 (37)	128 (34.3)	79 (21.2)	21 (5.6)
Ignoring, failing to address, or encouraging disruptive behaviors by classmates	125 (33.5)	136 (36.5)	83 (22.3	21 (5.6)
Demanding a passing grade when a passing grade has not been earned	192 (51.5)	111 (29.8)	42 (11.3)	17 (4.6)
Being unresponsive to emails or other communication	103 (27.6)	151 (40.5)	75 (20.1)	34 (9.1)
Sending inappropriate or rude emails to others	249 (66.8)	83 (22.3)	19 (5.1)	11 (2.9)
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others	244 (65.4)	85 (22.8)	28 (7.5)	10 (2.7)
Using profanity (swearing, cussing) directed toward others	178 (47.7)	110 (29.5)	57 (15.3)	21 (5.6)
Threats of physical harm against others (implied or actual)	316 (84.7)	42 (11.3)	4 (1.1)	4 (1.1)
Property Damage	339 (90.9)	21 (5.6)	2 (.5)	3 (.8)
Making threatening statements about weapons	349 (93.6)	15 (4)	1 (.3)	2 (.5)

Note. $N = 373$. Percentages are in parentheses. Percentages may not total 100 because not all participants responded to all survey items.

The two behaviors identified by most participants as "not uncivil" were: expressing disinterest, boredom, or apathy about course content or subject matter ($n = 87$; 23.3%) and refusing or reluctant to answer direct questions ($n = 81$; 21.7%). The incivility behavior experienced "often" by participants falls about the 50th percentile: using a computer, phone, or other media device during class for unrelated purposes ($n = 202$; 54.2%). Four behaviors are almost tied at the 25th percentile as being experienced "often": holding side conversations that distract you or others ($n = 115$; 30.8%); expressing disinterest, boredom, or apathy about course

content or subject matter (n = 103; 27.6%); sleeping or not paying attention in class (n = 101; 27.1%); and arriving late for class or other scheduled activities (n = 94; 25.2%). These four behaviors can interrupt the continuity of classroom interaction, but were not identified consistently by participants as constituting incivility.

A K-W test was run to determine if there were differences in perceptions of incivility behaviors between seven groups of prelicensure registered nursing student participants rating the 24 incivility behaviors listed in the INE-R Survey (Clark et al., 2015) as: "not uncivil"; "somewhat uncivil"; "moderately uncivil"; and "highly uncivil" on a four-point Likert-type scale. Distributions of perceptions of incivility behavior rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of perceptions for 22 behaviors were not statistically significant between the groups with a range between $\chi^2(6) = 12.301$, p = .056 and $\chi^2(6) = 3.431$, $p = .753$. The mean ranks of two behaviors were statistically significant ($p \leq .05$) between groups, $\chi^2(6) = 14.465$, $p = .025$ (being unprepared for class or other scheduled activities) and $\chi^2(6) = 18.147$, $p = .006$ (skipping class or other scheduled activities).

A K-W test was run to identify differences in reports of the frequency of experienced incivility behaviors between seven groups of prelicensure registered nursing student participants rating the 24 different incivility behaviors listed in the INE-R Survey (Clark et al., 2015) as: "never"; "rarely"; "sometimes"; and "often" on a four-point Likert-type scale. Distributions of reports of frequency of experienced incivility behaviors were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks were not statistically different between groups with a range between $\chi^2(6) = 10.325$, $p = .112$ and $\chi^2(6) = 1.916$, $p = .927$.

Gender Differences. Three hundred thirty-seven (90.3%) females and 31 (8.3%) males participated in the study. Males comprise 15% of the average American undergraduate nursing

classroom (NLN, 2016). This study sample did not match the national average of 15%. Five participants (1.3%) preferred not to identify with either the male or female gender. Perceptions of incivility behaviors differentiated by gender are displayed in Table 4.

Table 4

Perceptions of Incivility Behaviors by Gender

Student Behaviors	Not Uncivil	Somewhat Uncivil	Moderately Uncivil	Highly Uncivil
Expressing disinterest, boredom, or apathy about course content or subject matter				
Prefer not to Answer	1 (.3)	2 (.5)	1 (.3)	1 (.3)
Male	11 (2.9)	15 (4)	3 (.8)	2 (.5)
Female	75 (20.1)	143 (38.3)	84 (22.5)	35 (9.4)
Making rude gestures or non-verbal behaviors toward others				
Prefer not to Answer	0	0	3 (.8)	2 (.5)
Male	5 (1.3)	8 (2.2)	12 (3.2)	5 (1.3)
Female	16 (4.3)	47 (12.6)	98 (26.3)	176 (47.3)
Sleeping or not paying attention in class				
Prefer not to Answer	0	2 (.5)	2 (.5)	1 (.3)
Male	9 (2.4)	13 (3.5)	5 (1.3)	4 (1.1)
Female	44 (11.9)	108 (29.1)	99 (26.7)	84 (22.6)
Refusing or reluctant to answer direct questions				
Prefer not to Answer	1 (.3)	2 (.5)	1 (.3)	1 (.3)
Male	11 (3)	12 (3.2)	6 (1.6)	2 (.5)
Female	69 (18.6)	112 (30.2)	74 (19.9)	80 (21.6)
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes				
Prefer not to Answer	0	1 (.3)	1 (.3)	3 (.8)
Male	2 (.5)	11 (3)	12 (3.3)	6 (1.6)
Female	21 (5.7)	89 (24.1)	113 (30.6)	110 (29.8)
Arriving late for class or other scheduled activities				
Prefer not to Answer	0	2 (.5)	3 (.8)	0
Male	6 (1.6)	7 (1.9)	11 (3)	6 (1.6)
Female	27 (7.3)	121 (32.6)	95 (25.6)	93 (25.1)
Leaving class or other scheduled activities early				
Prefer not to Answer	0	2 (.5)	3 (.8)	0

Table 4 (continued)

Male	9 (2.4)	10 (2.7)	8 (2.2)	4 (1.1)
Female	46 (12.5)	115 (31.3)	115 (31.3)	56 (15.2)
Being unprepared for class or other scheduled activities				
Prefer not to Answer	0	3 (.8)	0	2 (.5)
Male	4 (1.1)	14 (3.8)	11 (3)	2 (.5)
Female	47 (12.7)	130 (35.2)	108 (29.3)	48 (13)
Skipping class or other scheduled activities				
Prefer not to Answer	0	3 (.8)	0	2 (.5)
Male	11 (3)	8 (2.2)	4 (1.1)	7 (1.9)
Female	56 (15.3)	97 (26.5)	95 (26)	83 (22.7)
Being distant and cold towards others				
Prefer not to Answer	0	1 (.3)	1 (.3)	3 (.8)
Male	5 (1.3)	10 (2.7)	10 (2.7)	6 (1.6)
Female	20 (5.4)	43 (11.6)	105 (28.2)	168 (45.2)
Creating tension by dominating class discussion				
Prefer not to Answer	0	1 (.3)	2 (.5)	2 (.5)
Male	6 (1.6)	11 (3)	8 (2.2)	6 (1.6)
Female	22 (5.9)	73 (19.7)	128 (34.6)	111 (30)
Holding side conversations that distract you or others				
Prefer not to Answer	0	2 (.5)	1 (.3)	2 (.5)
Male	4 (1.1)	10 (2.7)	9 (2.4)	8 (2.2)
Female	13 (3.5)	44 (11.8)	119 (32)	160 (43)
Cheating on exams or quizzes				
Prefer not to Answer	0	1 (.3)	0	4 (1.1)
Male	9 (2.4)	2 (.5)	1 (.3)	19 (5.1)
Female	27 (7.3)	7 (1.9)	30 (8.1)	269 (72.9)
Making condescending or rude remarks toward others				
Prefer not to Answer	0	0	2 (.5)	3 (.8)
Male	8 (1.6)	6 (1.6)	3 (.8)	16 (4.3)
Female	14 (3.8)	21 (5.7)	45 (12.2)	253 (68.6)
Demanding make-up exams, extensions, or other special flavors				
Prefer not to Answer	1 (.3)	0	3 (.8)	1 (.3)
Male	9 (2.4)	5 (1.3)	10 (2.7)	7 (1.9)
Female	28 (7.5)	54 (14.6)	120 (32.3)	133 (35.8)
Ignoring, failing to address, or encouraging disruptive behaviors by classmates				
Prefer not to Answer	0	0	3 (.8)	2 (.5)
Male	9 (2.4)	6 (1.6)	5 (1.3)	11 (3)
Female	24 (6.5)	51 (13.7)	108 (29.1)	152 (41)

Table 4 (continued)

Demanding a passing grade when a passing grade has not been earned				
Prefer not to Answer	0	1 (.3)	1 (.3)	3 (.8)
Male	7 (1.9)	3 (.8)	7 (1.9)	14 (3.8)
Female	26 (7)	24 (6.5)	64 (17.3)	220 (59.5)
Being unresponsive to emails or other communication				
Prefer not to Answer	0	2 (.5)	1 (.3)	2 (.5)
Male	7 (1.9)	7 (1.9)	8 (2.2)	7 (1.9)
Female	22 (5.9)	92 (24.9)	120 (32.4)	102 (27.6)
Sending inappropriate or rude emails to others				
Prefer not to Answer	0	0	0	4 (1.1)
Male	9 (2.4)	1 (.3)	8 (2.2)	13 (8.4)
Female	25 (6.8)	11 (3)	49 (13.3)	249 (67.5)
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others				
Prefer not to Answer	0	1 (.3)	0	4 (1.1)
Male	9 (2.4)	1 (.3)	2 (.5)	19 (5.1)
Female	28 (7.5)	3 (.8)	18 (4.8)	287 (77.2)
Using profanity (swearing, cussing) directed toward others				
Prefer not to Answer	0	0	0	4 (1.1)
Male	7 (1.9)	5 (1.3)	9 (2.4)	10 (2.7)
Female	27 (7.3)	24 (6.5)	64 (17.3)	221 (59.6)
Threats of physical harm against others (implied or actual)				
Prefer not to Answer	1 (.3)	0	0	4 (1.1)
Male	8 (2.2)	2 (.5)	1 (.3)	20 (5.4)
Female	28 (7.5)	7 (1.9)	4 (1.1)	297 (79.8)
Property Damage				
Prefer not to Answer	1 (.3)	0	0	4 (1.1)
Male	8 (2.2)	2 (.5)	1 (.3)	20 (5.4)
Female	33 (8.9)	3 (.8)	9 (2.4)	291 (78.2)
Making threatening statements about weapons				
Prefer not to Answer	1 (.3)	0	0	4 (1.1)
Male	8 (2.2)	2 (.5)	0	21 (5.6)
Female	32 (8.6)	2 (.5)	5 (1.3)	297 (79.8)

Note. $N = 373$. Percentages are in parentheses. Percentages may not total 100 because not all participants responded to all survey items.

A K-W test was run to determine if there were differences in perceptions of incivility behaviors between participant gender groups rating the 24 different incivility behaviors listed in

the INE-R Survey (Clark et al., 2015). Distributions of perceptions of incivility behavior rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of perceptions of incivility behavior rankings were significantly different ($p \leq .05$) between 17 of the 24 behaviors with a significance range between $p = .000$ and $p = .045$ as displayed in Table 5.

Table 5

Significant Incivility Behaviors between Gender Groups

Behavior	Test Statistic	Significance
Making rude gestures toward others	17.015	.000
Sending inappropriate or rude emails to others	18.505	.000
Using profanity directed toward others	17.779	.000
Sleeping or not paying attention in class	8.270	.000
Being distant and cold toward others	15.944	.000
Threats of physical harm against others	13.825	.001
Making condescending or rude remarks toward others	12.214	.002
Making discriminating comments toward others	12.945	.002
Holding distracting side conversations	11.312	.003
Property damage	10.798	.005
Making threatening statements about weapons	10.565	.005
Creating tension by dominating class discussion	8.492	.014
Cheating on exams or quizzes	8.528	.014
Demanding make-up exams, extensions	8.124	.017
Demanding a passing grade when not earned	6.954	.031
Refusing or reluctant to answer direct questions	6.802	.033
Ignoring or encouraging disruptive classmate behaviors	6.185	.045

Note. $N = 373$.

Data was analyzed using a K-W test to compare the frequency of experiences of the 24 incivility behaviors listed on the INE-R Survey (Clark et al., 2015) across three gender categories. The distributions of reports of frequency of experienced incivility behaviors were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of 21 behaviors were not significantly different between groups with a range between $\chi^2(2) = 5.841$, $p = .054$ and $\chi^2(2) = .739$, $p = .606$. The mean ranks of three behavior frequencies were significantly different ($p \leq .05$) between groups as displayed in Table 6. The frequency of experienced incivility behaviors from the aggregate data differentiated by gender is displayed in Table 7.

Table 6

Significant Behavior Frequency between Gender Groups

Behaviors	χ^2	p
Sleeping or not paying attention in class	17.203	.000
Demanding a passing grade when it was not earned	7.190	.027
Demanding make-up exams, extensions, or other special favors	6.623	.036

Table 7

Frequency of Experienced Incivility Behaviors by Gender

Student Behaviors	Prefer not to Answer	Male	Female
Expressing disinterest, boredom, or apathy about course content or subject matter			
Never	0	0	23
Rarely	1	9	62
Sometimes	2	16	150
Often	2	4	97
Making rude gestures or non-verbal behaviors toward others			

Table 7 (continued)

Never	0	7	55
Rarely	1	11	111
Sometimes	4	9	105
Often	0	3	58
Sleeping or not paying attention in class			
Never	0	8	43
Rarely	0	12	66
Sometimes	1	8	126
Often	4	3	94
Refusing or reluctant to answer direct questions			
Never	0	10	116
Rarely	3	16	136
Sometimes	1	4	56
Often	1	1	21
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes			
Never	0	1	16
Rarely	0	7	43
Sometimes	1	12	82
Often	4	11	187
Arriving late for class or other scheduled activities			
Never	0	3	26
Rarely	1	12	95
Sometimes	3	10	123
Often	1	5	88
Leaving class or other scheduled activities early			
Never	1	3	43
Rarely	0	16	133
Sometimes	4	6	102
Often	0	4	48
Being unprepared for class or other scheduled activities			
Never	0	4	26
Rarely	1	15	119
Sometimes	3	8	120
Often	1	4	59
Skipping class or other scheduled activities			
Never	0	6	63
Rarely	2	16	116
Sometimes	2	5	109
Often	1	3	39
Being distant and cold towards others			
Never	0	6	69
Rarely	3	15	126
Sometimes	2	8	93

Table 7 (continued)

Often	0	2	42
Creating tension by dominating class discussion			
Never	0	6	65
Rarely	2	14	113
Sometimes	3	7	94
Often	0	4	57
Holding side conversations that distract you or others			
Never	0	3	21
Rarely	1	10	71
Sometimes	2	14	127
Often	2	4	109
Cheating on exams or quizzes			
Never	0	16	167
Rarely	3	12	89
Sometimes	1	2	47
Often	1	1	26
Making condescending or rude remarks toward others			
Never	0	6	76
Rarely	2	13	132
Sometimes	3	10	79
Often	0	2	42
Demanding make-up exams, extensions, or other special flavors			
Never	0	10	128
Rarely	1	13	114
Sometimes	3	5	71
Often	1	3	17
Ignoring, failing to address, or encouraging disruptive behaviors by classmates			
Never	1	15	109
Rarely	1	11	124
Sometimes	3	3	77
Often	0	2	19
Demanding a passing grade when a passing grade has not been earned			
Never	0	17	175
Rarely	2	8	101
Sometimes	3	4	35
Often	0	1	16
Being unresponsive to emails or other communication			
Never	0	10	93
Rarely	1	11	139
Sometimes	4	4	67
Often	0	5	29
Sending inappropriate or rude emails to others			
Never	3	24	222

Table 7 (continued)

Rarely	1	5	77
Sometimes	0	1	18
Often	0	1	10
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others			
Never	2	18	224
Rarely	1	9	75
Sometimes	1	3	24
Often	1	1	8
Using profanity (swearing, cussing) directed toward others			
Never	1	13	164
Rarely	3	9	98
Sometimes	0	6	51
Often	0	3	18
Threats of physical harm against others (implied or actual)			
Never	3	27	286
Rarely	2	2	38
Sometimes	0	1	3
Often	0	1	3
Property Damage			
Never	4	26	309
Rarely	1	4	16
Sometimes	0	2	0
Often	0	1	2
Making threatening statements about weapons			
Never	4	28	317
Rarely	1	2	12
Sometimes	0	1	0
Often	0	1	1

Note. $N = 373$.

Age Differences. Table 8 displays the significant K-W test analysis results of student perceptions of incivility behaviors between the six participant age groups. Distributions of perceptions of incivility behavior rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean rank of perceptions of incivility behavior rankings were statistically significant ($p \leq .05$) for three behaviors. Table 9 displays the perceptions of the 24 incivility behaviors listed in the INE-R (Clark et al., 2015) differentiated by the six age groups.

Table 8

Significant Incivility Behaviors between Age Groups

Behaviors	χ^2	*p*
Skipping class or other scheduled activities	16.246	.006
Being unprepared for class or other scheduled activities	15.643	.008
Expressing disinterest, boredom, or apathy about course content or subject matter	12.728	.026

Table 9

Perceptions of Incivility Behaviors by Age

Student Behaviors	Not Uncivil	Somewhat Uncivil	Moderately Uncivil	Highly Uncivil
Expressing disinterest, boredom, or apathy about course content or subject matter				
18 – 24	21 (5.6)	54 (14.5)	38 (10.2)	17 (4.6)
25 – 34	33 (8.9)	58 (15.6)	21 (5.6)	10 (2.7)
35 – 44	21 (5.6)	27 (7.3)	17 (4.6)	5 (1.3)
45 – 54	9 (2.4)	18 (4.8)	9 (2.4)	3 (.8)
55 – 64	3 (.8)	3 (.8)	3 (.8)	1 (.3)
65 - Over	0	0	0	1 (.3)
Making rude gestures or non-verbal behaviors toward others				
18 – 24	10 (2.7)	16 (4.3)	44 (11.9)	60 (16.2
25 – 34	5 (1.3)	18 (4.9)	39 (10.5)	60 (16.2)
35 – 44	5 (1.3)	12 (3.2)	20 (5.4)	32 (8.6)
45 – 54	1 (.3)	7 (1.9)	9 (2.4)	22 (5.9)
55 – 64	0	2 (.5)	1 (.3)	7 (1.9)
65 - Over	0	0	0	1 (.3)
Sleeping or not paying attention in class				
18 – 24	12 (3.2)	41 (11.1)	44 (11.9)	32 (8.6)
25 – 34	17 (4.6)	47 (12.7)	34 (9.2)	24 (6.5)
35 – 44	20 (5.4)	17 (4.6)	14 (3.8)	18 (4.9)
45 – 54	3 (.8)	14 (3.8)	12 (3.2)	10 (2.7)
55 – 64	1 (.3)	4 (1.1)	2 (.5)	3 (.8)
65 - Over	0	0	0	1 (.3)
Refusing or reluctant to answer direct questions				
18 – 24	24 (6.5)	48 (13)	26 (7)	32 (8.6)

Table 9 (continued)

25 – 34	29 (7.8)	40 (10.8)	33 (8.9)	19 (5.1)
35 – 44	13 (3.5)	27 (7.3)	9 (2.4)	20 (5.4)
45 – 54	12 (3.2)	9 (2.4)	10 (2.7)	8 (2.2)
55 – 64	3 (.8)	2 (.5)	3 (.8)	2 (.5)
65 - Over	0	0	0	1 (.3)
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes				
18 – 24	8 (2.2)	31 (8.4)	46 (12.5)	44 (12)
25 – 34	6 (1.6)	38 (10.3)	43 (11.7)	34 (9.2)
35 – 44	9 (2.4)	18 (4.9)	20 (5.4)	22 (6)
45 – 54	0	11 (3)	12 (3.3)	15 (4.1)
55 – 64	0	3 (.8)	5 (1.4)	2 (.5)
65 - Over	0	0	0	1 (.3)
Arriving late for class or other scheduled activities				
18 – 24	7 (1.9)	44 (11.9)	36 (9.7)	43 (11.6)
25 – 34	12 (3.2)	39 (10.5)	38 (10.3)	32 (8.6)
35 – 44	11 (3)	25 (6.8)	16 (4.3)	17 (4.6)
45 – 54	2 (.5)	20 (5.4)	12 (3.2)	5 (1.4)
55 – 64	1 (.3)	2 (.5)	6 (1.6)	1 (.3)
65 - Over	0	0	0	1 (.3)
Leaving class or other scheduled activities early				
18 – 24	15 (4.1)	43 (11.7)	47 (12.8)	25 (6.8)
25 – 34	14 (3.8)	43 (11.7)	45 (12.3)	19 (5.2)
35 – 44	17 (4.6)	23 (6.3)	18 (4.9)	11 (3)
45 – 54	6 (1.6)	16 (4.4)	11 (3)	3 (.8)
55 – 64	3 (.8)	2 (.5)	4 (1.1)	1 (.3)
65 - Over	0	0	0	1 (.3)
Being unprepared for class or other scheduled activities				
18 – 24	9 (2.4)	46 (12.5)	49 (13.3)	24 (6.5)
25 – 34	21 (5.7)	52 (14.1)	33 (9)	15 (4.1)
35 – 44	14 (3.8)	28 (7.6)	20 (5.4)	7 (1.9)
45 – 54	6 (1.6)	17 (4.6)	12 (3.3)	4 (1.1)
55 – 64	1 (.3)	4 (1.1)	5 (1.4)	0
65 – Over	0	0	0	1 (.3)
Skipping class or other scheduled activities				
18 – 24	16 (4.4)	32 (8.8)	33 (9)	47 (12.9)
25 – 34	23 (6.3)	41 (11.2)	35 (9.6)	22 (6)
35 – 44	18 (4.9)	20 (5.5)	14 (3.8)	14 (3.8)
45 – 54	7 (1.9)	13 (3.6)	13 (3.6)	6 (1.6)
55 – 64	3 (.8)	2 (.5)	3 (.8)	2 (.5)
65 – Over	0	0	0	1 (.3)
Being distant and cold towards others				

Table 9 (continued)

18 – 24	8 (2.2)	17 (4.6)	37 (10)	68 (18.3)
25 – 34	8 (2.2)	12 (3.2)	44 (11.9)	58 (15.6)
35 – 44	7 (1.9)	17 (4.6)	19 (5.1)	26 (7)
45 – 54	1 (.3)	7 (1.9)	13 (3.5)	18 (4.9)
55 – 64	1 (.3)	1 (.3)	3 (.8)	5 (1.3)
65 - Over	0	0	0	1 (.3)
Creating tension by dominating class discussion				
18 – 24	12 (3.3)	32 (8.7)	36 (9.8)	50 (13.6)
25 – 34	7 (1.9)	22 (6)	57 (15.4)	36 (9.8)
35 – 44	7 (1.9)	22 (6)	23 (6.2)	16 (4.3)
45 – 54	2 (.5)	9 (2.4)	18 (4.9)	10 (2.7)
55 – 64	0	0	4 (1.1)	5 (1.4)
65 - Over	0	0	0	1 (.3)
Holding side conversations that distract you or others				
18 – 24	7 (1.9)	23 (6.2)	45 (12.1)	55 (14.8)
25 – 34	5 (1.3)	17 (4.6)	48 (12.9)	52 (14)
35 – 44	4 (1.1)	9 (2.4)	23 (6.2)	33 (8.9)
45 – 54	1 (.3)	6 (1.6)	9 (2.4)	23 (6.2)
55 – 64	0	1 (.3)	4 (1.1)	5 (1.3)
65 - Over	0	0	0	1 (.3)
Cheating on exams or quizzes				
18 – 24	11 (3)	3 (.8)	9 (2.4)	107 (29.1)
25 – 34	11 (3)	5 (1.4)	10 (2.7)	95 (25.8)
35 – 44	7 (1.9)	2 (.5)	9 (2.4)	49 (13.3)
45 – 54	6 (1.6)	0	2 (.5)	31 (8.4)
55 – 64	1 (.3)	0	1 (.3)	8 (2.2)
65 - Over	0	0	0	1 (.3)
Making condescending or rude remarks toward others				
18 – 24	7 (1.9)	7 (1.9)	17 (4.6)	99 (26.9)
25 – 34	6 (1.6)	9 (2.4)	21 (5.7)	85 (23.1)
35 – 44	6 (1.6)	4 (1.1)	9 (2.4)	48 (13)
45 – 54	1 (.3)	6 (1.6)	2 (.5)	30 (8.2)
55 – 64	0	1 (.3)	1 (.3)	8 (2.2)
65 - Over	0	0	0	1 (.3)
Demanding make-up exams, extensions, or other special flavors				
18 – 24	9 (2.4)	23 (6.2)	48 (13)	49 (13.2)
25 – 34	15 (4.1)	15 (4.1)	53 (14.3)	39 (10.5)
35 – 44	9 (2.4)	14 (3.8)	17 (4.6)	29 (7.8)
45 – 54	4 (1.1)	5 (1.4)	11 (3)	19 (5.1)
55 – 64	1 (.3)	2 (.5)	4 (1.1)	3 (.8)
65 - Over	0	0	0	1 (.5)
Ignoring, failing to address, or encouraging				

Table 9 (continued)

disruptive behaviors by classmates				
18 – 24	9 (2.4)	20 (5.4)	42 (11.4)	59 (15.9)
25 – 34	12 (3.2)	17 (4.6)	46 (12.4)	47 (12.7)
35 – 44	6 (1.6)	18 (4.9)	15 (4.1)	29 (7.8)
45 – 54	5 (1.4)	2 (.5)	10 (2.7)	22 (5.9)
55 – 64	1 (.3)	0	3 (.8)	6 (1.6)
65 - Over	0	0	0	1 (.3)
Demanding a passing grade when a passing grade has not been earned				
18 – 24	8 (2.2)	9 (2.4)	27 (7.3)	86 (23.3)
25 – 34	10 (2.7)	11 (3)	25 (6.8)	74 (20.1)
35 – 44	9 (2.4)	6 (1.6)	13 (3.5)	41 (11.1)
45 – 54	5 (1.4)	1 (.3)	6 (1.6)	27 (7.3)
55 – 64	1 (.3)	1 (.3)	1 (.3)	7 (1.9)
65 - Over	0	0	0	1 (.3)
Being unresponsive to emails or other communication				
18 – 24	8 (2.2)	32 (8.7)	48 (13)	41 (11.1)
25 – 34	9 (2.4)	39 (10.6)	38 (10.3)	35 (9.5)
35 – 44	7 (1.9)	22 (6)	25 (6.8)	15 (4.1)
45 – 54	4 (1.1)	7 (1.9)	14 (3.8)	14 (3.8)
55 – 64	1 (.3)	1 (.3)	4 (1.1)	4 (1.1)
65 - Over	0	0	0	1 (.3)
Sending inappropriate or rude emails to others				
18 – 24	10 (2.7)	6 (1.6)	20 (5.4)	93 (25.3)
25 – 34	13 (3.5)	4 (1.1)	20 (5.4)	83 (22.6)
35 – 44	6 (1.6)	1 (.3)	12 (3.3)	50 (13.6)
45 – 54	5 (1.4)	1 (.3)	3 (.8)	30 (8.2)
55 – 64	0	0	2 (.5)	8 (2.2)
65 - Over	0	0	0	1 (.3)
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others				
18 – 24	13 (3.5)	1 (.3)	7 (1.9)	109 (29.4)
25 – 34	12 (3.2)	3 (.8)	8 (2.2)	99 (26.7)
35 – 44	6 (1.6)	1 (.3)	3 (.8)	59 (15.9)
45 – 54	5 (1.3)	0	1 (.3)	33 (8.9)
55 – 64	1 (.3)	0	1 (.3)	8 (2.2)
65 - Over	0	0	0	1 (.3)
Using profanity (swearing, cussing) directed toward others				
18 – 24	11 (3)	12 (3.2)	26 (7)	81 (21.9)
25 – 34	13 (3.5)	10 (2.7)	28 (7.6)	70 (18.9)
35 – 44	4 (1.1)	6 (1.6)	14 (3.8)	45 (12.2)
45 – 54	5 (1.4)	1 (.3)	3 (.8)	30 (8.1)
55 – 64	1 (.3)	0	2 (.5)	7 (1.9)
65 - Over	0	0	0	1 (.3)

Table 9 (continued)

Threats of physical harm against others (implied or actual)				
18 – 24	12 (3.2)	4 (1.1)	2 (.5)	112 (30.2)
25 – 34	13 (3.5)	4 (1.1)	2 (.5)	103 (27.8)
35 – 44	6 (1.6)	1 (.3)	1 (.3)	61 (16.4)
45 – 54	5 (1.3)	0	0	34 (9.2)
55 – 64	1 (.3)	0	0	9 (2.4)
65 - Over	0	0	0	1 (.3)
Property Damage				
18 – 24	13 (3.5)	2 (.5)	4 (1.1)	111 (29.9)
25 – 34	15 (4)	2 (.5)	4 (1.1)	101 (27.2)
35 – 44	8 (2.2)	1 (.3)	2 (.5)	58 (15.6)
45 – 54	5 (1.3)	0	0	34 (9.2)
55 – 64	1 (.3)	0	0	9 (2.4)
65 - Over	0	0	0	1 (.3)
Making threatening statements about weapons				
18 – 24	13 (3.5)	2 (.5)	2 (.5)	113 (30.5)
25 – 34	15 (4)	2 (.5)	2 (.5)	103 (27.8)
35 – 44	7 (1.9)	0	1 (.3)	61 (16.4)
45 – 54	5 (1.3)	0	0	34 (9.2)
55 – 64	1 (.3)	0	0	9 (2.4)
65 - Over	0	0	0	1 (.3)

Note. $N = 373$. Percentages are in parentheses. Percentages may not total 100 because not all participants responded to all survey items.

The differences in reports of the frequency of experienced incivility behaviors between the six participant age groups rating the 24 different incivility behaviors listed in the INE-R Survey (Clark et al., 2015) were analyzed using a K-W test. Distributions of reports of frequency of experienced incivility behaviors were not similar for 19 behaviors, assessed by visual inspection of a boxplot. The different mean ranks ranged between $\chi^2(5) = 9.541$, $p = .089$ and $\chi^2(5) = 2.703$, $p = .746$. Table 10 displays the five behaviors identified by the K-W test with statistically significant frequencies between the six age groups.

Table 10

Significant Frequency of Incivility Behaviors by Age

Behaviors	χ^2	*p*
Making threatening statements about weapons	25.177	.000
Property damage	18.998	.002
Demanding make-up exams, extensions	14.630	.012
Threats of physical harm against others	14.326	.014
Ignoring or encouraging disruptive classmate behaviors	11.281	.046

Race/ethnicity Differences. Differences in participant perceptions of the 24 incivility behaviors listed in the INE-R Survey (Clark et al., 2015) between the ten race/ethnicity groups were analyzed using the K-W test. Distributions of perceptions of incivility behavior rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean rank of perceptions were not statistically different between groups ranging between, $\chi^2(9) = 16.619$, $p = .055$ and $\chi^2(9) = 4.912$, $p = .842$. Table 11 displays the three incivility behaviors with mean ranks that were statistically significant between race/ethnicity groups.

Table 11

Significant Incivility Behaviors between Race/Ethnicity Groups

Behaviors	χ^2	*p*
Sleeping or not paying attention in class	19.188	.024
Refusing or reluctant to answer direct questions	18.914	.026
Being unresponsive to emails or other communication	17.291	.044

A K-W test was run to identify differences in reports of the frequency of experienced incivility behaviors between the ten race/ethnicity groups. Reports of frequency of experienced incivility behaviors were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks were not significantly different for 18 of the 24 behavior frequencies ranging from $\chi^2(9) = 16.600$, $p = .055$ to $\chi^2(9) = 5.299$, $p = .807$. Table 12 contains the six behavior frequencies that were statistically significant. Table 13 displays the participant data differentiated by the ten race/ethnicity groups for the frequency of experiencing the 24 incivility behaviors listed in the INE-R (Clark et al., 2015).

Table 12

Significant Behavior Frequency between Race/Ethnicity Groups

Behaviors	χ^2	*p*
Property damage	36.252	.000
Making discriminating comments	28.812	.001
Ignoring or encouraging disruptive behavior	25.295	.003
Being unresponsive to emails or other communication	19.551	.021
Refusing or reluctant to answer direct questions	18.362	.032
Being unprepared for class	17.783	.038

Table 13

Perceptions of Incivility Behaviors by Race/Ethnicity

Student Behaviors	Not Uncivil	Somewhat Uncivil	Moderately Uncivil	Highly Uncivil
Expressing disinterest, boredom, or apathy about course content or subject matter				
Prefer not to Respond	0	4 (1.1)	4 (1.1)	1 (.3)
Arab or Arab American	0	1 (.3)	0	2 (.5)

Table 13 (continued)

Asian or Asian American	7 (1.9)	4 (1.1)	4 (1.1)	1 (.3)
Black, Afro-Caribbean, or African American	5 (1.3)	5 (1.3)	6 (1.6)	5 (1.3)
Caucasian, Non-Hispanic White, or Euro-American	59 (15.8)	118 (31.6)	61 (116.4)	23 (6.2)
Latino or Hispanic	7 (1.9)	12 (3.2)	11 (2.9)	2 (.5)
Multiracial	8 (2.1)	11 (2.9)	2 (.5)	2 (.5)
Native American or Alaskan Native	1 (.3)	3 (.8)	0	0
Native Hawaiian or Pacific Islander	0	2 (.5)	0	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Making rude gestures or non-verbal behaviors toward others				
Prefer not to Respond	0	1 (.3)	3 (.8)	5 (1.3)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	1 (.3)	3 (.8)	6 (1.6)	6 (1.6)
Black, Afro-Caribbean, or African American	1 (.3)	3 (.8)	1 (.3)	16 (4.3)
Caucasian, Non-Hispanic White, or Euro-American	15 (4)	37 (9.9)	85 (22.8)	123 (33.1)
Latino or Hispanic	2 (.5)	5 (1.3)	10 (2.7)	15 (4)
Multiracial	1 (.3)	5 (1.3)	6 (5.3)	11 (3)
Native American or Alaskan Native	1 (.3)	1 (.3)	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	2 (.5)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Sleeping or not paying attention in class				
Prefer not to Respond	0	2 (.5)	3 (.8)	4 (1.1)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	3 (.8)	7 (1.9)	4 (1.1)	2 (.5)
Black, Afro-Caribbean, or African American	4 (1.1)	2 (.5)	4 (1.1)	11 (3)
Caucasian, Non-Hispanic White, or Euro-American	38 (10.2)	89 (24)	77 (20.8)	55 (14.8)
Latino or Hispanic	6 (1.6)	9 (2.4)	9 (2.4)	8 (2.2)
Multiracial	2 (.5)	11 (3)	7 (1.9)	3 (.8)
Native American or Alaskan Native	0	3 (.8)	0	1 (.3)
Native Hawaiian or Pacific Islander	0	0	2 (.5)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Refusing or reluctant to answer direct questions				
Prefer not to Respond	1 (.3)	3 (.8)	3 (.8)	2 (.5)
Arab or Arab American	0	0	1 (.3)	2 (.5)
Asian or Asian American	4 (1.1)	8 (2.2)	3 (.8)	1 (.3)
Black, Afro-Caribbean, or African American	4 (1.1)	7 (1.9)	6 (1.6)	4 (1.1)
Caucasian, Non-Hispanic White, or Euro-American	58 (15.6)	89 (24)	55 (14.8)	58 (15.6)
Latino or Hispanic	7 (1.9)	10 (2.7)	7 (1.9)	7 (1.9)
Multiracial	3 (.8)	8 (2.2)	6 (1.6)	6 (1.6)
Native American or Alaskan Native	4 (1.1)	0	0	0
Native Hawaiian or Pacific Islander	0	1 (.3)	0	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes				
Prefer not to Respond	0	1 (.3)	4 (1.1	4 (1.1)

Table 13 (continued)

Arab or Arab American	0	0	2 (.5)	1 (.3)
Asian or Asian American	0	5 (1.4)	6 (1.6)	5 (1.4)
Black, Afro-Caribbean, or African American	2 (.5)	3 (.8)	5 (1.4)	10 (2.7)
Caucasian, Non-Hispanic White, or Euro-American	18 (4.9)	80 (21.7)	85 (23)	75 (20.3)
Latino or Hispanic	1 (.3)	8 (2.2)	10 (2.7)	13 (3.5)
Multiracial	2 (.5)	3 (.8)	10 (2.7)	8 (2.2)
Native American or Alaskan Native	0	1 (.3)	2 (.5)	1 (.3)
Native Hawaiian or Pacific Islander	0	0	2 (.5)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Arriving late for class or other scheduled activities				
Prefer not to Respond	1 (.3)	4 (1.1)	4 (1.1)	0
Arab or Arab American	0	1 (.3)	0	2 (.5)
Asian or Asian American	2 (.5)	6 (1.6)	7 (1.9)	1 (.3)
Black, Afro-Caribbean, or African American	3 (.8)	8 (2.2)	5 (1.3)	5 (1.3)
Caucasian, Non-Hispanic White, or Euro-American	21 (5.7)	93 (25.1)	73 (19.7)	72 (19.4)
Latino or Hispanic	3 (.8)	11 (3)	9 (2.4)	9 (2.4)
Multiracial	2 (.5)	6 (1.6)	8 (2.2)	7 (1.9)
Native American or Alaskan Native	1 (.3)	1 (.3)	1 (.3)	1 (.3)
Native Hawaiian or Pacific Islander	0	0	2 (.5)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Leaving class or other scheduled activities early				
Prefer not to Respond	1 (.3)	5 (1.4)	3 (.8)	0
Arab or Arab American	0	0	1 (.3)	2 (.5)
Asian or Asian American	2 (.5)	5 (1.4)	8 (2.2)	1 (.3)
Black, Afro-Caribbean, or African American	3 (.8)	8 (2.2)	6 (1.6)	3 (.8)
Caucasian, Non-Hispanic White, or Euro-American	41 (11.1)	87 (23.6)	91 (24.7)	38 (10.3)
Latino or Hispanic	5 (1.4)	9 (2.4)	11 (3)	7 (1.9)
Multiracial	1 (.3)	11 (3)	5 (1.4)	6 (1.6)
Native American or Alaskan Native	1 (.3)	2 (.6)	0	1 (.3)
Native Hawaiian or Pacific Islander	1 (.3)	0	1 (.3)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Being unprepared for class or other scheduled activities				
Prefer not to Respond	1 (.3)	5 (1.4)	3 (.8)	0
Arab or Arab American	0	1 (.3)	1 (.3)	1 (.3)
Asian or Asian American	1 (.3)	10 (2.7)	3 (.8)	2 (.5)
Black, Afro-Caribbean, or African American	6 (1.6)	4 (1.1)	8 (2.2)	3 (.8)
Caucasian, Non-Hispanic White, or Euro-American	35 (9.5)	103 (27.9)	88 (23.8)	33 (8.9)
Latino or Hispanic	4 (1.1)	13 (3.5)	8 (2.2)	6 (1.6)
Multiracial	2 (.5)	8 (2.2)	7 (1.9)	5 (1.4)
Native American or Alaskan Native	2 (.5)	2 (.5)	0	0
Native Hawaiian or Pacific Islander	0	1 (.3)	1 (.3)	1 (.3)
Other Race or Ethnicity	0	0	0	1 (.3)
Skipping class or other scheduled activities				
Prefer not to Respond	2 (.5)	2 (.5)	3 (.8)	2 (.5)
Arab or Arab American	1 (.3)	0	0	2 (.5)

Table 13 (continued)

Asian or Asian American	2 (.5)	6 (1.6)	4 (1.1)	4 (1.1)
Black, Afro-Caribbean, or African American	4 (1.1)	6 (1.6)	2 (.5)	9 (2.5)
Caucasian, Non-Hispanic White, or Euro-American	50 (13.7)	77 (21)	78 (21.3)	51 (13.9)
Latino or Hispanic	5 (1.4)	10 (2.7)	5 (1.4)	11 (3)
Multiracial	2 (.5)	6 (1.6)	5 (1.4)	10 (2.7)
Native American or Alaskan Native	1 (.3)	1 (.3)	2 (.5)	0
Native Hawaiian or Pacific Islander	0	0	0	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Being distant and cold towards others				
Prefer not to Respond	1 (.3)	2 (.5)	2 (.5)	4 (1.1)
Arab or Arab American	0	0	1 (.3)	2 (.5)
Asian or Asian American	1 (.3)	3 (.8)	8 (2.2)	4 (1.1)
Black, Afro-Caribbean, or African American	2 (.5)	2 (.5)	5 (1.3)	12 (3.2)
Caucasian, Non-Hispanic White, or Euro-American	14 (3.8)	40 (10.8)	89 (2.9)	117 (31.5)
Latino or Hispanic	4 (1.1)	4 (1.1)	6 (1.6)	18 (4.8)
Multiracial	3 (.8)	2 (.5)	4 (1.1)	14 (3.8)
Native American or Alaskan Native	0	1 (.3)	1 (.3)	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Creating tension by dominating class discussion				
Prefer not to Respond	1 (.3)	2 (.5)	4 (1.1)	2 (.5)
Arab or Arab American	1 (.3)	0	0	2 (.5)
Asian or Asian American	1 (.3)	3 (.8)	9 (2.4)	3 (.5)
Black, Afro-Caribbean, or African American	4 (1.1)	1 (.3)	7 (1.9)	9 (2.4)
Caucasian, Non-Hispanic White, or Euro-American	13 (3.5)	70 (18.9)	101 (27.3)	75 (20.3)
Latino or Hispanic	4 (1.1)	5 (1.4)	10 (2.7)	13 (3.5)
Multiracial	3 (.8)	2 (.5)	5 (1.4)	12 (3.2)
Native American or Alaskan Native	1 (.3)	2 (.5)	1 (.3)	0
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Holding side conversations that distract you or others				
Prefer not to Respond	0	2 (.5)	3 (.8)	4 (1.1)
Arab or Arab American	0	0	1 (.3)	2 (.5)
Asian or Asian American	1 (.3)	2 (.5)	5 (1.3)	8 (2.2)
Black, Afro-Caribbean, or African American	3 (.8)	2 (.5)	6 (1.6)	10 (2.7)
Caucasian, Non-Hispanic White, or Euro-American	10 (2.7)	38 (10.2)	96 (25.8)	116 (31.2)
Latino or Hispanic	2 (.5)	3 (.8)	11 (3)	16 (4.3)
Multiracial	1 (.3)	6 (1.6)	5 (1.3)	11 (3)
Native American or Alaskan Native	0	3 (.8)	1 (.3)	0
Native Hawaiian or Pacific Islander	0	0	1 (.3)	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Cheating on exams or quizzes				
Prefer not to Respond	1 (.3)	1 (.3)	0	7 (1.9)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	2 (.5)	1 (.3)	1 (.3)	11 (3)
Black, Afro-Caribbean, or African American	6 (1.6)	0	1 (.3)	14 (3.8)

Table 13 (continued)

Caucasian, Non-Hispanic White, or Euro-American	18 (4.9)	7 (1.9)	24 (6.5)	210 (56.9)
Latino or Hispanic	4 (1.1)	1 (.3)	3 (.8)	24 (6.5)
Multiracial	4 (1.1)	0	2 (.5)	17 (4.6)
Native American or Alaskan Native	1 (.3)	0	0	3 (.8)
Native Hawaiian or Pacific Islander	0	0	0	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Making condescending or rude remarks toward others				
Prefer not to Respond	0	1 (.3)	1 (.3)	7 (1.9)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	1 (.3)	1 (.3)	2 (.5)	12 (3.3)
Black, Afro-Caribbean, or African American	3 (.8)	2 (.5)	1 (.3)	14 (3.8)
Caucasian, Non-Hispanic White, or Euro-American	10 (2.7)	19 (5.1)	37 (10)	193 (52.3)
Latino or Hispanic	3 (.8)	1 (.3)	6 (1.6)	22 (6)
Multiracial	2 (.5)	2 (.5)	3 (.8)	16 (4.3)
Native American or Alaskan Native	1 (.3)	1 (.3)	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Demanding make-up exams, extensions, or other special flavors				
Prefer not to Respond	2 (.5)	2 (.5)	1 (.3)	4 (1.1)
Arab or Arab American	1 (.3)	0	0	2 (.5)
Asian or Asian American	2 (.5)	2 (.5)	9 (2.4)	3 (.8)
Black, Afro-Caribbean, or African American	3 (.8)	2 (.5)	7 (1.9)	9 (2.4)
Caucasian, Non-Hispanic White, or Euro-American	20 (5.4)	44 (11.9)	96 (25.9)	99 (26.7)
Latino or Hispanic	4 (1.1)	5 (1.3)	12 (3.2)	11 (3)
Multiracial	5 (1.3)	2 (.5)	6 (1.6)	10 (2.7)
Native American or Alaskan Native	1 (.3)	1 (.3)	2 (.5)	0
Native Hawaiian or Pacific Islander	0	1 (.3)	0	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Ignoring, failing to address, or encouraging disruptive behaviors by classmates				
Prefer not to Respond	0	1 (.3)	2 (.5)	6 (1.6)
Arab or Arab American	0	1 (.3)	0	2 (.5)
Asian or Asian American	1 (.3)	5 (1.3)	4 (1.1)	6 (1.6)
Black, Afro-Caribbean, or African American	3 (.8)	2 (.5)	6 (1.6)	10 (2.7)
Caucasian, Non-Hispanic White, or Euro-American	19 (5.1)	46 (12.4)	90 (24.3)	104 (28)
Latino or Hispanic	4 (1.1)	1 (.3)	8 (2.2)	19 (5.1)
Multiracial	4 (1.1)	1 (.3)	4 (1.1)	14 (3.8)
Native American or Alaskan Native	2 (.5)	0	1 (.3)	1 (.3)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Demanding a passing grade when a passing grade has not been earned				
Prefer not to Respond	1 (.3)	1 (.3)	1 (.3)	6 (1.6)
Arab or Arab American	1 (.3)	0	0	2 (.5)

Table 13 (continued)

Asian or Asian American	3 (.8)	0	3 (.8)	10 (2.7)
Black, Afro-Caribbean, or African American	3 (.8)	2 (.5)	4 (1.1)	11 (3)
Caucasian, Non-Hispanic White, or Euro-American	18 (4.9)	21 (5.7)	53 (14.3)	167 (45.1)
Latino or Hispanic	2 (.5)	2 (.5)	7 (1.9)	21 (5.7)
Multiracial	3 (.8)	2 (.5)	4 (1.1)	14 (3.8)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Being unresponsive to emails or other communication				
Prefer not to Respond	0	2 (.5)	3 (.8)	4 (1.1)
Arab or Arab American	0	1 (.3)	0	2 (.5)
Asian or Asian American	1 (.3)	6 (1.6)	3 (.8)	6 (1.6)
Black, Afro-Caribbean, or African American	3 (.8)	5 (1.4)	7 (1.9)	5 (1.4)
Caucasian, Non-Hispanic White, or Euro-American	15 (4.1)	81 (21.9)	95 (25.7)	68 (18.4)
Latino or Hispanic	4 (1.1)	2 (.5)	11 (3)	15 (4.1)
Multiracial	3 (.8)	4 (1.1)	8 (2.2)	8 (2.2)
Native American or Alaskan Native	3 (.8)	0	1 (.3)	0
Native Hawaiian or Pacific Islander	0	0	1 (.3)	2 (.5)
Other Race or Ethnicity	0	0	0	1 (.3)
Sending inappropriate or rude emails to others				
Prefer not to Respond	0	1 (.3)	1 (.3)	6 (1.6)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	2 (.5)	0	1 (.3)	13 (3.5)
Black, Afro-Caribbean, or African American	3 (.8)	1 (.3)	3 (.8)	14 (3.8)
Caucasian, Non-Hispanic White, or Euro-American	19 (5.1)	9 (2.4)	44 (11.9)	186 (50.4)
Latino or Hispanic	3 (.8)	1 (.3)	6 (1.6)	22 (6)
Multiracial	5 (1.4)	0	2 (.5)	16 (4.3)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Making discriminating comments (racial, ethnic, gender, etc.) directed toward others				
Prefer not to Respond	1 (.3)	1 (.3)	0	7 (1.9)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	1 (.3)	1 (.3)	1 (.3)	13 (3.5)
Black, Afro-Caribbean, or African American	3 (.8)	1 (.3)	1 (.3)	16 (4.3)
Caucasian, Non-Hispanic White, or Euro-American	22 (5.9)	2 (.5)	13 (3.5)	223 (59.9)
Latino or Hispanic	3 (.8)	0	5 (1.3)	24 (6.5)
Multiracial	5 (1.3)	0	0	18 (4.8)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Using profanity (swearing, cussing) directed toward others				
Prefer not to Respond	0	1 (.3)	0	7 (1.9)

Table 13 (continued)

Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	2 (.5)	0	5 (1.3)	9 (2.4)
Black, Afro-Caribbean, or African American	3 (.8)	1 (.3)	5 (1.3)	12 (3.2)
Caucasian, Non-Hispanic White, or Euro-American	21 (5.7)	23 (6.2)	56 (15.1)	160 (43.1)
Latino or Hispanic	4 (1.1)	1 (.3)	5 (1.3)	22 (5.9)
Multiracial	2 (.5)	3 (.8)	2 (.5)	16 (4.3)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Threats of physical harm against others (implied or actual)				
Prefer not to Respond	2 (.5)	0	0	7 (1.9)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	2 (.5)	0	0	14 (3.8)
Black, Afro-Caribbean, or African American	4 (1.1)	1 (.3)	0	16 (4.3)
Caucasian, Non-Hispanic White, or Euro-American	19 (5.1)	7 (1.9)	4 (1.1)	230 (61.8)
Latino or Hispanic	3 (.8)	1 (.3)	1 (.3)	27 (7.3)
Multiracial	5 (1.3)	0	0	18 (4.8)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Property Damage				
Prefer not to Respond	2 (.5)	0	0	7 (1.9)
Arab or Arab American	1 (.3)	0	0	2 (.5)
Asian or Asian American	2 (.5)	1 (.3)	0	13 (3.5)
Black, Afro-Caribbean, or African American	4 (1.1)	1 (.3)	0	16 (4.3)
Caucasian, Non-Hispanic White, or Euro-American	23 (6.2)	2 (.5)	9 (2.4)	226 (60.8)
Latino or Hispanic	3 (.8)	1 (.3)	1 (.3)	27 (7.3)
Multiracial	5 (1.3)	0	0	18 (4.8)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)
Making threatening statements about weapons				
Prefer not to Respond	2 (.5)	0	0	7 (1.9)
Arab or Arab American	0	0	0	3 (.8)
Asian or Asian American	2 (.5)	0	1 (.3)	13 (3.5)
Black, Afro-Caribbean, or African American	4 (1.1)	1 (.3)	0	16 (4.3)
Caucasian, Non-Hispanic White, or Euro-American	23 (6.2)	2 (.5)	3 (.8)	232 (62.4)
Latino or Hispanic	3 (.8)	1 (.3)	1 (.3)	27 (7.3)
Multiracial	5 (1.3)	0	0	18 (4.8)
Native American or Alaskan Native	2 (.5)	0	0	2 (.5)
Native Hawaiian or Pacific Islander	0	0	0	3 (.8)
Other Race or Ethnicity	0	0	0	1 (.3)

Note. $N = 373$. Percentages are in parentheses. Percentages may not total 100 because not all participants responded to all survey items.

Coping Strategies

These remaining two research questions pertain to the coping strategies employed by nursing students when student-to-student incivility was experienced:

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 (Folkman & Lazarus, 1985; Folkman et al., 1986).

5. Do coping strategies vary by program type, age, gender, or race/ethnicity?

This section presents the results of the frequency distributions and K-W calculations for the data obtained in response to these two research questions.

The study participants were asked to recall an incivility incident experienced as either a victim or a witness to use as a mental frame of reference while completing the Ways of Coping (Revised)* Questionnaire items (Folkman & Lazarus, 1985; Folkman et al., 1986). The participant responses to the questionnaire items were analyzed as eight separate coping strategies contained in three different categories. Problem-Focused Coping contains two coping strategies: planful problem-solving (PP) (4 items) and confrontive coping (CC) (6 items). Emotion-Focused Coping contains five coping strategies: escape-avoidance (EA) (7 items), distancing (D) (5 items), self-controlling (SC) (7 items), positive reappraisal (PA) (7 items), and accepting responsibility (AR) (4 items). The third category, Combined Problem-Focused and Emotion-Focused Coping, only contains one strategy: seeking social support (SS) (5 items).

Nursing Student Program Type Differences. This study sample contained prelicensure registered nursing students from seven different academic venues. The data was analyzed to identify any relationship between the employed coping strategies and matriculation in the different nursing program types. The results are very scattered across all of the 45 Ways of

Coping (Revised)* (Folkman & Lazarus, 1985) Questionnaire items. None of the strategies were statistically significant for participant employment frequency. Participants identified 22 questionnaire items as having been *used a great deal* on the four-point Likert-type scale with the highest response rate being 24% (n = 88) for the problem-focused coping strategy of planful problem-solving. Table 14 displays the five Ways of Coping (Revised)* (Folkman & Lazarus, 1985) Questionnaire items that received the highest number of *used a great deal* responses. Measures of central tendency were used to analyze frequencies of coping strategy employment by nursing students. The Kruskal-Wallis (K-W) test was used to compare coping strategy use between the seven nursing student program types.

Table 14

Coping Strategies Rated as "Used a Great Deal"

Coping Strategy	Survey Item	*n*	Percent
PP	Just concentrated on what I had to do	88	24
PA	Changed or grew as a person	82	22.2
D	Looked for the silver lining, so to speak; tried to look on the bright side of things.	70	19
SC	Tried not to burn my bridges, but leave things open somewhat.	62	16.8
SC	I tried to keep my feelings to myself	62	16.8

Table 15 displays the aggregate data for the most frequently employed coping strategies by nursing students. These survey items were rated as "*used quite a bit"* on the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). Nursing students do employ planful problem-solving (PP) by concentrating on what they need to do next (Folkman & Lazarus, 1985). Students also seek social support (SS) by talking to someone about the situation.

Table 15

Coping Strategies Frequently Employed

Coping Strategy	Survey Item	Frequency Perception	*n*	Mean	*SD*
PP	Just concentrated on what I had to do next.	Used quite a bit	153	1.7989	.91181
SS	Talked to someone to find out more about the situation.	Used quite a bit	135	1.4568	.93677
SC	I tried to keep my feelings to myself.	Used quite a bit	132	1.3767	1.00358
SC	Tried not to burn my bridges.	Used quite a bit	131	1.4351	.98077
SC	I tried to keep my feelings from interfering with other things too much.	Used quite a bit	128	1.1931	.72328
SC	I tried not to act to hastily or follow my first hunch.	Used quite a bit	121	1.0099	.77539
PA	Rediscovered what is important in life	Used somewhat	103	.9308	.80064

Table 16 displays the coping strategies that were never employed (*not used*) by nursing students. Students rated all seven of the escape-avoidance (EA) survey items as *never used*. This could be considered a positive result indicating nursing students in this sample are addressing student-to-student incivility. Participants responded *not used* to five of the seven PA survey items indicating that students do not employ positive appraisal coping strategies when experiencing student-to-student incivility. This could be considered a negative result. Nursing students should become critical thinkers able to appraise a situation to develop coping and interventional strategies.

Table 16

Coping Strategies Not Employed

Coping Strategy	Survey Item	Frequency Perception	*n*	Mean	*SD*
CC	Took a big chance or did something very risky.	Not used	253	.2946	.55134
EA	Tried to make myself feel better by eating, drinking, smoking, using drugs or medications.	Not used	247	.5649	.92385
EA	Slept more than usual.	Not used	239	.5865	.91618
EA	Took it out on other people.	Not used	238	.3544	.61160
CC	I did something which I didn't think would work.	Not used	232	.5059	.77005
D	Went along with fate; sometimes I just have bad luck.	Not used	223	.6108	.88645
EA	Hoped a miracle would happen.	Not used	217	.7757	1.08498
EA	Avoid being with people in general.	Not used	174	.5724	.73212
EA	Had fantasies or wishes about how things might turn out.	Not used	162	.6421	.77440
D	Tried to forget the whole thing.	Not used	137	1.0486	1.00557
EA	Wished that the situation would go away or somehow be over with.	Not used	108	.8473	.78207
PA	Rediscovered what is important in life.	Not used	103	.9308	.80064

A K-W test was run to determine if there were differences in employed coping strategies between seven groups of prelicensure registered nursing student participants rating 45 different coping behaviors listed in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985) as: "not used"; "used somewhat"; "used quite a bit"; and "used a great deal" on a four-

point Likert-type scale. Distributions of employed coping strategy rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean rank of 42 employed coping strategy rankings were not significantly different between groups, ranging from $\chi 2(6) = 11.602$, $p = .071$ to $\chi 2(6) = 2.404$, $p = .879$. The mean ranks of three strategies were statistically significant between groups as displayed in Table 17.

Table 17

Significant Coping Strategies between Program Types

Coping Strategies	Survey Item	$\chi 2$	p
PP	Drew on my past experiences.	15.466	.017
CC	I let my feelings out somehow.	13.983	.030
SS	Talked to someone about how I was feeling.	13.589	.035

Gender Differences. One purpose of this study was to determine if nursing student coping strategies vary by gender. The data was analyzed using a K-W test to identify any differences in employed coping strategies between gender groups rating 45 different coping behaviors listed in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). Distributions of employed coping behavior rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks were not significantly different between groups, ranging from $\chi 2(2) = 5.430$, $p = .066$ to $\chi 2(2) = .006$, $p = .997$. Table 18 displays the seven scores that were statistically significant between groups.

Table 18

Significant Coping Strategies between Gender Groups

Coping Strategy	Survey Item	$\chi 2$	*p*
CC	I did something which I didn't think would work, but at least I was doing something.	8.922	.012
CC	Took a big chance or did something very risky.	8.292	.016
D	Went along with fate; sometimes I just have bad luck.	6.962	.031
CC	I let my feelings out somehow.	6.928	.031
EA	Hoped a miracle would happen.	6.836	.033
PP	Drew on my past experiences; I was in a similar situation before.	6.694	.035
SC	I tried to see things from the other person's point of view.	6.003	.050

Age Differences. Today's nursing classroom is a conglomerate of generations. Age differentials influence the teaching/learning environment and student interpersonal interactions. A K-W test was run to determine if there were differences in employed coping strategies between six groups of prelicensure registered nursing student participants rating 45 different coping behaviors listed in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). Distributions of employed coping strategy rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean rank of 31 employed coping strategy rankings were not statistically significantly different between groups, ranging from $\chi 2(5) = 4.724$, $p = .450$ to $\chi 2(5) = 2.303$, $p = .806$. The mean ranks of 14 scores were statistically significant between groups. The data is displayed in Table 19.

Table 19

Significant Coping Strategies between Age Groups

Coping Strategy	Survey Item	$\chi 2$	*p*
EA	Wished that the situation would go away or somehow be over with.	20.457	.001
EA	Tried to make myself feel better by eating, drinking, smoking, using drugs or medication.	19.147	.002
EA	Took it out on other people.	18.161	.003
EA	Slept more than usual.	18.346	.003
AR	I apologized or did something to make up.	16.957	.005
SC	I tried to keep my feelings to myself.	15.978	.007
SS	Talked to someone to find out more about the situation.	15.724	.008
SC	Tried not to burn my bridges, but leave things open somewhat.	14.306	.014
CC	Tried to get the person responsible to change his or her mind.	13.409	.020
PR	Changed or grew as a person in a good way.	12.458	.029
CC	I expressed anger to the person(s) who caused the problem.	11.455	.043
SC	I tried not to act too hastily or follow my first hunch.	11.278	.046
AR	Criticized or lectured myself.	11.121	.049
SS	Accepted sympathy and understanding from someone.	11.083	.050

Race/Ethnicity Differences. Racial and ethnic heritage are integral to a person's cognitive comprehension of and affective experience in the world. Incivility will be individually defined and experienced in reference to race, ethnicity, and culture (Clark, 2008a; Nordstrom et al., 2009).The data was analyzed using a K-W test to determine if there were differences in employed coping strategies between ten race/ethnicity groups rating 45 different coping

strategies listed in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). Distributions of rankings were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of employed coping strategies were not statistically significant between 30 strategies, ranging from $\chi2(9) = 16.851$, $p = .051$ to $\chi2(5) = 4.879$, $p = .845$. Table 20 contains the mean ranks of the 15 strategies that were statistically significant between groups.

Table 20

Significant Coping Strategies between Race/Ethnicity Groups

Coping Strategy	Survey Item	$\chi2$	*p*
PR	I came out of the experience better than when I went in.	28.119	.001
PR	Found new faith.	25.990	.002
PP	Changed something so things would turn out all right.	25.610	.002
PR	Changed or grew as a person in a good way.	26.668	.002
SS	Accepted sympathy and understanding from someone.	22.503	.007
D	Went along with fate; sometimes I just have bad luck.	21.400	.011
EA	Hoped a miracle would happen.	19.951	.018
PR	Rediscovered what is important in life.	19.951	.018
CC	Took a big chance or did something very risky.	19.573	.021
AR	Criticized or lectured myself.	18.693	.028
PR	I prayed.	17.040	.030
CC	I did something which I didn't think would work, but at least I was doing something.	18.053	.035
SS	Talked to someone who could do something concrete about the problem.	17.925	.035
SC	I thought about how a person I admire would handle this situation and used that as a model.	17.173	.046
SS	Talked to someone about how I was feeling.	16.931	.050

Summary

An anonymous online survey was used to collect data from a nonprobability national sample of prelicensure registered nursing students. Descriptive statistics were used to analyze frequency distributions in the collected data. The Kruskal-Wallis test was used to identify any comparisons between nursing program types, age groups, genders, and race/ethnicity groups within the sample. The three main purposes of this study were to identify the behaviors nursing students believed constituted student-to-student incivility, determine the frequency of incivility behaviors, and describe the coping strategies employed when student-to-student incivility was experienced.

The data analysis revealed that there is very little consensus on which behaviors constitute incivility. Participants only agreed that four of the 24 behaviors in the INE-R Survey (Clark et al., 2015) were consistently uncivil. Making threatening statements about weapons, threats of physical harm against others, property damage, and making discriminating comments are considered to constitute incivility by the majority of the study participants. Prelicensure registered nursing students are not employing any specific coping strategies with any regularity when experiencing student-to-student incivility. The most frequent response to the Ways of Coping (Revised)* Questionnaire items (Folkman & Lazarus, 1985) was *not used*. Students could benefit from educational programs about coping strategies and how to employ them.

CHAPTER 5

DISCUSSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Discussion

Incivility Behaviors Identified

Four behaviors were identified as "highly uncivil" by greater than 80% of the prelicensure registered nursing student participants: making threatening statements about weapons (n = 322; 86.3%); threats of physical harm against others (n = 321; 86.1%); property damage (n = 315; 84.5%); and making discriminating comments (n = 310; 83.1%). These perceptions are encouraging since all of these behaviors are illegal in American society under civil codes or federal Title IX statutes. These four behaviors could be a good foundation for a congruent list of uncivil behaviors to embrace across the discipline of nursing. The data analysis revealed no pattern to the student perceptions of the remaining 20 incivility behaviors.

This result matches previous incivility studies which have not identified a pattern of highly uncivil behaviors or frequently experienced behaviors. Classroom inattentiveness was reported to be the most problematic uncivil behavior in a survey of 409 Nursing Program Directors (Lashley & De Meneses, 2001). Cheating on assessments was reported to be *always uncivil* by 82% of the survey sample composed of 32 nursing faculty and 324 nursing students (Clark & Springer, 2007a). Talking in class was identified as the most frequently occurring form of student incivility in a survey sample of 15 nursing faculty and 186 nursing students (Clark & Springer, 2007b). The "Violence against Student Nurses in the Workplace" Survey was administered to 126 student nurses (Hinchberger, 2009). All 126 participants reported witnessing

or experiencing violence (69% = verbal abuse; 21% = bullying; 10% = physical abuse). Each study identifies a different uncivil behavior of interest.

Being unprepared for class or other scheduled activities (p = .025) and skipping class or other scheduled activities (p = .006) are two behaviors of interest in the current study. Results of a K-W test identified these two behaviors as being statistically significant ($p \leq .05$). The student frequency experience ratings for these same two behaviors over the past 12 months were "rarely" (n = 149, 112) and "sometimes" (n = 135, 131). Students may already be self-monitoring these two behaviors with the positive result of reduced behavior incidence. Peer pressure is a very strong impetus to conform to societal norms. In a cohort of nursing students, the society is the academic environment of classroom and clinical setting.

Frequency of Incivility Behaviors

Fewer experiences of student-to-student incivility behaviors were reported by the participants than anticipated by the PI. Approximately half of the participants reported the frequency of experiencing "using a computer, phone, or other media device during class for unrelated purposes" (n = 202; 54.2%) as *often*. This was the highest reported experienced incivility behavior. Participants inconsistently rated this behavior as constituting incivility: *somewhat (*n = 101), *moderately* (n = 126), or *highly* (n = 119) *uncivil*. The next four most frequently experienced incivility behaviors listed on the INE-R were not consistently identified by participants as constituting incivility. These five behaviors are compared in Table 21. The subjective nature of incivility perceptions cannot be explicated through quantitative research. Empirical frequencies assess the amount without exploring the causality. Inconsistent perceptions of incivility are preventing the development of a universal definition of incivility. Until incivility can be defined, constituent uncivil behaviors cannot be identified.

Table 21

Compare Incivility Experience Frequencies to Behavior Perceptions

Behavior	Frequency Rated *Often*		Behavior Rated *Highly Uncivil*	
	n	%	*n*	%
Using a computer, phone, or media device during class	202	54.2	119	31.9
Holding distracting side conversations	115	30.8	170	45.6
Expressing disinterest or boredom about course content	103	27.6	38	10.2
Sleeping or not paying attention in class	101	27.1	89	23.9
Arriving late for class	94	25.2	99	26.5

Quantifying the frequency of nursing student-to-student incivility behaviors in this study did not supported the frequency of the phenomenon reported in the literature (Clark, 2008a; Clark, 2008b; Clark et al., 2009; Jenkins et al., 2013; Norris, 2010; Tangitu, 2010). The study sample included prelicensure registered nursing students from seven program types, six age categories, three self-reported gender designations, and ten race/ethnicity groups. Using nonprobability sampling through self-enrollment in the online survey skewed the opportunity for an even distribution of participants. The K-W analysis was intended to address this sampling difficulty.

Coping Strategies Employed

Study participants were asked to recall an interpersonal incivility experience and the coping strategies employed to address the encounter while completing the Ways of Coping

(Revised)* Questionnaire items (Folkman & Lazarus, 1985; Folkman et al., 1986). The past experience with incivility could have been as a victim or as a witness.

Participants engaged in cognitive appraisal as they completed the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985; Folkman et al., 1986). Lazarus and Folkman (1984) define cognitive appraisal as a process of evaluating an encounter with another person or a situation in relation to its potential to affect an individual's state of wellness. The eight coping strategies identified in the study data were differentiated into three categories as problem-focused (PP and CC), emotion-focused (EA, D, SC, PA, and AR), or problem-focused and emotion-focused combined (SS) (Folkman & Lazarus, 1985).

Participant responses to the Ways of Coping *(Revised) Questionnaire identified eight coping strategies employed by nursing students experiencing student-to-student incivility. These eight strategies were divided into three categories. Problem-focused coping is an active, cognitive, intellectual, and analytical process to identify risks and benefits of possible solutions to the experienced student-to-student incivility. Students engaged in problem-focused coping used the coping strategies of planful problem-solving (PP) and confrontive coping (CC). Nursing students used emotion-focused coping to reduce the emotional stress that accompanied being a victim or witness of student-to-student incivility. Students did not incorporate intellectual planning or consider possible outcomes when using the affective emotion-focused coping strategies. Emotion-focused coping strategies include escape-avoidance (EA), distancing (D), self-controlling (SC), positive reappraisal (PA), and accepting responsibility (AR). Seeking social support (SS) is a combination of both problem-focused and emotion-focused coping. SS is a positive coping strategy when nursing students address incivility methodically and analytically.

SS is a negative coping strategy when nursing students are reactive and spontaneous in their responses to incivility behaviors (Folkman & Lazarus, 1985).

EA was addressed in seven items in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985). The most frequently selected response was *not used* for six of the escape-avoidance activities when experiencing incivility. Students do not employ PA. Survey participants responded *not used* to five of the seven positive reappraisal coping items (n = 103, 139, 143, 188, and 248). Nursing faculty strive to inculcate nursing students with critical thinking skills. PA coping strategies were expected to be readily employed by students experiencing academic incivility. AR was addressed in four survey items. All four were most frequently answered with *not used.* While *"criticized or lectured myself"* was *not used* by 171 students (mean = .9264, *SD* = 1.04935), it was *used a great deal* by 45 students and *used quite a bit* by 54 students. Much teaching is needed on avoiding self-deprecation when experiencing student-to-student incivility. "I apologized or did something to make up" almost tied between *not used* (n = 127) and *used somewhat* (n = 126). If a student is apologizing for causing another student to engage in uncivil behavior, education is needed to help students understand their role in academic, collegial, and professional relationships. This may be a positive result. The students could be assuming responsibility for initiating student-to-student uncivil behavior. Forty five students selected *used a great deal.* Education is needed if these are the same 45 students who self-criticize when experiencing incivility behaviors.

Implications

This study addressed two research gaps. Few research studies have explored the phenomenon of nursing student-to-student incivility in the classroom and clinical setting. This study specifically investigated the phenomenon of student-to-student incivility as experienced by

prelicensure registered nursing students. The second research gap is the lack of knowledge about the coping strategies employed by nursing students experiencing student-to-student incivility. This study explored the coping strategies employed by prelicensure registered nursing students experiencing student-to-student incivility.

A consistent universally accepted list of incivility behaviors does not currently exist within the discipline of nursing. The discipline of nursing must begin by identifying incivility behaviors that will not be tolerated. The 24 behaviors used in this study as part of the INE-R provide a good foundation for academic incivility research in pursuit of a universal list. Aggregate data shows making threatening statements about weapons (n = 322; 86.3%); threats of physical harm against others (n = 321; 86.1%); property damage (n = 315; 84.5%); and making discriminating comments (n = 310; 83.1%) are considered highly uncivil and are the least frequently experienced behaviors. This was a positive data result since these are all illegal activities in the United States.

Human behavior is subjective, culturally motivated, and environmentally mediated. An empirical foundation is needed to bring consistent thought to this phenomenon. Until incivility can be defined, it cannot be addressed, discussed, taught, mediated, contained, or stopped. Additional phenomenological research with specific samples of prelicensure registered nursing program types or male students could add to the body of knowledge. Investigating cohorts of nursing students with previous public service work histories could offer insight into the use of coping strategies when experiencing student-to-student incivility. Public service employment venues include restaurants, retail establishments, tutoring, child care, and financial institutions. Research using focus groups or Socratic interviewing to investigate the coping strategies nursing students are currently employing when experiencing student-to-student incivility would be

valuable. A new survey tool could be developed incorporating these identified coping strategies to facilitate collection of empirical data about nursing student coping strategy employment.

Limitations

Nonprobability convenience sampling was a study limitation. The PI could not recruit a representative number of participants from each prelicensure registered nursing program type, gender category, student age group, or racial/ethnic group.

Electronic survey dissemination was a limitation. Participant confidentiality was protected by not meeting the PI, but more students may have completed the survey if an opportunity to meet the PI to discuss the study had been available. The survey was broadcast at the end of the academic semester leading into the summer through addresses registered with a national student nurse organization. Some prelicensure students do not review their emails during the summer months. Without direct personal interaction, some students do not pay attention to an electronic survey invitation. The personal and subjective nature of incivility experiences may have hindered participation. Over 900 people opened the survey, but only 373 submitted completed surveys.

The low male gender response rate is a limitation. Only 31 (8.3%) male participants completed and submitted the entire survey. This data is not a significant representation of the current male nursing school 15% enrollment rate. Males do not consider as many behaviors to constitute incivility as females. This low male participant rate cannot statistically amend the low total study results for incivility behavior identification.

Empirical and phenomenological research studies exploring the specific concept of nursing student-to-student incivility are needed. The statements in the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985) are designed to elicit responses about

previous stress encounters. Students may not equate incivility with stress. Using the Ways of Coping (Revised)* Questionnaire with a Focus Group or Socratic Interviewing could help the PI obtain rich objective and subjective data about student-to-student incivility experiences. Incivility is an interpersonal experience which could be explored using semi-structured interviews or participant narratives.

Recommendations for Future Research

Academic incivility affects individual students, nursing education as an entity, and the collective discipline of professional nursing. Additional research is needed to fully understand the phenomenon of nursing student-to-student incivility. Future research recommendations include:

- A limitation of this study was the nonprobability convenience sampling method. The researcher suggests repeating this study using a purposeful sample of prelicensure registered nursing students who have experienced student-to-student incivility as a victim or witness. Rich data could be collected from a sample of students who had all experienced incivility.
- This study explored student-to-student incivility among prelicensure registered nursing students. Research could be conducted to understand how student-to-student incivility is experienced by other healthcare occupation students. The same study could be conducted with a sample that includes students in training programs to become licensed practical nurses (LPN), licensed vocational nurses (LVN), certified nursing assistants (CNA), or certified medical assistants (CMA).
- A qualitative phenomenological study using Socratic Interviewing could be conducted to investigate the lived experiences of a sample of nursing students who had experienced

student-to-student incivility. Differences in the psychosocial outcomes of direct personal victimization could be compared to vicarious incivility traumatization as a witness.

- This was a single time-point study. Longitudinal quantitative studies could be conducted using the Ways of Coping (Revised)* Questionnaire (Folkman & Lazarus, 1985) following students across their academic programs. Data could help describe positive and negative effects of time spent as a nursing student on the coping strategies employed when experiencing student-to-student incivility.

Conclusions

Incivility is a real phenomenon. Student-to-student incivility occurs in the nursing classroom and clinical setting. This quantitative descriptive study did not identify the magnitude of student-to-student incivility the PI expected. This would be a good finding if the PI did not see student-to-student incivility every day in the nursing classroom. Prelicensure registered nursing students did identify several behaviors as uncivil. Students agreed that using media and electronic devices for purposes not related to class, conducting side conversations, acting bored, sleeping or not paying attention, and arriving to class late all constituted incivility. Students did not identify the quantity of incivility behaviors or frequency of experiences the PI expected. These study results do not match the literature. It is possible that the students did not understand the term "incivility" so they had difficulty completing the survey. Students did not identify any particular coping strategies currently being employed when experiencing student-to-student incivility. Most responses to items about coping strategies were *not used*. This study ends with as many questions as it began.

One goal of this study was to show how serious a problem incivility is in nursing academia. Very little information was garnered to help define incivility or identify its behaviors.

Teaching nursing students to adhere to a professional code that promotes removal of a vague incivility concept will be difficult. Nursing students cannot be expected to embrace a "no tolerance for incivility" stance unless it is well defined with discernable antecedents and constructs. Behaviors that the discipline of nursing hopes to inculcate in students need to be specifically recognized by nursing academia as professional and positive. Behaviors the discipline of nursing wants to remove need to be identified, defined, and recognized as unprofessional and negative. Education programs about incivility, interpersonal interaction, professional comportment, stress, coping, and coping strategies are needed in nursing academia to help students understand incivility, how to address it, and how to work to eliminate it.

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APPENDICES

Appendix A

East Tennessee State University IRB Exempt Approval

EAST TENNESSEE STATE UNIVERSITY

Office for the Protection of Human Research Subjects • Box 70565 • Johnson City, Tennessee 37614-1707
Phone: (423) 439-6053 Fax: (423) 439-6060

IRB APPROVAL – Initial Exempt

March 28, 2016

Robin Foreman

RE: Coping Strategies of Prelicensure Registered Nursing Students Experiencing Student-to-Student Incivility
IRB#: 0316.30e
ORSPA#:

On **March 28, 2016**, an exempt approval was granted in accordance with 45 CFR 46. 101(b)(2). It is understood this project will be conducted in full accordance with all applicable sections of the IRB Policies. No continuing review is required. The exempt approval will be reported to the convened board on the next agenda.

- New protocol submission xform, CV of PI, consent script version 3.25.16, SURVEY LINK, survey

Projects involving Mountain States Health Alliance must also be approved by MSHA following IRB approval prior to initiating the study.

Unanticipated Problems Involving Risks to Subjects or Others must be reported to the IRB (and VA R&D if applicable) within 10 working days.

Proposed changes in approved research cannot be initiated without IRB review and approval. The only exception to this rule is that a change can be made prior to IRB approval when necessary to eliminate apparent immediate hazards to the research subjects [21 CFR 56.108 (a)(4)]. In such a case, the IRB must be promptly informed of the change following its implementation (within 10 working days) on Form 109 (www.etsu.edu/irb). The IRB will review the change to determine that it is consistent with ensuring the subject's continued welfare.

Sincerely,
George Youngberg, M.D., Chair
ETSU/VA Medical IRB

Cc: Dr. Blowers

Accredited since December 2005

Appendix B

East Tennessee State University IRB Stamped Approved

Dear Participant:

My name is Robin Ann Foreman, and I am a PhD in Nursing student at East Tennessee State University. I am working on a doctoral dissertation in Nursing. In order to finish my studies, I need to complete a research project. The name of my research study is "Coping Strategies of Prelicensure Registered Nursing Students Experiencing Student-to-Student Incivility."

The purposes of this study are to identify the behaviors prelicensure registered nursing students believe constitute student-to-student incivility, determine with what frequency student-to-student incivility behaviors are experienced in the nursing classroom and clinical setting, and describe the coping strategies employed by prelicensure registered nursing students when student-to-student incivility is experienced. I would like to give a brief online electronic survey to prelicensure registered nursing student members of the National Student Nurses' Association using the online Nursing Checkbox System®. It should only take about 15 minutes to complete. The survey will remain open for 30 days. After this time, the survey will no longer be accessible.

You will be asked questions about the behaviors you believe constitute incivility, the frequency these behaviors occur in the nursing classroom and clinical setting, and the coping strategies you employ when you experience student-to-student incivility. Since this project deals with your personal memories of interacting with incivility, it might cause some minor stress. However, you may also feel better after you have had the opportunity to express yourselves about how you coped with the incivility experiences. This study may provide the benefit of increasing information about incivility behaviors, incivility occurrences, and coping strategies employed when experiencing student-to-student incivility.

Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties, as is the case with emails. In other words, we will make every effort to ensure that your name is not connected with your responses. Specifically, Nursing Checkbox System® has security features that will be enabled: IP addresses will not be collected and SSL encryption software will be utilized. Although your rights and privacy will be maintained, the ETSU IRB (for non-medical research) and personnel particular to this research, (the PI-Robin Ann Foreman), have access to the study records.

If you do not want to fill out the survey, it will not affect you in any way. You may skip any questions you do not wish to answer or simply exit the online survey form if you wish to remove yourself entirely.

Participation in this study is voluntary. You may refuse to participate. You can quit at any time. If you quit or refuse to participate, the benefits or treatment to which you are otherwise entitled will not be affected.

If you have any research-related questions or problems, you may contact me, Robin Ann Foreman, at 423/646-4047. I am working on this project under the supervision of Dr. Sally S. Blowers. You may reach her at 423/797-0854. Also, the chairperson of the Institutional Review Board at East Tennessee State University is available at 423/439-6054 if you have questions about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you can't reach the study staff, you may call an IRB Coordinator at 423/439-6055 or 423/439/6002. If you choose to participate in this study, you may access the survey online by clicking on this link, or copying the link and pasting it into your computer browser:
https://com.etsu.edu/esurvey/Survey.aspx?s=c9ad55790687447a9a113764b7f944e5&u=bda9e&3
fd18-46c2-9f36-7bfe50178599&forceNew=true&test=true

APPROVED
By the ETSU/VA IRB
MAR 28 2016
By _____
Chair IRB Coordinator

Sincerely,

Robin Ann Foreman

Clicking the AGREE button below indicates

- You have read the above information
- You voluntarily agree to participate
- You are at least 18 years of age or older

☐ I AGREE
☐ I DO NOT AGREE

Appendix C

INE-R Survey Licensure Agreement

COPYRIGHT LICENSE AGREEMENT

KR 3/04/16

2015 This License Agreement (the "License") is made and entered into this 10th day of March, ~~2014~~, by and between Boise State University, hereinafter referred to as the "Licensor," and Robin Ann Foreman, PhD(c), MSN, RN, hereinafter referred to as the "Licensee."

WHEREAS, the Licensor owns certain rights, title and interests in the Incivility in Nursing Education Revised (INE-R) Survey, hereafter called the "Licensed Works," and

WHEREAS, the Licensor desires to grant a license to the Licensee and Licensee desires to accept the grant of such license pursuant to the terms and provisions of this License Agreement for the purposes of permitting Licensee to use the Licensed Works for non-commercial purposes as outlined herein;

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11. Notice. Any notice required or permitted by this License may be delivered in person or sent by registered or certified mail, return receipt requested to the party at the address as hereinafter provided, and if sent by mail it shall be effective when posted in the U.S. Mail Depository with sufficient postage attached thereto:

LICENSOR	LICENSEE
Boise State University Attn: Office of Technology Transfer 1910 University Drive Boise, ID 83725-1135	Robin Ann Foreman, PhD(c), MSN, RN East Tennessee State University Graduate School of Nursing PO BOX 70629 Johnson City, Tennessee 37614

Notice of change of address shall be treated as any other notice.

12. Applicable Law. The License shall be governed by Idaho law. All construction pursuant to or interpretation of this License shall comply with and conform to all applicable state, federal and local laws, regulations, rules and orders.

13. Default. Any failure of either party to perform in accordance with the terms of this Agreement shall constitute a breach of the agreement. In the event of a material breach by Licensee, Licensor may, upon written notice to Licensee, declare this License Agreement terminated and may seek such other and further relief as may be provided by law, including, but not limited to, a temporary or permanent injunction against Licensee's continued use of the Licensed Works, actual and/or statutory damages, costs of suit, and reasonable attorney fees incurred by Licensor as a result of the breach, plus interest on all amounts from the date of the breach until paid in full, at the highest rate permitted by law.

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In witness whereof, the parties hereto have executed this License on the day and year first above written.

Licensee:

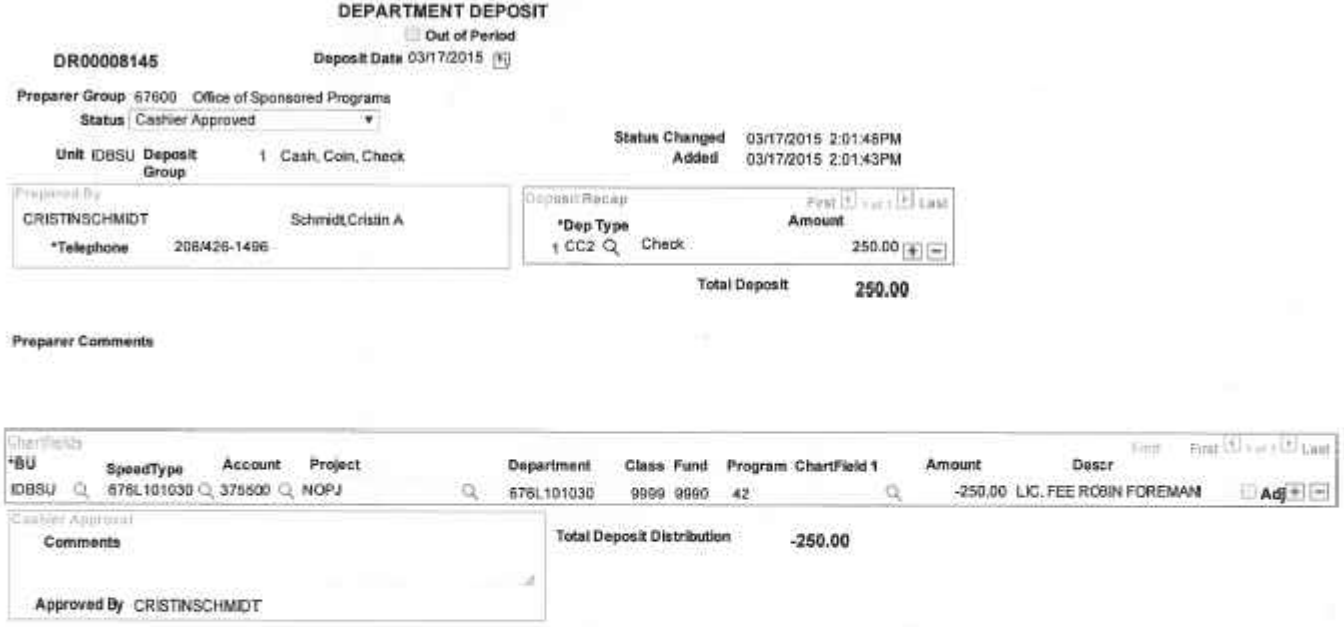
By: Robin Ann Foreman
Robin Ann Foreman, PhD(c), MSN, RN

Date: March 11, 2015

Licensor:

By:
Katy Ritter, Director
Office of Technology Transfer

Date: 3/17/15



DEPARTMENT DEPOSIT

Out of Period

DR00008145 Deposit Date 03/17/2015

Preparer Group 67600 Office of Sponsored Programs

Status Cashier Approved

Unit IDBSU Deposit Group 1 Cash, Coin, Check

Status Changed 03/17/2015 2:01:46PM

Added 03/17/2015 2:01:43PM

Prepared By

CRISTINSCHMIDT Schmidt,Cristin A

*Telephone 208/426-1496

Deposit Recap

	*Dep Type		Amount
1	CC2	Check	250.00

Total Deposit 250.00

Preparer Comments

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IDBSU	676L101030	375500	NOPJ	676L101030	9999	9990	42		-250.00	LIC. FEE ROBIN FOREMAN	Adj

Cashier Approval

Comments

Approved By CRISTINSCHMIDT

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Appendix D

Ways of Coping Questionnaire Public Domain Information Letter

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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OSHER CENTER FOR INTEGRATIVE MEDICINE AT UCSF
1701 DIVISADERO STREET, SUITE 100
SAN FRANCISCO, CALIFORNIA 94115

TEL: 415 353 7719
FAX: 415 353 7554
E-MAIL: FOLKMAN@OCIM.UCSF.EDU

SUSAN FOLKMAN, PH.D.
PROFESSOR OF MEDICINE AND
DIRECTOR

Dear Colleague:

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Sincerely,

Susan Folkman, Ph.D.
Professor of Medicine
Director, Osher Center for Integrative Medicine at UCSF

VITA

ROBIN ANN FOREMAN

Education:	Ph.D. in Nursing, East Tennessee State University, Johnson City, Tennessee, 2017 M.S.N. in Nurse Education, King University (formerly King College), Bristol, Tennessee, 2007 B.S.N. in Nursing, King University (formerly King College), Bristol, Tennessee, 2004, *Summa Cum Laude* A.D.N. in Nursing, Excelsior University (formerly Regent's College of New York), Albany, New York, 1999, With Honors L.P.N. in Nursing, Wise County Vocational Technical Center, Wise, Virginia, 1991 Public Schools, Baltimore, Maryland
Professional Experience:	Assistant Professor of Nursing, King University, Bristol, Tennessee, 2008 - Present Graduate Teaching Assistant in Nursing, King University, Bristol, Tennessee, 2007
Presentations:	July, 2016-"The ICE Model: Promoting Professionalism-Cultivating Civility" at the Johnston Memorial Hospital SOAR Orientation in Abingdon, Virginia. March, 2016-Podium Presentation-"The Case for Civility" at the Annual Research Day of Epsilon Sigma-at-Large Chapter of Sigma Theta Tau at East Tennessee State University, Johnson City, Tennessee. October, 2014-Podium Presentation-"Mashing the Myths of Incivility: A Healthcare Necessity" at the Compassion Conference 2014 in Bristol, Tennessee. April, 2014-Podium Presentation-"Discouraging Piracy and Mutiny upon Your Ship: Exposing the Myths of Incivility" at the Future of Nursing Research Conference at Tennessee Technological University, Cookeville, Tennessee.
Honors:	Member of the Epsilon Sigma Chapter-at-Large of Sigma Theta Tau International Nursing Honor Society Member of the Sigma Alpha Lambda Honor Society East Tennessee State University Chapter Member of the Golden Key Honor Society East Tennessee State University Chapter