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Jasmine Jackson
jjackson5@harding.edu

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HARDING UNIVERSITY

Pediatric Bullying Education in Arkansas Baccalaureate Nursing Programs

Jasmine Jackson

Harding University

Pediatric Bullying Education in Arkansas Baccalaureate Nursing Programs

Seen not only within the country but also within local communities, a prevalent problem that many young children and adolescents face is child abuse and neglect (CAN). Globally, at least 1.4 billion children between the ages of 2 and 17 years experienced physical, emotional, and/or sexual violence in 2014 (Hillis, Mercy, Amobi, & Kress, 2016). About 674,000 children in the U.S. were CAN victims in 2017 (U.S. Department of Health and Human Services [USDHHS], Administration for Children and Families [ACF], & Administration on Children, Youth and Families [ACYF], 2017). This abuse can take many different forms: physical, sexual, emotional, child neglect, and exposure to domestic or family violence.

Physical abuse involves "non-accidental physical injury to a child" (Childhelp, n.d.). Physical abuse not only brings about physical scars but emotional scars that are remembered by victims as revealed by the one in four adults who reported being victims of physical abuse when they were children (World Health Organization [WHO], n.d.). Currently, 12% of children are reported to have experienced physical abuse in the past year (WHO, n.d.). Sexual abuse, another form of CAN, is "unwanted sexual activity, with perpetrators using force, making threats, or taking advantage of victims not able to give consent" (American Psychological Association, n.d., para. 1). One in four girls and one in thirteen boys in the U.S. will experience sexual abuse in childhood (Center for Disease Control and Prevention [CDC], 2020). CAN that may be a little more difficult to identify in children is emotional abuse, when the child's mental and social development is harmed over a period of time (Childhelp, n.d.). Emotional abuse can be perpetrated through verbal assaults, rejection, put-downs, purposefully causing fear, isolation, intimidation, and in other ways in which self-esteem and confidence are hindered (Reach Out, n.d.). Child neglect occurs when a child is not receiving proper care, supervision, affection, and

support to help ensure their health, safety, and well-being (Childhelp, n.d.). This can be seen through physical neglect, inadequate supervision, emotional neglect, medical neglect, and educational neglect (Childhelp, n.d.).

The duty of reporting CAN lies largely with those serving in the healthcare, community support, and education fields. Social workers, school personnel and employees, mental health professionals, child care providers, medical examiners or coroners, law enforcement officers, physicians, nurses, and other health-care workers are professionals mandated by law to report child abuse and neglect if they have reason to suspect that it has occurred (Children's Bureau/ACF/ACYF/USDHHS, 2019). Recognition of the signs of CAN and identification of child victims is only made possible by specific education to that end. Medical personnel made up 9.6% of CAN report sources in 2017 (USDHHS, ACF, & ACYF, 2017). Deservingly, there is a lot of emphasis on identifying CAN within the nursing profession.

Even though CAN is most commonly conceptualized as abuse brought upon a child by a parent or caregiver or another adult, bullying is oftentimes referred to as peer abuse (Prevent Child Abuse America, n.d.). Bullying is not a new concept or phenomenon. It is also important to note that "bullying is not an epidemic" and nationally, rates of bullying have not increased (USDHHS, 2017c). However, in recent years more energy has been focused on bullying awareness and curbing the increase in bullying and related suicides. Within the last decade, there has been an ever-increasing spotlight on bullying because it "is a universal public health problem and impacts large numbers of adolescents" with 26% of adolescent participants reporting bullying involvement (Craig et al., 2009, p. 220). It is also important to note as described by Prevent Child Abuse America (n.d.), bullying impacts a child's physical, social, emotional or cognitive development. According to the CDC, "bullying is a type of youth violence defined as

unwanted aggressive behavior by another youth or group of youths who are not siblings or current dating partners; bullying involves an observed or perceived power imbalance and is often repeated multiple times or is highly likely to be repeated" (2019, para. 1). In addition, Dixon and Crawford (2012) state that emotional abuse may "involve serious bullying, causing children frequently to feel frightened or in danger" (p. 386).

There are different roles to be recognized in the realm of adolescent bullying in addition to the bully and the victim. It is important to remember the bystander who "reinforce the bully, assist the bully, defend the victim, passively watch the encounter, or act as if nothing is happening" (Waseem et al., 2016, p. 247). In addition, another role is that of the bully-victim, those that experience both being the victim and being the bully. With each of these roles, there are risk factors (e.g., health problems, poverty, seen as weak or unable to defend themselves, having few friends, etc. [Hornor, 2018; USDHHS, 2018]) and consequences (e.g., depression, anxiety, decreased academic performance, increased use of tobacco and alcohol [USDHHS, 2020]).

There are also different forms of bullying. When many think of bullying, the first thought that comes to mind is "traditional" bullying, often depicted in the media as the school bully shoving the victim into the lockers or dumping food on them in the cafeteria. Bullying is more than physical. It may also include verbal bullying (e.g., teasing, name-calling, inappropriate sexual comments) and social bullying (e.g., excluding others, spreading rumors, embarrassing others) (USDHHS, 2019). Though it is less prevalent than other types of bullying (USDHHS, 2017c), cyberbullying has become an ever-increasing problem. Most bullying occurs at school, but cyberbullying has made it easier for bullying to take place on and off the school campus and also helps to make the perpetrator anonymous, lending to the increase of this problem. However,

there are many incidents of aggressive behavior that can be mistaken for bullying when it is not "(e.g., one-time physical fights, online arguments, incidents between adults)" (USDHHS, 2017c, para. 5). The *Youth Risk Behavior Survey* conducted by the CDC in 2018 found that 14.9% of adolescents in 9th through 12th grade stated they had been electronically bullied, while 19.0% stated that they had been bullied on school property. There is a need for change and progression in federal laws to address the issue of bullying as a type of CAN. Since nurses are mandatory reporters of CAN, action should be taken to make screening and reporting of bullying a routine requirement, especially with the negative outcomes and effects that it has on adolescents and their future.

Bullying Prevention

Bullying prevention is key and there has been state legislature, public service announcements, and school policies put in place to try to combat the problem and raise awareness of the issue; however, "Currently, no federal statute directly addresses bullying, although federal laws do address particular kinds of harassment based on race, national origin, and sex" (Freeman, Thompson, & Jaques, 2012, p. 883). Additionally, it is also noted that lesbian, gay, bisexual, transgender, and queer (LGBTQ)-specific language is not included in most of the state policies addressing bullying (Hooker, 2019). Adolescents that identify as LGBTQ are more likely to be bullied than their heterosexual counterparts (USDHHS, 2018). In 2018, 13.3% of heterosexual students stated they had been bullied electronically and 17.1% said they had been bullied on school property, much lower than the 27.1% and 33.0% of LGBTQ students that had been bullied (CDC, 2018).

Experts have not agreed on the best method for addressing bullying. This has been the case for legislation related specifically to cyberbullying, stating that regulations are trying to

control what some consider to be free speech (Freeman et al., 2012). In terms of prevention, Arkansas anti-bullying laws require prevention programs or strategies to be implemented by the school district as a part of student services programs (USDHHS, 2017a). The argument about free speech is even seen within Arkansas regulations which state that Section Act 1029 is not intended to "unconstitutionally restrict protected rights of freedom of speech, freedom of religious exercise, or freedom of assembly" (Antibullying Policy Amendment 1029, 2019, p. 8). Protected groups are also mentioned within the Arkansas anti-bullying laws, which "prohibit acts that may address an attribute of the other student, public employee, or person with whom the other student or public school employee is associated with" (USDHHS, 2017a, para 6). These attributes include "race, color, religion, ancestry, national origin, socioeconomic status, academic status, disability, gender, gender identity, physical appearance, health condition, or sexual orientation" (USDHHS, 2017a, para 6).

To prevent and address bullying, entire school community involvement is expected. It is expected that a culture of respect is created and facilitated by students, families, administrators, teachers, and school staff (e.g., bus drivers, nurses, cafeteria and front office staff) (USDHHS, 2017b, para 2). Bullying most commonly occurs at school, especially since children spend most of their weekdays at school; however, these signs and symptoms can be present anywhere there are children. Because of this, nurses must assess bullying in patients that they see either in a school, clinic, emergency department, or hospital. Arkansas laws and regulations require school districts to provide training to all employees about state laws and regulations related to bullying as well as their role in preventing and responding to acts of bullying (USDHHS, 2017b). In addition, "Evaluators should have a conversation with the child's family about bullying. The

parents need to take responsibility for supporting their child through this potentially difficult time period" (Freeman et al., 2012, p. 894).

Implications for Nurses

Injury and violence prevention in *Healthy People 2020* reflect a need to better understand trends, causes, and prevention strategies related to bullying (Office of Disease Prevention and Health Promotion [ODPHP], 2020a). In terms of specific objectives, reducing bullying among adolescents from 19.9% in 2009 to 17.9% is the goal for 2020 (ODPHP, 2020b). Though bullying alone is not linked to suicide or even suicidal ideation or behavior, bullying does put adolescents at risk for suicide (USDHHS, 2020). Reduction in suicides is another *Healthy People 2020* goal, from 11.3 suicides per 100,000 people to 10.2 suicides per 100,000 people (ODPHP, 2020c). Specifically, there is a goal of reducing adolescent suicide attempts from 1.9 per 100 adolescents down to 1.7 per 100 adolescents (ODPHP, 2020c). Though bullying is an issue that mostly affects adolescents in school or at home, "Learning about the incidence, prevalence, and warning signs of bullying is an important intervention" (Hooker, 2019, p. 64). School nurses are at the frontlines where signs and symptoms can be assessed; however, "nurses working in EDs, urgent care, primary care, or even medical-surgical units should also be on alert for these indicators" (Hooker, 2019, p. 64). In a United Kingdom (UK) study conducted by Scott, Dale, Russell, & Wolke (2016), parents and young people's views were assessed regarding general practitioners (GPs) taking a more active role in identifying, supporting, and helping children who are being bullied. Results from the study suggested that parents and young people believed that "GPs being removed from the school setting was an advantage. The doctors' independence from both the family and school was considered beneficial and likely to allow a more objective assessment of the child and situation" (Scott et al., 2016, p. 5). They also thought that those

factors would make it easier for adolescents to open up and speak with these adults about their experience with bullying (Scott et al., 2016).

Adolescents are a vulnerable group due to their continually developing brains. Adolescents are more likely to act on impulse, misread or misinterpret social cues and emotions, get into accidents of all kinds, get involved in fights, and engage in dangerous or risky behavior (American Academy of Child & Adolescent Psychiatry [AACAP], 2016). Unlike most adults, adolescents are less likely to think before they act, pause to consider the consequences of their actions, or change their dangerous or inappropriate behaviors (AACAP, 2016). Not only does bullying have an effect on adolescents when it occurs, but it can also have future side effects. Adolescents that experience bullying may develop: depression, social anxiety, loneliness, isolation, stress-related health problems (e.g., headache, stomach ache), low self-esteem, school avoidance and academic problems, aggressive behaviors, and contemplate, attempt, or commit suicide (Promoting Relationships & Eliminating Violence Network [PREV Net], n.d.). Not only are there consequences for those that are bullied, but adolescents that bully other students are more at risk for long-lasting consequences as well. These include: not knowing the difference between right and wrong, delinquency, substance use, academic problems, increased school drop-out rates, aggression, sexual harassment, dating aggression, gang and criminal involvement in adulthood, difficulties in relationships with others, and being bullied themselves (PREV Net, n.d.). During physical assessments and mental health screenings nurses have an opportunity to be the first person to ask a child about their experience with bullying, provide the proper education, and perform effective interventions. Therefore, does nursing baccalaureate education prepare nurses to assess and intervene with children who are bullied? The purpose of this descriptive pilot study is to learn about bullying content in Arkansas baccalaureate nursing curricula.

Literature Review

Through a power search through several databases (i.e. CINAHL, MEDLINE, Psychology Database, PsychINFO, etc.), there was a lack of research dedicated towards pediatric bullying education in nursing programs. Using a combination of search terms like "bullying," "nursing education," "pediatric bullying," "pediatric education," "pediatric bullying education," "student nurses," and those of the like, results were numerous but did not pertain to the topic at hand. Research about bullying education among other disciplines was also done with some avail. There were no research articles that were discovered by the researcher to further understand this specific topic within nursing education, but many research articles were available to further help clarify the consequences of bullying, how bullying is viewed among nurses, adolescent and parent perception of nurse involvement in bullying, bullying education in higher curricula, what guidelines and suggestions are currently available, and skills and training needed to properly address this issue.

Risk Factors and Long-Term Effects of Bullying

There are many risk factors associated with bullying. The threat is present with bullies and victims of bullying. Specific risk factors that make adolescents targets for bullying include: having a chronic illness, physical disability, obesity, underweight, depressed, anxious, having behavior problems, and having a learning disability. Also having a different appearance, being a minority (e.g., racial, ethnic, religious), being an immigrant, identifying as LGBTQ, poverty, foster care, and being in a group home can increase the likelihood of an adolescent being the victim of bullying. In addition, having poor family functioning, having a lack of close relationships, and exposure to trauma (e.g., child maltreatment, familial interpersonal violence, parental drug/alcohol concerns, parental mental/health concerns) puts adolescents at potential

dangers to bullying. Risk factors also include being seen as weak or unable to defend themselves, have low self-esteem, are less popular than others and have few friends, or seen as annoying, provoking, or antagonizing for the attention of others (Hornor, 2018; USDHHS, 2018). Many of these risk factors are already areas in which adolescents may have trouble individually or with their own family (i.e. LGBTQ, alcoholism, depression). Bullying only adds another layer of stress in a child's life.

Though having a disability is associated with adolescent bullying, Blake, Zhou, Kwok, and Benz (2016) revealed that adolescents with disabilities partook in a range of different bullying roles and that their risk varied depending on their disability type. This can be seen, as also illustrated by Blake et al. (2016), in adolescents with poor interpersonal skills and their inability to effectively relate to others socially, being more likely to be bully-victims than non-involved students. Some additional risk factors for the bully include: those that are connected to peers, have social power, are concerned with popularity, and tend to dominate and be in control of others (USDHHS, 2018). Furthermore, adolescents that are isolated from their peers, depressed or anxious, have low self-esteem, are less involved in school, are easily pressured by peers, or are unable to identify with their emotions or feelings are at increased risk of becoming bullies. Plus, adolescents that are aggressive or easily frustrated, have less parental involvement or have familial problems at home, think badly of others, do not follow rules, think positively of violence, or have friends that are bullies may also be more likely to be a bully (USDHHS, 2018). Though nurses may know at least some information about bullying, it is imperative that more education is taught to future nurses since many of these risk factors overlap between the bully and the bully-victim. Risk factors related to bullying can be learned by nursing students to help better identify patients in whose life bullying exists. It is one thing to identify if

and how bullying is affecting a child's life, but it is another thing to know what to do with that information.

Bullying is a problem seen in pediatric health care that affects the physical, mental, and social health of adolescents (Hornor, 2018). Just like with abuse and neglect that a child may encounter in their own household, bullying is another form of trauma. With both child abuse and bullying, superior power that the perpetrator holds is used to manipulate, violate, and tear down the psychological morale of the victim (Carlisle & Rofes, 2007). Interestingly and maybe even surprisingly, those bullied by peers, compared to those that experienced maltreatment in childhood, had more unfavorable effects on their mental health in early or young adulthood (Lereya, Copeland, Costello, & Wolke, 2015). These adverse effects, as described by Carlisle and Rofes (2007), include vulnerability, fear, anxiety, running away from school, obsessive-compulsive disorder, and evocative language and are effects that bullying can have on adults. Among study participants, self-esteem (destroyed, obliterated, and inferiority complex), psychomotor symptoms (e.g., bed-wetting for three years), depression, suicidal ideation, and delayed physical growth were also found (Carlisle & Rofes, 2007). These are serious, life-altering, and possibly debilitating issues and illnesses that can be easily prevented by reducing bullying. Also noted is that sexual and emotional abuse was connected with mental health issues as opposed to physical and harsh parenting that had weak or no association with mental health issues in adulthood (Lereya et al., 2015). How does this translate into the mental/emotional abuse that is often associated with bullying among adolescents? As suggested, bullying experiences from childhood can follow adolescents into adulthood.

Nurses' Perception and Understanding of Bullying

To understand and determine the reason for inclusion or exclusion of bullying education, nurses' perception of bullying and the role they believe they play in the prevalence of bullying needs to be assessed. A little over half of the school nurses and certified nursing assistants/health technicians (CNA/HT) stated that their school had a bullying prevention program (Salmeron & Christian, 2016). Additionally, only 21.2% stated that the school nurse or CNA/HT had a role in preventing bullying and 60.6% stated they needed more information on bullying (Salmeron & Christian, 2016). Similarly, Hackett (2013) found that school nurses lacked clarity and had confusion as to what is their role in child protection and desired more clarity. Knowledge about bullying alone is not enough for providers. The provider's confidence in their ability to screen for bullying along with their attitudes about the importance of screening is what makes the difference (Hutson, Melnyk, & Hensley, 2019). Participating in education programs to understand bullying is very important, but can only become vital when the recipients of the education find worth, value, and importance in the material being taught. It is surprising that less than a quarter of nurses and CNA/HTs stated that they had a role in preventing bullying (Salmeron & Christian, 2016), especially coming from people within a profession where advocating for patients is a top priority.

When it comes to health care providers addressing bullying, there is not the same devotion to the cause as there should be in comparison to the attention of a child's physical needs and health. As expressed by Vessey, DiFazio, and Strout (2013), there is very little evidence that the nursing profession has taken an active role in addressing the issues of bullying although the prevalence and dangerous effects of bullying are evident. With screening, 52.9% of pediatric care providers (PCP), most of them being pediatric nurse practitioners, stated that they screened

for bullying, 26.7% screened for cyberbullying, 85.3% screened for depression, 55.4% screened for anxiety, and 30.7% screened the patient for self-esteem issues (Hutson et al., 2019). In addition, less than half of PCPs are confident in their knowledge and recognition of signs and symptoms of bullying and even less in their screening ability (Hutson et al., 2019).

Similarly, in a review of organizations' websites that met the review criteria put forth by the researchers (provides clinical care to children, ambulatory patients, and individuals with conditions commonly associated with bullying [i.e. deformities, disabilities, chronic illnesses, addiction, violence]), only 7 or 8% had information on youth bullying that could be identified. Out of those, three were pediatric-specific facilities (Vessey et al., 2013). With results like these coming from nurses and specialized providers that work in an environment where bullying takes place or among a population that deals with bullying often, it would be interesting to see whether nursing programs prepare students adequately to tackle these issues.

There are many different possible reasons for the low levels of screening and confidence in recognizing bullying victims. One reason for the low screening rate, as theorized by Hutson et al. (2019), is because of the lack of quality screening tools to detect bullying that is both simple and reliable. The lack of a defined and objective screening tool for bullying is also highlighted by Waseem et al. (2016) leading to relying more on suspicion than knowledge to recognize bullying. However, Waseem et al. (2016) also note that there are several validated tools out there to help identify bullying, but argue that they are not suitable for every setting due to the length of the tools. Stephens, Cook-Fasano, and Sibbaluca (2018) state that evidence-based screening tools are not available to aid in the identification of bullies or victims of bullying. This may not seem significant, but many adolescents and parents think positively about filling out a survey about bullying (Scott et al, 2016). Not having an appropriate screening tool could be the thing that

comes in between adolescents getting the help they need. However, they do list screening tools like the HEEADSSS (home and environment, education and employment, eating and exercise, activities, drugs/substances, sexuality, suicide/depression, and safety) review of systems, the Rapid Assessment for Adolescent Preventive Services, and Beck Depression Inventory-II. Additional bullying assessment tools described by Waseem et al. (2016) are the Swearer Bully Survey, Olweus Bullying Questionnaire, Peer Relations Assessment Questionnaire, the Peer Relationship Survey, the Personal Experiences Checklist, and the California Bullying Victimization Scale. Though there are many screening tools available, research and evaluation into these tools are not rigorous enough (Blake, Banks, Patience, & Lund, 2014). Vessey et al. (2013) also found that evidence of the quality and specificity of detection and identification of effective management of health problems related to bullying is limited and more research is needed. Therefore, education about bullying may not be included in nursing curricula because there is not standard nursing education, resources, or tools available from which to teach.

Adolescent and Parent Perception of Health Care Participation

In addition to nurses' perception of bullying identification, adolescent patients and their parents also have opinions as to whether health care professionals should be involved in the support of a child that is being bullied. Scott et al. (2016) state that there are many reasons for adolescents not to tell their parents about bullying; therefore, their opinion on the issues and the other sources of support in their life need to be heard. Because parents may not know about bullying that is taking place within the lives of their children, nurses play an even larger role in possibly being another form of support. Nurses must provide an opportunity to break the silence and help (Scott et al., 2016). However, there was a small portion of the participants that did not think that addressing bullying was within the scope of the GP and would rather it be tackled by

teachers and parents. In contrast to the belief that health care providers do not play a role, Carter and Wilson (2015) cite the importance of collaboration between nurses, administrators, teachers, and parents as a multidisciplinary team to address bullying, specifically cyberbullying.

Barriers to communication among adolescent and GPs about bullying included not understanding why it was being asked by the GP, the concern with the questioning being genuine as opposed to just completing a required task, not having a connection with the doctor, lacking knowledge or training to properly deal with bullying, and feeling awkward or uncomfortable being asked about bullying. Similarly, Montreuil, Butler, Stachura, and Gros (2015) found four reoccurring categories of interventions identified by both parents and children: getting to know the child, personalized care, being available to the child, and communicating calmly. The same sentiment stated by Hackett (2013) states that effective communication with children, young adults, and professionals is essential.

There are times when adolescents do not tell trusted adults in their lives about bullying. This was seen in a study in which almost half of the participants stated that they did not tell anyone about the bullying and 33.3% reported that they told their parents but that nothing changed (Carlisle & Rofes, 2007). Nurses are adults whom adolescents trust and are capable of bullying intervention. Jones, Waite, and Clements (2012) state that “Nurses across all practice settings could benefit from enhancing their knowledge and skills given that many are on the frontline of the healthcare arena and could conduct primary prevention strategies in the problem of school violence” (p. 10). Likewise, Jackson, Vaughn, and Kremer (2018) note that “educational preparation could be effectively extended to nursing and other medical staff that often screen or collect initial information before the physician-patient encounter” (p. 65). Nurses can be advocates for adolescents when their voices are not heard from others in their life.

Bullying Education in Higher Education Curricula

While searching the literature, there was difficulty finding research concerning bullying awareness and education in baccalaureate nursing programs. However, research that appeared repeatedly was the topic of workplace and academic bullying and incivility. Upon a power search through several databases (i.e. CINAHL, MEDLINE, Psychology Database, PsychINFO, etc.), searching "incivility in nursing" and "education" produced 1,207 results. This is an issue to which nursing students may become introduced in the clinical or educational setting. This is ever-increasing within nursing, especially since most new nurses have reported experiencing or witnessing workplace incivility (Clark, Ahten, & Macy, 2014). Clark, Ahten, and Macy (2013), Clark et al. (2014), Egues and Leinung (2014), Hutchinson (2009), and Sidhu and Park (2018) focused on examining the education being done with nursing students to prepare them for handling workplace bullying and incivility when it occurs after graduation or even while still in nursing school. Sidhu and Park (2018) identified eight concepts to include in the education: empowerment, awareness about self, awareness about bullying, support, self-efficacy, communication, collaboration, and socialization. They further explain that empowered nursing students encountering bullying will feel more comfortable handling and coping with the issue (Sidhu & Park, 2018). Though this information is targeted towards bullying of nursing students, the empowerment that is taught to nursing students can be a concept that could help victims of bullying that graduates may have as patients.

It is also important that education on incivility be incorporated throughout nursing curricula, clinical experiences, simulations, and post-conference content (Clark et al. 2014). The focus of anti-bullying education among nursing students should be on "(a) conflict management and conflict resolution, (b) dealing with difficult people, (c) communication and listening skills

enhancement, (d) the art of negotiation, and (e) dealing with stress management" (Egues & Leinung, 2014, p. 243). Additionally, nursing students learning about policies, procedures, support, communication skills and techniques, and the essence of bullying (Sidhu & Park, 2018) may indirectly help them be able to understand and identify bullying both when it is directed towards them and when they hear or see it in their adolescent patients. Bullying behavior within nursing programs and in the workplace can cause nursing students to leave nursing programs, can be a source of anxiety and job dissatisfaction for nursing faculty, cause new nurses to leave the profession early, and be a source of frustration and disillusionment of experienced nurses (Clark et al., 2013). Additionally, it may negatively affect nurse-patient relationships and interactions (Egues & Leinung, 2014). If these negative consequences can come from bullying that adults face, how important is it to educate adolescents about bullying?

Questions may arise as to why pediatric bullying education is not included within a nursing curriculum and why literature over the topic is scarce. Within each state, the standards for nursing program education are considered and curriculum is created based on State Boards of Nursing Rules and Regulations. In accordance with the Arkansas State Board of Nursing Rules and Regulations, the requirements put forth include theory content and clinical experiences that focus on prevention of illness for individual and groups, care for persons throughout the lifespan (including cultural sensitivity), and restoration, promotion, and maintenance of physical and mental health (Arkansas State Board of Nursing, 2018). Though pediatric and mental health nursing course content must be included within Arkansas BSN programs, there are no specifics noted as to what diseases or topics must be included within them, like bullying. This is similar to *The Essentials of Baccalaureate Education National Guidelines for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008). Additionally, the *2019*

NCLEX-RN® Test Plan put forth by the National Council of State Boards of Nursing (2019) does not use bullying as a topic of inclusion within the NCLEX-RN® examination, though abuse and neglect and health promotion and maintenance of children ages 3 through 17 years is included. Surely if bullying was a topic within the NCLEX-RN® examination, its presence would be more prominent within nursing education. Another reason why pediatric bullying education may not be included within baccalaureate nursing program curricula could possibly be because there are other nursing topics perceived as more important, difficult, or complex being taught to prepare nursing students for licensure examinations and post-graduation experiences.

Though not within the BSN nursing curriculum, Cincinnati Children's Hospital Medical Center has developed an anti-bullying curriculum, *Girls Guide to End Bullying* (Cincinnati Children's Hospital Medical Center, 2013). It is a web-based interactive curriculum targeted to students, teachers, or parents to learn tips, advice, and activities to understand and overcome the various types of bullying. According to the hospital, "The curriculum has statistically significant proven effectiveness to decrease the experiences of being bullied by 5 percent, with an 11 percent decrease for those girls who were experiencing high levels of bullying before curriculum exposure." (Cincinnati Children's Hospital Medical Center, 2013, para. 2).

Researchers from other disciplines involved with children have also examined the bullying curriculum within their college programs. Berzin and O'Connor (2010) found that 40 out of the 58 social work syllabi examined had content related to bullying or school violence. Within education, Lester, Waters, Pearce, Spears, and Falconer (2018) found that there was a high level of knowledge about bullying, but less reported being skilled in discussing and managing bullying. In addition, participants reported little discussion about preventing and controlling bullying (Lester et al., 2018). Just like seen among current nurses, another study

showed that pre-service teachers' understanding of the nature and definition of bullying is unclear (Bauman & Del Rio, 2005). Banas (2014) states that preservice teachers need the opportunity to practice skills that they are expected to be able to do, like assessment, planning, implementation, administering, controlling, communicating, and advocating. In addition, Bauman and Del Rio (2005) notes that strategies to prevent and intervene with bullying needs to include describing, demonstrating, and practicing through use of videos, role play, and technology that allows the application of knowledge to be made before a pre-service teacher has to face bullying in their classroom. Crettenden and Zerk (2012), while looking at psychology programs, found that few programs offered units dedicated to child abuse and neglect. Participants stated that there were limited opportunities for teaching this topic due to the limited room in which to teach it in the program (Crettenden & Zerk, 2012). Therefore, not only is education about bullying in nursing curricula scarce, but the literature also reveals that similar results are found in other occupations that often work with children. Formal education and having the opportunity to apply the information taught is an effective way to teach nursing students about bullying.

Current Nursing Guidelines and Suggestions

Hackett (2013), Hutson et al. (2019), and Scott et al. (2016) did not focus on the topic of pediatric bullying education in nursing programs, though, it was helpful in understanding how educated nurses and HCPs feel about assessing bullying in their patients, what they understand their role to be in this issue, and current interventions that are being done by them. The American Academy of Pediatrics (2009) suggests introducing the topic of bullying and screening for bullying at every annual well-child visit starting at six years old. Not only should screening focus on those that are bullied, but it should also assess if children are possible perpetrators of bullying

or are witnesses to the problem, since education and support are needed for all members of the bullying triad (Blaney & Chiocca, 2011). Additionally, Hornor (2018) suggests familial psychosocial assessment, which includes: parental mental health concerns, maternal or paternal abuse as a child, support system, drug and alcohol use, and other potential concerns. Blaney and Chiocca (2011) recommend understanding the child's peer relationships to understand their psychosocial context, help the child build a strong sense of self, and work with the patient to establish healthy coping strategies. In addition, it is important to teach bystanders to become a part of the solution by educating them about how to recognize and intervene when bullying is seen (Blaney & Chiocca, 2011).

Axford, Farrington, Clarkson, Bjornstad, Wrigley, and Hutchings (2015), Blake, et al. (2016), Dilillo, Mauri, Mantegazza, Fabiano, Mameli, and Zuccotti (2015), Freeman et al. (2012), and Van Ouytsel, Walrave, and Vandebosch (2015) examined the need for education and assistance of teachers as well as parents through school policies, workshops, handouts, and further interventions. Through the inclusion of parents in their child's bullying, it is imperative to assess whether parents are unknowingly supporting a culture of bullying (e.g., encouraging social cliques) and to also make sure that they are not referring to bullying as a normal part of adolescence (Blaney & Chiocca, 2011). Concurrently, additional interventions that did not seem effective for adolescent victims of bullying, as stated by Freeman et al. (2012), include ignoring the bullying that is occurring, telling the child to fight back, and the parents contacting the other adolescent's parents directly. Nurses as well need to report bullying to appropriate agencies and institutions (e.g., police, the adolescent's school), educate themselves and parents about bullying and reporting laws, and familiarize themselves with current and proposed bullying legislation (Hooker, 2019).

Nurses should be aware of the physical and mental impact of cyberbullying and engage in health strategies and early detection of cyberbullying through community awareness and education (Carter & Wilson, 2015). It may also be helpful to be familiar with the most popular internet and social media websites (Carter & Wilson, 2015) and to inquire if adolescents show any psychological or behavioral symptoms to see if they are actually related to cyberbullying or if it is caused by other problems (Van Ouytsel et al., 2015). Teaching must also be done with parents to educate them about subjects like co-viewing, communication and accurate interpretation of what the adolescent views, and setting limits on screen time (e.g., time using social media, limiting access to one room in the house) (Dawson, 2017). As demonstrated, there is guidance and suggestion out there related to bullying education for adolescents, parents, and other adults working with children. Can this possibly be translated into the classroom when educating nursing students?

Skills and Training Needed

From research, it is known how effective proper education can be. Among school nurses and CNA/HTs, there was increased knowledge of bullying, chance of reporting a bully, and assisting a victim of bullying (Salmeron & Christian, 2016) when educated. Just like all the other education that is provided while in nursing school, bullying is another important topic to discuss. Education is needed to understand what defines a bully, since there are not any evidence-based guidelines that specifically characterize bullying (Salmeron & Christian, 2016). Hackett (2013) found that experiential learning, the use of small group work, and scenarios were effective methods of learning. Participants expressed the need for more regular training and annual updates for information that was appropriate, relevant, purposeful, and school nurse specific.

Just like any question asked by the patient during a health care visit or hospital admission, adolescents may not always be honest or forthcoming about their experience with bullying, whether as the bully or the one being bullied, for a multitude of reasons. As stated by Hutson et al. (2019), it is important for health care workers to understand the importance of screening for bullying. Changing attitudes and self-reliance in pediatric providers when it comes to screening and intervening in bullying is needed, not just providing education on bullying behavior (Hutson et al., 2019).

There is evidence of the incidence and negative effects that bullying has on the victim, the bully, and the people around them. There is no argument about the importance of bullying prevention. Though research has looked at adolescent, parent, and nurse perception of bullying along with current guidelines and suggestions, there is a lack of research about bullying content in nursing education that does not involve work incivility. As future nurses, it is imperative that students are educated so that they can confidently tackle the issue of bullying. To better understand how nurses can make a positive impact on bullying incidence, how nursing students are being taught about bullying education needs to be examined. In addition, assessing the perception that nursing students and nursing faculty have about bullying is also needed. If there is no sense of value coming from either the student or the educator about the content, education will be neither present nor effective.

Purpose of the Study

The purpose of this descriptive pilot study is to examine the curricular content of pediatric bullying education in Arkansas baccalaureate nursing programs. Curricular content may include what is bullying, assessment tools and methods, nursing interventions, and pediatric education. Research questions to further guide this study are: What is the occurrence of pediatric

bullying education in baccalaureate nursing programs?, What does pediatric bullying education look like?, What perceptions do nursing faculty have about the inclusion of pediatric bullying education?, and Do nursing faculty believe that their graduates are equipped to handle bullying among their pediatric patients?

Methodology

This study was conducted using a non-experimental descriptive design. The purpose of this pilot study was to describe pediatric bullying education in Arkansas baccalaureate nursing programs, a topic in which there is limited research. Through the survey, questions were asked to gather more information about the state of Arkansas baccalaureate nursing education and to increase specific current knowledge about pediatric bullying content in Arkansas BSN programs. Since the researcher is an undergraduate nursing student at an Arkansas university, Arkansas was chosen as the study setting.

Participants (Population, Setting, and Sampling Plan)

The participants, gathered through a convenience sample, consisted of one nursing faculty member from each of the 12 Arkansas baccalaureate nursing programs. By representing Arkansas nursing programs and faculty, the study was meant to generalize the population. Demographic information is presented in Table 1.

Instrumentation

The instrument that was used for this study was an electronic survey created specifically for this study, “Pediatric Bullying Education in Nursing Curricula Survey.” The instrument consisted of a total of 24 mixed items. The survey included questions pertaining to the research as well as questions to retrieve demographic characteristics of the participant and their nursing program. Nine of the questions were multiple-choice. Four of those multiple-choice questions

required a selection from four options: “Yes,” “No,” “Unknown,” and “Other.” For the “Other” option, the participants were instructed to explain via a short answer text box. The other five of the multiple-choice items allowed participants to choose demographic information that best characterized them. There were nine open-ended questions. Six questions were Likert-scale items where participants were instructed to pick from four options: “Strongly Disagree”, “Disagree”, “Neither Agree nor Disagree”, “Agree”, or “Strongly Agree.” There was no scoring system attached to the survey. Since the survey was created specifically for this study, the reliability and validity of the instrument are unknown. SurveyMonkey® was used to send the survey via email. SurveyMonkey® is a password-protected website that allows for confidential survey collection, organization of survey data, and sharing of survey results through a link that can be shared with participants. No personal identifying information was asked of the participants within the survey and no email address was connected to the surveys completed lending to the anonymity of the survey. However, SurveyMonkey® does indicate which participants completed the survey, but did not identify which survey belonged to each of the nursing programs that participated. A copy of the “Pediatric Bullying Education in Nursing Curricula Survey” is included in Appendix A.

Procedure (Data Collection)

Once Institutional Review Board (IRB) exemption was obtained for this non-experimental descriptive mixed-method pilot study, an email was sent to the deans or program chairs of each of the 12 baccalaureate nursing programs in Arkansas asking for their participation. Participants were notified that participation was voluntary and free of obligation. Consent was assumed with the completion of the survey. The survey questions were sent electronically by the researcher to a staff member from the researcher’s nursing program. The

staff member then electronically sent the survey through a SurveyMonkey® account. At the end of May the survey was sent to the 12 deans or BSN program chairs in Arkansas. Initially, a reminder email was planned to be sent nine days later and the results were planned to be sent to the researcher 15 days later. However, the researcher was informed by one of the participants a day after the survey was emailed that the Likert scale was not labeled. Corrections were made and the survey was re-emailed six days after the initial survey email was sent. A reminder email was sent out a week later. Since there were only two responses to the survey, the researcher called each of the remaining nursing programs. Out of the 10, two deans spoke with the researcher. Messages were left for deans of six of the eight remaining BSN programs. Four days later, the researcher called the two schools that were not available for messages during the initial phone calls. One answered and referred the researcher to another faculty member to whom to send the survey. The other school did not answer and a message was left. A reminder email was sent two weeks following the corrected survey with a reminder of the survey due date. Participants had a total of 22 days to complete the survey on SurveyMonkey®.

Descriptive statistics were used to summarize the participants' demographic data and the quantitative questions This information is displayed in Table 1, 2, 3, and 4. Qualitative data responses were examined repeatedly for emergent themes, recurring consistency within the data (Polit & Beck, 2018). While the purpose of this qualitative data analysis was to better understand the concept of pediatric bullying education in Arkansas baccalaureate nursing curricula, few repeated themes emerged. Further discussion of the qualitative data is included in the Results section of this paper.

Ethical Concerns

Few ethical concerns were related to the study. It is a non-experimental study, so participants were not partaking in an intervention. Results were coming strictly from survey responses. A possible ethical concern was the fear of identification via survey responses. Therefore, the survey was reviewed by a faculty mentor to make sure that questions and responses could not identify specific faculty members or a particular nursing program. Also, specific respondents were not identified in the data analysis.

Assumptions

One of the assumptions within this research is that the sample, nursing faculty in Arkansas baccalaureate nursing programs, appropriately represents the population, nursing faculty in baccalaureate nursing programs within the United States. Another assumption is that the survey questions were accurately answered by the participants. With some of the questions, participants may have been influenced to answer how they thought or believed they should (the more desired answer) have answered as opposed to what they actually thought or believed. There is also the assumption that the faculty member that knows the curriculum well was the one completing the survey, even if it meant that the survey was forwarded to that faculty member by the dean or director of the program that received the email. It is also assumed that the participants had an interest in the topic of bullying and pediatric bullying education. Through interest they were more likely to respond to the email, take their time and complete the survey both thoroughly and accurately. Since the survey was completed during summer break and during the coronavirus pandemic, it was created so that it could be completed within 10 to 15 minutes. It was assumed that brevity encouraged participation.

Limitations

A limitation of this research study is that the survey used to gather results is one that was created specifically for this research; therefore, the validity and reliability are unknown. In addition, the survey was not reviewed by an expert in pediatric or mental health nursing; however, the survey was reviewed by the researcher's mentor before being sent. With the descriptive nature of the survey, it was assumed that a nurse educator without specific training in bullying could accurately answer the questions. There is also a chance that the survey did not reach and was not completed by the appropriate nursing faculty member, one that would be able to best answer the questions. The sample size was small, consisting of 12 nursing faculty members. In addition, the sample was a convenience sample as opposed to being randomized. Another limitation is that the survey was sent out during the summer. There is a possibility that nursing faculty did not check their email as often during the summer break. In addition, there is a chance that the recipients of the survey email were on vacation or that the email was quickly and easily "hidden" in their inbox by other emails that they received. Also, the time of the research was during the coronavirus pandemic, so there is a chance that nursing faculty were not in their office or checking their email as they would have if it was a "normal" summer. Lastly, the definition of bullying was never provided to the participants, which could mean that each of the participants had their own definition and meaning of bullying.

Data Analysis

With the purpose of the research study being to examine pediatric bullying education in baccalaureate nursing programs in Arkansas, the research was analyzed in view of the guiding research questions. A total of three weeks was allowed for survey completion. The results were then gathered and analyzed. Descriptive statistics were used to summarize the participants'

responses through survey demographic data collected (Table 1). Participants are those that were mailed the survey and those that responded are called respondents. Descriptive statistics were also used to analyze the survey quantitative questions in Tables 2, 3, and 4. Qualitative data responses provided by the respondents were initially planned on being examined repeatedly for emergent themes, recurring consistency within the data (Polit & Beck, 2018). The purpose of the use of this qualitative data is to understand the concept of pediatric bullying education in nursing curriculum. In light of a small response rate and few detailed short-answer responses, there was a lack of variation between responses. With some of the qualitative questions, only one response was given. Therefore, the qualitative data received was unable to be analyzed through coding and the creation of themes. Instead, the qualitative data was reviewed by repeatedly reading short-answer responses and looking for patterns among responses. Connections between the qualitative and quantitative results were also examined.

Quantitative Data

A total of six out of the 12 nursing programs responded to the survey, a 50% response rate. Wanting to understand more about the educational and clinical nursing experience of the participants, the researcher asked about the specialty area of clinical nursing in which the respondents currently or previously worked. Four of the respondents had expertise in areas of nursing related to the topic of the research: pediatric and mental health nursing. However, it is interesting to note that five of the respondents have not taught or do not currently teach classes in these areas (Table 1).

The aim of the research was to examine pediatric bullying education in Arkansas baccalaureate nursing programs. Because of the lack of literature related specifically to this topic, data were obtained through both quantitative and qualitative short-answer questions to

discover more specific information about bullying in the nursing curricula. Specific questions used to guide the research are located in Appendix A.

Perception of bullying and pediatric bullying education. Survey questions one, two, and four pertain to the respondents' perceptions of bullying and pediatric bullying education. 100% of nursing faculty value pediatric bullying education. All of the respondents thought that it is important to teach pediatric bullying prevention education to students in BSN programs. In addition, all respondents stated that they or a loved one had experienced bullying in their life. 66.67% of respondents either agreed or strongly agreed that the number of adolescents who are bullied is related to whether bullying prevention is addressed as noted in Table 3 (question four). However, 33.33% of respondents reported that they neither agree nor disagree with the statement.

Inclusion of pediatric bullying education. To understand further how pediatric bullying education is taught, questions seven, 10, and 11 (Table 2 and 4) addressed the inclusion of pediatric bullying education in the curriculum. 50% of the respondents stated that pediatric bullying education was included in their nursing program (question seven). There were three responses to questions 10 and 11. The majority of the three indicated that they did not know how it was included in the curriculum (question 10) or how if it was integrated in hands-on activities (question 11).

Nursing students' preparation. Questions 13, 14, 15, and 16 (Table 3) pertain to nursing students' preparation. Regarding BSN graduates' knowledge about bullying, most respondents (66.67%) reported that they agreed or strongly agreed that their graduates were knowledgeable about risk factors. 66.67% of respondents stated that they were knowledgeable about possible long-term effects of bullying and that they were knowledgeable about how to

handle adolescents that are bullies. In addition, 50% stated that their nursing graduates were knowledgeable about performing interventions for adolescents that they recognized as being bullied. One respondent disagreed with the statement that they believe that BSN graduates from their program are knowledgeable about performing interventions for children and adolescents that they recognize as being bullied and are knowledgeable about how to handle children and adolescents that are bullies. Interestingly, half of the respondents' nursing programs included pediatric bullying education within their program (question seven) and one out of six reported how it was taught in the curriculum (question 10). The remaining respondents did not know how it was taught. Nevertheless, the majority of respondents believed that their students were knowledgeable and competent on the topic of pediatric bullying.

Qualitative Data

Perception of bullying and pediatric bullying education. With question three, four respondents provided short-answer descriptions detailing bullying experience in their life or in the life of a loved one:

"Experienced bullying by [sic] in school and the work place"

"clinical workplace"

"Peer to peer in the academic setting. Peer to peer in the clinical setting"

One of the more descriptive answers by the fourth respondent included their child's experience with bullying along with their own experience in the workplace. They go into detail by stating:

"My child was bullied in school... Students on his bus were throwing trash on him and calling him names and making fun of him. I was subject to harassment at work by a male coworker who made everyone miserable. When I would not tolerate his actions as they put patients at risk…, I would get yelled at, cursed at,… At times he would point his

> *finger in my face and raise his voice and quasi threaten me. Despite complaints to administration, he retained his job and, as far as anyone could tell, he never even got in trouble."*

Noting the purpose of the study, the respondent may be able to understand more personally the effect that bullying can have mentally and emotionally on children since it was experienced by their own child. Though the purpose of this research was not to seek a correlation between the inclusion of pediatric bullying curriculum and personal experience with bullying, this may play a role in their perceived value of bullying education provided within their school's nursing program.

All respondents answered that they have experienced bullying. However, only four respondents answered question two about their experiences with bullying. With one exception, all responses to question two lacked enough detail to allow for more understanding about their specific experiences with bullying.

Inclusion of pediatric bullying education. All respondents thought that pediatric bullying education was important, as illustrated in question one, but not all nursing programs reported it within their curriculum. Three respondents (50%) stated that their school's nursing program included pediatric bullying education and one respondent stated that they did not know whether it was or was not included within the curriculum (question 11). One respondent further explained by stating:

> *"We mention harassment and bullying, but more in a general sense—not in terms of prevention strategies. Additionally, we do not focus on pediatric bullying (as far as I know)."*

Specifics regarding pediatric bullying education and the content of the education revealed differences among nursing programs (reported in question nine). The three responses included:

"risk factors, signs or [sic] bullying, plan of care, resources"

"How to treat all people regardless of race, socioeconomic level, gender, or life choices. How to advocate for the most vulnerable or left out"

"*patient assessment and social referrals*"

Pediatric bullying education is different in each of the nursing programs; however, the last two responses are too generic to confirm whether pediatric bullying education was included in the curriculum or not.

Interestingly, the reason for including pediatric bullying education in nursing curricula was also different across nursing programs. In question eight, respondents stated that bullying education is included in their curriculum because of:

"*National Guidelines"*

"*Bullying is not Christian behavior or witness*"

"*To prepare our graduates for advocacy roles"*

How do these dissimilar reasons for including pediatric bullying education in the curriculum affect the way in which the teaching takes place?

Confidence in teaching pediatric bullying education. One respondent stated that they felt comfortable teaching over the topic of bullying in the general sense, but explained that they "would like some specific training." That same respondent further explained:

"I would like specific statistics and proven strategies that have shown to be effective in reducing bullying. I feel like I can discuss the topic, but formally teaching bullying prevention education, no, I would like some specific training."

As previous literature has hypothesized (Stephens et al., 2018; Vessey et al., 2013; Salmeron & Christian, 2016), the lack of research and evidence related to bullying in nursing curricula may be holding nursing educators back from feeling confident about their ability in pediatric bullying education with their nursing students. Obviously there is a need for more research on the most effective way to teach this content as well as a need for more nursing related data and statistics about the role that nurses play in pediatric bullying and how effective nurses are in this role.

Findings obtained through data analysis of this study display similarities between the six nursing faculty in their experiences and perception of pediatric bullying education. All faculty believe this is important content; however, results have revealed that pediatric bullying education is not a part of nursing content in all Arkansas BSN nursing programs. In addition, all respondents have experienced bullying. A majority believe their graduates are competent to manage pediatric bullying, but this content is present in only 50% of the nursing programs surveyed. Differences exist in how bullying content is taught and why it is included in BSN nursing programs surveyed. Because of these results, more questions arise in regards to pediatric bullying education in baccalaureate nursing programs.

Discussion

Studies (Hackett, 2013; Hutson et al., 2019; Salmeron & Christian, 2016) have been done regarding the knowledge, confidence, and education that school nurses, nurse practitioners, and primary care providers have received regarding bullying. In addition, because of the spotlight on incivility and bullying towards nursing students in school, in clinical, and in the workplace post-graduation, more education has been done to make sure that students are able to handle situations like this in an appropriate manner (Clark et al., 2013; Clark et al., 2014; Egues & Leinung, 2014; Hutchinson, 2009; Sidhu & Park, 2018). However, there was no published research found

regarding the inclusion of specific pediatric bullying education in baccalaureate nursing programs to help students be able to identify, respond, and care for adolescents that are affected by bullying. Through the use of an online survey, the focus of this pilot descriptive study was on Arkansas baccalaureate nursing programs. Due to external time constraints, the survey was limited to the state in which the researcher is receiving her nursing education. Through participation from six of twelve BSN programs, information and data were gathered to better understand this understudied concept.

All nursing faculty that responded stated that they had experienced bullying. Four of six provided additional information. One of the four provided specific descriptions of their experiences. Pediatric bullying education in Arkansas BSN programs was perceived as important by all respondents, similar to education majors' attitudes towards bullying and interest in additional training (Bauman & Del Rio, 2005). Differing from Salmeron and Christian's (2016) study where more than 75% of school nurses and CSA/HT did not believe that they played a role in preventing bullying, more than half of participants in this study agreed that the number of adolescents who are bullied is associated with bullying prevention. If all respondents have experienced bullying, is it possible that all adolescent patients that nurses see in a variety of health care settings are dealing with either past or present bullying? Half of the respondents stated that pediatric bullying education is a part of their school's nursing curriculum. This left the researcher wondering, if 100% stated they thought it was important and experienced it themselves, why is it not included in the curriculum of all the respondents' nursing programs? Like acknowledgments made by graduate psychology program faculty in regard to limited opportunities to teach CAN (Crettenden & Zerk, 2012), many reasons for these results from

respondents may exist: lack of space in the curriculum to include it, grouping it with other types of abuse, not thinking that it is needed in nursing education, or some other reason.

Additionally, qualitative data revealed that there was inconsistent specific education about bullying. What pediatric bullying nursing education looked like varied among respondents. One respondent reported that in a more general sense, harassment and bullying are taught to their nursing students while another respondent stated that pediatric bullying education was more specific: the inclusion of risk factors, signs and symptoms, assessments, and resources available. Because of differing degrees of specificity and content of bullying education, this may not be a situation strictly found in nursing education as expressed by Lester et al. (2018). In their study, pre-service education students were knowledgeable about bullying but participants were unsure about how to deal with covert (64%) or cyberbullying (70%). What would nursing students' competency look like if taught specific aspects of bullying? Is it enough for nursing students to be taught a basic understanding of bullying? This mirrors recommendations in psychology education from Crettenden and Zerk (2012), who stated that their research findings indicated a need "about the minimum level of information required" to appropriately address CAN (p. 84). In addition, does education over this topic look different because there are no evidence-based guidelines on the most effective way to teach pediatric bullying education? This is evidenced by one respondent who stated that they "would like specific statistics and proven strategies…" (question six). Of all the respondents, three (50%) stated that pediatric bullying education was included in their program and one expressed that they did not know (16.67%) if it was included in their program. Furthermore, two of the three respondents whose programs did include content on bullying did not know specifically how the bullying content was taught in their curriculum (question 11).

While half (questions 15 and 16) or most (questions 13 and 14) of the respondents believed their graduates are competent enough to address adolescent bullying, it is unknown how this competence is determined. This may be due to a lack of survey questions regarding competence assessment related to adolescent bullying. One respondent believed that more data and evidence-based strategies, teaching, and training are needed to have the knowledge and skills to teach pediatric bullying content to BSN students. The need for more information on bullying was something echoed by respondents in Salmeron and Christian's (2016) research. Additionally, participants in Hackett's (2013) research displayed interest and the need for more specific training and annual updates. This information reflects some of the knowledge claims within Lester et al.'s (2018) research reporting that respondents were less skilled in discussion and management of bullying and that there was a lack of conversation about preventing and controlling bullying.

The majority of this study's respondents reported either neutrally or in agreement to the statement regarding nursing students from their nursing programs having knowledge about the risk factors and long-term effects of bullying, being knowledgeable as to how to perform interventions for children and adolescents that they recognize as being bullied, and how to handle children and adolescents that are bullies. However, one respondent stated that they did not believe that their BSN graduates were knowledgeable about performing interventions for those that were bullied and one respondent answered similarly in regard to students being able to handle those that are bullied. Do nursing programs measure or evaluate students' competency in addressing pediatric bullying? Is this belief and confidence in their nursing students due to other topics on which they are educated that they believe could also help them in the situation (i.e., material taught about vulnerable populations, nursing management, patient advocacy, or

abuse)? How did respondents know that graduates can perform nursing interventions appropriately? Bauman and Del Rio (2005) suggest the importance of the use of simulated situations to prepare students before they experience a bullying situation in the classroom, or in this case, the clinical setting. As noted by Salmeron and Christian's (2016) study, practicing nurses working in the school setting need more teaching over what defines a bully. How do nursing programs assure graduate competency regarding pediatric bullying?

Limitations

In addition to limitations identified before the start of the study (refer to the Methodology section of the paper), more were identified upon study completion. This was a small-scale descriptive pilot study with a 50% response rate out of 12 Arkansas baccalaureate nursing programs. Though valuable preliminary information was obtained, more research needs to be done to learn if these findings are representative of BSN programs throughout the United States. Because of the small size of this pilot study, no recommendations can be made. More research is needed to learn the best way to address pediatric bullying education in BSN programs. Since the study was conducted during the summer months and during the coronavirus pandemic, contact with educators and nursing program directors was more challenging than at other times of the year. The effectiveness of gathering qualitative data was another problem faced. Phone calls with participants as opposed to reliance on an online survey may help gather more detailed and clear information.

After conducting the research and analyzing data results, there were survey limitations found that could have impacted the way respondents answered the questions. The survey did not provide an operational definition of bullying. Though most people probably have an idea of what is "bullying", the term "bullying" may have had different meanings to each respondent. Wording

that could have possibly limited the answers that the respondents selected include the word choice in questions one, four, five, 13, 14, 15, and 16 when asking respondents about their beliefs versus what they think. According to Merriam-Webster dictionary "belief" is "a state or habit of mind in which trust or confidence is placed on some person or thing" ("belief", n.d.) while "think" is "to have as an opinion" ("think", n.d.). Regarding instrumentation, "neither agree nor disagree" ended up being an ambiguous response. Respondents could have selected this option because they did not know the answer to the question or they were unsure of the answer. Instead of giving the respondents the option to answer "neither agree nor disagree", allowing the respondents to answer "unknown or unsure" would allow for more analysis clarity.

Since the survey was sent out to the deans or BSN program chairs, there is a chance that the survey respondents were not those that were most knowledgeable about specific curriculum content. This is something that was highlighted by at least two respondents that did not know specific information about what pediatric bullying education looked like or how it was included in their program (questions seven and 11). In addition, respondents could have been mistaken about the information that they provided on the survey. Because the research study is drawing information from one faculty member within the nursing program, it is not known if that information is completely accurate or if all faculty members from the program would answer the questions in the same way. All qualitative questions were not answered by all study respondents. Two respondents skipped a question (question three) and respondents that did answer gave more generalized answers to the questions (questions eight and nine). It is possible that some respondents skipped it because they did not feel comfortable answering the question, they did not know the answer to the question, they did not see the question, or the question was unclear.

Since there was a 50% response rate to the survey, the researcher does not know how the results would have differed if all participants responded to the survey. Therefore, this study has provided very preliminary data about the state of pediatric bullying education in Arkansas BSN programs. The lack of qualitative data patterns makes it difficult to draw conclusions from the data. Therefore, there was not enough qualitative data generated to provide evidence-based information about pediatric bullying education in Arkansas baccalaureate nursing programs.

Implications and Recommendations

Due to limited knowledge drawn from analysis of the survey results, more follow up research is needed. Specifically, survey questions need to be refined and include competency assessment regarding pediatric bullying. Bullying has been around for years, but with the development and rise of social media, it has changed where and when it happens (Anderson, 2018). Among respondents, all experienced bullying, but it may not have been the same type or intensity as many adolescents now experience. This may be the case with cyberbullying, which is a more recent phenomenon. The majority of respondents were over 40 years of age so they did not have any experience with this type of bullying during their adolescent years.

Curriculum committees within BSN nursing programs should examine the pediatric bullying content in their program. Faculty development on pediatric bullying may be warranted especially since not all of the respondents were comfortable, confident, or sure about teaching it. At the state and national level, there are numerous nurse educator conferences organized throughout the country (e.g., Nurse Educator Institute, BSN Sharing Day, National League for Nursing Educational Summit). Pediatric bullying education would be an appropriate topic to discuss since according to the CDC (2018), 14.9% of adolescents in 9th-12th stated they had been bullied electronically and 19.0% stated they had been bullied on school property. There is

an obvious need for this content to be included in nursing curriculums. It is also important to note, there is no content specifically related to bullying in the Arkansas State Board of Nursing Rules and Regulations, the *National Council of State Boards of Nursing 2019 NCLEX-RN© Test Plan*, or the *AACN Essentials of Baccalaureate Education National Guidelines*. This may be why, in this survey, specific pediatric bullying education was sometimes excluded from nursing curriculum content.

A research topic that needs to be further investigated is one that focuses on the knowledge nurses have to recognize and address pediatric bullying. Moreover, experimental research needs to be done to determine best practices to teach pediatric bullying content. Additionally, surveying adolescent patients and their guardians to assess the bullying in their life, what they think are nurses' roles, and if they feel that nurses asked or showed interest in bullying behavior in their life is important.

Conclusion

Though this is a first step in understanding nursing education about pediatric bullying, this study indicates a need for more evidence-based knowledge and more professional development of nursing faculty. What is known from this study are the positive perceptions that nursing faculty have about pediatric bullying education. However, the occurrence of pediatric bullying education in Arkansas baccalaureate nursing programs, the differences and non-specific nature of pediatric bullying education among nursing programs, and the confidence that nursing faculty have in their students' knowledge and skills related to bullying need to be further studied. Since this research was a pilot study, it allowed for better understanding and identification of questions that should be asked. The success of bullying education among nursing students needs to be assessed when included within nursing curricula. Comprehensive evidence-based

educational criteria regarding pediatric bullying need to be developed for nursing programs. Faculty development regarding pediatric bullying needs to occur to enhance quality educational outcomes. Given the global and national widespread incidence of pediatric bullying and its presence on the *Healthy People 2020* agenda for U.S. healthcare, nursing graduates need to be educationally prepared to address this important issue to promote optimal holistic pediatric health.

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Appendix A

Pediatric Bullying Education in Nursing Curricula Survey

1. Do you think that it Is important to teach pediatric bullying prevention education to nursing students in BSN programs?

A.) Yes

B.) No

C.) Other (Please Specify): _____

2. Have you experienced bullying in your life either personally, with a close friend or family member, and/or in the clinical/workplace setting with patients?

A.) Yes

B.) No

C.) Other (Please Specify): _____

3. If answered “Yes”, please explain.

_____

_____

_____

4. I believe that the number of adolescents who are bullied is related to whether bullying prevention is addressed.

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

5. Do you think that you have the knowledge and skills to teach pediatric bullying prevention education to nursing students in BSN programs?

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

6. If you answered “Strongly Disagree” or “Disagree” please explain.

_____

_____

_____

7. Is pediatric bullying education a part of your school's BSN program?

A.) Yes

B.) No

C.) Unknown

D.) Other (Please Specify):_____

8. If you answered "Yes" to bullying education being part of your curriculum, why is it included in the class material?

_____

_____

_____

9. If you answered "Yes" to bullying education being part of your curriculum, what is included in pediatric bullying education (e.g., educating students about risk factors, complications, patient assessments)

_____

_____

_____

10. If you answered “Yes” to bullying education being part of your curriculum, how is pediatric bullying education included in the curriculum?

A.) Pediatric bullying education is integrated throughout the class in which it is taught.

B.) Taught throughout the entirety of the nursing program.

B.) Pediatric bullying education is taught as separate content.

C.) Pediatric bullying education is taught in a unit about child abuse, school violence, and/or adolescent mental health.

D.) Unknown

E.) Other (Please Specify): _____

11. Is pediatric bullying education integrated in clinical simulations, case study exercises, or other interactive or hands-on activities that allow nursing students to put into practice what they are taught?

A.) Yes

B.) No

C.) Unknown

12. If answered “Yes”, please explain.

_____

_____

_____

13. I think or believe that BSN nursing graduates from my program are knowledgeable about the risk factors of bullying.

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

14. I believe that BSN graduates from my program are knowledgeable about the possible long-term effects of bullying.

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

15. I believe that BSN graduates from my program are knowledgeable about performing interventions for children and adolescents that they recognize as being bullied.

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

16. I believe that BSN graduates from my program are knowledgeable about how to handle children and adolescents that are bullies.

A.) Strongly Disagree

B.) Disagree

C.) Neither Agree Nor Disagree

D.) Agree

E.) Strongly Agree

Demographics

School

17. School

A.) Public

B.) Private

Nursing Program

18. Number of years that program has been established:

A.) 0-10 years

B.) 11-20 years

C.) 21-30 years

D.) 31-40 years

E.) 41-50 years

F.) 51-60 years

G.) 60+ years

H.) Unknown

19. Approximate number of students in the nursing program:

A.) 0-50 students
B.) 51-100 students
C.) 101-150 students
D.) 151-200 students
E.) 201-250 students
F.) 251-300 students
G.) 301+ students
H.) Unknown

Faculty

20. Number of years that you have been working in nursing education?

A.) 0-10 years
B.) 11-20 years
C.) 21-30 years
D.) 31-40 years
E.) 41+ years

21. Number of years that you have been a registered nurse (RN)?

A.) 0-10 years
B.) 11-20 years
C.) 21-30 years
D.) 31-40 years
E.) 41+ years

22. In what specialty area of clinical nursing did/do you work? (e.g., medical-surgical, oncology, orthopedics, pediatrics)?

_____

_____

_____

23. In what classes within the nursing program do you teach?

_____

_____

_____

This survey was developed for this research study by Jasmine Jackson.

Tables

Table 1

Participant Demographic Information

Characteristics	n	%
School		
Public	4	66.67%
Private	2	33.33%
Years Program Has Been Established		
0-10	2	33.33%
11-20	0	0%
21-30	1	16.67%
31-40	1	16.67%
41-50	1	16.67%
51-60	1	16.67%
60+	0	0%
Unknown	0	0%
Approximate Number of Students in the Program		
0-50 students	1	16.67%
51-100 students	0	0%
101-150 students	1	16.67%
151-200	1	16.67%
201-250 students	1	16.67%
251-300 students	2	33.33%
301+ students	0	0%
Unknown	0	0%
*Number of Years Working in Nursing Education		
0-10 years	1	20%
11-20 years	4	80%
21-30 students	0	0%
31-40 students	0	0%
41+ students	0	0%
Number of Years as a Registered Nurse		
0-10 years	0	0%
11-20 years	2	33.33%
21-30 years	3	50%
31-40 years	1	16.67%
41+ years	0	0%
*^Specialty Area of Nursing Have and/or Currently Work In?		
Long-Term Acute	1	16.67%
Medical-Surgical Adult	1	16.67%
Mental Health Nursing	2	33.33%
Pediatrics	2	33.33%
*^Classes in Nursing Program They Do and/or Have Taught		
Research/Evidence-Based Practice	2	33.33%
Leadership	1	16.67%

Health Assessment	2	33.33%
Pathophysiology	1	16.67%
Simulation Coordinator	1	16.67%
Concepts of Professional Nursing 1 & 2 Clinicals	1	16.67%
Overview of Professional Nursing	1	16.67%
Informatics, Inquiry, and Evidence-Based Practice	1	16.67%
Capstone	1	16.67%
Mental Health	1	16.67%
Professional Role	1	16.67%
Fundamentals	1	16.67%
Cultural Competence	1	16.67%

* Five of the participants responded. One respondent skipped the question.
^ More than one response accepted.

Table 2

Survey Quantitative Questions (Yes/No)

Survey Questions	Yes	No	Unknown	Other
Q1: Do you think that it is important to teach pediatric bullying prevention education to students in BSN programs?	6 (100%)	0 (0%)	0 (0%)	N/A
Q2: Have you experienced bullying in your life either personally, with a close friend or family member, and/or in the clinical/workplace setting with patients?	6 (100%)	0 (0%)	0 (0%)	N/A
Q7: Is pediatric bullying education a part of your school's BSN program?	3 (50%)	2 (33.33%)	1 (16.67%)	0 (0%)
*Q11: Is pediatric bullying education integrated in clinical simulations, case study exercises, or other interactive or hands-on activities that allows students to put into practice what they are taught?	0 (0%)	1 (33.33%)	2 (66.67%)	N/A

*Three participants responded. Three participants skipped the question.

Table 3

Survey Quantitative Questions (Likert Scale)

Survey Questions	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Q4: I believe that the number of adolescents who are bullied is related to whether bullying prevention is addressed.	0 (0%)	0 (0%)	2 (33.33%)	2 (33.33%)	2 (33.33%)
Q5: Do you think that you have the skills, education, and experience to teach pediatric bullying prevention education to nursing students in BSN programs?	0 (0%)	1 (16.67%)	2 (33.33%)	2 (33.33%)	1 (16.67%)
Q13: I think or believe that BSN nursing graduates from my program are knowledgeable about the risk factors of bullying.	0 (0%)	0 (0%)	2 (33.33%)	4 (66.67%)	0 (0%)
Q14: I believe that BSN graduates from my program are knowledgeable about the possible long-term effects of bullying.	0 (0%)	0 (0%)	2 (33.33%)	3 (50%)	1 (16.67%)
Q15: I believe that BSN graduates from my program are knowledgeable about performing interventions for adolescents that they recognize as being bullied.	0 (0%)	1 (16.67%)	2 (33.33%)	3 (50%)	0 (0%)

Q16: I believe that BSN graduates from my program are knowledgeable about how to handle adolescents that are bullies.	0 (0%)	1 (16.67%)	2 (33.33%)	3 (50%)	0 (0%)

Table 4

Q10: How is pediatric bullying education included in the curriculum?

Response Options	N=3 (%)
Pediatric bullying education is integrated throughout the class in which it is taught.	0 (0%)
Taught throughout the entirety of the nursing program.	1 (33.33%)
Pediatric bullying education is taught as separate content.	0 (0%)
Pediatric bullying education is taught in a unit about child abuse, school violence, and/or adolescent mental health.	2 (66.67%)
Unknown	0 (0%)

*Three participants responded. Three participants skipped the question.