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Research Article

Workplace Bullying in Nursing Clinical Education: A Social Learning Perspective

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Abstract

Background: Workplace bullying in clinical learning environments remains a pervasive issue in nursing education, with significant implications for student well-being and professional development. Despite high global prevalence, theoretical explanations for how such behaviours are sustained within clinical settings remain limited. This study examined the prevalence, forms, and sources of workplace bullying among nursing students during clinical education and interpreted the findings using Social Learning Theory.

Methods: A cross-sectional study was conducted among second- and third-year nursing students at a government nursing education institution in Sri Lanka. Census sampling was used to recruit all eligible students (second year: n = 142; third year: n = 98; total eligible: = 240). Data were collected using a validated self-administered questionnaire that assessed non-physical incivility, physical aggression, sexual harassment, and reporting behaviours. Data were analyzed using SPSS Statistics version 25. Descriptive statistics and the Mann–Whitney U test were used for data analysis.

Results: Of the 220 respondents (response rate = 91.6%), 75.9% reported experiencing at least one form of negative workplace behavior. Non-physical incivility was most prevalent (75.5%), followed by physical aggression (15.9%) and sexual harassment (9.1%). Staff nurses (53.6%) and nurse managers (38.6%) were the primary perpetrators. Despite the high prevalence, only 12.7% of students formally reported incidents. Third-year students reported significantly higher total negative behaviour scores (mean rank = 132.74 vs. 97.54, $p < 0.001$) than second-year students.

Conclusions: Workplace harassment is highly prevalent among Sri Lankan nursing students but is significantly underreported. Primarily, it manifests as non-physical incivility carried out by staff nurses and nurse managers. Institutional strategies focusing on positive role modeling, strengthened reporting systems, and enforcement of anti-bullying policies are essential to promote psychologically safe and educationally supportive clinical learning environments.

Keywords: *Clinical Education, Clinical Learning Environment, Nursing Students, Social Learning, Workplace Bullying*

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Introduction

Workplace bullying in clinical learning environments (CLE) is increasingly recognized as a significant challenge in nursing education. Bullying has been defined as repeated negative actions, including verbal hostility, exclusion, unfair criticism, and humiliation, directed toward individuals who have limited power to defend themselves (Piri et al., 2025; Yosep et al., 2024;). Such behaviours can undermine students' psychological well-being, impair learning experiences, and negatively influence professional development.

Clinical placements represent a critical component of nursing education, where students are expected to develop professional competencies while adapting to complex healthcare environments. During this period, students often occupy a vulnerable position within hierarchical healthcare systems, where power imbalances between students and experienced staff may increase the risk of mistreatment. Previous research has consistently shown that nursing students frequently encounter various forms of bullying and incivility during clinical placements (Birks et al., 2024; Masadeh et al., 2024; Pan et al., 2024).

A recent global systematic review reported prevalence rates of bullying among nursing students ranging from approximately 60% to over 90%, highlighting the widespread nature of the problem across diverse healthcare contexts (Zhou et al., 2023). These behaviours are most commonly expressed through non-physical actions such as dismissive communication, exclusion from learning opportunities, and public criticism. Although less frequent, physical aggression and sexual harassment have also been documented in clinical education settings and may have profound psychological consequences for affected students (Budden et al., 2017; Luhanga et al., 2019).

The consequences of workplace bullying extend beyond individual distress. Studies have shown associations between bullying experiences and increased levels of anxiety, burnout, reduced self-efficacy, and decreased engagement in clinical learning (Fang et al., 2020; Hodgins et al., 2024; Zhang et al., 2024). Moreover, hostile learning environments may indirectly affect patient care by compromising teamwork, communication, and professional development within healthcare systems (Pogue et al., 2022).

Bandura's Social Learning Theory (SLT) provides a useful framework for understanding how bullying behaviours may develop and persist within clinical environments. According to this theory, individuals learn behaviours through observation, imitation, and reinforcement within social contexts (Bandura, 1977). When students observe negative behaviours modeled by authority figures and perceive that such behaviours occur without consequences, they may come to view them as acceptable professional conduct. Over time, these learned behaviours may become embedded within workplace culture and transmitted across generations of healthcare professionals (Goh et al., 2022).

In Sri Lanka, nursing education is mainly controlled by the state and culminates in a nursing diploma. It is characterized by a

highly structured, government-run curriculum. Concurrently, the Sri Lankan healthcare system is defined by a rigid, deeply entrenched hierarchical structure in which nursing students hold the lowest tier of clinical authority.

In this environment, students spend extensive time observing the daily interactions, communication styles, and power dynamics of senior registered nurses and ward managers. This unique organizational culture creates an ideal context for SLT, as students are continuously positioned to observe, internalize, and potentially imitate positive or negative behavioral norms modeled by those in power.

Despite increasing global attention to workplace bullying in nursing education, research examining this issue within the Sri Lankan context remains limited, particularly from a theoretical perspective. Understanding the prevalence, sources, and forms of bullying within local CLEs is essential for developing effective institutional interventions. Therefore, this study aimed to examine workplace bullying among nursing students during clinical placements in Sri Lanka and to interpret these experiences using SLT as an explanatory framework.

Methods

Study design and setting

A quantitative descriptive cross-sectional study was conducted between October and December 2025 at a College of Nursing in Sri Lanka.

Participants and sampling

All second- and third-year students enrolled in the Diploma in Nursing program of a selected College of Nursing were invited to participate.

The selected government College of Nursing was chosen because it represents the largest cohort of diploma nursing students in the region, providing a homogenous sample. A census sampling approach was used within the selected institution, where the entire accessible population of second- and third-year students was targeted (2nd year: n = 142; 3rd year: n = 98; total eligible = 240). Inclusion criteria required students to be in their second or third year, ensuring they had at least 12 months of clinical placement experience. Of the 240 eligible participants invited, 220 completed the questionnaire (2nd year: n = 139; 3rd year: n = 81), yielding a response rate of 91.6%.

Data collection instrument

Data were collected using a structured self-administered questionnaire developed by the researchers based on an extensive review of the literature on workplace bullying in nursing education, particularly drawing on the work of Budden and co-authors (Budden et al., 2017). Existing instruments such as the Negative Acts Questionnaire were considered; however, a context-specific tool was developed to better capture culturally embedded hierarchical and communication dynamics within Sri Lankan clinical settings.

The instrument assesses three domains of negative workplace behavior: non-physical incivility, physical aggression, and sexual harassment. Responses were measured using

a four-point Likert frequency scale ranging from 0 =Never to 3= Often. [Never = 0, Occasionally (1–2 times) = 1, Sometimes (3–5 times) = 2, Often (>5 times) = 3].

The questionnaire was administered in English, the medium of instruction in nursing education in Sri Lanka. Content validity was established through expert review by a panel of five experts, comprising three nursing educators with doctoral qualifications and two researchers experienced in instrument development. The experts evaluated the questionnaire for relevance, clarity, comprehensiveness, and cultural appropriateness for the Sri Lankan context. Based on their feedback, minor modifications were made to improve the wording and clarity of several items. A pilot test involving 20 students confirmed the clarity and relevance of the items. The pilot test was conducted with 20 first-year students from the same institution ensuring no overlap with the final study sample. The instrument demonstrated excellent internal consistency (Cronbach's $\alpha = 0.94$).

While strict definitions of workplace bullying often require prolonged and repeated exposure (e.g., weekly incidents over six months), clinical placements for nursing students in Sri Lanka are typically organized as short-term rotations, generally lasting an average of 3 to 4 weeks per ward or specialty. Because students rotate frequently, requiring continuous six-month exposure to a single perpetrator is methodologically unfeasible. Therefore, consistent with broader educational research, this study adopts a continuum approach, capturing exposure to any negative acts or incivility that have the potential to escalate into systematic bullying, as even isolated incidents can severely impact student self-efficacy and learning.

Statistical analysis

Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the prevalence and characteristics of bullying experiences. Mann-Whitney U test was conducted to compare negative behaviour scores between second-year and third-year nursing students as the data were not distributed normally. Data were analyzed using SPSS version 25. Statistical significance was set at $p < .05$.

Each item was scored on a 4-point frequency scale (0 = Never, 1 = Occasionally [1–2 times], 2 = Sometimes [3–5 times], 3 = Often [>5 times]). To examine overall levels of negative behaviors and compare groups, composite sum scores were calculated. Subscale sum scores were computed by summing the responses for all items within each domain: non-physical incivility (11 items, range 0–33), physical aggression (6 items, range 0–18), and sexual harassment (5 items, range 0–15). The Total Negative Behavior score was calculated as the sum of all 22 items across the three subscales (range 0–66), where higher scores indicate a greater frequency of exposure to negative behaviors (Budden et al., 2017; Einarsen et al., 2020).

Any form of negative workplace behaviour was defined as the experience of at least one incident of negative behaviour during clinical training, encompassing one or more of the three measured domains: non-physical incivility, physical aggression, and sexual harassment. Participants who reported

experiencing at least one behaviour from any of these domains were classified as having experienced any form of negative workplace behaviour.

While the questionnaire quantified the prevalence and forms of bullying, Bandura's Social Learning Theory was employed as an overarching interpretive framework during the analysis and discussion phases to explain the underlying social mechanisms behind the observed behaviours.

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from the Ethical Review Committee of KIU University, Sri Lanka. Approval No. KIU/ERC/24/444. Written informed consent was obtained from all participants. Participation was voluntary, and anonymity was ensured.

Results

Participant characteristics and exposure to negative workplace behaviours

Of the 240 eligible students invited to participate, 220 completed the questionnaire, yielding a response rate of 91.6%. The vast majority of participants were female (96.8%). Ages ranged from 24 to 30 years (Mean±SD; 25.4±1.16). 63.2% were second-year and 36.8% third-year students.

Overall, 75.9% of students reported experiencing at least one form of negative workplace behavior during the previous year of their clinical placement. Non-physical incivility was the most prevalent form (75.5%), followed by physical aggression (15.9%) and sexual harassment (9.1%) (Table 1).

Bullying patterns

Non-physical incivility was the most prevalent form (75.5%), with the most frequent behaviours being non-verbal dismissive facial expressions (70.5%) and being spoken to in a loud, harsh, or disrespectful tone (62.1%). Being ignored or excluded during clinical activities and receiving no acknowledgment for good work were also frequently reported. The non-physical incivility subscale mean was 0.85 (SD = 0.97) (Table 2).

Physical aggression was uncommon (M = 0.03, SD = 0.15), with unwanted physical contact such as pushing or shoving (11.8%) being the most reported. Sexual harassment was relatively rare most often involving inappropriate touching (6.4%) (Table 3).

Sources of negative behaviours

Staff nurses (53.6%) and nurse managers (38.6%) were the main perpetrators, followed by auxiliary staff (25.9%) and peers (22.7%). Clinical instructors accounted for negligible reports (4.5%) (Table 4).

Reporting behavior and reasons for non-reporting

Out of the total participants, the majority (139; 63.2%) reported that they did not report any mistreatment to authorities. A smaller proportion (28; 12.7%) indicated that they reported mistreatment, while 53 respondents (24.1%) stated that the question was not applicable, as they had not experienced any negative behaviors.

Among respondents who did not report the mistreatment, the most commonly reported reason for not reporting was fear of negative

Table 1: Overall prevalence of negative workplace behavior (n = 220)

Type of bullying	Frequency	Percentage (%)
Any form of negative workplace behavior	167	75.9
Non-physical incivility	166	75.5
Physical aggression	35	15.9
Sexual harassment	20	9.1

Table 2: Prevalence of non-physical incivility among nursing students (n = 220)

Non-physical incivility behaviours						
Item	**Never Frequency (%)**	**Occasionally Frequency (%)**	**Sometimes Frequency (%)**	**Often Frequency (%)**	**Mean**	**SD**
Non-verbal dismissive facial expressions	65 (29.5)	81 (36.8)	43 (19.5)	31 (14.1)	1.18	1.01
Spoken to in a loud, harsh, or disrespectful tone	83 (37.7)	59 (26.9)	37 (16.8)	40 (18.2)	1.16	1.12
Criticized unfairly in front of others	108 (49.3)	58 (26.5)	34 (15.5)	19 (8.7)	0.84	0.99
Ignored or excluded during clinical activities	81 (37.9)	66 (30.8)	33 (15.4)	34 (15.9)	1.09	1.08
Made to feel embarrassed or belittled	124 (57.9)	51 (23.8)	27 (12.6)	12 (5.6)	0.66	0.90
Unfair duty allocation or scheduling	94 (44.1)	73 (34.3)	21 (9.9)	25 (11.7)	0.89	1.00
Assigned an unfair workload	121 (56.0)	50 (23.1)	29 (13.4)	16 (7.4)	0.72	0.96

compared with others						

Table 2: Prevalence of non-physical incivility among nursing students (n = 220) *(Cont.)*

No acknowledgment for good work	92 (42.4)	69 (31.8)	32 (14.7)	24 (11.1)	0.94	1.01
Denied opportunities for clinical learning	119 (54.8)	52 (24.0)	34 (15.7)	12 (5.5)	0.72	0.92
Culturally or socially insensitive remarks	163 (75.1)	30 (13.8)	14 (6.5)	10 (4.6)	0.41	0.81
Not treated as a valued healthcare team member	120 (54.8)	59 (26.9)	17 (7.8)	23 (10.5)	0.74	0.99

Table 3: Prevalence of physical aggression and sexual harassment among nursing students (n=220)

Behavior	Frequency	%
Physical aggression		
Unwanted physical contact (pushing or shoving)	26	11.8
Threatening physical gestures	0	0.0
Hitting or striking	1	0.5
Struck with an object	0	0.0
Threatened with physical harm	12	5.5
Personal belongings mishandled or damaged	2	0.9
Sexual harassment		
Inappropriate physical touching	14	6.4
Threats related to sexual behaviours	3	1.4
Sexually inappropriate comments or jokes	2	0.9
Suggestive gestures or behaviours	1	0.5
Requests for inappropriate personal interaction	9	4.1

Table 4: Sources of negative workplace behaviours reported by nursing students (n = 220)

Source	Never Frequency (%)	Occasionally Frequency (%)	Sometimes Frequency (%)	Often Frequency (%)	Mean	SD
Staff nurses	101 (46.0)	67 (30.6)	20 (9.1)	31 (14.1)	0.91	1.06
Nurse managers	132 (60.0)	51 (23.5)	25 (11.3)	9 (4.1)	0.59	0.85
Auxiliary staff	161 (73.1)	35 (15.9)	16 (7.3)	6 (2.7)	0.39	0.74
Other student nurses	164 (74.5)	37 (16.8)	6 (2.7)	7 (3.2)	0.33	0.69
Patients	166 (75.4)	37 (16.8)	9 (4.1)	2 (0.9)	0.29	0.59
Patients' relatives or friends	177 (80.4)	31 (14.1)	6 (2.7)	3 (1.4)	0.24	0.57
Doctors	178 (81.0)	31 (14.1)	8 (3.6)	1 (0.5)	0.23	0.53
Administrative staff	185 (84.0)	22 (10.0)	6 (2.7)	2 (0.9)	0.19	0.51
Clinical instructors/mentors	208 (94.5)	7 (3.2)	3 (1.4)	0 (0.0)	0.06	0.29

Table 5: Comparison of bullying behaviour scores between second-year and third-year nursing students (n = 220)

Variable	Items (K)	Mean Rank (2nd Year)	Mean Rank (3rd Year)	Mann–Whitney U	p value
Total negative behaviour score	22	97.54	132.74	3828.0	<0.001
Non-physical incivility total score	11	97.72	132.43	3853.5	<0.001
Physical aggression total score	06	107.18	116.20	5168.0	0.111
Sexual harassment total score	05	105.95	118.31	4997.0	0.005

consequences (119; 85.6%). This was followed by lack of knowledge of the reporting procedure (107; 77.0%). More than half of the participants also agreed that reporting would not result in any action (75; 54.0%) and that the experience was considered part of training (73; 52.5%). A smaller proportion indicated that the incident was not important to them (56; 40.3%).

Comparison of experience of bullying with academic year

Third-year students reported significantly higher scores for non-physical incivility behaviours than second-year students (mean rank = 132.43 vs. 97.72; U = 3853.5, $p < 0.001$). Similarly, sexual harassment scores were significantly higher among third-year students (mean rank = 118.31 vs. 105.95; U = 4997.0, p = 0.005). No statistically significant difference was observed in physical aggression scores between the two groups (mean rank = 116.20 vs. 107.18; U = 5168.0, p = 0.111). The total negative behaviour score was significantly higher among third-year students compared with second-year students (mean rank = 132.74 vs. 97.54; U = 3828.0, $p < 0.001$) (Table 5).

Discussion

While individual acts of incivility and negative workplace behaviours may seem minor in isolation, this study demonstrates that when these behaviours occur collectively and systematically within a hierarchical clinical environment, they constitute workplace bullying. Through the lens of SLT, this study examined how these negative behaviours are experienced and normalised among nursing students. The results demonstrate that bullying in CLEs remains a common experience for nursing students and is shaped by social, organizational, and hierarchical influences within healthcare settings.

The overall prevalence of bullying observed in this study (75.9%) indicates that exposure to negative behaviours during clinical education is widespread. This finding is consistent with global evidence suggesting that bullying and incivility are highly prevalent among nursing students in clinical placements, with a recent systematic review reporting rates ranging from 60% to over 90% internationally (Zhou et al., 2023). However, direct comparisons require caution. The relatively high prevalence observed in the present study likely reflects the broader operational definition used, which captured exposure to any negative act rather than restricting measurement to systematic bullying based on rigid duration thresholds. Consequently, the 75.9% figure likely encompasses a wider spectrum of incivility and isolated mistreatment that might otherwise be excluded in studies utilizing stricter criteria, yet these behaviours still hold significant implications for student well-being.

The findings also demonstrate that non-physical bullying was the most common form experienced by students. These subtle forms of mistreatment are widely recognized as the dominant manifestations of bullying within nursing education (Budden et al., 2017; Luhanga et al., 2019). Unlike overt aggression, non-physical bullying often occurs in ambiguous interpersonal interactions that may be difficult to challenge or formally report. As a result, these behaviours may persist without intervention and gradually erode students' confidence and sense of belonging within the clinical team. Previous studies have shown that repeated exposure to such interactions can negatively affect self-efficacy, emotional well-being, and learning engagement among nursing students (Fang et al., 2020; Zhang et al., 2024).

In contrast, physical aggression and sexual harassment were reported less frequently in this study. While consistent with previous research indicating that overt abuse is less common than psychological mistreatment (Budden et al., 2017; Luhanga et al., 2019), even isolated incidents of physical or sexual harassment can severely undermine psychological safety and professional identity formation (Hodgins et al., 2024). Furthermore, the predominantly female composition of the sample (96.8%) necessitates a gendered interpretation of the high rates of non-physical bullying. Within the patriarchal context of Sri Lankan society, where a predominantly female nursing workforce operates within a broader, male-dominated healthcare hierarchy, power dynamics may manifest uniquely. This socio-cultural environment may inadvertently foster specific forms of non-physical mistreatment, such as culturally insensitive remarks, microaggressions, and exclusion from professional opportunities, which align with the subtle forms of bullying most frequently reported in this study.

Regarding the lower reported rates of sexual harassment specifically, these figures likely reflect systematic underreporting rather than true absence. In South Asian cultural contexts, entrenched social norms often discourage open disclosure of sexual harassment due to fear of stigma, reputational harm, and perceived inadequacy of institutional support mechanisms (Yosep et al., 2024). From a SLT perspective, nursing students may learn that bullying behaviours are tolerated when senior staff who engage in such conduct experience few or no negative consequences. The observation of unchallenged misconduct, coupled with barriers to reporting such as fear of retaliation and perceived organizational inaction, may reinforce the acceptability of these behaviours and contribute to the perpetuation of a culture of silence within CLEs (Qutishat et al., 2026; Shorey & Wong, 2021; Yang et al., 2024).

An important finding of the present study concerns the sources of bullying behaviours. Staff nurses and nurse managers were identified as the primary perpetrators, followed by auxiliary staff and peers. These findings are consistent with previous research indicating that bullying in clinical education frequently originates from individuals occupying positions of authority within healthcare hierarchies (Birks et al., 2024; Karatuna et al., 2020). Clinical environments are often characterized by hierarchical structures in which registered nurses and other senior healthcare professionals have considerable influence over nursing students' learning opportunities, clinical evaluations, and daily responsibilities. Within these settings, workplace stressors such as heavy patient workloads, staffing shortages, and demanding clinical environments may contribute to negative interpersonal interactions. However, contemporary evidence suggests that workplace bullying is also shaped by organizational culture, leadership practices, and entrenched hierarchical norms, which can facilitate the normalization of uncivil and bullying behaviours if left unaddressed (Goh et al., 2022; Shorey & Wong, 2021).

The finding that registered nurses were the most frequently identified perpetrators in the

present study is consistent with the broader literature on horizontal violence and the enduring "nurses eat their young" phenomenon. This concept describes the tendency for experienced nurses to engage in bullying, incivility, or other negative behaviours toward junior colleagues and nursing students, particularly within hierarchical clinical environments (Gillespie et al., 2017; Shorey & Wong, 2021). Furthermore, evidence suggests that workplace bullying in nursing may operate as a self-perpetuating cycle, whereby individuals who experienced bullying during their own education or early professional careers may later reproduce similar behaviours toward those they supervise, thereby reinforcing a culture of incivility across successive generations of the profession (Johnson, 2019; Shorey & Wong, 2021) thereby normalizing a cycle of intergenerational bullying. However, in contrast to some findings where clinical instructors were reported as the main perpetrators (Luhanga et al., 2019), the present study found that in the Sri Lankan context, clinical instructors/mentors were the least frequently reported source (4.5%). This relatively low proportion may reflect a more supportive orientation among those specifically assigned teaching roles, as well as more structured and educationally guided supervisory relationships within the clinical learning environment.

SLT provides a useful framework for interpreting these dynamics. According to Bandura (1977), individuals acquire behaviours through observation, imitation, and reinforcement within social environments. In clinical settings, students frequently observe how senior staff interact with colleagues and learners. When aggressive or dismissive behaviours are modeled by authority figures and occur without consequences, these behaviours may be perceived as acceptable professional conduct. Over time, such interactions may become internalized and reproduced by future practitioners, contributing to the persistence of bullying across generations of nurses (Shorey & Wong, 2021). The presence of peer-related bullying observed in this study may reflect this process of behavioral transmission, whereby students adopt communication patterns they have observed within the clinical hierarchy.

Another significant finding is the extremely low rate of formal reporting of bullying incidents. Only a small proportion of students reported experiencing bullying through official channels, despite the high prevalence of negative experiences. This pattern is consistent with previous research showing that underreporting is a common issue in nursing education (Qutishat et al., 2025; Yang et al., 2024). Fear of retaliation, uncertainty about reporting procedures, and lack of confidence in institutional responses are frequently identified as barriers to reporting bullying behaviours. In the present study, fear of negative consequences was the most commonly reported reason for not reporting incidents. When students believe that reporting will lead to retaliation, academic disadvantage, or social isolation, silence may become the perceived safest option. Over time, such dynamics contribute to the normalization of bullying within CLEs.

The finding that third-year students reported

significantly higher bullying scores than second-year students also warrants consideration. One possible explanation is that senior students spend more time in clinical environments and therefore have greater exposure to workplace interactions. Alternatively, more experienced students may develop greater awareness and ability to recognize behaviours that constitute bullying or incivility. Previous studies have reported similar patterns, suggesting that increased clinical exposure may increase both the likelihood of experiencing bullying and the ability to identify it (Masadeh et al., 2024). From a SLT perspective, prolonged immersion in clinical hierarchies may also mean that third-year students have had more opportunity to observe, internalize, and even begin to normalize negative behavioral patterns modeled by senior staff, a process that, if left unaddressed, risks perpetuating the very cycle of bullying that this study seeks to illuminate. Longitudinal research would be valuable in clarifying how students' perceptions and experiences evolve throughout their training.

Implications

Taken together, the findings of this study highlight the complex social processes that sustain bullying within CLEs. Bullying behaviours appear to be reinforced through hierarchical structures, social modeling, and institutional silence. Addressing this issue therefore requires interventions at multiple levels. At the individual level, training programs that promote assertiveness, resilience, and effective communication can help students respond more confidently to challenging situations. At the interpersonal level, fostering supportive supervisory relationships and mentoring structures may improve the quality of student–staff interactions. At the organizational level, clear anti-bullying policies, accessible reporting systems, and protection against retaliation are essential to creating psychologically safe learning environments (Park & Choi, 2023).

Importantly, meaningful change in CLEs depends on the behaviours demonstrated by senior staff and educators. When leaders consistently model respectful communication, provide constructive feedback, and support student learning, they can help establish positive professional norms. Through these processes, the mechanisms described by SLT may be redirected toward the reinforcement of supportive and collaborative behaviours rather than the perpetuation of hostility. Promoting such cultural change is essential for ensuring that nursing students develop not only clinical competence but also professional values grounded in respect, empathy, and psychological safety.

Strengths and Limitations

The study's strengths include its strong theoretical foundation in SLT, high response rate, census sampling approach, use of a validated questionnaire, and comprehensive assessment of different forms of workplace bullying. The study also identifies key perpetrators and reporting patterns, providing valuable evidence for developing targeted interventions and policies to improve the safety and quality of CLEs for nursing students.

This study has several limitations too. First,

its cross-sectional design restricts the ability to infer causal relationships between observed variables. Second, reliance on self-reported data may have introduced recall errors and social desirability bias. Because participants were asked to recall bullying experiences over the previous year, recall bias may have influenced the accuracy of their responses. Third, as data were collected from a single nursing institution, the findings may not be generalizable to other settings with different organizational cultures. Fourth, the findings may predominantly reflect the experiences of female students and may not be generalizable to male nursing students, who may experience different forms of bullying. In addition, the self-administered questionnaire design raises the possibility of common method bias. Furthermore, the operational definition used in this study captured any exposure to negative acts (reporting > 0 on the frequency scale). Therefore, the study measures the broader prevalence of clinical incivility and negative behaviours, rather than strictly differentiating between isolated interpersonal conflicts and chronic, systematic bullying based on rigid duration thresholds. Additionally, the newly developed instrument was evaluated for content validity and internal consistency, but construct validity through exploratory or confirmatory factor analysis was not conducted due to sample size constraints. Future studies should assess the factor structure of this context-specific tool. Finally, the absence of qualitative exploration limited the study's capacity to capture the nuanced personal and contextual dimensions of students' experiences with bullying.

Conclusions

Workplace bullying is not an isolated occurrence but a pervasive structural challenge within Sri Lankan CLEs. This study revealed that the vast majority of nursing students experience mistreatment, mainly through subtle, non-physical behaviours that are routinely normalised and severely underreported.

Students observe and internalize hierarchical power dynamics that effectively allow for incivility due to the lack of institutional accountability. If left unchallenged, this socialization process risks embedding the intergenerational transmission of bullying into the next generation of nurses.

Disrupting this cycle requires moving beyond superficial policy changes. Healthcare institutions must actively strengthen the supportive dynamics of clinical instructors to model positive behaviours while simultaneously building robust, retaliation-free reporting systems. Ensuring a psychologically safe learning environment is essential for protecting student well-being, disrupting the intergenerational cycle of mistreatment within the nursing profession, and safeguarding the future quality and safety of patient care.

Future research should incorporate longitudinal and mixed-methods approaches to examine the evolution of bullying experiences and their psychosocial consequences over time. Expanding the study across multiple institutions would enhance external validity and allow for cross-cultural comparisons. At the institutional level, clear anti-bullying policies, anonymous reporting

mechanisms, and structured support systems should be implemented. Training programs for clinical staff focusing on professional behavior, communication, and mentorship are essential. Interventions grounded in SLT, particularly those promoting positive role modeling, should be developed and evaluated.

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Conflict of interest

The authors declared that they have no conflicts of interest.

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