

## Article

# The Dual Landscape of Clinical Placements for Nursing Students: High-Quality Learning and Bullying

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## Abstract

**Background:** Nursing students spend a substantial proportion of their education in clinical practice; hence, the quality of these environments plays a critical role in shaping students' learning outcomes. While research finds that nursing students often encounter bullying and harassment during clinical placement, the characteristics of positive and high-quality learning situations during these placements are less clearly described in the literature. **Methods:** A convergent, quantitative-dominant mixed-methods study was conducted between April and June 2024. Quantitative and qualitative data were collected concurrently; statistical analysis described prevalence and associations, while thematic analysis explored students' experiences and contextualised the quantitative findings. **Results:** Statistical and thematic analyses indicated that high-quality learning emerged from the interplay of inclusion, mastery and active participation. A gradual transition from observation to independent practice, combined with appropriate challenges and opportunities for reflection, characterised the most effective learning situations. Approximately 50% of the students perceived themselves as victims of bullying or harassment, which impaired learning and prompted some to consider leaving nursing programs. The juxtaposition of positive and negative experiences highlighted team inclusion as the pivotal factor for both enhancing learning and preventing bullying. **Conclusions:** Being included as part of the team emerged as the main driver of positive clinical learning, whereas feeling isolated from the team was interpreted as bullying or harassment. These results indicated that well-prepared students, empowered supervisors, and inclusive organisational cultures supported by transparent reporting and response systems can provide the foundation for both high-quality learning and the prevention of bullying and harassment in clinical education.



Academic Editor: Yasuki Ishizaki

Received: 5 July 2026

Revised: 26 July 2026

Accepted: 28 July 2026

Published: 31 July 2026

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**Keywords:** clinical placements; learning environment; supervisory practices; team cohesion; inclusion; bullying and harassment; organisational culture

## 1. Introduction

Nursing students undertake an important component of their education in clinical settings, making the quality of these environments critical to learning outcomes. An optimal clinical setting cultivates an inspiring learning atmosphere, where students are supported, respected and encouraged [1,2]. Research highlights the critical role of relationships among students, clinical supervisors and nurse educators in shaping the quality of the clinical experiences, e.g., [3–5]. Regular feedback, opportunities for reflection, and practical guid-

ance from the supervisor are key elements in enhancing students' clinical competence, confidence, motivation and self-esteem [6,7].

Belongingness theory [8] proposes that humans have a fundamental need to feel accepted and connected to others. Belongingness is a deeply personal, context-dependent experience that develops as individuals perceive themselves to be secure, accepted, included, valued, and respected by a particular group [9]. It also involves feeling connected to, or integral within, that group, and having one's professional and personal values aligned with the group's values. Many factors shape a student's perception of belonging during clinical placements; a welcoming learning environment, supportive instructor-student relationship, the attitudes and behaviours of the clinical team, and shared expectations of the students' role; all of which affect learning outcomes [10–14].

When belonging, fairness and psychological safety are absent, there is a risk of bullying [15]. Bullying—also referred to as mobbing—can be defined as 'situations where a worker, supervisor, or manager is systematically and repeatedly mistreated and victimised by fellow workers, subordinates, or superiors' [15], creating a hostile work environment in which insulting or offensive remarks, persistent criticism, personal abuse, or even physical abuse and threats prevail. Such behaviours typically involve power imbalance, leaving the target unable to defend themselves [16].

Bullying in nursing is a well-documented and pervasive phenomenon, e.g., [17,18], and an increasing body of research indicates that nursing students frequently experience bullying or harassment during clinical placements. Reported prevalence rates vary widely, ranging from 9% to 96% [19,20]. Research findings on demographic risk factors are mixed. Some studies suggest that bullying experiences increase with age and higher levels of education [21–23], while others report that younger students are more frequently targeted [24,25]. Bullying is more commonly reported among females [23,26–28], whereas males may exhibit greater confidence in maintaining personal safety [27]. Most incidents seem to occur in hospital settings [29,30].

Nursing students, due to their limited experience, young age, and reduced coping capacity, are particularly vulnerable to these dynamics [19,29,31]. The hierarchical gap between employed health personnel and students further exacerbates this vulnerability, and research finds that power imbalance between supervisors and students may stifle the critical reflection required for clinical practice [32].

Experiencing workplace incivility or bullying during clinical placements can negatively impact students' well-being, diminish the educational value of practice experiences, and even compromise patient safety [19,33,34]. Exposure to such behaviours disrupts the learning environment and increases students' intention to withdraw from their studies [35–37].

Supervisors or colleagues are most often identified as perpetrators of workplace bullying [15]. In healthcare environments, nurses themselves are frequently cited as aggressors [18,38], reinforcing the long-standing notion that 'nurses eat their own young' [39]. Bullying has been described as pervasive in nursing and, by some, as a "rite of passage" [24,40].

Proposed explanations for bullying during clinical placements include nurses' lack of awareness that their behaviour constitutes bullying, venting frustrations in high-stress environments, and negative attitudes toward students. Additional contributing factors may include jealousy, feelings of superiority, or a desire for control and power [41,42]. Responses to bullying vary; some nurses act as passive bystanders, others ignore the problem, and some adopt bullying behaviours themselves [40].

Evidence suggests that bullying in clinical settings has become normalised, embedding itself within the organisational culture [26,43]. When bullying is normalised, students may struggle to recognise and report such behaviours, particularly when fearing retaliation [26,28,42,44].

The aim of this study was to explore the experiences of Norwegian bachelor-of-nursing students during their clinical placements. The nursing programme is a three-year full-time degree, with roughly half of the curriculum devoted to hands-on clinical practice in both hospital and municipal health care settings.

Data on bullying and harassment among Norwegian nursing students are scarce, as are descriptions of the characteristics that define positive, high-quality learning situations during their clinical placements. This study sought to (1) identify the characteristics of high-quality learning situations, (2) examine the prevalence and forms of bullying and harassment, and (3) assess how these experiences impact students personally, affect their learning and work performance, and influence their intention to discontinue nursing studies. The findings from this study can help to strengthen the conditions that support effective learning in clinical practice.

## 2. Materials and Methods

### 2.1. Study Design and Sampling

This study applied a convergent quantitative-dominant mixed-methods design, where quantitative and qualitative data were collected simultaneously, analysed separately, and integrated during interpretation, according to [45]. This integration allowed for a more comprehensive interpretation of the research questions, where the quantitative analysis established statistical patterns across the sample, while the qualitative themes helped contextualise and expand upon the quantitative patterns [45–47].

Data were collected via an anonymous online survey that was distributed to enrolled Norwegian bachelor-of-nursing students through the Norwegian Nurses Organization for students (<https://www.nsf.no/nsf-student>, accessed on 1 March 2024) from April to June 2024. At the time this survey was conducted, 13,720 nursing students were registered in Norway, and about 90% of them (about 12,350 students) were expected to receive information about the survey through their membership in the organisation. In total, 1045 students completed the survey.

Participation was voluntary, and students were informed that survey responses would be used for research purposes. Completion and submission of the questionnaire implied consent. No questions were mandatory, and respondents could exit the survey at any time. The questionnaire was administered in Norwegian, and analyses results were translated into English. Data collection was handled using the secure survey platform Nettskjema.no, developed and hosted by the University of Oslo ([nettskjema@usit.uio.no](mailto:nettskjema@usit.uio.no)). Participant anonymity and data confidentiality were ensured by excluding identifying information and using the secure Nettskjema system.

The questionnaire's content validity was supported through adaptation of previously used items and review by nursing students and nursing colleagues during pilot testing. The questionnaire used in the present study comprised 20 questions: four socio-demographic questions (gender, year of study, year of enrolment, and Norwegian birth status), two questions probing high-quality learning experiences, and 14 questions assessing bullying and harassment. The survey design on bullying and harassment was adapted from Hewett [30], whose original instrument consisted of 14 questions addressing workplace violence among students, reporting, and management. Seven of Hewett's questions were incorporated into this study and adapted to the Norwegian context, informed by international research on bullying among nursing students to enhance cultural relevance. The remaining questions were developed based on evidence from the broader literature on bullying and harassment in nursing education. The questionnaire was reviewed by a small group of Norwegian nursing students and nursing colleagues to assess the appropriateness, clarity and comprehensibility of its content. As the items were designed to measure the occurrence of specific

events, rather than attitudes, perceptions or latent constructs, an assessment of internal consistency was not considered applicable.

Most questions were closed-ended and rated on a four-point frequency scale (Likert scale), such as [1] Never (0 times); [2] Occasionally (1–2 times); [3] Sometimes (3–5 times) and [4] Often (>5 times). Additionally, two open-ended questions were included to provide deeper insight into students' positive and negative experiences during clinical placements.

Closed-ended responses were analysed statistically, whereas open-ended responses were subjected to qualitative thematic analyses. The responses to these open-ended questions were subjected to thematic analysis: (1) please share examples of learning situations you found particularly impactful, and (2) please share examples of experiences you perceived as bullying or harassment. Although open-ended survey responses may lack the depth and probing opportunities afforded by face-to-face interviews, thereby limiting the qualitative analysis, the numerous detailed responses yielded rich and comprehensive insights that enhanced the interpretation of and provided context for the closed-ended questionnaire data.

The study was approved by the Norwegian Agency for Shared Services in Education and Research (SIKT), ref.no. 153671, in accordance with SIKT's guidelines (<https://sikt.no/en/personvernhandbok-forskning/carrying-out-project-without-processing-personal-data>, accessed on 1 March 2024).

## 2.2. Data Analysis

The data obtained from the survey were analysed using Microsoft 365 Excel version 2306 and SPSS version 31. Due to the ordinal nature and non-normal distribution of the Likert scale data, non-parametric statistical methods were utilised for the analyses. Results presented as percentages were based on the number of completed values for each variable. The chi-square test was used to assess associations between categorical, binary variables, and all expected cell counts met the assumption of being greater than five. Spearman's Rho correlation was used to measure the effect size for  $2 \times 2$  contingency tables. Odds Ratios (ORs) were calculated to assess the strength of associations between exposure and outcome in  $2 \times 2$  contingency tables (e.g., bullying in relation to year of study or gender, etc.) For these analyses, respondents were classified as having experienced bullying or harassment if they reported 'occasionally, sometimes or often'.

Kruskal–Wallis tests with post-hoc comparisons using Dunn's method with a Bonferroni correction for multiple tests were conducted to evaluate whether there were differences between three or more groups measured at the ordinal level. Mann–Whitney U test was utilised when comparing two groups. Statistical significance was set at 0.05 for all analyses.

The qualitative data were analysed in their original Norwegian using reflexive thematic analysis following the six-step approach outlined by Braun and Clarke [48]. The qualitative analysis aimed both to provide a descriptive account of the students' experiences and to interpret underlying meanings in the material. The authors read the answers repeatedly to gain a comprehensive understanding of the data. The material was then subjected to a systematic and iterative coding process, during which codes were organised in NVivo Software version 15.2.2. Quotes were used to support the themes and the quantitative analyses. Once a tentative set of codes had been established, the authors engaged in joint discussions to refine and assess the emerging analysis. Through this process, subthemes were identified and further developed into preliminary themes. These themes were subsequently reviewed and adjusted; some were divided, merged, or removed to ensure analytical clarity and relevance. A thorough review of each theme was conducted, with particular attention to scope, core meaning, and coherence. The qualitative findings

were then integrated with the quantitative results in line with the mixed-methods design. Reporting followed the mixed-methods reporting standards [49,50].

### 3. Results

#### 3.1. Background Data

A total of 1045 students participated in the survey. The majority of the students were female (87%) and predominantly born in Norway (86%), reflecting the typical characteristics of Norwegian nursing students (Table 1). All students were enrolled in a three-year Bachelor of Science in Nursing program (BSc), with their distribution across study years being relatively even: 30% in the first year, 35% in the second year, and 36% in the third year.

**Table 1.** Demographic variables.

| Variables           |          | Frequency N (%) |
|---------------------|----------|-----------------|
| Gender              |          |                 |
|                     | Female   | 907 (87.0)      |
|                     | Male     | 130 (12.5)      |
|                     | Other    | 6 (0.6)         |
| Norwegian-born      |          |                 |
|                     | Yes      | 897 (85.8)      |
|                     | No       | 147 (14.1)      |
| Year of study (BSc) |          |                 |
|                     | 1st year | 309 (29.6)      |
|                     | 2nd year | 363 (34.7)      |
|                     | 3rd year | 373 (35.7)      |

#### 3.2. Perceptions of High-Quality Learning Experiences During Clinical Placements

The majority of students (63%) indicated that they had encountered high-quality learning opportunities on multiple occasions (more than five times) during their clinical placements (Table 2). Only 1% responded ‘Never’ to this question. A Kruskal–Wallis test indicated that there were significant differences in perceived high-quality learning situations across years of study,  $\chi^2(2, N = 1043) = 10,383, p = 0.006$ . Post-hoc comparisons indicated that the mean rank of third-year students was significantly higher than the mean rank of first-year students (550 vs. 486,  $p = 0.006$ ), suggesting that third-year students experienced more high-quality learning situations than first-year students. However, there was no significant difference in mean rank between third- and second-year students ( $p = 0.507$ ), or between first- and second-year students ( $p = 0.176$ ).

Approximately half of the students provided additional detailed insights through free-text comments. Through systematic coding, refinement, and interpretative work, five overarching themes were developed that captured the essence of what students reported as particularly conducive to learning.

**Table 2.** Joint display of quantitative and qualitative findings regarding high-quality learning opportunities.

| Quantitative Analyses <sup>1</sup>                                                                                        | Never, N (%)                                                                                                                             | Occasionally, N (%)                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Sometimes, N (%) | Often, N (%) | Total, N (%) |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------|--------------|
| Frequency of high-quality learning situations (N = 1044)                                                                  | 10 (1)                                                                                                                                   | 117 (11.2)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 263 (25.2)       | 654 (62.6)   | 1044 (100)   |
| Perceptions of team inclusion (N = 1041)                                                                                  | 46 (4.4)                                                                                                                                 | 240 (23.1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 345 (33.1)       | 410 (39.4)   | 1041 (100)   |
| <b>Qualitative analysis of perceived high-quality learning opportunities (N = 544), open-ended responses <sup>2</sup></b> |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |              |              |
| Themes                                                                                                                    | Subtheme                                                                                                                                 | Quotes                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |              |              |
| Theme 1:<br>Supervision as the key to learning                                                                            | Supportive supervisory relationship<br>Reflective dialogue                                                                               | “I learned a great deal by gaining trust and responsibility and by participating in professional reflections.”                                                                                                                                                                                                                                                                                                                                                              |                  |              |              |
| Theme 2:<br>Learning through practical procedures                                                                         | Observation before performance<br>Guided practice with supervision<br>Independent practice with safety                                   | “Learning situations where a nurse provides safe guidance before giving me the opportunity to perform the procedure myself.”<br>“Situations where something unexpected and acute happens with a patient.”                                                                                                                                                                                                                                                                   |                  |              |              |
| Theme 3:<br>Development of professional identity fostered by experiences of mastery                                       | Taking responsibility<br>Being challenged in realistic situations<br>Trust from supervisors                                              | “The most valuable learning situations were often characterized by supervisors who challenged me as a student.”<br>“Supervisors have allowed me to take initiative, placing me in challenging situations so that I can learn to master them and better understand my own reactions.”                                                                                                                                                                                        |                  |              |              |
| Theme 4:<br>Learning through communication                                                                                | Communication with patients and relatives<br>Ethical conversations and dilemmas                                                          | “Communications with people in a life-crisis.”<br>“Engaging in conversations with relatives about ending ongoing treatment.”<br>“When challenging ethical dilemmas arose that I could discuss with my supervisor.”                                                                                                                                                                                                                                                          |                  |              |              |
| Theme 5:<br>The importance of the learning environment                                                                    | Inclusion as part of the team<br>Good structure and planning<br>Supervisor availability and time<br>Sense of belonging supports learning | “Good structure and well-planned learning situations.”; “Time pressure is often a factor that contributes to less meaningful learning situations. Supervisors should have a reduced workload when they are responsible for students.”; “We were included and allowed to participate in various procedures, and we observed that both the supervisor and other colleagues were willing and motivated to support our learning”; “Felt like a part of the team straight away.” |                  |              |              |

<sup>1,2</sup> Quantitative and qualitative analysis, respectively.

The integration of quantitative and qualitative findings showed that they were complementary, where the qualitative themes helped contextualise and expand upon the quantitative patterns (Table 2). However, the findings in theme 5 demonstrated that the quantitative and qualitative findings were convergent, both highlighting the central role of team inclusion. The synthesised findings are presented thematically below, with selected student quotes illustrating key elements within each theme. The following five themes were identified:

#### Theme 1: Supervision as the key to learning

Integrating the quantitative and qualitative findings highlighted supervision as the primary factor influencing the quality of their learning experiences (Table 2). High-quality supervision was described not only in terms of clinical instruction, but also through its relational and emotional dimensions. Students highlighted supervisors who were available, supportive, and able to provide both guidance and constructive challenges. The importance of feeling safe, included, and recognised as a learner was repeatedly emphasised. One student noted that “My supervisor fostered a sense of mastery and supported my learning within a safe environment,” while another valued “Supervisors who challenge us while providing consistent support.” Time for reflection was also central: “When the supervisor takes time to reflect with me after a clinical situation.”

#### Theme 2: Learning through practical procedures

The combined quantitative and qualitative findings revealed hands-on experience as fundamental to high-quality learning (Table 2). Many articulated a preferred learning trajectory that moved from observation to supervised performance and eventually to independent practice. This structured progression allowed them to develop confidence, technical skill, and clinical reasoning. As one student stated, “I experienced great learning situations when I first could observe a procedure before trying it myself.” Others highlighted the importance of practising independently with supervision available: “(When) my supervisor allowed me to carry out tasks independently while providing guidance.” Unexpected or acute clinical situations were also perceived as particularly powerful learning opportunities, as they required students to apply knowledge under pressure and engage in real-time decision-making.

#### Theme 3: Development of professional identity fostered by experiences of mastery

The combined quantitative and qualitative findings indicated that challenges and mastery contributed to perceived high-quality learning, and supported students’ emerging professional identity (Table 2). Students described how responsibility, trust, and exposure to realistic clinical challenges contributed to feelings of mastery and professional growth. Leading care activities, managing unexpected situations, or being encouraged to take initiative were repeatedly described as formative. As one student explained, “Situations where I am challenged and allowed to try to resolve the challenges myself.” This contributed significantly to their learning. Another highlighted that “When the students run the ward, with the supervisor in the background”, they developed both confidence and a sense of readiness for practice. These experiences marked a transition from student to novice practitioner.

#### Theme 4: Learning through communication

The combined quantitative and qualitative findings indicated that meaningful interpersonal relationships with patients and relatives enhanced perceived clinical learning outcomes (Table 2). Many students reported that encounters requiring communication and relational competence constituted some of the most meaningful learning experiences.

These included communication with patients and relatives, navigating emotionally complex conversations, and engaging with ethical dilemmas. Examples included “Conversations with relatives about deterioration in the patient’s condition.” Students described such experiences as emotionally demanding but highly educational, supporting the development of empathy, ethical reflection, and therapeutic communication skills.

#### Theme 5: The importance of the learning environment

The integrated findings in Table 2 showed that the organisational and cultural factors in the clinical environment strongly impacted the students’ access to meaningful learning opportunities. Approximately 40% of students reported that they were often (more than five times) regarded as active participants of the clinical team, while the majority indicated they were only included occasionally, sometimes, or never. A Mann–Whitney U test indicated that students who felt frequently included as part of the clinical team reported significantly higher frequency of high-quality learning situations than others ( $z = -12,683$ ,  $p < 0.001$ ). The importance of being treated as team members was emphasised in the free-text responses.

Moreover, having well-structured learning activities and supervisors with sufficient time for teaching were repeatedly highlighted as essential. Several students described how inadequate supervision, such as a lack of time, lack of support, or being treated as workforce, limited their learning opportunities, illustrating the critical role of supervisory conditions. One student wrote, “I have experienced high-quality learning situations in placements where I was not treated merely as labour but rather recognized as a student,” while another noted, “I have not always been included as part of the team, but the experience is most valuable when I am fully included.”

Students also described how time pressure and lack of structure could undermine learning, leading to fragmented experiences and fewer opportunities for practice, as illustrated by a student: “It is often so busy that there is neither time for guidance nor reflection.”

As presented above (Table 2 and in text), the qualitative findings illuminated the quantitative pattern when combined: high-quality learning primarily emerged when students had access to supportive supervision, safe opportunities to practice, progressive responsibility, and when included as part of the team.

#### *3.3. Students’ Experiences of Bullying and Harassment*

The students were asked whether they had experienced any negative situations during their clinical placements that they would classify as bullying or harassment. Nearly 50% reported experiencing bullying or harassment occasionally, sometimes, or often, while 50% reported never experiencing bullying or harassment (Table 3). Moreover, 63% of the students experiencing bullying or harassment had also witnessed others being bullied or harassed occasionally (32%), sometimes (9%) or often (4%).

While 61% of the third-year students and 53% of the second-year students reported having experienced bullying or harassment (occasionally, sometimes or often), only 31% of the first-year students reported the same (Table 3). A Kruskal–Wallis test indicated that there was a significant difference in perceived bullying across year of study,  $\chi^2(2, N = 1043) = 48,905$ ,  $p < 0.001$ . Post-hoc comparisons indicated that the mean rank of third- and second-year students was significantly higher than the mean rank of first-year students (573 vs. 431 and 547 vs. 431, respectively,  $p < 0.001$ ). However, there was no significant difference in mean rank between third- and second-year students ( $p = 0.603$ ). These results indicated that third- and second-year students experienced more bullying than first-year students.

**Table 3.** Perceptions of experienced bullying behaviour by gender, birthplace, and year of study.

|                   | Never N (%) | Occasionally N (%) | Sometimes N (%) | Often N (%) |
|-------------------|-------------|--------------------|-----------------|-------------|
| Gender            |             |                    |                 |             |
| Female            | 451 (49.7)  | 277 (30.5)         | 108 (11.9)      | 66 (7.3)    |
| Male              | 68 (52.3)   | 37 (28.5)          | 16 (12.3)       | 7 (5.4)     |
| Norwegian born    |             |                    |                 |             |
| Yes               | 472 (52.6)  | 259 (28.9)         | 105 (11.7)      | 54 (6.0)    |
| No                | 49 (33.3)   | 57 (38.8)          | 20 (13.6)       | 21 (14.3)   |
| Year of study     |             |                    |                 |             |
| 1st year students | 210 (68.0)  | 53 (17.2)          | 28 (9.1)        | 15 (4.9)    |
| 2nd year students | 166 (45.7)  | 114 (31.4)         | 45 (12.4)       | 35 (9.6)    |
| 3rd year students | 146 (39.1)  | 149 (40.0)         | 52 (13.9)       | 25 (6.7)    |

A slightly higher proportion of female students reported experiencing bullying or harassment (49.7%) compared to male students (46.2%). However, a chi-square test revealed no significant association between gender and perceived bullying or harassment ( $\chi^2 = 0.44$ ,  $p = 0.508$ ). In contrast, students not born in Norway were more than twice as likely to have experienced bullying or harassment when compared to those born in Norway, as assessed by an Odds Ratio (OR) analysis (66.7% vs. 46.6%,  $\chi^2 = 19.59$ ,  $p < 0.001$ , respectively; OR = 2.30, 95% CI [1.59, 3.31]).

When asked about the types of bullying or harassment they had experienced, six themes emerged from the integrated quantitative and qualitative findings (Table 4). The quantitative and qualitative findings converged, as the qualitative themes contextualised and elaborated upon the quantitative patterns, reinforcing the conclusions. The synthesised findings are presented thematically below, with selected student quotes illustrating key elements within each theme.

#### Bullying theme 1: Lack of belonging in the clinical environment

Convergent quantitative and qualitative findings indicated that being excluded from the clinical team and ignored by the staff was perceived as bullying (Table 4). The most frequent type of bullying or harassment reported was ‘Treated as though I was not part of the clinical team’. Moreover, chi-square- and correlation analyses indicated a significant negative association between frequent inclusion in the clinical team and perceived bullying or harassment ( $\chi^2 = 101.36$ ,  $p < 0.001$ ; Spearman’s Rho:  $-0.311$ ,  $p < 0.001$ ). These findings suggested that inclusion within the clinical team strongly influenced students’ perception of bullying and harassment. Consistently, the thematic analysis found that the students described experiences of social exclusion and lack of belonging within their clinical placements.

Many felt they were “not treated as part of the team, only like extra hands,” and reported that “some employees did not recognize me as part of the work team, and I was not included in learning situations.” Exclusion was both subtle and overt, such as when “all the nurses often gathered in the staff room, closed the door completely, and left us students standing out in the hallway like question marks.” Social isolation extended into breaks: “In some placements, it is easy to be excluded during lunch if you are ‘just a student’,” and one student explained, “I was not allowed to eat lunch with the others. . . I had to go to the cafeteria.” Students also described being ignored when seeking guidance: “The room went silent and everyone looked down at the floor.” Accordingly, 52% of the students reported that they felt ignored while in clinical placements. Overall, these experiences left several students feeling overlooked, unwanted, and like “a burden,” reinforcing a clear sense that some staff were “tired of having students.”

### Bullying theme 2: Experiences of disrespect and devaluation

Convergent quantitative and qualitative findings showed that students reported being humiliated, ridiculed, and unfairly criticised (Table 4). They reported frequent experiences of gossip and mocking that contributed to an unsafe and unprofessional learning environment, and several described “a lot of gossiping from permanent staff,” including supervisors who “gossiped about their own placement student(s).” Some learned that “the staff on the ward were gossiping about me,” while others overheard supervisors speaking about them, which felt “very uncomfortable.” Gossip was widespread: “They mentioned colleagues by name and spoke loudly in the staff room.”

Nearly one-third of students reported being ridiculed, such as being “practically ridiculed by the department manager” or mocked in a “condescending, taunting manner.” Many concluded: “I have felt mocked by healthcare personnel”; they “rolled their eyes, made sharp comments, and showed clearly negative body language.”

### Bullying theme 3: Identity-based discrimination and marginalisation in the learning environment

Convergent quantitative and qualitative findings indicated that students experienced ethnic and racial discrimination, whereas appearance- and gender-based discrimination appeared only in the qualitative data (Table 4).

One-tenth of the students reported being subjected to racist remarks. Moreover, they described multiple experiences of identity-based discrimination that undermined their sense of safety and belonging in clinical placements. Several reported ethnic and racial microaggressions, such as being asked “which country I came from after pointing out an error made by a nurse,” or facing patient scepticism “because of my foreign appearance.” Others encountered explicit prejudice, including a service user who “only wanted ethnically Norwegian healthcare personnel.” Discriminatory attitudes also targeted family background— “being regarded with suspicion because my parents are from Eastern Europe.” Beyond ethnicity, students described hostility toward queer identities through “anti-Pride and anti queer rants” and “homophobic staff.” Gender based and appearance-based biases also emerged, with comments about being the “wrong” gender and that men have no place in healthcare”, being “bullied because of my weight,” or even “excluded from performing procedures because of my appearance.”

### Bullying theme 4: Sexual harassment and boundary violations in the clinical learning environment

Convergent quantitative and qualitative findings showed that five per cent of students reported experiencing sexual harassment during their clinical placements, and some elaborated on this in their free-text responses (Table 4). These incidents came from patients, peers, and healthcare staff, creating situations where students felt unsafe and professionally undermined. Several students reported sexually inappropriate behaviour from patients, such as unsolicited comments and physical contact: “I received several sexually inappropriate comments and was touched by patients.” Similar experiences occurred across settings, including mental health care: “A patient behaved in a sexually inappropriate way during my psychiatric placement.” Sexual misconduct also occurred within the student group, as one student noted: “Sexual harassment that came from a fellow student.” Such incidents challenged expectations of collegial support and safety among peers. Equally concerning were cases of boundary violations by staff, who hold authority in the clinical environment. Together, these accounts show how sexualised behaviours in clinical placements compromise students’ psychological safety and create a learning environment marked by boundary violations and discomfort.

#### Bullying theme 5: Institutional and interpersonal dynamics that devalue students and restrict learning

Convergent quantitative and qualitative findings showed that more than 40% of the students reported that they were denied learning opportunities, and in their free-text responses, they described how structural and interpersonal conditions within their placements limited learning opportunities and undermined their professional development (Table 4). Several accounts highlighted gatekeeping of learning opportunities, such as being denied access to procedures or cross-department observation: “I was denied learning opportunities... and told I would have to do it in my free time.” Other students were excluded from procedures because speciality students were given priority. Alongside restricted access, students reported misuse of authority and task-based devaluation. The learning climate was further shaped by disrespect and social exclusion, including undignified communication, lack of acknowledgement, and failure to learn students’ names: “I was just called ‘the student’ the entire placement.” Overall, these experiences contributed to a learning environment characterised by devaluation, restricted access, and reduced psychological safety, which students felt negatively impacted their confidence and learning outcomes.

Students also described experiences of being used as workforce rather than being supported as learners, and half of the students reported that they were given unfair work allocation. Many reported being assigned routine or low-skill tasks that limited their access to meaningful learning opportunities. One student explained that they were “prevented from joining doctor’s rounds and other learning opportunities” and instead used primarily for basic care tasks, leading them to feel “in the way despite showing strong motivation to learn.” Several students also described being allocated tasks for the convenience of staff, rather than for learning purposes. As one student noted, a healthcare worker “liked to exploit the students, for example by having us do feeding, refilling toilet paper or cleaning the utility room so she could take longer breaks.” Others reported being scheduled as part of the regular staffing or assigned tasks that staff themselves avoided: “I was exploited as part of the workforce. I was given tasks the staff did not want to do.”

Taken together, these accounts illustrate a pattern in which students’ learning needs were deprioritised, their role as learners was diminished, and they were treated primarily as additional labour. This environment contributed to feelings of underappreciation and hindered the development of professional competence.

#### Theme 6: Hostile and unsafe supervisory practices undermining learning

Convergent quantitative and qualitative findings indicated physical and emotional safety violations (Table 4). Students described experiencing a range of hostile behaviours from staff, patients, and supervisors that significantly undermined their sense of safety and ability to learn. They further described experiences of being devalued or publicly reprimanded in ways that undermined their professional identity. One student recounted being “scolded in front of a patient and their relatives when I was only supposed to observe a procedure”, while another explained being “yelled at in front of a patient and their relatives when I was only supposed to observe a procedure.” Such encounters created an atmosphere of intimidation and anxiety rather than support. Most concerning were instances of physical aggression, such as one student who described being “hit in the face by a former supervisor.” Such conditions undermine the psychological safety of the learning environment for nursing students.

**Table 4.** Joint display of quantitative and qualitative findings regarding person-related bullying.

| Qualitative Thematic Analysis (N = 134), Open-Ended Responses                                 |                                                                                                                                                   |                                                                                                                                                                                                                                                                               | Quantitative Analysis (N = 547),<br>Frequencies of Selected Responses, “I Was. . .”                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Themes                                                                                        | Subthemes                                                                                                                                         | Quotes                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                       |
| Theme 1: Lack of belonging in the clinical environment                                        | Being ignored or excluded<br>Experiences of social exclusion                                                                                      | “You often encounter nurses who find it exhausting to have a student with them and make you feel it. This makes learning situations difficult.”                                                                                                                               | <ul style="list-style-type: none"> <li>• Treated as though I was not part of the clinical team (55%)</li> <li>• Ignored (52%)</li> </ul>                                                                                                                              |
| Theme 2: Experiences of disrespect and devaluation                                            | Being humiliated or ridiculed<br>Gossip or rumours spread about you; offensive remarks                                                            | “When they gossip and call other colleagues stupid, I can only imagine what they say about me—someone who is there to learn.”;                                                                                                                                                | <ul style="list-style-type: none"> <li>• Unfairly criticised (41%)</li> <li>• Ridiculed (29%)</li> </ul>                                                                                                                                                              |
| Theme 3: Identity-based discrimination and marginalisation in the learning environment        | Ethnic and racial aggression<br>Discrimination based on sexual orientation and appearance                                                         | “There have been several situations where I was asked which country I come from when I pointed out a mistake a nurse made.”                                                                                                                                                   | <ul style="list-style-type: none"> <li>• Subjected to racist remarks (10%)</li> </ul>                                                                                                                                                                                 |
| Theme 4: Sexual harassment and boundary violations in the clinical learning environment       | Being the target of sexual harassment<br>Peer-perpetrated sexual misconduct                                                                       | “Patient making inappropriate sexual remarks.”;<br>“Another nurse touched me in an inappropriate way.”                                                                                                                                                                        | <ul style="list-style-type: none"> <li>• Subjected to sexually charged remarks (11%)</li> <li>• Sexually harassed (5%)</li> </ul>                                                                                                                                     |
| Theme 5: Institutional and interpersonal dynamics that devalue students and restrict learning | Misuse of students as workforce<br>Devaluation and disrespect in professional interactions<br>Eroded psychological safety and learning conditions | “During my third-year placement, I was told that I could wash counters and make coffee since I was a student, and that these were suitable tasks for me.”;<br>“I was not allowed to participate in learning situations because intensive care nursing students had priority.” | <ul style="list-style-type: none"> <li>• Given unfair work allocation (52%)</li> <li>• Denied learning opportunities (40%)</li> <li>• Harshly judged (31%)</li> <li>• Denied acknowledgement for good work (31%)</li> <li>• Unfairly assigned shifts (20%)</li> </ul> |
| Theme 6: Hostile and unsafe supervisory practices undermining learning                        | Being shouted at<br>Threats of violence<br>Actual physical abuse                                                                                  | “Scolded by my supervisor because I had not learned how to document, even though the supervisor had previously told me I did not need to learn that yet.”                                                                                                                     | <ul style="list-style-type: none"> <li>• Verbally abused (sworn, shouted or yelled at) (33%)</li> <li>• Subjected to physical attacks (2%)</li> </ul>                                                                                                                 |

### 3.4. Response to Bullying

Most students reported exposure to bullying or harassment during their clinical placements in nursing homes (43%), while approximately one-third indicated experiences of bullying or harassment during medical or surgical practice (both 30%). Registered nurses were most frequently identified as the perpetrators (73%), followed by other staff members (34%), and, to a lesser extent, patients (19%).

Experiencing bullying or harassment during clinical placement had a negative impact on the students' psychosocial well-being. Students provided responses describing their personal reactions to being bullied or harassed, and the most frequently reported reactions were feelings of inadequacy, followed by anxiety or fear, and feeling humiliated or embarrassed (Table 5). Furthermore, 39% of the students who experienced bullying or harassment considered leaving their nursing studies (Table 5). Hence, being subjected to bullying or harassment behaviours affected the students' psychological well-being, their turnover intention, but also their work performance, as reflected in the students' responses (Table 5).

**Table 5.** Consequences of exposure to bullying or harassment.

| <b>Personal Consequences (N = 516)</b>                            | <b>N</b> | <b>(%)</b> |
|-------------------------------------------------------------------|----------|------------|
| I felt inadequate                                                 | 287      | 55.6       |
| I felt anxious or fearful                                         | 237      | 45.9       |
| I felt humiliated or embarrassed                                  | 218      | 42.2       |
| I felt confused                                                   | 183      | 35.5       |
| My personal relationships were negatively impacted                | 128      | 24.8       |
| I felt angry                                                      | 127      | 24.6       |
| I felt depressed                                                  | 114      | 22.1       |
| I experienced no adverse personal effects                         | 78       | 15.1       |
| Other                                                             | 42       | 8.1        |
| <b>Consequences for work performance (N = 516)</b>                | <b>N</b> | <b>(%)</b> |
| Made me consider withdrawing from nursing studies                 | 200      | 38.8       |
| I was afraid to engage in patient follow-up                       | 165      | 32.0       |
| It had no impact on my work performance                           | 159      | 30.8       |
| It negatively affected how I collaborated with others             | 137      | 26.6       |
| I remained at home and reported being ill                         | 107      | 20.7       |
| It adversely affected the standard of care I provided to patients | 50       | 9.7        |

### 3.5. Reporting of Bullying or Harassment

When asked whether they had ever reported an incident of bullying or harassment, 25% of students indicated that they had done so. Most reports were directed to the clinical supervisor or the university (Table 6).

However, nearly 40% of these students stated that no action was taken in response to their report. Only one-fifth of students reported that action was taken, and the issue resolved. Among those who had never reported bullying or harassment, many explained that they believed no action would be taken, or that they feared reprisals (Table 6).

**Table 6.** Reporting of bullying and harassment incidents and subsequent actions taken.

| <b>Incidence Was Reported to (N = 262)</b>                        | <b>N</b> | <b>(%)</b> |
|-------------------------------------------------------------------|----------|------------|
| My clinical supervisor                                            | 139      | 53.1       |
| The university                                                    | 124      | 47.3       |
| The clinical facility                                             | 93       | 35.5       |
| Others                                                            | 11       | 4.2        |
| The police                                                        | 0        | 0.0        |
| <b>Action taken in response to reporting (N = 262)</b>            | <b>N</b> | <b>(%)</b> |
| No action was taken                                               | 101      | 38.5       |
| Unsure if action was taken                                        | 70       | 26.7       |
| Yes, but the issue was not resolved                               | 62       | 23.7       |
| Yes, and the issue was resolved                                   | 54       | 20.6       |
| <b>Reasons for not reporting bullying or harassment (N = 389)</b> | <b>N</b> | <b>(%)</b> |
| No action will be taken                                           | 102      | 26.2       |
| I am afraid of being subjected to reprisals                       | 101      | 26.0       |
| I do not know where/how to report it                              | 86       | 22.1       |
| It is not important enough                                        | 80       | 20.6       |
| Other reasons                                                     | 49       | 12.6       |
| It is part of the job                                             | 39       | 10.0       |

#### 4. Discussion

A smooth transition from student to competent nurse places considerable demands on the quality of the clinical learning environment. The aim of this study was to identify, from students' perspective, the characteristics that defined both perceived high-quality and poor learning situations during clinical placements.

The integrated results from the quantitative and qualitative analyses in this study suggested that high-quality learning situations emerged at the intersection of inclusion, mastery and active participation. The most effective learning experiences were characterised by a gradual transition from observation to independent practice, supported by appropriate challenges and reflective learning. Previous research finds that introducing students to challenging yet supportive learning opportunities where questioning and reflection are encouraged can reinforce their sense of mastery and their ability to manage future situations independently [51–54].

Several students in this study reported that meaningful relational and communicative experiences further contributed to valuable learning experiences, contrasting earlier studies reporting negative communicative experiences among students [55,56]. Others emphasise, however, that developing communication skills is important for the progress from nursing student to novice practitioner [57–59].

Most of all, students in the present study emphasised the importance of an inclusive learning environment where they were integrated into the clinical team with time available for learning. This was underscored by the close association of inclusion in the clinical team and perceived high-quality learning situations, but also among the results showing that students who felt included were less likely to report bullying or harassment. These findings suggest that inclusion within the clinical team strongly influenced students' perception of high-quality learning situations, but also their perception of bullying and harassment.

Approximately half of the students reported, however, incidents of perceived bullying or harassment during clinical placements, consistent with previous studies [19,20]. The integrated results from quantitative and qualitative analyses demonstrated that experiences of being ignored, humiliated, ridiculed or otherwise devalued were among the most frequently reported incidents. However, ethnic-, racial-, appearance- and gender-based

discrimination was also reported, thus highlighting the need for targeted interventions to foster inclusivity and reduce discriminatory behaviours [18,21,24].

Bullying prevalence appeared to increase with students' level of education, which is consistent with previous studies [21–23]. Several explanations may account for this pattern. Senior students may be subject to higher expectations in clinical practice, increasing their exposure to situations in which bullying behaviours occur. Alternatively, they may have a greater ability to recognise and report unacceptable behaviour than junior students [28,41]. It is also possible that second- and third-year students reported incidents that had occurred earlier in their programme, as the survey did not specify a reporting timeframe.

This finding contrasts with studies suggesting that junior students are at greater risk of bullying than senior students [24,25]. Such vulnerability has been attributed to factors including limited clinical experience, younger age, and less developed coping strategies, all of which may reduce students' capacity to manage challenging interpersonal situations [19,29,31].

However, the present study revealed a more nuanced picture, with third-year students reporting both higher levels of bullying and a greater number of high-quality learning situations than students in earlier years. One possible interpretation is that increased maturity, responsibility, and clinical exposure provide senior students with richer learning opportunities while simultaneously placing them at greater risk of negative interpersonal interactions. This suggests that clinical learning environments may offer both significant educational benefits and increased vulnerability to bullying as students progress through their training.

Many students who reported witnessing bullying had also been victims of bullying themselves, indicating substantial overlap between witnessing and experiencing bullying. This may reflect shared exposure, and/or heightened awareness of bullying among those who have been victimised. Previous research suggests that victimisation is associated with a negative social-cognitive style, characterised by more adverse perceptions of others and a tendency to attribute negative events to situational factors [60].

Bullying and harassment during clinical placements adversely affected students' psychosocial well-being, workplace performance and patient care, and increased their intentions to withdraw from nursing programs. Similar to previous research [21,26,36,37], students exposed to bullying reported feeling inadequate, fearful, humiliated, confused, angry or depressed. Such experiences may undermine learning, reduce students' sense of belonging, and decrease satisfaction, prompting some to consider withdrawing from nursing studies [21,26,35–37], consistent with findings in the present study.

Transitions across multiple learning sites—with different peers, teaching staff and professional colleagues—may hinder students' integration, reduce their sense of belonging, and increase their turnover intentions [61]. The need to belong acts as a fundamental motivator, exerting profound influence over both cognitive processes and emotional patterns [8]. Conversely, the deprivation of social attachments is associated with significant impairments in health, psychological adjustment, and overall well-being. The recent literature highlights that nursing students' sense of belonging influences the effectiveness of their clinical experiences [13], underscoring the necessity of fostering belongingness in clinical placements.

Many students had endured bullying without reporting it, mainly because they doubted any action would be taken, and secondarily due to fear of retaliation, which is consistent with previous findings [62–64]. Some even described bullying as “part of the job”, which is consistent with previous studies suggesting that such behaviours in clinical settings have become normalised [26,43].

These results suggest that the characteristics of high-quality learning situations, as well as the extent and nature of experienced bullying and harassment, had a common denominator—team inclusion. Consequently, interventions should target multiple levels of the clinical learning environment, including students, clinical supervisors, and healthcare organisations.

#### I. Student preparation: Building confidence, resilience and awareness

Adequate preparation prior to clinical placement may strengthen students' confidence, resilience, and ability to engage actively within the clinical team. Previous research indicates that well-prepared students are better equipped to participate in learning opportunities, contribute to clinical work, and develop a sense of belonging [14,65,66]. This may enhance their acceptance within the team while reducing vulnerability associated with insecurity, anxiety, and fear of making mistakes.

Educational institutions should therefore prepare students not only clinically but also socially and psychologically for placement. This preparation should include training on professional communication, strategies for managing challenging interpersonal situations, and education about bullying and harassment, including how to recognise unacceptable behaviours. Students should also receive clear information about available support services and reporting procedures.

#### II. Supervisor empowerment: supporting inclusive clinical supervision

Given the pivotal role of clinical supervision in shaping students' learning experiences, efforts to prevent bullying should include measures to strengthen supervisors' capacity to provide effective support and inclusion. The present findings suggest that students who felt welcomed, involved and valued within their team experienced both better learning opportunities and fewer negative interactions.

However, clinical supervisors face a daunting challenge of simultaneously caring for patients and teaching learners in a time-constrained environment [67]. In high-stress environments, even well-intentioned supervisors may struggle to fulfil their mentoring role. Organisations should therefore provide supervisors with dedicated preparation and continuing professional development. Protected time for supervision and mentoring should also be prioritised to reduce the tension between clinical and educational responsibilities.

Importantly, responsibility for student inclusion should extend beyond the designated supervisor. Responsibility for student support and inclusion should be shared across the clinical team, as collective engagement may facilitate more consistent supervision, enhance students' sense of belonging, and promote a supportive learning environment.

#### III. Organisational culture and systems: fostering belonging and psychological safety

Creating a culture of inclusion and psychological safety is essential for both learning and bullying prevention. Evidence indicates that cohesive teams enhance interpersonal relationships, collaboration and learning [68,69]. Strong team inclusion is associated with empowerment and performance [70], whereas weak team cohesion and high job stress are associated with workplace bullying [71]. Healthcare organisations should therefore actively foster cultures in which students are regarded as legitimate members of the clinical team rather than temporary visitors.

A critical component of anti-bullying culture is the establishment of safe, transparent, and responsive reporting systems. Students should have access to confidential reporting mechanisms without fear of retaliation, and reporting procedures should be clearly communicated, including how concerns will be addressed and what support is available.

Taken together, these findings indicate that successful clinical placements require coordinated efforts across all three levels. Well-prepared students, empowered supervisors,

and inclusive organisational cultures supported by transparent reporting and response systems can provide the foundation for both high-quality learning and the prevention of bullying and harassment in clinical education.

## 5. Limitations

Although this study identifies associations between team inclusion and reduced perceptions of bullying, a clear causality cannot be established. Longitudinal data would therefore be required to determine whether inclusion has a protective effect against bullying.

In addition, the survey relies entirely on self-reported data, which may be influenced by recall and reporting bias. Students may have under- or over-reported experiences of bullying and harassment due to differences in recall, interpretations or awareness of such behaviours. In addition, social desirability bias may have influenced responses, with some participants reluctant to disclose negative experiences or more inclined to report positive learning experiences. Although the anonymous survey design may have mitigated these effects, the findings should be interpreted as reflecting students' perceived experiences rather than objectively verified events.

A potential sampling bias must also be considered, as participants were recruited through the national student nurses' organisation. This may have resulted in a slight over-representation of students with stronger views. Nonetheless, as approximately 90% of nursing students are members of this organisation, the sample is likely to be broadly representative.

## 6. Conclusions

Although clinical placements are organised somewhat differently between hospitals and countries, this study and prior research have demonstrated that the challenges for nursing students are universal. Hence, the solutions for safeguarding students' well-being and fostering their professional development may also be universal.

The principal value of this study lies in its identification of team inclusion as a key factor underpinning both high-quality clinical learning experiences and the prevention of bullying and harassment. By highlighting the interconnected roles of student preparation, supervisory support and organisational culture, the findings provide a framework for developing more inclusive, supportive and psychologically safe clinical learning environments.

**Author Contributions:** Conceptualisation, M.S.E.; methodology, M.S.E. and L.K.H.; software, M.S.E. and L.K.H.; validation, M.S.E. and L.K.H.; formal analysis, M.S.E. and L.K.H.; investigation, M.S.E.; data curation M.S.E.; writing—original draft preparation, M.S.E.; writing—review and editing, M.S.E. and L.K.H. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research received no external funding.

**Institutional Review Board Statement:** The study was conducted in accordance with the Declaration of Helsinki and by the Norwegian Agency for Shared Services in Education and Research (SIKT), ref.no. 153671, in accordance with SIKT's guidelines (<https://sikt.no/en/personvernhandbok-forskning/carrying-out-project-without-processing-personal-data>, accessed on 1 March 2024).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The data presented in this study are available on request from the corresponding author due to privacy concerns.

**Conflicts of Interest:** The authors declare no conflicts of interest.

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