I, Peggy A Berry, hereby submit this original work as part of the requirements for the degree of Doctor of Philosophy in Nursing Research.

It is entitled:
Workplace Bullying: Exploring the Prevalence, Impact, and Consequences to Nurses

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Workplace Bullying: Exploring the Prevalence, Impact, and Consequences to Nurses

A dissertation submitted to the Graduate School of the University of Cincinnati in partial fulfillment of the requirements for the degree of

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by

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Abstract

Introduction: Most novice nurses will experience workplace bullying (WPB) behaviors within 1-2 years of licensure. This exposure adversely affects work productivity. The purposes of this study were to (1) explore factors that resulted in the adoption of WPB behaviors; (2) determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on bullying exposure frequencies and select nurse characteristics; and (3) explore strategies to manage or stop WPB behaviors.

Methods: A longitudinal quantitative dominant mixed methods design was used with nurse respondents (n=80) from three Midwestern states who participated in a prior study on WPB. In Manuscript 1, respondents completed a multicomponent survey. Descriptive statistics, nonparametric statistics, and path analysis were computed to explore trait anxiety, perception of bullying behaviors, self-labeling as a target, and adoption of bullying behaviors. In Manuscript 2, data from a purposeful sub-sample (n=37) of respondents who maintained employment after an observed or targeted WPB incident and continued bullying behaviors were analyzed using descriptive and Mann-Whitney U statistics. Next semi-structured interviews with 11 respondents were conducted. Interview transcripts were analyzed using content analysis.

Results: In Manuscript 1, 11 respondents adopted bullying behaviors. There was no difference in the adoption of bullying based on WPB exposure ($\chi^2 = 2.26, p = .38$). For respondents (n=31) who had a positive history of being bullied prior to their nurse licensure, statistically significant findings were seen with age (Md = 33 vs. 26, U = 456.5, $p = .04$), state anxiety (Md = 40 vs. 34, U = 480.5, $p = .008$), and posttraumatic stress symptoms (Md = 29 vs. 23, U = 506.5, $p = .017$) compared to respondents (n=49) with no history of WPB behaviors prior to their nurse licensure. The final path model displayed a path from self-labeling as a target at Time 1 (2010), trust in
management, and anxiety state to the adoption of WPB behaviors through a common variable of self-labeling as a target of WPB behaviors at Time 2. This path achieved a minimum fit ($\chi^2 [36, N = 80] = 23.116, p = .952$) with GFI = .95, RMSEA < .001, AGFI = .70, and NFI = .545. In Manuscript 2, significant differences were seen with perceived stress, anxiety, and posttraumatic symptoms for persons with frequent to daily WPB behavior exposure. A significant difference was seen between respondents 29 years and younger (n=23, Md = 21) and respondents 30 years and older (n=12, Md = 33) for posttraumatic stress symptoms ($U = 86.5, p = .018$). Narrative analyses demonstrated bullied novice nurses avoided perpetrators rather than ask for assistance. Nurse peers and leaders minimized WPB behaviors. Half the nurses interviewed were making plans to leave their current employment.

**Conclusions:** As WPB behaviors become or remain embedded into the unit culture, the risk of more nurses adopting bullying behaviors will likely continue. Elimination of WPB behaviors is complicated and requires a cultural change for how some nurse leaders and their employees address aggression and violence in their workplaces.
Dedication

To my family, I love you all. David Berry, thank you, we stayed financially afloat. Kobe Jordan, thank you for giving up “grandma” time. Kristina Vineyard, Sean Vineyard, Ellen Wangler, Mary Beth Koenig, Arthur Koenig, thank you for the verbal support. To David Yamada, Gary and Ruth Namie, Cheryl Dellasega, Beth Boyton, and other advocates for psychologically safe workplaces, thank you for your thoughts, emails, opportunities, and mentions. We will all work together to demonstrate organizational profitability by making work physically and psychologically safe. Work should not hurt. I also am grateful for two unique situations that helped solidify my reason for studying WPB. I was a target, squashed in-between a hospital culture in the midst of change and direct reports who had lost a long time manager. I was unprepared to overcome the barriers of emotions, distrust, and anger from below and the emotions, distrust, and anger from above related to the organizational change. Change is a great motivator and learning to adapt to change makes the difference between thriving, surviving, or extinction. The second incident involved a student nurse. A charge nurse was verbally abusing her and I step in to stop it. In this encounter, I found my challenge and meaning. I made it a point to learn more about workplace bullying to understand the multiple whys of aggression and give some explanations and meanings to workplace aggression. With that, I will continue to collaborate with others to raise awareness and find better ways to improve and maintain healthy and safe workplace environments through research and evidence-based practices.
Acknowledgements

I am grateful to my chair, Dr. Gordon Gillespie, for his patience, mentoring and discussions on human aggression and violence. Dr. Gillespie has coached and mentored me with much thought and time to keep me focused towards the end. He has guided me in the waltzing of design, implementation, and completion of this study. I hope to continue to write with him on future analyses of all the data collected with this research. I also am grateful to Dr. Bonnie Fisher and Dr. Denise Gormley for stepping up to be part of my committee. Bonnie has given me careful insight on my writing and statistical analysis. Bonnie’s immense writing and grant history has been an inspiration to me as well as her vast knowledge on violence. I hope to pattern my career to her prolific and critical abilities in writing. Dr. Gormley stepped in when others had to leave. Her administrative excellence as a nurse executive and the challenges she had to go through to obtain her Ph.D. are inspiring. Although they were unable to stay on committee, I want to thank Dr. Donna Gates and Dr. John Schaffer, both gifted in violence research, for their faith in me as a Ph.D. student and candidate.

Without funding, none of this would have happened. I would like to acknowledge the National Institute for Occupational Safety and Health Pilot Research Training Program of the University of Cincinnati for their generous support with my preliminary study and the American Nurses Foundation for their generous support of my dissertation.

Finally, I thank all the novice nurses who took time out of their day to fill out one more survey, answer my calls for interviews, and want to be the next protectors of newly hired novice nurses. You will make it happen.
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>NAQ</td>
<td>Negative Acts Questionnaire</td>
</tr>
<tr>
<td>NIOSH</td>
<td>National Institution for Occupational Safety and Health</td>
</tr>
<tr>
<td>PCL-C</td>
<td>Posttraumatic Stress Disorder Checklist-Civilian Version</td>
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<tr>
<td>RN</td>
<td>Registered Nurses</td>
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<tr>
<td>STAI</td>
<td>State Trait Anxiety Inventory</td>
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<tr>
<td>U.S.</td>
<td>United States</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WPB</td>
<td>Workplace Bullying</td>
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CHAPTER 1: PROBLEM, PURPOSE, AND SIGNIFICANCE

Repeated workplace bullying (WPB) behaviors continue in healthcare (Berry, Gillespie, Gates, & Schafer, 2012). Anyone can be a target of WPB behaviors. However, through systematic, escalating, and prolonged exposure to WPB behaviors, targets begin to suffer psychologically and physically (Einarsen, Hoel, Zapf, & Cooper, 2011). WPB behaviors can be, but not limited to, unwarranted criticism, gossiping, unfair task assignments, or belittling comments. Nurses are targets in an incivil environment, whether they are able to respond and WPB behaviors escalate, or unable to respond to WPB behaviors, either through a power imbalance (the perpetrator has a leadership position), confusion on how to respond, or deniability by the perpetrator (Berry et al., 2012; Einarsen et al., 2011).

Despite The Joint Commission (2008) standard for elimination of disruptive behaviors in healthcare (e.g., WPB, incivility, disruptive behavior, horizontal violence, verbal abuse, etc.), nurse-to-nurse WPB behaviors continue as novice nurses and experienced newly-employed nurses are socialized into the organizational unit. In a descriptive study of 212 staff nurses in diverse practices with variable years of experience, Vessey, Demarco, Gaffney, and Budin (2009) conveyed that more than 70% self-reported being bullied. Berry et al. (2012) indicated over 70% of novice nurses experienced a sentinel WPB event directed towards them (57.9%; n=114) or as witnesses (14.7%; n=29) in the one month prior to the initial web-based survey. The WPB behaviors were primarily perpetrated by nursing colleagues and leadership (59.4%, n=117), and negatively correlated to work productivity ($r = -.322$, $p = .045$) (Berry et al., 2012).

Descriptions of negative behaviors varied from poor orientation, “initiation,” to withholding pay (a wage and hours act violation).
The following exemplars demonstrate how WPB behaviors can create stress and be part of a poor psychosocial environment at the organizational unit level.

“Being a new nurse, there is one nurse who continues to give more intense assignments to the new nurses. In this instance, I have struggled on those nights and felt overwhelmed and stressed out. It has been verbalized that they do this on purpose because it is a "initiation" phase for new nurses. The same nurse deems it okay to go in to my patient rooms and do assessments on my patients. It feels as if he does not trust me because I am a new nurse and am new to the hospital. The incidents that have caused the most stress were the nights where I purposefully received a harder assignment. The entire shift I was on edge and felt like a bad nurse and incompetent” (unpublished narrative, Berry et al., 2012).

“A female charge nurse was unable to provide coverage for a 30 minute lunch period over a 12 hour shift and stated that we did not have to take a lunch if we did not want to. I assumed that I would be paid for the extra half hour I worked. Later in the night, she explained that she would not okay the 30 minute period being paid because it would reflect back on her. I later addressed the issue with our nurse manager” (unpublished narrative, Berry et al., 2012)

Simons (2008) measured prevalence of twice weekly exposure to WPB behaviors at 31% of 511 newly-licensed Massachusetts nurses. In Washington State, Johnson and Rae (2009) reported a prevalence of 27.3% exposed to twice weekly WPB behaviors in a population of 249 Emergency Nurse Association members. In Ohio, Kentucky, and Indiana, 42 (21.3%) of 197 novice nurses experienced daily WPB with 86 (54.7%) self-labeling as a target (Berry et al., 2012). These prevalence rates are above the general U.S. population prevalence of 13% for experiencing WPB behaviors (Schat, Frone, & Kelloway, 2006). A 2014 national survey of the general population (N=1000) indicated 27% of Americans had experienced abusive conduct in the past year (Workplace Bullying Institute, 2014). Exposure to WPB behaviors has been associated with adverse affects to nurses’ productivity, employment retention, and psychological wellbeing (Berry et al., 2012, Simons; 2008; Vessy et al., 2009). The use of WPB behaviors
within the first years of novice nurse integration undermines not only retention and the learning necessary to move the novice nurse through to competent nurse and silences novice nurses into acceptance of adverse working conditions.

**Statement of the Problem**

Novice nurses must successfully navigate a stressful healthcare environment in addition to WPB behaviors while acquiring the skills and experience needed to progress to a competent nursing professional. A newly-licensed registered nurse (RN) with less than one year’s experience is a novice (Benner, 1984). According to Benner (1984), a beginner nurse must work two to three years to build competence and work five years to become an expert. However, novice nurses may have more vulnerability to WPB in a stressful work environment (Budin, Brewer, Chao, & Kovner, 2013). WPB behaviors make the transition from novice to beginner problematic.

WPB behaviors are psychological aggression in the work environment. These negative behaviors are labelled as Type III Violence. Type III Violence is interpersonal aggression between employees or from employer to employee that can escalate to violence and death (U. S. Department of Health and Human Services, 2006). Employee perception of his or her work environment helps to create the work-related stress leading to psychological and physical consequences to the employee (Leka & Cox, 2008). WPB behaviors and the perception of being a target drive enormous physical and psychological costs to employees and employers (Hill & Joyce, 2013).

In some healthcare organizations, WPB behaviors may be the social norm. For those nurses embedded into the organizational culture, WPB behaviors are no longer workplace stressors but a way of doing business (Hutchinson, Wilkes, Jackson, & Vickers, 2010). As a new
employee and new professional nurse, the novice nurse’s transition to the facility or unit culture becomes strained by those adverse social norms. The roles of being a new nurse and new employee produce an asymmetrical exchange between novice and tenured nurses related to power imbalance (Blau, 1987; Molm, 1987). The power imbalance from this asymmetrical exchange may increase the stress and anxiety reaction of the nurse; thus increasing the perception of a hostile work environment rife with incivility and WPB behaviors. While coping styles and social support may mitigate the effects of WPB behaviors, there is a gap in the literature about social support from the organization, peer group, or family when WPB behaviors occur and if social support influences employee retention (Chen, Kawachi, Coakley, Schwartz, & Colditz, 2000).

WPB behaviors may be a social norm that tenured nurses pass on to novice nurses by modeling WPB behaviors, thereby perpetuating the WPB cycle (Dellasega, 2011). As a method of avoiding the conflict associated with WPB behaviors, nurses have historically switched healthcare employers when they become dissatisfied with their current job (Dellasega, 2011). Given the economic climate of recession, nurses exposed to WPB behaviors may believe they are not able to seek other employment. These nurses may adopt WPB behaviors as a coping or defense strategy to prevent further targeting by previous perpetrators. There was a gap in the researcher’s understanding into how and why nurses adopt WPB behaviors as a coping strategy or a social norm after maintaining employment whether they stay in the same facility or move on.

In the United States’ (U. S.), healthcare staff and nurse researchers recognized the historical use of WPB behaviors to integrate novice nurses into the organization, but lacked a consistent measure. The Negative Acts Questionnaire (NAQ; Einarsen, Hoel, & Notelaers, 2009)
provided a consistent measure to document the perception of being a target of WPB behaviors and exposure frequency of the WPB behaviors. WPB behaviors then were correlated to intent to leave healthcare organizations (Johnson & Rae, 2009; Simons, 2008). Increased intent to leave caused alarm within the nursing community related to anticipated future nursing shortages (Johnson & Rae, 2009; Simons, 2008; Vessey et al., 2009).

There are multiple reasons to leave a position, not just WPB behaviors. There was a gap in the current state of WPB research on whether nurses continued employment with the same organizational unit, transferred within the same organization, left for another organization, or disengaged from the profession temporarily or permanently because of WPB behavior exposure. Although there may have been additional variables influencing intent to leave, to recruit and retain an adequate supply of RN for future practice, it was critical to understand how and why WPB behaviors continue in healthcare. Additionally, it was important to know how novice nurses exposed to WPB behaviors continued to work in unit cultures with high WPB behavior exposure.

**Purpose of the Study**

The purposes of this study were to (1) explore factors that resulted in the adoption of WPB behaviors in a sample of 148 Ohio, Kentucky, and Indiana nurses who participated in a prior study on WPB behaviors; (2) determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on bullying exposure frequencies and select nurse characteristics; and (3) explore strategies to manage or stop WPB behaviors.

**Specific Aims**

Listed below are the specific aims and rationale for the aims.
**Aim 1: Determine the proportion of nurses adopting WPB behaviors.** The rationale for this aim was to determine the relationship of previous exposure (Time 1) to WPB behavior to use of WPB behaviors towards others. Researchers have linked WPB behavior exposure to use of WPB behaviors in previous studies (Anderson & Pearson, 1999; Lee & Brotheridge, 2006; Quine, 2001; Vessey et al., 2009; Yildirim, 2009). Nurses may exhibit WPB behaviors as a coping or defense strategy to prevent further targeting by previous perpetrators. Little was known regarding which nurses will adopt WPB acts as a coping strategy or a social norm after maintaining employment whether they stay in the same facility or move on.

*Hypothesis 1.* Nurses exposed to moderate to high WPB behavior at Time 1 will adopt WPB behaviors towards others compared to those nurses who experienced little or no WPB behavior exposure.

**Aim 2: Test a hypothesized model for the adoption of WPB behaviors.** A proposed path model was constructed to describe the direct and indirect paths to self-labeling as a target to adoption of WPB behaviors towards others. WPB exposure has been correlated to self-labeling as a target and self-labeling has been attributed to the use of bullying towards others (Lee & Brotheridge, 2006; Matthiesen & Einarsen; 2007).

*Hypothesis 2a.* There would be a significant difference between adoption of WPB behaviors based on exposure levels to WPB behaviors.

*Hypothesis 2b.* Trait anxiety would be statistically higher for those novice nurses who exited the unit after experiencing WPB behaviors as compared to those novice nurses who experience WPB behaviors but did not exit the unit.

*Hypothesis 2c.* The hypothesized model would fit the data.
**Aim 3: Describe the consequences of WPB behavior exposure.** Organizational consequences occur with embedded WPB behaviors in professional peer relationships. Work productivity was negatively correlated to WPB ($r = -.32$, $p = .01$; Berry et al., 2012). Some nurses leave the organizational unit by transferring within or exiting the organization (Vessey, et al., 2009). There was significant positive correlation between WPB and intent to leave ($r = .51$, $p < .001$) with nurses experiencing bullying three times more likely to express intent to leave employment (Johnson & Rae, 2009; Simons, 2008). Loss of interest in the job may occur when nurses continue to work on a unit attenuated with WPB behaviors (Vessey et al., 2009).

Having to work in an environment appraised as hostile may cause posttraumatic stress symptoms. Sustained WPB behaviors are psychologically stressful related to loss of control over the situation and lack of resources for appropriate response (Duffy & Sperry, 2014). When WPB behaviors are perceived as threatening (targeted, repeated, unwanted), stress and anxiety may increase. When experiencing WPB, 90% ($n = 191$) of nurses experienced moderate to severe stress when bullied (Vessey et al., 2009).

WPB behavior exposure has been linked to posttraumatic stress symptoms as a work strain caused by both work environment and personality factors (Balducci, Fraccaroli, & Schaufeli, 2011; Matthiesen & Einarsen, 2007). Systematic and persistent WPB may lead to chronic posttraumatic stress symptoms (Tehrani, 2004). Tehrani (2004) noted symptoms of posttraumatic stress disorder were present in 44% ($n = 72$) of care professionals exposed to chronic WPB behaviors. Malik and Farooqi (2014) noted significant positive correlations between general workplace harassment and posttraumatic stress symptoms for female physicians ($n=100; r=.58, p<.01$), and female nurses ($n=100; r=.52, p<.01$).
Almost all humans have had exposure to traumatic events at some point in their lives. In the U.S., the prevalence for posttraumatic stress disorder is 11.7% (Norris & Slone, 2013). A person must have direct, witnessed, indirect, or repeated exposure to a traumatic event for posttraumatic stress symptoms to occur. Posttraumatic stress symptoms are hyperarousal, numbing, and the intrusion of traumatic events through nightmares or flashbacks, or avoidance of things, persons, or situations reminding them of the trauma (National Center for PTSD, 2014).

The selection of coping style and social groups may buffer perceived stress and anxiety state by influencing appraisal. (Lakey & Orehek, 2011). Researchers studying stressful nursing practice endorsed problem-focused (proactive coping) as more effective when managing stress from trauma care (Gillespie & Gates, 2013) and patient aggression (Gillespie, Gates, Miller, & Howard, 2010). In addition, primary social support by work peers or nurse leaders by what these social groups do or say about WPB behaviors may assist nurses through the appraisal of WPB behaviors and moderate perceived stress, anxiety state, and posttraumatic stress symptoms.

**Hypothesis 3.** There would be significant statistical differences in perceived stress, anxiety state, and posttraumatic stress symptoms between novice nurses based on WPB exposure levels.

**Aim 4: Explore strategies to manage or stop WPB behaviors.** Nurses who were novice to beginner nurses at the time of the first study were interviewed to determine the strategies used to manage after or stop WPB behaviors while employed on the same unit with the same employer from the first study. The rationale for this aim was to explore what worked or did not work in eliminating WPB behaviors directed towards those nurses. Future interventions may be developed and tested to reduce the harmful effects of WPB based on this information.
Definitions of Terms

For the purposes of this study, the following variables are described conceptually and applied operationally through measurement.

WPB behavior exposure level. The conceptual definition of WPB behavior exposure is any number of behaviors as being targeted towards the nurse by coworkers, nurse leaders, or other healthcare personnel. These WPB behaviors may be part of an incivil environment, a social norm, escalating work conflict, or targeted WPB (Einarsen et al., 2011). To the individual nurse, these behaviors trigger no emotional response or emotional responses (e.g., anger, annoyance, hurt, shame, humiliation) through unwarranted criticism, gossiping, unfair task assignment, or belittling comments (Einarsen et al., 2011).

The operational measure of WPB behaviors was self-reported by the respondent using the NAQ. The NAQ was assigned weighted values to the Likert-scale response using the number of working days in a six-month period to create a continuous scale variable for the intensity of bullying (Berry et al., 2012; Simons, 2008). The 22 NAQ items were weighted as never = 0, now & then = 2, monthly = 6, weekly = 25, and daily = 125, resulting in a possible range of 0 to 2,750. Respondents with an NAQ weighted score summing 0 to 49 indicated infrequent exposure to WPB behaviors. Respondents with an NAQ weighted score summing 50 or greater indicated frequent to daily exposure to WPB behaviors. A sum of 50 indicates twice weekly bullying and provides a demarcation point for WPB with a sum of 125 considered daily WPB (Simons, 2008). The NAQ weighted sum was used as a continuous variable for path analysis. The sample was divided into two groups based in the NAQ sum.
Self-labeled as target. A conceptual definition of self-labeled as a target is when the nurse identifies as a WPB victim. The nurse believes he or she was a target of frequent, intentional WPB behaviors occurring over a six-month period and they feel helpless to stop it (Einarsen et al., 2011). Target orientation is subjective and does not give insight into the negative behaviors experienced by the target (Nielsen, Notelaers, & Einarsen, 2011). The operational definition of self-labeling was the respondent self-reported yes to the last statement on the NAQ:

“Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will not refer to a one time incident as bullying. Using the above definition, please mark whether you have been bullied at work over the last six months” (Einarsen et al., 2009).

Nurse. For the purposes of this study, the population studied is novice to beginner RN in practice less than three years in the study (T1, 2010). The conceptual definition of novice nurse was based on the seminal work of Benner (1984), who documented the transitions associated from novice nurses with less than a year in practice to competent nurse, which may take up to three years of practice. The operational definition of nurse was any nurse with less than three years practice confirmed by inputting the year he or she was graduated from their first nursing degree program that was not more than three years prior to the date of the first study.

Social support. As a conceptual definition, social support is the individual’s perception of support regarding work conflict, regardless of the quality or availability of support. Social support may be from family, non-nurse friends, nurse peers, or nurse leaders (Giblin & Lakey, 2010). Social support was believed to buffer stress by influencing appraisal and coping by what friends, family, peers, and the organization say or do regarding the stressful event (Lakey & Orehek, 2011). Low social support at work has been identified as a risk factor in workplace
violence and distress (Magnavita, 2014). The operational definition of social support occurs when the nurse selected a social support group most commonly used in work conflict.

**Coping styles.** A conceptual definition of coping style is the mental or physical actions used to manage the emotions associated with stressful events (Lazarus, 1999). There are three types of coping styles: problem- (e.g., positive reframing, acceptance, taking action to resolve the issue, talking to friends), emotion- (e.g., humor, prayer, expressing negative feelings, blaming yourself), and avoidance-focused coping (e.g., self-distraction, denial, giving up, drinking alcohol) (Burgess, Irvine, & Wallymahmed, 2010; Lazarus & Folkman, 1984). The operational definition of coping style was the choice the nurse makes in choosing their dominant coping style used in work conflict.

**Appraisal.** The conceptual definition of appraisal is the personal interpretation of behaviors an individual uses within the context of a situation that determines the strategies used to cope with behaviors as the person sees or construes events (Larrabee et al., 2010; Lazarus & Folkman, 1984). There are several points in the appraisal process that occurs within this study. One operational definition of appraisal is the self-labeling as a target. The nurse is personally interpreting WPB behaviors as intentional and targeted. Perceived stress and perceived anxiety state are also appraisals and are discussed later.

**Trait anxiety.** The conceptual definition of trait anxiety is a stable personality trait that governs behavioral feelings of anxiety responses to situations (Persson, Hogh, Hansen, Nordander, Ohlsson, Balogh et al., 2009). High trait anxiety may cause consistent appraisal of stressful situations as threatening with anxious affect (Bieling, Antony, & Swinson, 1998). Anxiety trait has been cited as an antecedent to self-labeling as a target or perpetrator of bullying (Hogh, Mikkelsen, & Hansen, 2011; Persson et al., 2009). Operationally, the State Trait Anxiety
Inventory (STAI) (Spielberger, Reheiser, Ritterband, Syddeman, & Unger, 1995) was used as a continuous variable to measure high trait anxiety for the path analysis. Based on means, standard deviations, and Cronbach’s alpha for working adults between the ages of 19-39 years old, the standard mean for trait anxiety was established for males (n = 446, M = 35.55, SD = 9.76, α = .92) and females (n = 210, M = 36.15, SD = 9.53, α = .92) (Spielberger, Gorsuch, & Lushene, 1983, p. 14).

Duffy and Sperry (2014) caution against fundamental attribution error when researching WPB. The over-emphasis of personality traits as an explanation for being a target of WPB minimizes the important of situational and organizational influences (Duffy & Sperry, 2014). Even so, personal characteristics are cited as antecedents to being a target or perpetrator of bullying. Personality traits, considered stable characteristics, govern behavioral responses to situations. Persson et al. (2009) examined the influence of personality trait between non-bullied respondents, targets, and witnesses (n=247) on a hypothesized model using trait anxiety. Bullied respondents had higher scores on neuroticism related traits (somatic trait anxiety and psychic trait anxiety). In another study of 466 shipping company employees, Vie, Glasø, and Einarsen (2010) reported a strong positive correlation between trait anxiety and WPB behaviors to self-labeling as a target (r = .60, p < .01). However, the frequency of negative behaviors was a stronger predictor with trait anxiety and trait anger acting as independent predictors to self-labeling as a target.

Trait and state anxiety also may alter the perception of coworker behaviors, amplifying and increasing perceived stress. Given high trait anxiety, even low levels or intermittent behaviors of ambiguous WPB behaviors (e.g., incivility, disruptive behaviors, disrespectful behaviors) over an extended period of six months or longer may elicit a heightened stress
response leading high anxiety state, self-labeling as bullied, or the adoption of WPB behaviors. However, even with low anxiety trait, continuous stressful stimulus over time may sustain state anxiety (Lazarus, 1999). This, in turn, could increase the risk of posttraumatic stress disorder.

**Psychological consequences.** As a conceptual definition on psychological consequences, each person’s emotional response to WPB behaviors is dependent on the appraisal of each situation in that context (Evans, Hodge, & Pless, 1994). Nurses are exposed to multiple stressors, not only in their work environment but also outside of work. WPB behaviors may not be the only stressor. Any stressor may trigger perceived stress, anxiety state, or posttraumatic stress symptoms. The individual responses to stressors are indicators of ineffective coping and social support, as well as risk factors for patient violence (Pai & Lee, 2011). The operational definitions and instruments for stress, anxiety state, and posttraumatic stress symptoms are listed below.

**Perceived stress.** Perceived stress is conceptually defined as a person’s appraisal to life, its events, and how unpredictable, uncontrollable, and overloaded the person believes his or her life to be (Cohen, Kamarch, & Mermelstein, 1983). Perceived stress was operationally defined by the nurse answering ten questions on the Perceived Stress Scale (Cohen & Williamson, 1988). The Perceived Stress Scale was summed and used as a continuous variable for path analysis. Based on a U. S. sample (n = 2,387), a mean score was noted for the Perceived Stress Scale (ten questions) as 13.02 with a standard deviation of 6.35 (Cohen & Williamson, 1988).

When experiencing WPB, 90% (n = 191) of nurses experienced moderate to severe stress when bullied (Vessey et al., 2009). A stressful healthcare environment creates susceptibility to nurse-on-nurse verbal abuse, a WPB behavior. After verbal abuse, targets may escalate to verbal abuse towards the perpetrator creating an escalating work conflict. Rowe and Sherlock (2005) evaluated the frequency and impact of verbal abuse to nurses by other nurses (n=213). Over 96%
(n=206) experienced verbal abuse with staff nurses as the frequent source of that abuse. The verbal abuse affected the relationship with the abusive nurse, influencing trust and supportive environment. When verbal abuse occurred, nurses returned the same verbal abuse as a coping strategy. Nurses may adopt the WPB behaviors directed towards them as a way to work through a hostile and stressful work environment.

**State anxiety.** Conceptually, anxiety state is a “momentary or situational emotional reaction” to an event (Kantor, Endler, Heslegrave, & Kocovski, 2001). Operationally, anxiety state will be used as a continuous variable, as measured by the STAI (Spielberger et al., 1983). Based on the means, standard deviations and Cronbach’s alpha for working adults between the ages of 19 – 39, the standard mean for males (n=446, M = 36.54, SD = 9.76, α = .92) and females (n=210, M = 36.17. SD =10.96, α = .93) (Spielberger et al., 1983, p. 14).

**Posttraumatic stress symptoms.** Conceptually, with individuals traumatized by an event or series of events, that person may re-experience traumatic events via intrusive or recurrent thoughts, be on guard during experiences that are similar through hyperarousal, and may avoid internal or external cues that caused or represent what caused the trauma (Lazarus, 1999). Operationally, the Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C; National Center for PTSD, 2010) provided a range (17-85) for a total symptom severity score. The summed scores were used with three factors in hyperarousal, intrusive thoughts, and avoidance. A diagnosis was not made although a score above 30 indicates a potential diagnosis of posttraumatic stress disorder (Bliese, Wright, Adler, & Cabrera, 2008).
**Employment setting.** Additional questions were asked to determine if the nurse was still employed in the same facility and the same unit. These questions are detailed in Appendix D and summarized below:

- a. Are you still working in the same organization? Yes or no
- b. If yes, the nurse was asked if they were working on the same unit
- c. If no, the nurse was asked why and to write a narrative
- d. If no, the nurse was asked to identify current employment status: (1) employment in another facility or (2) unemployed with categories of seeking an RN position, return to school, seeking non-nursing position, health condition, or family needs.

**Perceived organizational trust.** A conceptual definition of perceived organization trust is the assumption by the employee that the management or organization will protect and take into consideration the employee’s safety and well-being when doing business activities (Cook, Hardin, & Levi, 2005). Nurse leaders, whether supervisors or managers and above, are perceived by nurses as a representative of the organization through their management of nursing staff. Organizational trust is operationally defined by the nurse answering the following question: “When faced with stressful work situations, I trust the management to look out for me at the place where I work.” This question was acquired from a study by Grubb, Roberts, Swanson, Burnfield, and Childress (2005) on organizational trust from a general industry survey of human resource professionals.
Demographic and personal characteristics. Individual characteristics (e.g., age, gender, ethnicity, educational level, etc.) are independent of the organization. Demographic and personal characteristics were merged from the study.

Organizations. Type of facilities where nurses worked were identified (e.g. hospital, nursing home, public health, outpatient, magnet status, etc.).

Significance

This study has significance to the occupational safety, health, and well-being of the nurses, the patients they care for, and organizational profitability.

Significance to occupational safety and health. The psychosocial work environment adversely affected by WPB behaviors is a significant focus for the World Health Organization (WHO; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) and the National Occupational Research Agenda (2009) of the National Institute for Occupational Safety and Health (NIOSH). Krug et al. (2002) stated that WHO focuses on WPB behaviors, because of the physical consequences associated with the adverse psychosocial aspects of work. The Occupational Research Agenda (2009) also has identified the need for research focused on psychosocial factors, interpersonal conflict, and work-related violence.

NIOSH (2006) and The Joint Commission (2008) both recognize the impact of WPB behaviors on nurses’ confidence and capacity to deliver safe patient care. Findings from Berry et al. (2012) reflect the risk to novice nurse productivity and their ability to deliver safe care. As a result, understanding the effects of WPB behavior exposure on nurses at different career points may ultimately lead to the development of a more stylized intervention to protect psychological health and increase the ability to provide safe and competent care until all healthcare organizations adopt “just” cultures.
Although The Joint Commission Standard on disruptive behaviors was already in effect at the time of the 2010 data collection, WPB behaviors still were highly prevalent in the study sample (Berry et al., 2012). This finding indicated the pervasiveness of the problem at the peer level. This proposed study may determine if WPB behaviors have decreased over time. This study also may determine the extent that novice nurses adapt and model WPB behaviors as a method of social inclusion, protection into the work environment, or as a coping strategy itself.

**Significance to healthcare organizations.** The prevalence of WPB and frequency of WPB behaviors are underreported (McKenna, Smith, Poole, & Coverdale, 2003). Organizations may not be aware of the impact of WPB behaviors at the organizational unit level to decreased work productivity, increased turnover, and increased use of employer-provided healthcare benefits. Increasing organizational knowledge of these consequences may motivate healthcare organizations to prevent hostile work environments and stop WPB behaviors from escalating to physical violence and death (Hutton & Gates, 2008; NIOSH, 2009). A “just” culture of safety is desperately needed in the healthcare environment to protect both patients and employees from adverse harm (Gates, Gillespie, & Succop, 2011). Increasing organizational awareness is the first step to eliminating WPB behaviors from the environment of care and potentially preventing the escalation to physical violence.

**Significance to novice nurses.** Novice nurses are still transitioning from student nursing practice to professional nursing practice in a new organizational culture (Benner, 1984; Benner, Sutphen, Leonard, & Day, 2010; Kramer, 1974; Pellico, Brewer, & Kovner, 2009). Novice nurses must learn to prioritize patient care needs and manage multiple priorities with a workload fueled by nurse shortages (Pellico et al., 2009). However, successful transition from novice to
competent nurse requires the more tenured nurses to train and mentor novice and beginner nurses through the typical daily challenges.

Some tenured nurses also are the knowing or unknowing perpetrators of WPB behaviors (Berry et al., 2012). The way tenured nurses integrated novice nurses into the organizational unit may continue to pass on the same WPB behaviors. Novice nurses’ appraisal and coping styles while transitioning into professional practice, coupled with the additional stressor of WPB behaviors, may impede successful transition to competent nursing practice and decrease retention. Identifying and understanding what novice nurses perceive as WPB behaviors, what happens when they report WPB behaviors, and what helps, moderates, or buffers novice nurses during this transition period may increase retention at the organizational unit level and the profession as well. Creating a systematic method to resolving or reporting these incidents will assist individual nurses to find their voices at the organizational unit level to eliminate WPB behaviors as well as other safety issues.

**Rationale for a Mixed Methods Design**

Combining dominant quantitative data with qualitative narratives illuminates the stories behind the statistics (Creswell & Plano Clark, 2011). Mixed methods design was deemed the better approach to understanding the differences between novice nurses exposed to WPB behaviors in the first study, how they worked through and maintained employment, and whether they continued to have WPB behavior exposure. Individual stories of success or failure when faced with WPB behaviors create knowledge from the elements of the experiences and broaden the view of the reader. It may help explain why WPB behaviors continue in some healthcare environments and how individual novice nurses work through or experience the emotional effects. The telling or retelling of WPB stories creates a catharsis for the target, giving the target
additional insight and healing regarding the WPB experience (S. Einarsen, personal communication, May 20, 2011). By disseminating their stories, novice nurses and tenured nurses may be motivated towards changing their perceptions, responses, and coping styles to effectively eliminate these behaviors. Finally, nurse leaders may begin to recognize that prior social norms in staffing, mandatory overtime, or communication may be considered inappropriate acts of WPB and create safety hazards not only to the novice nurse, but to the patients as well.

Chapter Summary

The primary purpose of this study was to explore the strategies used by novice nurses who continued employment on the same organizational unit after experiencing or observing WPB behaviors. Peer-to-peer WPB behaviors may still be highly prevalent in healthcare on the unit level. To maintain the well-being and health of registered nurses for future healthcare delivery, identifying and strengthening novice nurse coping styles and social support is necessary. WPB behaviors as a work stressor need to be fully understood to eliminate the root causes from the healthcare environment. This study is the next step towards understanding the effective coping styles used by novice nurses when exposed to WPB behaviors. In understanding the individualized responses, intervention programs may be developed to bridge the novice nurse to competent nursing practice regardless of the organizational culture.
CHAPTER 2: REVIEW OF THE LITERATURE

In Chapter 2, the theoretical framework and theories guiding this study are discussed. The violence typology is outlined (NIOSH, 2004) and compared to an expanded violence typology. The competing terms associated with WPB in healthcare are reviewed. The WPB construct is described with exemplars to create a consistent approach to the measure of WPB in nursing. A review of the literature on WPB nurse prevalence, moderators, mediators, consequences, and interventions also are discussed.

Conceptual and Theoretical Framework

Cowie, Naylor, Rivers, Smith, and Pereira (2002) suggested a multi-modal approach to WPB research to give better understanding to its complexity. The overarching societal norms and culture influence prevalence and outcomes associated with WPB (Einarsen et al., 2011; Salin, 2003). WPB behaviors in any organization are influenced by those societal norms and cultures as well as the target’s and perpetrator’s interactions between themselves and that organizational culture.

Socio-Ecological Model. The Social-ecological Model provided an overarching framework to explain the social influences on organizations as antecedents to WPB behaviors (Krug et al., 2002). Table 1 depicts the variables related to the different levels of the Social-ecological Model: societal, community/organizational, relational, and individual. At the societal level, factors that create change (e.g., laws, culture, policies) also may promote WPB behaviors within organizations (Salin, 2003). At times, laws force organizational change in how business is conducted (Krug et al., 2002). In the U.S., laws and policies influence how healthcare organizations conduct business (e.g., Fair Labor Standards Act, Occupational Safety and Health Act, Workers’ Compensation) (U.S. Department of Labor, 2014). Additionally, U.S. healthcare
organization regulation occurs through the requirements on governmental reimbursements (e.g., Medicare, Medicaid) (Nesvisky, 2014). The implementation of the Affordable Care Act and Health Insurance Marketplace engaged additional challenges for a more efficient delivery system through broad changes in Medicare and Medicaid while testing new modes of payment and service delivery (Rosenbaum, 2011).

At the community/organizational level, community and organization change occurs related to societal and shared experiences. Viewpoints change related to historical events (e.g., New York City Trade Towers destruction, Middle East Gulf wars), philosophical views (e.g., feminism, pragmatism), and other social and cultural norms (Thomas & Inkson, 2009). It is in the community and organizational settings that social relationships occur and these settings may potentiate or deescalate WPB behaviors, aggression, and violence (Centers for Disease Control and Prevention [CDC], 2002).

At the relational level (e.g., peer, family, organization support), the modifying variables may influence employment decision and whether the novice nurse adopts WPB behaviors against the next generation of novice nurses. The relationship level creates the occupational stressors or buffers the stressor by influencing appraisal and coping at the individual level by what friends, family, peers, and the organization say or do regarding the stressful event (Lakey & Orehek, 2011). Although biological and personal history factors (e.g., age, education, prior history of bullying, trait anxiety, perceived stress, coping styles, interpersonal trust) are measurable, the personal characteristics and personality do not always predict effective or ineffective coping mechanisms (Lazarus & Folkman, 1984).

At the individual level, biological and personal history (e.g., prior history of child abuse, WPB, or intimate partner violence; age; education; income; gender; health) are used to determine
risk factors associated with being a target of WPB behaviors. Again, the individual level also is influenced by the community and organizational changes and culture.

In the healthcare environment, the global economy influences the social context of behavior, including institutional and cultural variables (Sallis, Owen, & Fisher, 2008). Economic pressures may produce nursing shortages with reorganization causing layoffs. The resultant shifting of managerial roles creates more stress in a restrained economic environment of healthcare (Stanley, Martin, Michel, Welton, & Nemeth, 2008). Understanding these influences of society and culture creates an understanding that there is no “us” or “them” in the workplace sandbox.

Recognizing the influence between societal, community/organizational, relationship, and individual levels helps to explore the root causes that lead to behaviors. Governmental laws push down to healthcare organizations creating organizational change and stress. Organizational stress and change push further down into the unit level and to employees. WPB behaviors may develop from the stress of organizational change to governmental demands (CDC, 2002; Gates, 2001).

WPB behaviors are occupational stressors that interact with novice nurses’ state anxiety and the stress with learning their new role as a nurse (Fink, Krugman, Casey, & Goode, 2008; Tuckey, Dollard, Hosking, & Winefield., 2009; Zapf & Gross, 2001). Novice nurses use appraisal, coping styles, and use of social support to navigate through these multiple stressors to manage their work and maintain their current position. WPB behaviors as an individual stressor are easier to understand using Gates’ Framework for Coping and Stress (Gates, 2001) at the relationship and individual levels (Figure 1).
Table 1: Socio-Ecological Model for Studying Workplace Bullying

<table>
<thead>
<tr>
<th>Societal</th>
<th>Community/Organizational</th>
<th>Relational</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social norms and values</td>
<td>Social norms, values, beliefs</td>
<td>Family/Partner</td>
<td>Knowledge, skills, abilities</td>
</tr>
<tr>
<td>Culture</td>
<td>Education and surveillance</td>
<td>Outside peers</td>
<td>Coping styles</td>
</tr>
<tr>
<td>Health policies</td>
<td>programs</td>
<td>Professional peers</td>
<td>Personal history</td>
</tr>
<tr>
<td>Economic policies</td>
<td>Organizational control</td>
<td>Supervisor</td>
<td></td>
</tr>
<tr>
<td>Educational policies</td>
<td>Job tasks</td>
<td></td>
<td>Past history</td>
</tr>
<tr>
<td>The Joint Commission Standard</td>
<td></td>
<td></td>
<td>Other characteristics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Perceived norms, role, beliefs</td>
</tr>
</tbody>
</table>

(Adapted from CDC, 2002; Krug et al., 2002)
**Gates’ Coping and Stress Model.** Nested at the relational and individual levels of the Socio-Ecological Model, Gates’ (2001) Coping and Stress Model was used as the framework to study WPB exposure (Figure 1). Gates’ (2001) model developed through research with nursing assistants and contemporary research on stress and coping. Novice nurses have a high stress level entering into a new environment (Fink et al., 2008). Gates’ (2001) model provided the micro-level framework to explore coping and stress of WPB behaviors at the relationship and individual levels (Figure 1).

**Cognitive Theory of Psychological Stress and Coping.** Gates’ model drew from Lazarus and Folkman (1984) Cognitive Theory of Psychological Stress and Coping. Work stress creates harmful physical and emotional responses when there is a conflict with job requirements and the capabilities, resources, or needs of the worker (Gates, 2001). Employee conflict, incivility, WPB, and violence may be the outward behaviors of the physical and emotional responses to the daily hassles of work and personal stress (Di Martino, 2003).

The novice nurse’s personal interpretation of WPB behaviors as a stressor will determine outcomes including whether he or she successfully stops, navigates through unscathed, or becomes a victim. Likewise, the novice nurse’s cognitive and behavioral actions (coping) to those internal and external demands will resolve, deflect, or cause increasing distress in response to WPB behaviors (Folkman, Lazarus, Gruen, & DeLongis, 1986; Larrabee et al., 2010; Lazarus & Folkman, 1984). The modifying variables of family, peer, and organizational support potentiate, disable, or modify personal interpretation (appraisal) and coping styles to WPB (Lakey & Orehek, 2011). These groups provide the social identity and interpersonal support that buffer or modify the novice nurse’s perception of WPB as a work stressor (Di Martino, 2003; Folkman et al., 1986; Zapf & Gross, 2001).
In examining the stress effect patterns of hospital staff nurses (n=260), Hillhouse and Adler (1996) found there were three nursing groups with unique stress effect patterns even though the cohort was homogenous. The first group had low stressor/low stress effect with high social support (31.5%). The second group (43%) had high scores on some of the nursing stress scales, but low scores on perceived social support and high stress with physician conflict. The last group (26%) had high stressor/high stress effect with low unit social support. Social support of peers, family, and the organization are moderating variables in coping styles. Novice nurses need that social support and positive personal interaction to maintain their position within an organization and in nursing.

Gates’ Coping and Stress Model (2001) was used as a framework to examine the individual characteristics of the targets exposed to WPB behaviors. Lazarus and Folkman’s (1984) Cognitive Theory of Psychological Stress and Coping as well as the Social Exchange Theory (Blau 1968; Emerson, 1976; Homans, 1983) were used to further explain the impact of social support, trust, and reciprocity in the appraisal, coping styles, and social support within the work environment. Lazarus and Folkman’s (1984) theory recognizes the encounters or transactions in cognitive appraisal and coping as critical mediators of stressful person-environment relationships with both immediate and long-term outcomes (Folkman et al., 1986). Likewise, Social Exchange Theory (Blau 1968; Emerson, 1976; Homans, 1983) looks at the transactions as a cost-benefit analysis on equity of reciprocity.

**Social Exchange Theory.** Social Exchange Theory (Blau, 1968; Emerson, 1976; Homans, 1983) has been used by social psychologists and sociologists to explain social behavior. A simple explanation of Social Exchange Theory is that in any relationship, there is a cost-benefit analysis done to determine if social exchange is equitable. Two elements of Social
Exchange Theory were applied to this study: (1) reciprocity or trust and (2) power in exchange. The way a person acts is contingent on the rewarding actions of others, resulting in mutually rewarding relations (Cropanzano & Mitchell, 2005). When there is an uneven exchange, stress in exchange occurs, causing one individual to have power over another (Emerson, 1976). Stated succinctly, the organizational culture influences the behavior of its employees interpersonally and towards the organization based on positively or negatively perceived organizational support, justice, and reciprocity.

A major concept of Social Exchange Theory is the building of trust that occurs in each interaction between the actors (Emerson, 1976). An assumption of reciprocity is as people treat each other equally in exchange; they help each other (Parzefall & Salin, 2010). A balanced reciprocity in the exchange means the nurse will experience less WPB behaviors and continue employment, have decreased intent to leave employment, and express positive job satisfaction. The nurse needs to trust other employees and the organization that he or she will receive favorable treatment without a contract (Cropanzano & Mitchell, 2005). However, when the exchange is uneven, or perceived as uneven, the greater the perceived inequity, distress, and power imbalance (Arries, 2009).

**Philosophical perspective.** Blau (1968), Emerson (1976), and Homans (1983) were the key theorists for Social Exchange Theory. Skinner (1971) a psychologist who promoted behaviorism, learned behavior, and behavior measurement influenced these theorists Lazarus and Folkman’s (1984) Cognitive Theory of Psychological Stress and Coping also is rooted in the same psychology of stimulus-organism-response background (Lazarus, 1999; Lazarus & Folkman, 1984). The philosophical underpinnings of both theories are deductive, strongly postpositivist, and pragmatic.
This dissertation used Gates’ Stress and Coping Model (Gates, 2001) as a framework to explore the effects of WPB as a chronic stressor and its effects on employment choices and psychological outcomes. Lazarus and Folkman’s (1984) theory was used to further understand and explain appraisal and social support processes that buffer novice nurses from adverse outcomes. Social Exchange Theory (Blau 1968; Emerson, 1976; Homans, 1983) offered another explanation on power in relationships through reciprocity and trust.

Summary of Theoretical Framework

Because it was crucial to understand individual, relationship, community/organizational, and societal levels, the Socio-ecological Model (Krug et al., 2002) was used to discuss the overarching societal and economic pressures at the community/organizational level. In turn, organizational stress interactions with at the relational and individual levels creating different realities and perceptions of WPB behaviors and its causes within an organizational culture and unit. Individual perceptions create a fragmented view when assessing behaviors at the individual level when there are complex dynamics and behaviors within the organization and unit promoting WPB behaviors. Gates’ Stress and Coping Model (Gates, 2001) was used as a framework to explore WPB as a chronic work stressor guided by Lazarus and Folkman’s (1984) Cognitive Theory of Psychological Stress and Coping and Social Exchange Theory (Blau, 1968; Emerson, 1976; Homans, 1983). This approach provided insight as to the effectiveness or ineffectiveness of coping styles and social support in the socialization of novice nurses into an organization.

Review of Literature

WPB is an internationally recognized problem in healthcare. In healthcare, organizational profitability hinges on how well nurses “care for” their patients (Stanley et al., 2008). Senior
leaders need to endorse and support programs that educate, train, communicate, monitor, and stop disruptive behaviors (Rosenstein & O’Daniel, 2008). There are common societal antecedents that interplay together which influence organizations, perpetrators, and targets. Most of these societal antecedents go unrecognized by those nurses in the midst of a bullying culture.

Multiple lenses provide a way to describe, explain, or mitigate the reasons why WPB continues (Speedy, 2006). The context within each organization is as different as are the individuals involved in WPB behaviors. WPB behaviors can be multi-directional, as subordinates can bully up as well as supervisors bully down (Duffy, 2009). Likewise, targets are sometimes powerless to alter the course from lack of training or socialization to expect abusive treatment (Dyess & Sherman, 2009; Griffin, 2004; Hutchinson et al., 2010; Lewis, 2006).

The interpersonal human interaction within the organizational environment can sustain chronic WPB by ignoring, enabling, or rewarding the perpetrators (Hutchinson et al., 2010). Conversely, education and promotion of coping and social support styles may lead to job retention without the adverse consequences of poor patient outcomes, physical or psychological strain through self-efficacy (Gates, 2001; Giblin & Lakey, 2010; Lakey & Orehek, 2011). The personal interpretations of WPB as a social norm, daily hassle, or stressor, create the individual coping styles (mediators), and use of support systems (moderators) which may potentiate, prevent, or buffer the employees’ (or nurses’) experience with WPB (Berry et al., 2012; Larrabee et al., 2010).

In 1974, Kramer documented novice nurses’ adverse socialization as more bachelor prepared nurses began to flow into an environment of heavily diploma-trained tenured nurses. Negative behaviors continued in the socialization of novice nurses into the unit culture (Benner, 1984; Cox, 1987; Kramer, 1974). Because of socialization, WPB behaviors may go
unacknowledged by the perpetrator and adopted as a social norm by novice nurses. Adverse enculturation continues today as peers and tenured nurses socialize novice nurses using WPB behaviors that minimize and silence concerns expressed by novice nurses.

The Organization

An organizational culture does not emerge instantly or by accident, but evolves over time and mentally programs its members through interactions with each other and the environment (Thomas & Inkson, 2009). Nurses have accepted or rationalized the verbal aggression from patients, peers, and physicians as part of that stressful environment (Bigony, Lipke, Lundberg, McGraw, Pagac, & Rogers, 2009; Cox, 1987; Cox & Kerfoot, 1990; Dunn, 2003; Lewis, 2006; Rowe & Sherlock, 2005). Nurses have been socialized to the expectation that verbal aggression, and even physical violence with injuries, are a normal part of the job. The organizational culture must change to ensure the physical and psychological safety of nurses. The paradigm is shifting from exclusive patient safety to the intertwining of patient safety to nurse physical and psychological safety (Lucian Leape Institute, 2013).

Organizational practices and procedures used to increase profitability may also unintentionally harm employees by creating an oppressive, demeaning, bureaucratic organizational culture (Einarsen et al., 2011; Salin, 2003). Through its leadership, an organization manages its workforce and influences employees through social context, culture, and the economic climate of doing business (Einarsen, Hoel, Zapf, & Cooper, 2003; Gates, 2001). Skogstad, Einarsen, Torsheim, Aasland, and Hetland (2007) found that work environments with a variety of job stressors with destructive forms of leadership help explain the presence of WPB within an organization. Most healthcare facilities are hierarchical in their organization structure.
Large, hierarchical organizations have a higher prevalence of bullying (Grubb et al., 2005). It is within these hierarchical organizations that novice nurses are socialized into the profession. The healthcare industry and nursing profession are considered chronically stressful occupations and one of the more stressful work environments with a higher prevalence of WPB than other professions (Di Martino, 2003; Hillhouse & Adler, 1996). As an example, a 2014 national survey of the general population (N=1000) indicated 27% of Americans had experienced abusive conduct in the past year (Workplace Bullying Institute, 2014). In 2010, 44.7% (n=88) of novice nurses self-identified as a target with over 70% (n= 149) experiencing or witnessing WPB behaviors within one month of the 2010 study (Berry et al., 2012).

Prior research with U.S. healthcare samples have mainly focused on ways to decrease and protect employees from physical violence (Grubb, Roberts, Grosch, & Brightwell, 2004). The focus has changed towards the psychosocial aspects of the work environment. WPB research is now driven by the enormous physical and psychological costs to employees and employers (Hill & Joyce, 2013).

**The Use of a Workplace Violence Typology**

WPB research has lacked standardized definitions and use of a standard tool (Zapf, Escartin, Einarsen, Hoel, & Vartia, 2011). Workplace bullying is indirect and direct human aggression stemming from employment. Not all human aggression is violent with the intent to harm someone physically but may be used to socialize the novice nurse into the organizational culture. WPB behaviors also are psychological harassment between employees (Brodsky, 1976; Di Martino, 2005; Randall, 2001). Two defining characteristics of WPB are it occurs because of employment, and employees are the targets and perpetrators.
Both physical and psychological behaviors are on a continuum of human aggression. WPB behaviors may still escalate from incivility and conflict and lead to physical violence and death (Anderson & Pearson, 1999; Caza & Cortina, 2007). Because the escalation can lead to physical violence and death, the Typology of Workplace Violence (NIOSH, 2004) was reviewed to determine the fit of WPB within that typology.

**Typology of violence.** NIOSH (2004) defined four types of violence in the workplace. Table 2 provides a summary of this typology. Type 1 violence is criminal intent (e.g., a person goes into a pharmacy to rob it, threatening, injuring, or killing the pharmacist). Type II violence is customer to employee violence (e.g., a nurse is beaten by a delusional patient, verbally threatened by family or visitors). Type III violence is employee-to-employee violence (e.g., a terminated employee kills the terminating manager; a fistfight occurs after increasing conflict between two employees). Type IV violence is when an intimate partner of an employee invades the work area (e.g., husband confronts wife in office, beating or killing her and coworkers). WPB comes under Type III of NIOSH’s workplace violence typology of employee-to-employee violence.

As a comparison, Bowie (2002) suggested the need to change the typology of violence to include psychological violence and harassment. A parallel typology inclusive of psychological violence emerged similar to the NIOSH (2004) typology. Table 2 presents a summary of this typology. The expanded workplace violence typology (Bowie, Fisher, & Cooper, 2005) is more inclusive of the outside violence that surrounds an organization. Type 1 is external/intrusive violence (e.g., terrorist acts, protests, random violence). Type 2 is consumer-related violence (e.g., vicarious trauma to staff, staff violence to clients). Type 3 is relational violence (e.g., worker-on-worker conflict, violence, incivility, WPB). In addition to staff-on-staff violence and
bullying, third party violence such as terrorist acts, domestic violence, and sexual harassment were added. Type 4 is organizational violence (e.g., against staff, against consumers, clients, patients) (Bowie et al., 2005). Again, WPB comes under Type 3 violence in this expanded violence typology.
<table>
<thead>
<tr>
<th>Typology</th>
<th>Sub-Typology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I: Criminal intent</td>
<td>Type 1: Intrusive violence</td>
</tr>
<tr>
<td>Criminal intent towards robbery</td>
<td>Criminal intent by strangers</td>
</tr>
<tr>
<td>Terrorist acts</td>
<td>Mental illness or drug related aggression</td>
</tr>
<tr>
<td>Protest violence</td>
<td></td>
</tr>
<tr>
<td>Type II: Customer/Client</td>
<td>Type 2: Consumer-related violence</td>
</tr>
<tr>
<td>Occurs in conjunction with normal job</td>
<td>Consumer/client/patients (and family)</td>
</tr>
<tr>
<td>May be constant or routine (e.g. police)</td>
<td>Violence against staff</td>
</tr>
<tr>
<td></td>
<td>Vicarious trauma to staff</td>
</tr>
<tr>
<td></td>
<td>Staff violence to clients/consumers</td>
</tr>
<tr>
<td>Type III: Worker-on-worker</td>
<td>Type 3: Relationship violence</td>
</tr>
<tr>
<td>Employee or former employee</td>
<td>Staff-on-staff violence and bullying</td>
</tr>
<tr>
<td>Caused by interpersonal or work related disputes</td>
<td>Domestic violence at work</td>
</tr>
<tr>
<td>Type IV: Personal violence</td>
<td>Type 4: Organizational violence</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>Organization violence against staff</td>
</tr>
<tr>
<td>Perpetrator usually not employee</td>
<td>Organization violence against consumers/clients/patients</td>
</tr>
</tbody>
</table>
There are many descriptors for aggressive behaviors in the workplace. The descriptors depend upon the researcher’s perceptions, attitudes, cultural background, paradigms, and operational focus (e.g., supervisor-to-employee, employee-to-employee, employee-to-supervisor, employee-to-company) which has further complicated a uniform descriptor of WPB (Di Martino, 2003). WPB behaviors are described as abusive supervision (Tepper, 2000); lateral violence, horizontal violence and oppressed group behavior (Dellasega, 2011; Griffin, 2004; Longo, 2007; Roberts, 1983; Skillings, 1992; Vessey et al., 2009); emotional abuse (Keashly, 2001); indirect, relational, and social aggression (Archer & Coyne, 2005); worker harassment (Brodsky, 1976); mobbing (Leymann, 1990); verbal abuse (single behavior) (Cox & Kerfoot, 1990; Rowe & Sherlock, 2005); disruptive behaviors (The Joint Commission, 2008); and incivility (Anderson & Pearson, 1999; Caze & Cortina, 2007).

Workplace incivility is single negative acts with an ambiguous intent to do harm (Anderson & Pearson, 1999). However, persistent incivility can lead to increasing, escalating interpersonal conflict, WPB, and violence (Anderson & Pearson, 1999; Hutton & Gates, 2008; Zapf & Gross, 2001). In some cases, persistent incivility may be seen as low intensity WPB (Einarsen et al., 2003). Before reviewing WPB nursing research, WPB is defined and its constructs discussed.

**Workplace Bullying Defined**

WPB is human aggression in the workplace (Archer & Coyne, 2005). WPB behaviors are carefully tailored in a creative and flexible way towards the target that takes away the power to defend against such acts (Cleary, Hunt, & Horsfall, 2010). Single acts of WPB are symptoms of an incivil work environment and are not considered WPB (Einarsen et al., 2011). These negative
behaviors may not be targeted. However, describing and measuring the WPB behaviors are important for linking consequences and providing a further understanding of WPB.

Rayner (1997) placed WPB behaviors in categories of threat to professional status, personal standing, isolation, overwork, and destabilization. Einarsen et al. (2009) placed WPB behaviors in three distinct subscales: work-related bullying (withholding information affecting performance, ordered to work below level of competence, opinions ignored, unreasonable deadlines, micromanagement, wage and hour rights ignored, unmanageable workload), person-related bullying (being humiliated or ridiculed, gossip, social exclusion, insults, hints to quit, being ignored, practical jokes, allegations of misconduct, excessive teasing or sarcasm), and physical-intimidation bullying (being shouted at, intimidated, threats of violence or physical abuse).

When measuring WPB behaviors, the subjective experiences of the target determines if the negative acts are WPB (Einarsen et al., 2011). From the target’s perspective, WPB behaviors are difficult to defend against related to an imbalance of power between the target and the perpetrator (Einarsen et al., 2011). A six-month timeframe is used to measure WPB for several reasons, even though targets may immediately perceive they are being bullied (Einarsen et al., 2011). WPB is not a one time act of incivility or personal conflict (Einarsen et al., 2011). WPB is a repeated and escalating process that becomes more frequent over time (Einarsen et al., 2011). In addition, Einarsen et al. (2011) state that severe bullying should have a duration of at least six months for measurement criteria.

**WPB Constructs**

To link consequences to WPB, a consistent measure must be used to quantify WPB behaviors and the frequency of exposure. For the purposes of this dissertation, the NAQ
(Einarsen et al., 2009) was used as a measure of WPB behavior exposure from respondents’ self-report of 21 different types of WPB behaviors directed toward them, as well as, respondents self-labeled themselves as “bullied.”

Einarsen et al.’s (2011) foundational constructs were used to provide context in building an argument on the differences associated between incivility, work conflict, and WPB. These constructs were built on mainland European research prior to the British, Australian, and U.S. recognition of this adverse work behavior. Based on Einarsen et al. (2011), the constructs to identify WPB are: target orientation, frequency, duration, intentional nature of the behavior, and imbalance of power. Each construct was discussed and demonstrated using the narratives from Berry et al.’s (2012) unpublished study findings. Lazarus and Folkman (1984) Cognitive Theory of Psychological Stress and Coping as well as the Social Exchange Theory (Blau 1968; Emerson, 1976; Homans, 1983) were used to illuminate and explain behaviors and situations within these constructs.

Berry et al. (2012) used an internet-based descriptive, cross-sectional design to determine the prevalence of WPB and the effects of WPB on work productivity. Nurses (n=197; 91.4% female) practicing less than three years wrote narratives describing WPB events. Respondents completed the Healthcare Productivity Survey (Gillespie, Gates, & Succop, 2010), NAQ (Einarsen et al., 2009), and a demographic survey. These respondents also documented the negative behaviors directed towards them over the last six months and self-labeled as, or not as, targets of WPB behaviors.

**Target Orientation (Self-Labeling).** Targets determine when WPB occurs (Einarsen et al., 2011). Out of 197 completed surveys (Berry et al., 2012), 46.6% (n=88) of respondents reported “yes” as bullied. After a weighted score based on the frequency of negative acts (never
was assigned, 21.3% (n=43) of novice nurses experienced WPB behaviors on a daily basis. When novice nurses scored higher weighted WPB exposure sums and answered “yes” to being a target of bullying, the more negative the impact to novice nurses’ productivity by a single WPB event (Berry et al., 2012).

There are different events or acts that occur on a daily basis in any work environment that are not WPB behaviors. Lazarus and Folkman (1984) refer to these events as daily hassles. The specific actions that may appear to be adverse to a new employee are merely accepted occupational stressors that have become a norm in that work unit (Krug et al., 2002).

**Frequency.** WPB is persistent and repetitive negative action(s) (Einarsen et al., 2011). As an example, every Friday night one or more employees may call off work due to illness. The supervisor assigns a heavier workload than expected to the novice nurse, because there is not enough staff to cover the absences. This is not WPB but work overload due to inability to sufficiently staff the department. However, assigning an unmanageable workload on a daily to weekly basis compared to other staff and micromanaging the nurse is WPB. All exemplars were taken from unpublished data from Berry et al.’s (2012) study. A 24-year-old female respondent relates this experience of assigning heavy workloads with micromanagement:

> “Being a new nurse, there is one nurse who continues to give more intense assignments to the new nurses. In this instance, I have struggled on those nights and felt overwhelmed and stressed out. It has been verbalized that they do this on purpose because it is a "initiation" phase for new nurses. The same nurse deems it okay to go in to my patient rooms and do assessments on my patients. It feels as if he does not trust me because I am a new nurse and am new to the hospital. The incidents that have caused the most stress were the nights where I purposefully received a harder assignment. The entire shift I was on edge and felt like a bad nurse and incompetent.”

A behavior not easily placed in the frequency category of repeated behaviors is rumors or gossip (Einarsen et al., 2011). The perpetrator may start a rumor without the intent of harming
the other employee but to increase political standing (Archer & Coyne, 2005). The perpetrator might not repeat the rumor, but others do. As the rumor spreads, the target may be socially isolated with the withdrawal of peer social support as the rumor gathers strength and changes peer relationships (Einarsen et al., 2011).

The target may be unaware of the rumor until peer or organizational relationships have changed significantly. A power imbalance is created for personal or political gain by rumor, increasing the “power” of the perpetrator over the target (Einarsen et al., 2011). Nurses have recognized that WPB occurs for individual and political reasons (Katrinli, Atabay, Gunay, & Cangarli, 2010). From the unpublished data, a 22-year-old female respondent wrote about rumors:

“Rumors were a huge issue on the unit I worked on. The nurses were single moms in their mid 30's, in the process of getting a divorce or even married. They began hanging out with many of the new younger male and female nurses who were in their 20's outside of work. They would bring stories from nights out back to the workplace and tell others that were not involved. This would create mass rumors throughout the work environment. I believed this was completely inappropriate since many of the rumors had to do with drinking and doing things that could cause the nurse in question to lose their jobs. It created tension and people not wanting to meet or hang out with people outside of work which I believe can be very beneficial to unit team development.”

**Duration.** The duration of the negative behaviors distinguishes WPB from other occupational stressors or incivility. Exposure to an unmanageable workload may be an intermittent occupational stressor related to illness, staffing issues, or learning needs. A novice nurse has not learned the prioritizing skills associated with what might be a normal workload for more tenured nurses (Dyess & Sherman, 2009). Leymann (1990) established the six-month period with Einarsen et al. (2003) justifying the six-month period to distinguish WPB from other occupational stressors. A six-month period does not mean WPB is limited to only that period. Vessey et al. (2009) documented targets enduring WPB on average 18 months. When the target
believes an unmanageable workload is intentionally and consistently assigned over a six-month timeframe, the adverse workload is WPB. The situation is unsafe for the novice nurse and the patients. Although a timeframe is not in the scenario, the threat of misconduct for voicing protocol conflict on patient/staff ratios is apparent in this example given from the unpublished data by a 41-year old female respondent:

“On a particular shift in a locked inpatient psych unit, the staffing to patient ratio was too high, and was less than the unit's protocols. When I brought it to the attention of the unit manager, she proceeded to inform me that the ratios were merely guidelines and if I didn't clock in and accept my assignment then I would be written up and reported to the Board of Nursing for abandonment. I did clock in and took my unsafe assignment and begged other staff to stay a few hours late. Later that day the manager called me into her office and told me that the staffing is as good as it will ever get (17 patients with 3 staff on an acute forensic adolescent unit) and if I couldn't accept it then I needed to move on. I also witnessed other nurses being threatened and terminated for also speaking up about staffing ratios.”

**Intentional.** WPB is intentional from the target’s perspective. Einarsen et al. (2011) state that only the perpetrator can verify intention, given the perpetrator the power to deny the intentional behaviors to harm the target. With incivility, there is an ambiguous intent to do harm (Anderson & Pearson, 1990; Hutton & Gates, 2008). In an incivil environment, there may be also deniability regarding intent to harm from a predatory perpetrator until the damage is irrevocable (Einarsen et al., 2003). Because of this, the target’s perception of intention is used, not the perpetrator (Einarsen et al., 2003; Einarsen et al., 2011; Leymann, 1990). In this exemplar from unpublished study data, a 31-year-old female respondent observes behaviors as intentional:

“The individual being bullied was another female nurse approximately 24 years old. Being new on the unit I noticed the older nurses had a tendency to be "too busy" to answer her questions or help her with tasks that involved at least two nurses (for example - turning and positioning patients). The other nurses failed to give her the same assistance that they give each other on a daily basis. She
expressed to me her frustration about the lack of help and feeling like she wasn't made to feel welcome on the unit.”

**Nature of the Behavior.** Reasons for violence are categorized as moral, ritualistic, recreational, and predatory (Black, 2004). The same may be true for WPB behaviors. Einarsen (1999) stated that at least two types of bullying occur: dispute-related and predatory bullying. Hostile aggression can occur in an escalating conflict for moral reasons (Bjorkqvist, 1994; Neuman & Baron, 2011). There is also a likelihood of unintentional harm playing a larger role when associated with the work environment through instrumental aggression, which is an aggressive act to obtain something of value (Neuman & Baron, 2011), similar to Black’s (2004) predatory violence. The perpetrator may use WPB not to harm the target, but to achieve political power in an organization (Ferris, Zinko, Brouer, Buckley, & Harvey, 2007; Zapf & Einarsen, 2011).

Social norms also may play a role in shaping or reinforcing WPB behaviors (Hutchinson et al., 2010; Neuman & Baron, 2011). A social norm is a spoken or unspoken rule or particular way of doing things (e.g., driving on the right side or left side of the road) which imposes the expected behaviors among a group (Bicchieri & Muldoon, 2011). WPB may have a long history in an organization (e.g. military, paramilitary, nursing) rooted and unrecognized as socialization through indoctrination of the new employee, or ritualistic initiations (Black, 2004; Kramer, 1974). WPB behaviors may be instrumental aggression used to mold the novice nurse into the culture and may not be recognized as WPB behaviors by the perpetrators.

Hutchinson et al. (2010) used data from a sequential mixed methods design study to test a multidimensional model of bullying using individual, work group, and organizational factors to determine critical antecedents of bullying. Using confirmatory factor analysis with structural equation modeling and maximum likelihood estimates, Hutchinson et al. (2010) found that
informal organizational alliances along with organizational tolerance, reward, and misuse of legitimate authority, processes, and procedures led to WPB in healthcare. Hutchinson et al. (2010) suggested a model with socialization processes within nursing normalized WPB behaviors. Nurse socialization ensured minimization and under-reporting of WPB behaviors and may well be the reason for underreporting by U.S. nurses on violent behaviors or injuries.

A strong predictor of adopting WPB behaviors is exposure to WPB behaviors (Hauge, Skogstad, & Einarsen, 2007). In a sample of Canadian general workers who said they were bullied (40%, n=180), 20% of bullied employees used WPB behaviors to stop the bullying (Lee & Brotheridge, 2006). Bullied respondents in three nursing studies also confirmed they bullied others (Vessey et al., 2009; Yildirim & Yildirim, 2007; Yildirim, Yildirim, & Timucin, 2007).

Given the tendency of nurses exposed to WPB behaviors to adopt WPB behaviors, there may be concerns that nurses hardened by WPB behaviors may cause nurses to act in a similar manner towards patients (Hoel, Giga, & Davidson, 2007; Randle, 2003; Smith & Cowie, 2010). Randle (2003) noted that student nurses adopted the norm of their collective working group, instead of challenging WPB behaviors. Students were not the only targets humiliated, belittled, or isolated by tenured nurses. Student nurses observed tenured nurses humiliating and belittling patients (Randle, 2003).

Using the example of the “unmanageable workload,” this behavior may have started as a way of acclimating the novice nurses to work environments with frequently uncontrollable job tasks based on unstable medical conditions as a way of hardening the nurse to the task. Some nurses may refer to this as “paying their dues,” “initiation,” or “rites of passage” (Kramer, 1974).

A 32-year-old female respondent describes a similar situation:

“Another new nurse that is the weaker of the 4 of us that all started together, is always talked about behind her, comments like she not as good as the others. She
is 52 last week she had a full (patient) load (five patients) that were trying. She was running around like her head was chopped off, asking for help, the charge nurse, female 50's, said leave her be, she can sink or swim, wouldn’t talk to her. It was stressful for everyone working, we were told to leave her be, she was crying at one point. I helped her as much as I could but I had my own (patients).”

**Imbalance of Power.** There is a power difference between the perpetrator and the target. WPB is not a conflict between opponents of equal strength but an escalating process where the target perceives being in a powerless position and cannot defend against the bully’s actions (Einarsen et al., 2003; Salin, 2003). Salin (2003) states power imbalances align with the overall societal beliefs about powerless people (e.g. female gender, minority status, age, people with physically or mentally challenges) and these same societal beliefs flow into organizational cultures. An exemplar on power imbalance occurred between a 45-year-old respondent and Director of Nursing (DON) from unpublished study data:

> “Myself and my staff were strong armed into having 8-9 (patients) and learn/teach a new medication administration system requiring several hours of training. I was not only relieved of my duties in order to train as instructed by the med technicians but was expected to train and continue care of my own 8 pts. I requested help three different times and was ignored until the time came to go live with the new medication software. Upon directing my request to my immediate supervisor a final time I was ignored and my DON stated that she felt I was being unwilling to do my job. I was very upset with the situation and the way it was poorly handled and resigned my position at the hospital never to work for them again. Not only was I ignored and refused but was downgraded as a someone who simply didn’t want to cooperate and do my job. This was completely unsatisfactory to me.”

Another way of looking at power imbalances at the individual level is through reciprocity via the Social Exchange Theory (Blau 1968; Emerson, 1976; Homans, 1983). The interpersonal power of the perpetrator increases through the imbalance of reciprocity (rewards or exchanges) when the target is dependent on the perpetrator for job security, knowledge, guidance, job assignments, direction, or support (Blau, 1987). Rather than be place in a powerless position in this exchange, she quit her position.
Summary of the WPB Construct

The constructs forming WPB are target orientation, frequency, duration, intentional nature of the behavior, and imbalance of power. To measure WPB, the target must perceive that he or she is the target of intentional, frequent and systematic negative actions over a minimum of six months with an inability to defend against those behaviors related to the perceived power difference between the target and the perpetrator (Einarsen et al., 2011).

Workplace Bullying Prevalence

Depending on the country, culture, and how WPB was operationalized and defined (e.g. single question, behaviors, frequency, duration), prevalence is estimated to vary between 2% to 54% of the working population (Zapf, Einarsen, Hoel, & Vartia, 2003). In 2011, Zapf et al. (2011) compiled a WPB prevalence of the working population ranging from 1% to 86.5%.

A Problem with Measurement

Unless a consistent approach is used to measure WPB, estimating WPB prevalence in nursing will vary. Studies using the NAQ (Einarsen et al., 2009) give a consistent approach to measuring WPB. Laschinger, Grau, Finegan, and Wilk (2010) stated the NAQ was a “gold standard” in determining WPB prevalence. Prior nursing research has been qualitative or descriptive cross-sectional regarding prevalence, intent to stay, and consequences, and has been useful in describing the problem of WPB in nursing.

WPB prevalence will vary to the measurement tool used, the country, culture, society, organization, individual units in an organization as well as the inconsistent approach to measurement, lack of clear definitions, methodological rigor, and poor response rates (Simons, 2008; Stanley, Dulaney, & Martin, 2007; Stanley et al., 2008; Vessey et al., 2009; Vessey, DeMarco, and DiFazio 2011). Vessey et al. (2011) identified two issues in nursing research: lack
of methodological rigor in nursing research and not examining the full scope of the negative behaviors associated with WPB. There is a gap with consistent, clear definitions, and poor response rates indicating the potential of sampling bias (Vessey et al., 2011). Vessy et al. (2011) attributed these issues to the beginning stages of identifying WPB prevalence as well as the psychological and physical consequences to nurses and to the organizations where nurses work.

Prevalence in Nursing

WPB prevalence in nursing varies from country to country and may be influenced by individualistic or collectivistic cultures (Hofstede, 2011), gender (Valentine, 2001), and conflict communication style (Mahon & Nicotera, 2011). Self-labeling and frequency of negative behaviors are the usual methods of reporting results when using the NAQ. WPB prevalence is grouped by individualistic and collectivist cultures based on Hofstede’s (2011) dimensions of national cultures (power distance, uncertainty avoidance, individualism, masculinity, long term orientation, and indulgence versus restraint). An individualistic culture socializes toward immediate family as social support, independence and taking care of self. The U.S., Canada, New Zealand, and European countries are individualistic cultures based on Hofstede’s (2011) cultural dimensions. A collectivistic culture emphasizes the good of the group instead of the individual. In a collectivistic culture, nonverbal cues weigh more highly than spoken words (Hofstede, 2011). Japan and Turkey are collectivistic cultures based on Hofstede’s (2011) cultural dimensions.

Individualistic culture. In Berry et al.’s (2012) study on 197 novice nurses, over 70% experienced a sentinel WPB event directed towards them (57.9%; n=114) or as witnesses (14.7%; n=29) in the one month prior to responding to the initial survey. In a descriptive study of 303 nurses, Vessey et al. (2009) reported more than 70% of nurses were bullied but there were
no definitions or time frame used. Using the NAQ (Einarsen et al., 2009), a clearer picture developed on the prevalence of nurse WPB.

Using twice weekly as a definition of WPB, in Washington State, Johnson and Rae (2009) reported a prevalence of 27.3% for twice weekly exposure in a population of Emergency Nurse Association members (n= 249). Simons (2008) measured prevalence at 31% of newly-licensed Massachusetts nurses (n= 511). In Berry et al. (2012), 43 (21.3%) novice nurses employed in Indiana, Kentucky, and Ohio experienced daily WPB with 86 (54.7%) self-labeling as a target.

Nurse WPB prevalence was measured at 33% in Canada (Laschinger et al., 2010) and 44% in Great Britain (Quine, 2001). Norwegian assistant nurse WPB prevalence was noted to be 3% (Einarsen, Matthiesen, & Skogstad, 1998). Hogh, Hoel, & Carneiro (2011) reported 9.2% of Denmark healthcare workers being bullied with 1.8% frequently bullied. In New Zealand, McKenna et al. (2003) explored the WPB experiences of RNs in their first year of practice with 31% of novice nurses reporting WPB.

**Collectivistic culture.** Japan is a collectivistic culture where nonverbal cues weigh more highly than spoken words (Hofstede, 2011). Using the NAQ, Abe and Henly (2010) an estimated prevalence of 10.2% (self-labeled) in Japanese hospital nurses (n = 946) in a healthcare organization. Exposure score (using a sum of the frequency of behaviors) was 15.9% (Abe & Henly, 2010). Using a workplace psychological violent behaviors instrument that mirrored the NAQ in most measures (Dilek & Aytolan, 2007), Yildirim (2009) found Turkish nurses had a WPB prevalence of 21% (n= 286). Turkey’s nursing profession is exclusively female by law. Given there are two ways to measure WPB exposure (by exposure to the frequency of the
behaviors directed towards a target and self-labeling as bullied), further explanation is offered under interpretation.

**Limitations in Studying Nurse WPB**

Both Stanley et al. (2008) and Vessey et al. (2009) studies on WPB behavior prevalence were not incorporated in the above review because both studies were descriptive only. Vessey et al. (2009) used a national, self-selected sample of staff RN (n = 212) who voluntarily entered an anonymous electronic survey appended to a continuing education article in *Nursing Spectrum* on WPB. The survey defined bullying as repetitive aggressive behavior by a person with higher position of power. The survey was descriptive with open-ended responses. Stanley et al. (2008) used a descriptive survey to examine lateral violence within one tertiary care medical center. Stanley et al. (2008) found an increased probability of sampling error with poor response rate from a convenience sample of hospital staff nurses (n = 601). Respondents reported observations only and 46% (n = 276) reported lateral violence was a serious problem in the medical center. Until nurse researchers adopt or develop a valid and consistent tool and definitions associated with aggression research, these continued sampling and methodological issues will continue.

**Interpretation.** Using the NAQ does not reduce the confusion on the approach for reporting results. When using the NAQ, researchers should determine a consistent interpretation of results to increase the strength of research results. Interpretation can be problematic. One key negative behavior “being exposed to an unmanageable workload” was eliminated from the results in Johnson and Rae’s (2009) study as this one behavior would have increased the frequency of daily WPB to 26%. Johnson and Rae (2009) indicated the reason for elimination was that unmanageable workload is a part of emergency nursing practice. However, Simons’(2008) and Berry et al.’s (2012) results indicated that a lesser percentage experienced
daily unmanageable workload (12.7% and 8.1% respectively) which may well indicate that emergency nurses frequently experience an unmanageable workload.

There are potentially two ways to interpret the NAQ. The NAQ gives respondents a list of 22 negative behaviors to mark levels of exposure to the behaviors. The negative behaviors are summed to determine an exposure level at a low, moderate or high exposure level. After the behavioral items, a question is asked as to whether the respondent believes they are bullied (also called self-labeling).

**Timeframe.** When discussing prevalence, each study varied on timeframe except for those studies using the NAQ (Abe & Henly, 2010; Berry et al., 2012; Einarsen et al., 1998; Johnson & Rae, 2009; Laschinger et al., 2010; Simon, 2008). The NAQ used a six-month period whereas Dilek and Aytolan (2007) used a 12-month period. Although there has been much discussion on length of time (six months vs. 12 months) and the frequency of behaviors (e.g. one time, once a week, twice weekly, or daily), Leymann (1990), Leymann & Gustafsson (1996), and Einarsen et al. (2011) supports a six-month period for measuring sustained WPB with a frequency of once weekly.

**Moderators.** Quine (2001) was the first researcher to document WPB in the National Healthcare System (NHS) trust. Using 20 negative behaviors culled from literature, respondents answered if there was persistent exposure over the last 12 months. There were no significant differences by age or gender with reports of bullying. Nurses working full time experienced WPB behaviors more than part-time nurses ($\chi^2 = 9.1$, df = 1, $p < .01$). According to Quine, social support was a moderator to the consequences of bullying. When results of nurse perceptions of bullying and social support were split at the median for two groups, there were main effects of
high bullying and poor social support on all outcome variables and interaction (modifying)
effects on job satisfaction, anxiety, depression, and intent to leave.

**Gender.** Nursing is a predominantly female profession. As such, there are female
gendered approaches to working through stressful events (Dellasega, 2011; Valentine, 2001). Women have been socialized towards maintaining interpersonal relationships during stressful situations and use avoidance rather than confrontation (Dellasega, 2011; Mahon & Nicotera, 2011; Valentine, 2001; Whitworth, 2008). Women’s social, personal, and work relationships change due to WPB (Lovell & Lee, 2011). Respondents reported changes in work and family relationships (Yildirim & Yildirim, 2007; Yildirim et al., 2007). WPB creates isolation at work with increased stress causing a “ripple effect” that follows the nurse home, creating more difficulty in maintaining the essential social support outside of work (Lewis & Orford, 2005).

**Mediators.** Mahon and Nicotera (2011) explored the communication styles with work conflict in a group of nurses (n=57). Most of the respondents chose avoidance or withdrawal from conflict in 30% (n=17) of the sample (Mahon & Nicoter, 2011). The authors expressed concern that the avoidance conflict style created a passive-aggressive work unit unable to resolve conflicts. In a review of literature, the ability to confront conflict and work collaboratively are seen in less than 10% of healthcare providers with avoidance being the preferred conflict management style (Mahon & Nicotera, 2011). However, coping styles and social support have been cited as having direct and mediating effects on both the work and non-work conflict as well as physical and psychological symptoms in shift work conflicts in nursing (Pisarksi, Bohle, & Callan, 1998) and general employee populations exposed to WPB (Jóhanndóttir & Ólafsson, 2004).
Summary of Limitations in Studying Nurse WPB

In describing the state of the science for WPB research in nursing, Vessey et al. (2011) attributed research gaps WPB being a new area of research with nursing as a population. Until recent use of the NAQ in the U.S. as a valid and reliable tool to measure WPB, there was little quantitative research on nurses. A consistent approach in the construct and measurement of WPB will assist nurse scientists to illuminate the problem of WPB more clearly and develop programs to assist nurses in recognizing this ongoing problem in their environments of care.

Interventions to Eliminate WPB

There is a dearth of substantive research on the best practice for resolving WPB within and outside of nursing. Stagg and Sheridan (2010) conducted a systematic review of the literature on WPB intervention programs targeted towards nursing and found little evidence of a measurable, systematic approach for the mitigation of WPB. Researchers are now just touching on how to create and sustain measurable results based on best practices, whether incivility or WPB.

Dellasega (2011) states that solving the problem of nurse-to-nurse WPB requires a three step process of education, relation, and integration. Simplistically stated, educate the nurses enacting or experiencing the behaviors; relate the behaviors in some way to what they are or are not doing, in order to reframe to the other nurse’s perspective; and integrate appropriate behaviors through role modeling into the unit. However, WPB is a complex and broad organizational issue. Organizational recognition and ownership of the problem is important to prevent or manage WPB in the private or public sector as well as academia (Mikkelsen, Hogh, & Poggaard, 2011; Saams 2010).
Recognition and education should address specific situations. When novice nurses or newly-hired experienced nurse orient into a new organization, they may be made to feel powerless by more tenured nurses because of the dependency of orientation. Novice and newly-hired experienced nurses depend upon others for information and guidance in the new organization (Griffin, 2004). Griffin (2004) taught cognitive rehearsal as a shield for nurse-to-nurse WPB. Griffin (2004) provided 26 novice and newly-employed nurses a one-hour educational program on impact of lateral violence through didactic lecture on the theories, outward behaviors, and instruction on the uses of cognitive rehearsal when confronted with those behaviors. After the lecture, another hour of role-playing occurred to rehearse what to say or do when confronted with WPB behaviors. Cue cards describing lateral violence and professional behavior were given to the group to carry as reference.

In describing the follow-up to this program, Griffin (2004) stated that confronting the WPB behaviors immediately towards the perpetrator was essential even though it was emotionally difficult for the novice nurses. When novice or newly-hired experienced nurse confronted the perpetrator about the negative behavior, the behavior stopped. After the confrontation, the novice or newly-hired experienced nurse was shunned by the perpetrator for about two weeks in some instances but the negative behaviors did cease. Seventy-five percent of the perpetrators of the lateral violence were surprised that their actions were taken negatively (Griffin, 2004). There is no information as to whether this program continued after data collection concluded although retention for these 26 nurses was high; 91% retained in the first year. Griffin’s program is now widely disseminated by the American Nurses Association to members and marketed to hospitals through nursesbooks.org (American Nurses Association, 2014).
Barrett, Piatek, Korber, and Padula (2009) conducted a six-month process improvement study to identify and improve nurse satisfaction and cohesion on four different patient care areas with low quality indicators on RN-RN interaction subscale of the National Database of Nursing Quality Indicators. Of the 145 RN targeted for team building interventions, individual evaluations through testing on communication styles, and education on lateral violence, 59 nurses participated in the study with 45 nurses finishing all components of the study. There was no significance difference between pre- and post-intervention on the mean scores of “How Well Are We Working Together” measure and group cohesion displayed a median pre-score of 510 that was significantly lower than the post-score (612, \( p = .037 \)). Although results of the National Database of Nursing Quality Indicators displayed improvement, whether these score differences were significant statistically was not addressed.

Barrett et al.’s (2009) analyses of qualitative data revealed some common linkage to the lack of RN satisfaction and turnover. There were tense physician-nurse relationships and communication conflicts between novice and experienced nurses with a chaotic work environment. Nurse leadership was identified as an important aspect of creating order in the chaos with clear and consistent follow-through on what would be unit expectations regarding lateral violence (Barrett et al., 2009). Organizational or leadership ownership was lacking to change the culture.

Dimarino (2011) described the strategic steps taken within one ambulatory center to control bullying behaviors. An education program was conducted on lateral violence with clear expectations on expected professional behaviors and the negative behaviors that would not be tolerated or overlooked. The professional standards were applied to all employees and physicians within the ambulatory care center. Although the interventions were not empirically tested, it is
important to note there was no staff turnover or reported incidences of lateral violence for one year. The owners of the ambulatory care center were fully vested in the elimination of disruptive behaviors from staff and physicians and would bar physicians who did not conform to the professional standards.

Kaplan, Mestel, and Feldman (2010) described their organizational program and implementation in response to The Joint Commission (2008) mandate to define and address disruptive behaviors, highlighting mediation with conflict. It is important to point out that one of the resources used to confront disrespectful behavior was the use of mediated conversations between perpetrator and target. Mediation may work in conflict management, miscommunication, and ambiguous incivility, but not with WPB (Saams, 2010). Power imbalance occurs within the dynamics of WPB, even if both parties start at the same level in a conflict (Einarsen et al., 2011). WPB behaviors are carefully tailored in a creative and flexible way towards the target that takes away the power to defend against such behaviors (Cleary et al., 2010).

*Crucial Conversations* and *Crucial Accountability* promotes structured communication (Patterson, Grenny, McMillan, & Switzler, 2005; Patterson, Grenny, Maxfield, McMillan, & Switzler, 2013) as a tool to address behaviors undermining the safety of patients that also creates the conspiracy of silence associated with human aggression. Maxfield, Grenny, Lavandero, and Groah (2005) recommendations for cultural change in the environment of care encompass personal motivation, personal ability, social motivation and ability, and structural motivation and ability (Maxfield et al, 2005). Maxfield et al. (2005) recognized the key to mitigating the issues silencing nurses’ voices requires effective safe practices, accountability measurement and
tracking, program design and teams for reminders and protocols for accountability, and transparency through dissemination of results.

**Summary of Interventions to Eliminate WPB**

Measurable interventional programs have not been broadly disseminated, most likely due to the beginning stages in recognizing and identifying the consequence of WPB behaviors to the patients, nurses, and organizational profitability. In addition, a systematic process of the evaluation, prevention, and mitigation of WPB behaviors has not been clearly identified. However, Maxfield et al. (2005) make clear that cultural change in the environment of care is necessary to promote improvements in patient safety. Nurse researchers reflect internal individual changes to promote resilience and communication between nurses. Both Maxfield et al. (2005) and Griffin (2004) support perpetrator confrontation on the behaviors to stop WPB reoccurrence. Organizational culture change, internal reflection, and careful communication on behaviors all are needed as WPB behaviors continue to affect the patient and nurse psychological and physical wellbeing through the nurse’s individual perception of physical and emotional safety in an environment attenuated with WPB behaviors.

**Consequences of WPB in Nursing**

The way nurses interact with other nurses and healthcare professionals mirror and affect healthcare organizations’ environments of care. WPB behaviors are a symptom of an unhealthy work environment and affects nurses’ professional and personal lives (Graveson, 1998). Successful patient outcomes are directly related to nurse satisfaction with job experiences. Important aspects of a successful job experience are nursing leadership and support as well as nurse-physician communication (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken et al., 2015).
Novice nurses may hire into unhealthy organizational cultures that do not consider the physical and psychological safety of their employees. Some organizational cultures and units knowingly or unknowingly use WPB behaviors in orienting staff to the system and unit culture. When the environment of care is attenuated with WPB, a cycle of emotional exhaustion, burnout, and attrition may occur weakening nursing care of the patient. Just as nurses’ cognitive abilities are affected when traumatized by violence, nurses who are bullied also report decreased cognitive abilities and ability to handle their work load (Berry et al., 2012; Cox, 1991; Gates et al., 2011; Laschniger et al., 2010).

**Psychological Consequences**

Nurse researchers have reported psychological consequences due to WPB. Depression was a common consequence of WPB in nursing. In Turkey, 45% (n=130) of bullied nurses tested positive for moderate to severe depression (Yildirim, 2009). Suicide was considered an option to escape WPB in 10% (n=7) by the targets of another study (Yildirim & Yildirim, 2007). Quine (2001) noted significant statistical differences between nurses not bullied and bullied in clinical levels of anxiety (n=34%, n=59) and depression (8%, n=14). Increased stress levels by 83% (n=143) were recorded (Quine, 2001). Vessey et al. (2009) described that 56% (n=107) of their sample reported depression with 90% (n=191) experiencing moderate to severe stress when bullied. Psychological problems (poor sleep, anxiety, depression, irritability) were reported more often by bullied nurses than non-bullied nurses ($F = 5.59, (1, 633), p < 0.02$) (Einarsen et al., 1998). Additional problems associated with WPB exposure were increased stress, and loss of interest in the job (Einarsen et al., 1998; Vessey et al., 2009).

Lewis (2004), in an ethnographic study of 10 nurse managers noted a climate of fear was associated with bullying. Workplace bullying created a feeling of lack of support and fear of
speaking out related to censure (retaliation). Nurse managers had poor knowledge of bullying events and how to handle them. According to Lewis (2006), WPB behaviors were deliberately and actively planned to discredit targets. Those nurses seen as perpetrators continued as serial perpetrators. In a grounded theory approach, Randle (2003) found 39 student nurses verbalized distressing and psychological damaging experiences with powerlessness at the belittlement and humiliation by tenured nurses. Hoel et al. (2007) examined WPB’s effects on the role of emotions in nursing and healthcare through focus groups of 48 nursing students as students socialized into a competitive healthcare environment with high workloads and understaffing. Hoel et al. (2007) noted nursing students suppressed and hardened their emotions to frequent but less severe negative behaviors as a coping mechanism to complete their work. Smith and Cowie (2010) expressed concerns that the “culture filter” of nursing creates an emotional detachment or desensitization associated with negative behaviors. Whether good or bad, the behaviors become normalized in order to “cope” or function through work environments attenuated with WPB behaviors.

Laschinger et al. (2010) tested a model linking novice nurses’ perceptions of structural empowerment to WPB and burnout. WPB exposure was correlated as negatively and statistically significant ($p = .01$) to structural empowerment ($\beta = - .37$) as well as to all three components of burnout (emotional exhaustion ($\beta = .41$); cynicism ($\beta = .28$); and efficacy ($\beta = -.17$) (Laschinger et al. 2010). Laschinger et al. (2010) did not break down the individual behaviors of WPB. However, this study is significant related to the high levels of emotional exhaustion experienced by bullied nurses.

Nurses who smoked tobacco or drank alcohol increased their substance use as a strategy to cope with WPB (Quine, 2001). Alcohol, cigarettes, and other drug use were reported by 26.2
to 29% of the Turkish nurses who were bullied (Yildirim & Yildirim, 2007; Yildirim et al., 2007). Researchers found that bullied nurses lashed out at other nurses in response to being bullied (Vessey et al., 2009; Yildirim & Yildirim, 2007; Yildirim et al., 2007). Family and personal life were affected by bullying in 55% to 67% of the nurses (Yildirim & Yildirim, 2007; Yildirim et al., 2007). Questions regarding family and personal life were not asked in any other study.

Posttraumatic stress disorder symptoms are not unknown to nurses who face traumatic events (Gates et al., 2011). Posttraumatic stress disorder also has been linked to WPB. WPB is an extreme social stressor (Hogh et al., 2011). Leymann and Gustafsson (1996) conducted a study of 64 Swedish patients diagnosed with chronic posttraumatic stress disorder involving WPB. Healthcare workers, which represented 10.3% of Sweden’s working population, were 23.4% of the study group. Laposa, Alden, and Fullerton (2003) studied work stress in 51 emergency department personnel. Twelve percent (n=6) met the full criteria for a diagnosis of posttraumatic stress disorder (Laposa et al., 2003). Using the Health Professionals Stress Inventory (revised version), interpersonal conflict was found to be significantly associated with avoidance ($r = .37, p < .05$) and arousal ($r = .37, p < .01$) clusters. Laposa et al. (2003) recommended improving the interpersonal climate by enhancing administrative support and encouraging supportive social relationships to assist nurses working through traumatic events. Gates et al. (2011) echo the need for nurse leaders to recognize the impact of traumatic events when there are no supportive structures in place.

**Physical Consequences**

WPB behaviors and perceived stress are linked together in reporting wide ranges of somatic complaints (e.g., headache, loss of concentration, changes in sleep patterns, tiredness,
gastrointestinal complaints) (Quine, 2001; Vessey et al., 2009; Yildirim & Yildirim, 2007; Yildirim et al., 2007). Quine reported that 26% (n=45) of those nurses bullied stated their health was adversely affected from bullying.

Organizational Consequences

WPB behaviors increase the cost of healthcare organizations through use of welfare benefits, replacement of staff, and nurse productivity. In a study of Finnish healthcare workers, bullying victims had a rate of medically certified sickness absence 51% greater than other healthcare employees (Kivimäki, Eloainio, & Vahtera., 2000). Similarly, bullied nurses reported wanting to avoid work with 8% (n = 13) taking time away from work after a WPB incident (Quine, 2001). Although not correlated to WPB, 10.6% of the nurses took “mental health” days in the Canadian study (Laschinger et al., 2010).

The consequences of WPB on long-term illness absences and turnover of Danish healthcare workers revealed that employees who were occasionally bullied (RR=1.40; 95% CI: 1.13-1.73) and bullied more frequently (RR = 2.27, 95% CI: 1.57-3.30) had a higher long-term sickness absence than non-bullied employees, after adjustment for age and gender. Risk of long-term illness absence was 92% higher for those exposed to frequent bullying (RR =1.92; 95% CI: 1.29-2.84) (Ortega, Christensen, Hogh, Rugulies, & Borg, 2011).

Job retention. Simons (2008) and Johnson and Rae (2009) correlated NAQ sums indicating twice weekly bullying to intent to leave. In Simons’ (2008) study, there was significant positive correlation between WPB and intention to leave (r = 0.51, p < .001). As WPB increased, so did intent to leave. Johnson and Rae (2009) noted that those bullied were three times more likely to leave employment. Of those nurses who self-labeled as bullied and in a position less than five years, 78.5% (n=95) resigned and found new jobs (Vessey et al., 2009).
In Stanley et al. (2008), 14% of those nurses surveyed stated they had left their prior job due to WPB. Work productivity in 197 novice nurses in Ohio, Indiana, and Kentucky was negatively correlated to WPB (\(r = -.322, p = 0.01\)) (Berry et al., 2012).

**Summary of the Consequences of WPB in Nursing**

As a stressor, WPB affects nurses physically and psychologically. Nurses recognize the ongoing issues associated with the stressful environment of care but have accepted verbal aggression from patients, peers, and physicians as part of that environment. WPB behaviors also affect the organization through nurse attrition, job dissatisfaction, decreased work productivity, and the motivation to carry out duties. Nurses also continue to enable these behaviors between each other by avoiding the minor conflicts potentiating incivility and WPB.

The best practices associated with eliminating WPB in the healthcare environment have not yet been determined. There have been descriptions of various programs on implementation of The Joint Commission Standard (2008) or new employee education with cognitive rehearsal. However, there is no documentation of long-term success for these programs.

**Chapter Summary**

Novice nurse WPB is a long-standing problem in healthcare made more visible as societal influences create stressors in the healthcare environment. WPB behaviors are not just a problem for individual nurses but an organizational and cultural norm no longer supported in society as the adverse psychological and physical consequences become more transparent. Nurses’ own personal interpretive styles, coping styles, and social supports may influence their personal stress or resilience to WPB stressors but the culture of care needs to change along with strengthening the buffering and coping styles of novice nurses to a stressful work environment.
WPB behaviors continue to occur at the unit level as a social norm and remain unchanged because of non-reporting or avoidance behavior by nurses. Educating nurses to their personal interpretive style, coping styles, and providing social support may influence the personal stress reactions to WPB. The underlying cultural and safety environment must change in healthcare towards all employees. Although research focused on exploring the coping and social support styles is important, understanding how novice nurses maintained employment through WPB without the poor psychological consequences and what strategies they used will assist in program development.
CHAPTER 3: METHODS

This chapter describes the methods used to conduct the study. Given the dissertation was formatted as manuscript option, the study hypotheses, research design, methods, data collection procedures, instrumentation, and data management for each data-based paper are included. The purpose of Manuscript 1 was to explore factors that resulted in the adoption of WPB behaviors in a sample of 148 Ohio, Kentucky, and Indiana nurses who participated in a prior study on WPB behaviors. The purpose of Manuscript 2 was to determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on bullying exposure frequencies and select nurse characteristics; and explore strategies to manage or stop WPB behaviors. The sample for Manuscript 2 focused on the respondents (n=37) who continued employment on the same organizational unit after experiencing or observing WPB behaviors. Because of the mixed method design, a mixing of the quantitative and qualitative findings was necessary. The mixing of these data occurred in the discussion section of Manuscript 2 (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). Manuscript 3 described the construct of WPB and is attached as Appendix A.

Manuscript 1: A Path Analysis for the Adoption of Workplace Bullying Behaviors

Study Hypotheses

Understanding the risks or protective factors associated with psychological distress symptoms, self-labeling as a target, and adopting bullying behaviors may provide important information for nursing leaders to design programs to prevent, decrease, or stop WPB behaviors. Therefore, the aims of this study were to (1) determine the proportion of nurses who adopted bullying behaviors; (2) attrition based on trait anxiety, WPB behaviors, state anxiety, perceived stress, and posttraumatic stress symptoms; and (3) test a hypothesized model for the adoption of
WPB behaviors. Based on a review of the relevant literature, three hypotheses were developed in relation to these aims:

H1. There would be a significant difference between adoption of WPB behaviors based on exposure levels to WPB behaviors.

H2. Trait anxiety would be statistically higher for those novice nurses who exited the unit after experiencing WPB behaviors as compared to those novice nurses who experience WPB behaviors but did not exit the unit.

H3. The hypothesized model would fit the data.

Methods

A longitudinal, exploratory, web-based design study was used with quantitative data collected at two time points (2010 and 2012). The 2012 sample (n=148) came from an equally distributed, stratified random sample of respondents drawn from Indiana, Kentucky, and Ohio state boards of nursing mailing lists who participated in the 2010 study (Berry et al., 2012). Institutional Review Board approval was secured prior to the implementation of study procedures.

Data Collection. Letters were mailed to the home addresses of the study sample inviting them to participate (see Appendix B). The URL address for the web-based survey collector and their unique study identification number were included in the letter. Additional invitations were mailed to their home addresses two and four weeks later to increase the response rate. Respondents agreed to the study by reading the informed consent page for the study within the web-based survey collector (see Appendix C) and completing the study survey. An overall
response rate of 56.7% (n=84) was achieved, with 8% lost (n=12) due to invalid mailing addresses.

**Instruments.** Respondents completed the Negative Acts Questionnaire (Einarsen et al., 2009), State Trait Anxiety Inventory (Spielberger et al., 1995), Perceived Stress Scale (Cohen et al., 1983), Posttraumatic Stress Disorder Checklist-Civilian Scale (National Center for PTSD, 2010), and categorical variables (see Appendix D). Each scale displayed good internal consistency. For State Trait Anxiety Inventory, the subscale for “trait” had more than 5% data missing completely at random. The Cronbach’s alpha for the “trait” scale before and after multiple imputation was .88. The Cronbach’s alphas, ranges, and means for each instrument based on respondent data are displayed in Table 3.

**The Negative Acts Questionnaire (NAQ).** The NAQ uses 22 items with three subscales (work-, person-, and physical-related bullying) and one question measuring perceived exposure to bullying and victimization at work over a six-month timeframe (Einarsen et al., 2009). The NAQ is negatively correlated with measures of organizational satisfaction ($r = -0.45, p < 0.001$) and organizational commitment ($r = -0.31, p = 0.001$) (Einarsen et al., 2009), work productivity ($r = -0.322, p = 0.045$) (Berry et al., 2012), and positively correlated to intent to leave ($r = 0.51, p < 0.001$) (Simons, 2008). Exposure to WPB behaviors was based on NAQ weighted values assigned to the Likert-scale response using the number of working days in a six-month period to create a continuous scale variable for the intensity of bullying (Berry et al., 2012; Simons, 2008). The 22 NAQ items were weighted as never = 0, now & then = 2, monthly = 6, weekly = 25, and daily = 125, resulting in a possible range of 0 to 2,750. Respondents with an NAQ weighted score summing 0 to 49 indicated infrequent exposure to WPB behaviors. Respondents with an NAQ weighted score summing 50 or greater indicated frequent to daily exposure to WPB behaviors. A
sum of 50 indicates twice weekly bullying and provides a demarcation point for WPB with a sum of 125 considered daily WPB (Simons, 2008).

**State Trait Anxiety Inventory.** The State Trait Anxiety Inventory measures trait and state anxiety. Higher scores (range 20-80) indicate greater anxiety. Instrument validity has been positively correlated to the Anxiety Scale Questionnaire (Pearson’s $R = .73$) and Manifest Anxiety Scale (Pearson’s $R = .85$) (Spielberger et al., 1983). Responses to items were summed after reverse coding 18 items to generate an anxiety trait score. The standard mean for trait anxiety was established for working adults between the ages of 19-39 years old (males [n = 446, $M = 35.55$, $SD = 9.76$, Cronbach’s $\alpha = .92$]; females [n = 210, $M = 36.15$, $SD = 9.53$, Cronbach’s $\alpha = .92$]) (Spielberger et al., 1983). Anxiety state occurs and dissipates rapidly after an emotional response to a situation or event, however anxiety state also can be sustained under constant stressors (Kantor et al., 2001). The standard mean for state anxiety was established for working adults between the ages of 19-39 years old (males [n = 446, $M = 36.54$, $SD = 9.76$, Cronbach’s $\alpha = .92$]; females [n = 210, $M = 36.17$, $SD = 10.96$, Cronbach’s $\alpha = .93$]) (Spielberger et al., 1983).

**Perceived Stress Scale.** The Perceived Stress Scale is a 10-item instrument measuring respondents’ perceived stress following a significant event (Cohen & Williamson, 1988). Four positively stated items were reverse coded, then all items were summed for a perceived stress score ranging from 0 to 22 ($M = 6.6$, $SD = 4.9$) for this sample. The Perceived Stress Scale was summed and used as a continuous variable for path analysis. Based on a U. S. sample (n = 2,387), a mean score was 13.02 with a standard deviation of 6.35 (Cohen & Williamson, 1988).

**Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C).** The PCL-C provided a range (17-85) for a total symptom severity score. The summed scores were used with
three factors in hyperarousal, intrusive thoughts, and avoidance. A clinical diagnosis cannot be made from this survey although a score above 30 indicates potential for diagnosis of posttraumatic stress disorder by a qualified clinician (Bliese et al., 2008; National Center for PTSD, 2010).

**Categorical variables.** Nine questions were asked about the adoption of WPB behaviors, trust in management, history of employment on the same unit prior to nurse licensure, history of bullying prior to nurse licensure, and if the respondent was still working on the same unit. “Used bullying” and “trust the management” were Likert-scaled questions. Educational attainment, age, and ethnicity were extracted from respondents’ 2010 data.

**Statistical Design**

Data analyses were conducted using Statistical Package for the Social Sciences (SPSS) and Analysis of Moment Structures (AMOS) (PASW Statistics, version 21, SPSS, Inc., Chicago, IL). Data were visually screened and values missing completely at random were identified by using SPSS Missing Values Analysis (PASW Statistics, version 21, SPSS, Inc., Chicago, IL). Data were replaced with the mode for that item when 1.8% or less of the responses were missing completely at random (Tabachnick & Fidell, 2007). After screening the data, one case was removed due to graduation date from nursing school. Three cases exceeded Mahalanobis distance related to outliers and were removed, leaving an analytical sample size of 80 cases. Trait anxiety had over 5% of data missing completely at random. An estimated means algorithm through multiple imputations was conducted (Schafer, 1997; Tabachnick & Fidell, 2007) for nonparametric testing.

Descriptive statistics and chi-square tests comparing column proportion were produced to compare the proportion of nurses who adopted WPB behaviors based on Time 1 WPB exposure.
groups. Nonparametric Mann-Whitney statistical tests were conducted to determine differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on trait anxiety, employment choice (exit or stayed), WPB behavior exposure levels, self-labeling as a target of WPB behaviors at Time 2 (2012), and history of being bullied prior to RN licensure. A posthoc power analysis was conducted using GPower (Faul, Erdfelder, Lang, & Buchner, 2009). Sufficient power (97%) was achieved to conduct the planned analyses based on the study sample size for Mann-Whitney statistic for two group comparisons. The resulting Cohen’s $d$ effect size was 9.1.

**Path Analysis.** A path analysis was conducted to test whether the hypothesized model fit the observed data. In exploring the data, correlations were first estimated using Spearman Rho with ranked and continuous variables. Age, trait anxiety score, exposure to WPB behaviors at Time 1 and Time 2, self-labeling as a target of WPB behaviors at Time 1 and Time 2, trust in management, perceived stress score, state anxiety score, posttraumatic stress symptoms score, and adoption of WPB behaviors were inputted in to SPSS IBM AMOS to determine the direct path to the adoption of WPB behaviors towards others. The path analysis was completed with missing trait anxiety cases. The rationale for using the sample with missing trait anxiety rather than the multiple imputation sample was use of the mean would create a better fit than it should with the potential of over-estimating the mean of trait anxiety as well as multiple imputations with estimated means should not be conducted with inferential statistics (Tabachnick & Fidell, 2007). Even so, according to Loehlin (2004), a sample size of 80 with 70 degrees of freedom and a RMSEA of .05 was needed to achieve a minimum power of 80%. The study was sufficiently powered for the path.
Manuscript 2: Coping and Managing after Workplace Bullying

Study Purpose

Nurses must successfully address the WPB behaviors directed towards them to stop the internal emotional response to WPB behaviors (Berry et al., 2012). However, the strategies nurses used to maintain employment without psychological distress symptoms are unknown in a work environment attenuated with high frequency of WPB behaviors. Therefore, the purpose of this study was to determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on WPB exposure levels and select nurse characteristics; and explore strategies to manage or stop WPB behaviors. It was hypothesized that there would be a significant difference in perceived stress, anxiety state, and posttraumatic stress symptoms between novice nurses based on WPB exposure levels.

Methods

A sequential quantitative dominant (QUANT/qual) mixed method study was conducted with Indiana, Kentucky, and Ohio nurses still employed at the same facility and unit from a prior study conducted in 2010 (reference removed for anonymity). A two-phase research design was used for this study (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). In Phase I, a quantitative web-based survey was implemented with the study sample. In Phase II, semi-structured interviews were conducted with a subset of the Phase I study sample (Figure 3). The mixing of quantitative and qualitative data occurred within the discussion to further describe emergent findings on what constitutes WPB behaviors, why WPB behaviors continue, and how these nurses continued to cope and reach out for social support as they worked through or stopped WPB in their initial position (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). University Institutional Review Board (IRB) approval was secured prior to study procedures.
Phase I Survey. The study sample was obtained from a previous study of novice nurses (n=197) in practice less than three years (Berry et al., 2012). From this previous sample, 148 nurses agreed to further contact for research. Letter invitations to participate were sent with the URL link to an internet survey along with a unique study identification number. After entering the web-based survey, respondents received instructions and a letter detailing their rights as research subjects. Of the 84 respondents who completed the study survey, 37 nurses had described a targeted or observed WPB event in the 2010 study, continued their employment on the same unit at the time of this followup survey, and composed the analytical study sample. Demographic data from the 2010 study were used in further analysis (i.e., ethnicity, gender, age, educational attainment) along with other categorical variables (i.e., history of bullying prior to RN licensure, working on unit prior to RN licensure).

Quantitative measures. Respondents completed a five-component survey. Please refer above to the first data based paper for a detailed explanation of the survey components.

Data analysis. Data were visually screened for missing data points using the Statistical Package for the Social Sciences (PASW Statistics, version 21, SPSS, Inc., Chicago, IL). Randomly occurring missing values were identified using SPSS Missing Values Analysis. Data were replaced with the mode for that variable when 1.8% or less of the items were missing at random (Tabachnick & Fidell, 2007). Descriptive statistics described respondent data. Mann Whitney statistics were conducted to determine differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on WPB exposure levels and other nurse characteristics. A posthoc power analysis using GPower (Faul et al., 2009) was performed. Sufficient power (87%) was achieved to conduct the planned analyses based on the study sample size and Mann Whitney statistic for two independent group comparisons. The resulting Cohen’s d effect size was 1.13.
Phase II Interviews

The purpose of Phase II was to qualitatively explore the strategies used by nurses who experienced or observed a WPB event, and managed in spite of, or stopped, WPB, while remaining on the same unit with their same employer. All respondents who qualified for the Phase I procedures were asked to participate in a 1:1 interview. Over a period of eight months, 11 nurses completed the interview procedures. Telephone interviews were facilitated by using a semi-structured interview guide. Questions inquired as to why respondents thought WPB behaviors occurred, what they did to cope after, or to stop WPB, and other actions taken to continue working on the same unit after WPB occurred.

Qualitative rigor and data analysis. Rigor was established by building trustworthiness using Lincoln and Guba (1985) criteria. Subject matter experts assisted in development and review of the semi-structured interview guide (Lincoln & Guba, 1985). The interviews were conducted by phone, recorded digitally by the primary investigator, then transcribed verbatim by a paid transcription service. The primary author verified the accuracy of the transcripts by listening to the audio recordings, amending transcripts as needed. Verified transcripts were transferred into NVivo 8 (QSR International, Doncaster, VIC, Australia) for analysis. An audit trail was developed and maintained to document coding discussions, decisions, and dispute resolution between investigators (see Appendix F). Lincoln and Guba (1985) state the audit trail is the “single most important trustworthiness technique” (p. 283) for maintaining the truth-value, applicability, consistency, and neutrality of the content analysis. After prolonged contact with narratives, line-by-line content analyses were conducted separately and together by investigators to code responses, and to group findings under themes (see Appendix F). Expert member checking occurred periodically for themes and subthemes to safeguard against bias by co-
investigators in managing paradigm or contract disjunctions (Lincoln & Guba, 1985). Linkages between narratives were refined into structured themes and subthemes through multiple comparisons and discussion between investigators on coping with, working through, or stopping WPB (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). The researchers used the qualitative data to make comparisons to the quantitative data for a better understanding of the psychological distress symptoms associated with the continuation of WPB behaviors in healthcare (Morse & Niehaus, 2009).

The initial semi-structured interview questions were:

1. What are the strategies you use to maintain employment?
2. What strategies do you use to keep working?
3. Why do you think you were targeted by the bully?
4. Who have you told that you are/were being bullied?
5. Who has been your main support over the last year with workplace issues?
6. What was the most meaningful support you received after being bullied?

   If the bullying had stopped:

7. What do you think made the bully stop bullying?
8. What strategies did you use to stop the bullying?

   If the bullying continued:

9. What are the circumstances as to why the bully keeps bullying you?
10. What have you tried, if anything, to stop the bullying?
Figure 2. Proposed Model to Adopting Bullying Behaviors

[Diagram showing causal relationships between various factors such as Trait Anxiety, Other Nurse Characteristics, Workplace Bullying Time 1, Self-labeled as Target Time 2, Trust Management, Workplace Bullying Time 2, Perceived Stress, Anxiety State, and Post-traumatic Stress Symptoms, leading to Adopt Bullying.]
Figure 3. Selection Criteria for Interview
Human Subjects Protections

Prior to the study procedures, University of Cincinnati (UC) Institutional Review Board (IRB) approval was secured. All information on subjects was kept secure in electronic format within the protective computerized research network of UC. Subjects received full disclosure regarding the purpose of the study and consented to participate by proceeding with the study survey. There were no known psychological or physical risks with completing the surveys or participating in an interview. Participants would have been directed to their Employee Assistance Program or National Suicide Hotline if they experienced or reported distress during the recall of WPB.

Strategies to protect the confidentiality of research respondents were accomplished by replacing names with pseudonyms on the qualitative transcripts prior to data analysis. Only de-identified and aggregate data were used for reports and dissemination. Identifiable electronic data (i.e., participant roster, code key) were stored on a password protected research server with access limited to the study team. Transcripts were destroyed by shredding at the conclusion of the qualitative data analysis.

Inclusion of women, minorities and children. All women and minorities meeting the inclusion criteria were eligible for study participation. The anticipated demographics were 94% of respondents would be women with 7% being a minority based on the findings from the previous study by Berry et al. (2012). This study drew from a previous cohort of participants that were aged 21 to 57 years. As a result, no children were included in this study.

Limitation of the Studies

These results were not limited to one facility or specialty but a broad range of practice settings. Certain specialties (e.g. psychiatric, emergency departments) may have had more
exposures to patient and family aggression and violence than other areas, adding to the situational stress and anxiety seen in these results (Gillespie & Fisher, 2014). Findings of the study also were limited to novice to beginner nurses in the Midwest U.S. area.

The study depended on self-reports of the respondents, potentially creating response bias. The small sample sizes further limited the study and caused the analyses to use nonparametric statistics; however, adequate power was achieved for the completed analyses preventing a Type II error.

Only 11 respondents were interviewed for the second phase of Manuscript 2 limiting narrative analyses. However saturation of the narrative analyses did occur. Important to note, those nurses scoring higher NAQ sums did not return emails or phone calls for interview. The interviewees who did respond had infrequent to daily bullying scores.

Statistical limitations were encountered in analyses for both manuscripts when using Simons’ (2008) NAQ weighted scores to determine categories associated with infrequent, frequent, and daily bullying. Using the weighted sums of the NAQ as an assessment of frequency was a limitation to the path analysis. The weighted sums were used to determine infrequent, frequent, and daily exposures to create categorical variable previously unavailable when starting this study. Based on the weighted effect size (Cohen’s $d = -1.29$, effect size = -.054) of the NAQ sum for 2012 and the non-weighted NAQ sum (Cohen’s $d = -2.33$, effect size -.76), the unweighted scoring would have been the better “fit” for analysis. Notelaers and Einarsen (2013) formulated cut-off scores based on the Receiver Operation Characteristic curve, creating three groups of exposure not bullied category was at 32 or less, 33-44 were consider bullied, and 45 or above, victims of severe bullying. Likewise, respondents in the current study were separated into three groups of infrequent, frequent, and daily WPB exposure. However, because of the limited
number of respondents, two groups were used when analyzing data based on NAQ weighted score. Respondents with an NAQ summing 49 or less indicated infrequent exposure to WPB behaviors. Respondents with an NAQ score summing 50 or above indicated frequent to daily exposure to WPB behaviors. Again, had Notelaers and Einarsen (2013) categories been available at the initial study (Berry et al., 2012), the percentages of respondents categorized as recipients of WPB behaviors may have been different.

Chapter Summary

This chapter described the research design, setting, data collection procedures, instrument description, data management, data analysis, qualitative semi-structured questions, assurance of trustworthy results from qualitative analysis, and human subjects’ protection. Chapters 4 and 5 will present the two data-based manuscripts based on these methods. Appendix A is a third manuscript discussing the problem of WPB behaviors.
CHAPTER 4: MANUSCRIPT 1: A Path Analysis for the Adoption of Workplace Bullying Behaviors

Over 75% (n = 149) of novice nurses experienced or witnessed workplace bullying (WPB) behaviors in their first employment as a registered nurse (Berry et al., 2012). The perpetrators of WPB behaviors included peers, direct reports, administrative staff, nurse leaders, and physicians (Berry et al., 2012). Given the profession of nursing promotes health and caring behaviors, it is counterintuitive that nurses would witness or be targets of WPB behaviors from nurse peers or leadership. WPB behaviors include disrespect, social isolation, unwarranted criticism, gossiping, unfair task assignments, and belittling comments enacted against another person or group (Einarsen et al., 2011).

Understanding the risks or protective factors associated with psychological distress symptoms, self-labeling as a target, and adopting bullying behaviors may provide important information to tailor programs to potentiate novice nurses’ abilities to prevent, decrease, or stop WPB behaviors towards others, themselves, or peers. The purpose of this study was to explore factors that resulted in the adoption of WPB behaviors.

Background

WPB behaviors are a form of psychological aggression in the work environment. These negative behaviors are Type III Violence. Type III Violence is interpersonal aggression between employees or from employer to employee that can escalate to violence and death (United States Department of Health and Human Services, 2006). Employee perception of his or her environmental work stressors create the work-related stress leading to psychological and physical consequences. The psychological and physical consequences drive enormous physical and psychological costs to employees and their employers (Hill & Joyce, 2013). Gates’ (2001)
Model for Stress and Coping provided the framework for inquiry with WPB behaviors as a chronic work stressor triggering constant appraisal, varied coping styles, and social support at the individual level (Figure 1). Gate’s (2001) model was developed from Lazarus and Folkman’s (1984) Cognitive Theory of Psychological Stress and Coping. In addition to Gate’s model, two elements of Social Exchange Theory were applied to this study: (1) reciprocity or trust and (2) power in exchange (Blau, 1987; Cropanzano & Mitchell, 2005). A major concept of Social Exchange Theory is the building of trust that occurs in each interaction between actors. An assumption of reciprocity is as people treat each other equally in exchange, they help each other (Emerson, 1976; Parzefall & Salin, 2010).

**WPB and Personal Characteristics**

WPB behaviors can be reciprocal and escalating (Persson et al., 2009). Work conflict can escalate from general incivility to intentionally targeted WPB (Einarsen et al., 2011). However, how or why someone becomes a target or adopts WPB behaviors is not that simple. Targets’ personal characteristics or antecedents (e.g. trait anxiety, trust, social support) have been implicated in self-labeling as a target of WPB and the personal adoption of WPB behaviors (Hogh, Mikkelsen, et al., 2011). If WPB behaviors escalate, novice nurses may adopt the same behaviors as a proactive coping strategy to prevent being a target in an organizational culture that ignores, enables, or rewards perpetrators (Hutchinson et al., 2010).

Personality traits, considered stable characteristics, govern behavioral responses to situations. Persson et al. (2009) examined the influence of personality traits between non-bullied respondents, targets, and witnesses (n=247) on a hypothesized model using trait anxiety. Bullied respondents had higher scores on neuroticism-related traits (somatic trait anxiety and psychic trait anxiety). In another study of 466 shipping company employees, Vie et al. (2010) reported a
strong positive correlation between trait anxiety and WPB behaviors to self-labeling as a target \((r = .60, p = .01)\). However, the frequency of negative acts was a stronger predictor with trait anxiety and trait anger acting as independent predictors to self-labeling as a target. Applying Lazarus’ (1999) observations with stress and emotion, trait anxiety and perceived stress also alter the perception of coworker behaviors, amplifying and increasing state anxiety causing interpretation of ambiguous WPB behaviors (i.e., incivility, disruptive behaviors, disrespectful behaviors, lateral or horizontal violence) as targeted bullying. State anxiety also may influence the adoption of WPB behaviors.

**Attrition.** When tenured nurses model WPB behaviors toward new employees and novice nurses, their negative behaviors perpetuate the WPB cycle as a social norm (Dellasega, 2011; Hutchinson et al., 2010). As a method of avoiding the conflict associated with WPB behaviors, nurses have historically switched employers when they became dissatisfied with their current job (Dellasega, 2011). Intent to leave increased with WPB behaviors and concerns were articulated that continued WPB behaviors towards new nurses would exacerbate future nurse shortages (Johnson & Rae, 2009; Simons, 2008). There are multiple reasons to leave a position, not just WPB behaviors. Given the economic climate of recession, nurses exposed to WPB behaviors may believe they are unable to seek other employment. These nurses may adopt WPB behaviors as a coping or defense strategy to prevent further victimization by previous perpetrators.

Intent to leave has been correlated to WPB but there is a gap in the literature on whether novice nurses exposed to WPB behaviors continued employment with the same employer, sought alternative employment in another healthcare facility, or became disengaged from the profession temporarily or permanently. There may have been additional variables influencing
intent to leave. However, given attrition costs are $22,000 to $64,000 per replacement, attrition from WPB behaviors affects healthcare organizations’ profitability (Robert Wood Johnson Foundation, 2009a). In order to recruit and retain an adequate supply of RN for future practice, it was critical to understand why WPB behaviors continue in healthcare and their effects on targets’ psychological wellbeing.

**Stressors and social support.** Work relationships create occupational stressors or buffer against other occupational stressors by influencing appraisal and coping at the individual level (Lakey & Orehek, 2011). When a nurse seeks social support (e.g. friends, family, professional nurse peers or leaders), their shared perception of the event determines the level of perceived stress (Lakey & Orehek, 2011). Nurses constantly use appraisal, coping styles, and use of social support to navigate through these multiple stressors to manage their work and maintain their current position.

Verbal abuse between nurses occurs in a stressful work environment. Rowe and Sherlock (2005) evaluated the frequency and impact of verbal abuse toward nurses by other nurses. Over 96% (n=206) of the nurses experienced verbal abuse with staff nurses being the frequent source of that abuse. When verbal abuse occurred, nurses reported negative job satisfaction, poor relationships with the aggressive nurse, and decreased sense of well-being, trust, and support in the work setting (Rowe & Sherlock, 2005). In spite of the negative effects, nurses reported responding with similar negative behaviors (Rowe & Sherlock, 2005). Not only did verbal abuse beget verbal abuse but also peer relationships influenced trust and support in the work setting.

**Organizational social support and trust.** Trust is an essential element in employee empowerment (Laschinger & Finegan, 2005). Loss of trust may result in the adoption of WPB behaviors by those who perceive themselves as targets. Bitmis and Ergeneli (2013) investigated
the mediating effects of trust and psychological capital on individual performance and job satisfaction with a sample of 260 female physicians and nurses. The researchers found trust and psychological capital were mediators for the relationship between individual performance and job satisfaction. Likewise, Laschinger et al. (2010) hypothesized a similar model on the impact of WPB behaviors to symptoms of burnout, which were emotional exhaustion and cynicism (distrust). Using data from a longitudinal study of novice nurses (n = 415), WPB significantly and negatively correlated to cynicism (r = -.29, p = .01) and emotional exhaustion (r = -.25, p = .01). In the model, WPB was statistically significant to emotional exhaustion (β = .41), cynicism (β = .28), and efficacy (β = -.17) (Laschinger et al., 2010).

Summary of Background

Berry et al. (2012) reported a curvilinear relationship to WPB and productivity, suggesting there are other unknown variables skewing the linear relationship. Although trait anxiety was used as a predictor, extended infrequent exposure to WPB behaviors may have led nurses to consider themselves as targets of WPB. Likewise, the path to self-labeling as a victim of WPB or using WPB behaviors may be just as complicated within healthcare systems. When nurses self-label as targets of WPB, there may be an even greater potential to adopt WPB behaviors towards others, even with low exposure.

Study Hypotheses

Understanding the risks or protective factors associated with psychological distress symptoms, self-labeling as a target, and adopting bullying behaviors may provide important information for nursing leaders to design programs to prevent, decrease, or stop WPB behaviors. Therefore, the aims of this study were to (1) determine the proportion of nurses adopting bullying behaviors; (2) compare attrition based on trait anxiety and WPB behaviors; and (3) test
a hypothesized model for the adoption of WPB behaviors. Based on a review of the relevant literature, three hypotheses were developed in relation to these aims:

H1. There would be a significant difference between adoption of WPB behaviors based on exposure levels to WPB behaviors.

H2. Trait anxiety would be statistically higher for those novice nurses who exited the unit after experiencing WPB behaviors as compared to those novice nurses who experience WPB behaviors but did not exit the unit.

H3. The hypothesized model would fit the data.

Methods

A longitudinal, exploratory, web-based design study was used with quantitative data collected at two time points (2010 and 2012). The 2012 sample (n=148) came from an equally distributed, stratified random sample of respondents drawn from Indiana, Kentucky, and Ohio state boards of nursing mailing lists who participated in the 2010 study (reference removed for anonymity). Institutional Review Board approval was secured prior to the study procedures.

Data Collection. Letters were mailed to the home addresses of the study sample inviting them to participate. The URL address for the web-based survey collector and their unique study identification number were included in the letter. Additional invitations were mailed to their home addresses two and four weeks later to increase the response rate. An overall response rate of 56.7% (n=84) was achieved with 8% lost (n=12) due to invalid mailing addresses.

Instruments. Respondents completed the Negative Acts Questionnaire (Einarsen et al., 2009), State Trait Anxiety Inventory (Spielberger et al., 1995), Perceived Stress Scale (Cohen et al., 1983), Posttraumatic Stress Disorder Checklist-Civilian Scale (National Center for PTSD,
2010), and categorical variables. Each scale displayed good internal consistency. For State Trait Anxiety Inventory, the subscale for “trait” had more than 5% data missing at random based on Missing Values Analysis using SPSS. The Cronbach’s alpha for the “trait” scale before and after multiple imputation was .88. The Cronbach’s alphas, ranges, and means for each instrument based on respondent data are displayed in Table 3.

**The Negative Acts Questionnaire (NAQ).** The NAQ uses 22 items with three subscales (work-, person-, and physical-related bullying) and one question measuring perceived exposure to bullying and victimization at work over a six-month timeframe (Einarsen et al., 2009). The NAQ is negatively correlated with measures of organizational satisfaction ($r = -.45 \ p = .001$) and organizational commitment ($r = -.31, \ p = .001$) (Einarsen et al., 2009), work productivity ($r = -.322, \ p < .01$) (Berry et al., 2012), and positively correlated to intent to leave ($r = .51, \ p < .001$) (Simons, 2008). Exposure to WPB behaviors was based on NAQ weighted values assigned to the Likert-scale response using the number of working days in a six-month period to create a continuous scale variable for the intensity of bullying (Berry et al., 2012; Simons, 2008). The 22 NAQ items were weighted as never = 0, now & then = 2, monthly = 6, weekly = 25, and daily = 125, resulting in a possible range of 0 to 2,750. Respondents with an NAQ weighted score summing 0 to 49 indicated infrequent exposure to WPB behaviors. Respondents with an NAQ weighted score summing 50 or greater indicated frequent to daily exposure to WPB behaviors. A sum of 50 indicates twice weekly bullying and provides a demarcation point for WPB with a sum of 125 considered daily WPB (Simons, 2008).

**State Trait Anxiety Inventory.** The State Trait Anxiety Inventory measures trait and state anxiety. Higher scores (range 20-80) indicate greater anxiety. Instrument validity has been positively correlated to the Anxiety Scale Questionnaire (.73) and Manifest Anxiety Scale (.85)
(Spielberger et al., 1983). Responses to items were summed after reverse coding 18 items to generate an anxiety trait score. The standard mean for trait anxiety was established for working adults between the ages of 19-39 years old (males \( n = 446, M = 35.55, SD = 9.76, \alpha = .92 \); females \( n = 210, M = 36.15, SD = 9.53, \alpha = .92 \)) (Spielberger et al., 1983). Anxiety state occurs and dissipates rapidly after an emotional response to a situation or event, however anxiety state also can be sustained under constant stressors (Kantor et al., 2001). The standard mean for state anxiety was established for working adults between the ages of 19-39 years old (males \( n = 446, M = 36.54, SD = 9.76, \alpha = .92 \); females \( n = 210, M = 36.17, SD = 10.96, \alpha = .93 \)) (Spielberger et al., 1983).

**Perceived Stress Scale.** The Perceived Stress Scale is a 10-item instrument measuring respondents’ perceived stress over the past month (Cohen & Williamson, 1988). Four positively stated items were reverse coded, then all items were summed for a perceived stress score. The Perceived Stress Scale was summed and used as a continuous variable (range 0 - 40). Based on a U. S. sample \( n = 2.387 \), a mean score was noted for the Perceived Stress Scale (ten questions) as 13.02 with a standard deviation of 6.35 (Cohen & Williamson, 1988).

**Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C).** The PCL-C provided a range (17-85) for a total symptom severity score. The summed scores were used with three factors in hyperarousal, intrusive thoughts, and avoidance. A clinical diagnosis cannot be made from this survey although a score above 30 indicates potential for diagnosis of posttraumatic stress disorder by a qualified clinician (Bliese et al., 2008; National Center for PTSD, 2010).

**Categorical variables.** Nine questions were asked about the adoption of WPB behaviors, trust in management, history of employment on the same unit prior to nurse licensure, history of
bullying prior to nurse licensure, and if the respondent was still working on the same unit. “Used bullying” and “trust the management” were Likert-scaled questions. Educational attainment, age, and ethnicity were extracted from respondents’ 2010 data.

**Statistical Design**

Data analyses were conducted using Statistical Package for the Social Sciences (SPSS) and Analysis of Moment Structures (AMOS) (PASW Statistics, version 21, SPSS, Inc., Chicago, IL). Randomly occurring missing values were identified using SPSS Missing Values Analysis. Data were replaced with the mode for that variable when 1.8% or less of the items were missing at random (Tabachnick & Fidell, 2007). After visually screening and cleaning the data, one case was removed due to matriculation date. Three cases exceeded Mahalanobis distance and were removed, leaving an analytical sample size of 80 cases. Trait anxiety had over 5% of data missing at random. An estimated means algorithm through multiple imputations was conducted (Schafer, 1997; Tabachnick & Fidell, 2007) for nonparametric testing.

Descriptive statistics and chi-square tests comparing column proportion were produced to compare the proportion of nurses who adopted WPB behaviors based on Time 1 WPB exposure groups. Nonparametric Mann-Whitney statistical tests were conducted to determine differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on trait anxiety, employment choice (exit or stayed), WPB behavior exposure levels, self-labeling as a target of WPB behaviors at Time 2 (2012), and history of being bullied prior to RN licensure. A posthoc power analysis was conducted using GPower (Faul et al., 2009). Sufficient power (97%) was achieved to conduct the planned analyses based on the study sample size for Mann-Whitney statistic for two group comparisons. The resulting Cohen’s $d$ effect size was 9.1.
Path Analysis. The third study aim was to determine whether the hypothesized model fit the observed data. In exploring the data, correlations were first estimated using Spearman Rho with ranked and continuous variables. Age, trait anxiety score, exposure to WPB behaviors at Time 1 and Time 2, self-labeling as a target of WPB behaviors at Time 1 and Time 2, trust in management, perceived stress score, state anxiety score, posttraumatic stress symptoms score, and adoption of WPB behaviors were inputted into SPSS IBM AMOS to determine the direct path to the adoption of WPB behaviors towards others. The path analysis was completed with incomplete data points for trait anxiety. According to Loehlin (2004), a sample size of 80 with 70 degrees of freedom and a RMSEA of .05 was needed to achieve a minimum power of 80%. The study was sufficiently powered for the path.

Results

Respondents were mostly white (n = 68; 85%), female (n = 75; 93.8%), with an Associate’s (n = 41; 51.3%) or Bachelor’s (n = 38; 47.5%) degree in nursing (see Table 4). In addition, 38.8% (n = 31) of the respondents had experienced some form of bullying (family, significant other, peers) prior to nurse licensure. The mean age of respondents was 29.1 years (SD = 6.2), ranging from 21 to 47 years in 2010. In 2010, 46 (57.5%) respondents were targets of WPB (see Table 5). By 2012, the number of respondents who were targets of WPB behaviors increased to 53 (66.3%). The sample mean for NAQ weighted scores were reflective of exposure to WPB behaviors had increased from 69.8 in 2010 to 72.7 in 2012, with self-labeling as a target having increased 11% (n = 7). Based on the Time 2 NAQ weighted scores, 12.5% (n = 10) of respondents had frequent (twice weekly but less than daily) WPB exposure with 18.8% (n = 15) exposed to daily or more WPB behaviors directed towards them. The combined scores indicated that 31.3% (n = 25) of the respondents met the criteria for WPB.
Respondents were dichotomized into low- and high-trait anxiety groups. Respondents (n = 26) with high-trait anxiety had nonsignificant median scores in perceived stress (Md = 6.5 vs. 6, U = 682.5, p = .84), state anxiety (Md = 34.5 vs. 38.5, U = 604, p = .60), posttraumatic stress symptoms (Md = 23 vs. 27.5, U = 593, p = .26), Time 1 exposure to WPB behaviors (Md = 14 vs. 29.5, U = 555, p = .13), and Time 2 exposure to WPB behaviors (Md = 20 vs. 26, U = 604.5, p = .32) as compared to respondents (n = 54) with low-trait anxiety scores. Respondents (n = 23) with high-trait anxiety had nonsignificant median scores for perceived stress (Md = 21 vs. 20, U = 325, p = .29), state anxiety (Md = 35 vs. 34.5, U = 325, p = .72), posttraumatic stress symptoms (Md = 23 vs. 24.5, U = 336.5, p = .87), Time 1 NAQ scores (Md = 14 vs. 38.5, U = 256, p = .11), and Time 2 NAQ scores (Md = 20 vs. 24, U = 285, p = .28) as compared to respondents (n = 30) with low-trait anxiety scores.

Respondents also were dichotomized into infrequent and frequent to daily exposure to WPB behaviors. Respondents (n = 25) exposed to frequent to daily WPB behaviors had statistically significant median scores in perceived stress (Md = 10 vs. 4, U = 326.5, p < .001), state anxiety (Md = 44 vs. 34, U = 351, p < .001), and posttraumatic stress symptoms (Md = 30 vs. 23, U = 421, p < .001) as compared to respondents (n = 55) with low WPB behavior exposures. Respondents (n = 25) experiencing frequent to daily WPB behavior exposure had nonsignificant results noted for trait anxiety (Md = 35.48 vs. 27, U = 542, p = .13) and age (30 vs. 27, U = 595, p = .34) as compared to respondents (n = 55) with infrequent WPB behavior exposures.

For respondents (n = 31) who had a previous history of bullying prior to their nurse licensure, statistically significant findings were seen with age (Md = 33 vs. 26, U = 456.5, p = .04), state anxiety (Md = 40 vs. 34, U = 480.5, p = .008), and posttraumatic stress symptoms (Md
= 29 vs. 23, \(U = 506.5, p = .017\) as compared to respondents (n = 49) with no history of bullying prior to their nurse licensure. For those respondents (n = 31) with the prior history of bullying, no significant results were seen in trait anxiety (Md = 35 vs. 35, \(U = 637, p = .28\)), Time 1 NAQ scores (Md = 30 vs. 15, \(U = 597.5, p = .14\)), Time 2 NAQ scores (Md = 22 vs. 24, \(U = 722, p = .82\)), and perceived stress scores (Md = 7 vs. 5.5, \(U = 641.5, p = .30\)) as compared to respondents (n = 49) with no history of bullying prior to their nurse licensure.

**Aim 1: Proportion of nurses adopting WPB behaviors.** Almost 14% of respondents (n = 11) answered yes to the adoption of WPB behaviors towards others. The number of respondents who adopted WPB behaviors by 2012 was greater for respondents (n = 9) experiencing low WPB behaviors at Time 1 compared to respondents (n = 2) who experienced high WPB behaviors at Time 1. A Chi-square test comparing column proportion indicated no association between nurses experiencing infrequent and frequent to daily WPB behaviors and the adoption of bullying behaviors by Time 2 (\(\chi^2 = [2, n = 80] = 2.26, p = .38\)). Therefore, Hypothesis 1 was not supported; there was no significant association between WPB exposure groups for the adoption of WPB behaviors.

Of the respondents who adopted bullying behaviors, nine respondents continued working on the same unit as they did in 2010. All 11 nurses adopting WPB behaviors were white females who self-labeled as targets of WPB behaviors. When comparing these 11 respondents to respondents (n=69) who did not adopt bullying behaviors, no significance differences were found for exposures to WPB behaviors based on Time 1 NAQ weighted sum (Md = 20 vs. 20, \(U = 367, p = .87\)), state anxiety (Md = 39 vs. 35, \(U = 299.5, p = .26\)), trait anxiety (Md = 35.48 vs. 35.01, \(U = 318.00, p = .38\)), perceived stress (Md = 28 vs. 24, \(U = 306.50, p = .31\)), and posttraumatic stress symptoms (Md = 28 vs. 24, \(U = 309.5, p = .33\)).
Aim 2: Attrition. From 2010 to 2012, 43.7% (n = 35) of respondents changed nursing units or employers. A Chi-square test comparing column proportion indicated no significant association for respondents who had experienced or observed a sentinel WPB event concomitant with high trait anxiety and low trait anxiety compared to exiting or staying on the same unit ($X^2 = [1, n = 64] = 2.01, p = .15$). Hypothesis 2 therefore was not supported. No significant differences were found between respondents (n = 26) who left the unit versus respondents who stayed on the same units from 2010 to 2012 based on exposure to WPB behaviors at Time 1 based on NAQ weighted sum (Md = 27 vs. 34, $U = 448, p = .92$), state anxiety (Md = 37.5 vs. 34, $U = 409.5, p = .51$), trait anxiety (Md = 35.48 vs. 35.48, $U = 345.00, p = .107$), perceived stress (Md = 6.5 vs. 5.0, $U = 438.5, p = .81$), and posttraumatic stress symptoms (Md = 27 vs. 22, $U = 399.5, p = .42$). Ten respondents (38%) who left their original unit cited the reason they left was stressful, hostile, or bullying work environments.

Aim 3: Model fit. The initial path model did not fit the data. For the second path model, insignificant correlations and covariances with age were removed from the model (except for posttraumatic stress symptoms) which resulted in a marginal fit. For the third path model insignificant correlation values with trait anxiety ($p = .41$), Time 1 WPB exposure ($p = .83$) and Time 2 WPB exposure ($p = .96$), and posttraumatic stress symptoms ($p = .484$) were removed from Time 2 self-labeling as a target. The covariance between Time 1 WPB exposure and perceived stress ($p = .85$) were removed. With the fourth path, insignificant correlation values of trait anxiety ($p = .71$), trust in management ($p = .67$), state anxiety ($p = .67$), and posttraumatic stress symptoms ($p = .50$) were removed from adopting bullying. Covariance between Time 1 self-labeling as a target and perceived stress ($p = .65$), state anxiety ($p = .53$), and posttraumatic stress symptoms ($p = .50$) were removed. The covariance between Time 2 WPB exposure sum
and perceived stress score \((p = .55)\) was removed. The reiterated adjustments occurred 11 times to reduce insignificant covariance values between variables. Time 1 self-labeling as a target \((r = .24, p = .02)\), trust in management \((r = .21, p = .03)\), and state anxiety \((r = .02, p = .03)\) were regressed on Time 2 self-labeling as a target. Time 2 self-labeling \((r = .15, p = .01)\) was then regressed to adoption of bullying.

The final model displayed a path from self-labeling as a target at Time 1 (2010), trust in management, and anxiety state to the adoption of bullying behaviors through a common variable of self-labeling as a target of WPB behaviors at Time 2. This path achieved a minimum fit \(\chi^2 [36, N = 80] = 23.116, p = .952\) with GFI = .95, RMSEA < .001, AGFI = .70, and NFI = .545. Both direct (unmediated) and indirect (mediated effects) of self-labeling as a target on adopting bullying indicated that as respondents self-labeling as a target went up by 1, adoption of bullying behaviors went up by 0.147. Self-labeling as a target in 2010, trust in management, and state anxiety had total (direct and indirect effects) in continuing to perceive oneself as a target in 2012. Trait anxiety did exert influence through covariance with exposure to WPB behaviors at Time 1 and self-labeling as a target at Time 1 as well as exposure to WPB behaviors at Time 2 and trust in management. Figure 4 displays the final model with significant regressions and correlations. The sample size was adequate as the model estimates of the parameters were stable without non-significant \(z\) tests for the model (Ullman, 2007).

Discussion

The frequency of exposure to WPB behaviors increased from Time 1 to Time 2. However, 50% of respondents were exposed to WPB behaviors at least once weekly over a six-month period with 60% of respondents self-identifying as targets of WPB behaviors at Time 2. The transition from novice nurse to competent nurse requires conducive learning environments.
(Duchscher, 2009; Kramer, Maguire, Schmalenberg, Halfer, Budin, & Hall, 2012). However, WPB behavior exposure as well as other forms of aggression seriously impede cognitive learning and poses a risk to quality care of patients (Berry et al., 2012; Gates et al., 2011). If WPB behaviors continue, the chronic nature of exposure to WPB behaviors may actually exhaust employee coping, hence the increase in self-labeling seen with this group (Jóhanndóttir, & Ólafsson, 2004; Vie et al., 2010).

Eleven respondents recognized that they adopted bullying behaviors. Nine respondents who adopted WPB behaviors continued to work on units where the 2010 WPB sentinel events were observed or targeted. On these units, it is probable to assume WPB behaviors were normalized and quite possibly the behaviors were ignored, enabled, or rewarded (Hutchinson et al., 2010). To control and decrease WPB behaviors at the unit level, nurse and organizational leadership should educate all staff on what is (and is not) professional behavior, determine if process improvement or ongoing leadership coaching is needed to assist the teamwork and function of the unit, or use outside researchers to conduct focus groups to determine other root causes associated with WPB behaviors (Dellasega, 2011).

Respondents experiencing WPB behaviors leave their units for many reasons. A third of respondents who left their original unit did so because of adverse work conditions (e.g. WPB behaviors, toxic work environment). Initially, trait anxiety was hypothesized to be associated with attrition; however, for this study’s sample, trait anxiety was not statistically associated with attrition. Regardless the reasons for attrition, healthcare organizations experiencing WPB behaviors at the unit level should evaluate hiring practices to employ persons who fit the position and desired work culture. In addition, one third of attrition could be avoided by implementing
cognitive rehearsal and safe support groups for new hires to help with onboarding and preventing WPB behaviors that may still occur towards new hires (Griffin, 2004).

The final model for this study (see Figure 2) is similar to Laschinger and Grau, (2012) model. In Laschinger and Grau’s model, WPB behavior exposure was positively related to both emotional exhaustion and cynicism (distrust). In the current path model, trust (and distrust) was pivotal in forming covariance with perceived stress, state anxiety, and posttraumatic stress symptoms with a direct effect to self-labeling as a target at Time 2. This path reflects that when leadership fails to act to support novice nurses or work to resolve stressful work situations, employees may lose trust in leadership. Nursing leaders are responsible for demonstrating supportive leadership by encouraging, coaching, and assisting novice nurses to resolve minor work conflicts (Laschinger & Grau, 2012; Moore, Leahy, Sublett, & Lanig, 2013; St-Pierre, 2012). When trust in leadership is not present, nurses may not seek help from them when experiencing WPB behaviors. In this study, only two respondents cited nurse leaders as a social support. This finding further reflects a gap in respondents’ trust in leadership. This gap needs to be addressed so that relationships between employee and employers are functional and ultimately address employer and employee needs (Cook et al., 2005).

The final model also demonstrated the influence of trait anxiety through covariance with exposure to WPB behaviors at Time 1 and Time 2, self-labeling as a target of WPB behaviors at Time 1, and trust in management. Duffy and Sperry (2014) caution against fundamental attribution error when researching WPB. The over-emphasis of personality traits as an explanation for being a target of WPB minimizes the importance of situational and organizational influences (Duffy & Sperry, 2014). Sustained WPB behaviors are psychologically stressful related to loss of control over the situation and lack of resources for appropriate
response (Duffy & Sperry, 2014). Therefore, healthcare administrators need to limit their focus away from individual susceptibility to eradication of WPB behaviors by a system’s approach for the long-term sustainable prevention of WPB behaviors as attrition and turnover occur.

Limitations

This study was limited by response bias. Respondents may not be willing to admit that they adopted the use of WPB behaviors knowing that these behaviors are maladaptive in the work setting or may not recognize their behaviors as WPB. Additionally, eligible nurses with high exposure to WPB may have opted not to complete the survey to prevent flashbacks about their previous or current WPB victimization. Findings of the study were limited to respondents in the Midwest United States; however, respondents did practice in multiple types of facilities and specialty areas. Certain specialties such as psychiatric and emergency care may have a higher number of exposures to patient and family aggression than other areas, adding to the situational stress and anxiety seen in these results. Although the final model achieved a minimum fit, there were large standard errors with state anxiety and exposure to WPB behaviors, most likely related to the WPB weighted scores. As a result, this may further limit the generalizability of the study findings.

Conclusion

Individual nurses need to recognize their personal traits, triggers, and responses to work stressors and learn respectful crucial confrontation to prevent and mitigate WPB behaviors. Equally, they need to know when and how to ask for assistance. Nurse leaders will need to foster employee trust by coaching employees or intervening themselves to stop WPB behaviors between peers. Ultimately, nurse leaders and staff working together may create and sustain change departing from an environment attenuated with WPB behaviors to a positive, just culture.
Research is needed on the long-term efficacy of interventions that move organizations through a sustained culture change.
<table>
<thead>
<tr>
<th>Scale</th>
<th>Items</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Acts Questionnaire (2010 data)</td>
<td>22</td>
<td>0 - 890</td>
<td>69.8</td>
<td>141.9</td>
<td>0.81</td>
</tr>
<tr>
<td>Negative Acts Questionnaire (2012 data)</td>
<td>22</td>
<td>0 - 539</td>
<td>72.7</td>
<td>115.1</td>
<td>0.70</td>
</tr>
<tr>
<td>Trait Scale (State Trait Anxiety Inventory)¹</td>
<td>20</td>
<td>21 - 52</td>
<td>35.5</td>
<td>6.4</td>
<td>0.88</td>
</tr>
<tr>
<td>State Scale (State Trait Anxiety Inventory)</td>
<td>20</td>
<td>20 - 76</td>
<td>38.5</td>
<td>11.2</td>
<td>0.95</td>
</tr>
<tr>
<td>Perceived Stress Scale</td>
<td>10</td>
<td>0 - 22</td>
<td>6.6</td>
<td>4.9</td>
<td>0.88</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder Checklist – Civilian</td>
<td>17</td>
<td>17 - 53</td>
<td>27.6</td>
<td>9.1</td>
<td>0.92</td>
</tr>
</tbody>
</table>

¹ Trait scale, n=56
Table 4

Participant Demographic Characteristics (n=80)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>68</td>
<td>85.0</td>
</tr>
<tr>
<td>Persons of color</td>
<td>12</td>
<td>15.0</td>
</tr>
<tr>
<td>Female</td>
<td>75</td>
<td>93.8</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>41</td>
<td>51.3</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>38</td>
<td>47.5</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>History of exposure to bullying prior to nursing license</td>
<td>31</td>
<td>38.8</td>
</tr>
<tr>
<td>Left unit since 2010</td>
<td>35</td>
<td>43.8</td>
</tr>
<tr>
<td>Adopted bullying behaviors</td>
<td>11</td>
<td>13.8</td>
</tr>
<tr>
<td>Variables</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>NAQ weighed score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low exposure (0 - 49):</td>
<td>57 (71.3)</td>
<td>55 (68.8)</td>
</tr>
<tr>
<td>Moderate exposure (50 – 124):</td>
<td>12 (15)</td>
<td>10 (12.5)</td>
</tr>
<tr>
<td>High exposure (125 or above):</td>
<td>11 (13.8)</td>
<td>15 (18.8)</td>
</tr>
<tr>
<td>Self-labeled as a target of WPB behaviors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>51 (63.8)</td>
<td>35 (43.8)</td>
</tr>
<tr>
<td>Yes, but rarely</td>
<td>20 (25.0)</td>
<td>29 (36.3)</td>
</tr>
<tr>
<td>Yes, now and then</td>
<td>8 (10.0)</td>
<td>16 (20.0)</td>
</tr>
<tr>
<td>Yes, several times a week</td>
<td>1 (1.3)</td>
<td>0</td>
</tr>
<tr>
<td>Adopted bullying behaviors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low exposure to WPB behaviors</td>
<td>n/a</td>
<td>7 (81.8%)</td>
</tr>
<tr>
<td>Moderate exposure to WPB behaviors</td>
<td>n/a</td>
<td>3 (27.2%)</td>
</tr>
<tr>
<td>High exposure to WPB behaviors</td>
<td>n/a</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>Trust management in work conflict.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>n/a</td>
<td>7 (8.8)</td>
</tr>
<tr>
<td>Agree</td>
<td>n/a</td>
<td>39 (48.8)</td>
</tr>
<tr>
<td>Disagree</td>
<td>n/a</td>
<td>20 (25.0)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>n/a</td>
<td>14 (17.5)</td>
</tr>
</tbody>
</table>
Table 6

Summary of Correlations and Intercorrelations between Measures (n=80)

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adopt Bullying</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T2 Self-labeled as bullied</td>
<td>.26*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 PCL-C</td>
<td>.11</td>
<td>.32**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Anxiety State</td>
<td>.13</td>
<td>.38**</td>
<td>.70**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Perceived Stress</td>
<td>.20</td>
<td>.25*</td>
<td>.41**</td>
<td>.35**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Trust Management</td>
<td>.09</td>
<td>.36**</td>
<td>.28*</td>
<td>.44**</td>
<td>.28*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 2012 NAQ Weighted Score</td>
<td>.08</td>
<td>.44*</td>
<td>.37**</td>
<td>.43**</td>
<td>.38**</td>
<td>.50**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 T1 Self-Labeled as bullied</td>
<td>.15</td>
<td>.20</td>
<td>.06</td>
<td>.10</td>
<td>.06</td>
<td>.12</td>
<td>.09</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 2010 NAQ Weighted Score</td>
<td>.02</td>
<td>.25*</td>
<td>.19</td>
<td>.26*</td>
<td>-.08</td>
<td>.11</td>
<td>.29*</td>
<td>.29*</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Trait Anxiety</td>
<td>.15</td>
<td>.11</td>
<td>.17</td>
<td>.15</td>
<td>.21</td>
<td>.08</td>
<td>.03</td>
<td>-.05</td>
<td>-.32*</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>10 Age</td>
<td>-.02</td>
<td>.09</td>
<td>.33**</td>
<td>.13</td>
<td>.10</td>
<td>.09</td>
<td>.03</td>
<td>.13</td>
<td>.04</td>
<td>-.09</td>
<td>1.00</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
1 Trait anxiety, n=56
Figure 4. Paths to Adopting Bullying through Self-labeling as a Target
CHAPTER 5: MANUSCRIPT 2: Coping and Managing After Workplace Bullying

Organizational cultures attenuated with workplace bullying (WPB) behaviors create stressful environments for novice nurses who are more vulnerable to that abuse (Budin et al., 2013). WPB behaviors occur at a critical time when novice nurses are socializing into peer groups through mentors. These same peers and mentors are under stress themselves related to the increased workload associated with orienting novice nurses (Topa, Guglielmi, & Depolo, 2014). With these continued stressors, novice nurses may feel powerless to address WPB behaviors between peers and perceive these WPB behaviors as intentionally targeted (Berry et al., 2012). This powerlessness may lead to adverse psychological effects. Because of this risk, the purpose of this study was to determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms using WPB exposure levels and select nurse characteristics.

Background

The prevalence of WPB behaviors against nurses has been estimated to range from 27.3% to 31% for twice weekly incidents and 21.3% for daily WPB for novice nurses (Berry et al., 2012; Johnson & Rae, 2009; Simons, 2008). As occupational stressors, WPB behaviors may occur while novice nurses experience stress and anxiety learning their new role as nurses (Budin et al., 2013). Given the stress and anxiety in their new role, WPB behaviors may increase leading to a sustained perceived stress and anxiety state, and subsequent risk for posttraumatic stress symptoms.

WPB consequences. When WPB behaviors become embedded in professional peer relationships, organizational consequences can occur. For example, WPB is negatively correlated to work productivity (r = - .32, p = .01; Berry et al., 2012). In response to WPB behaviors, some nurses leave the organizational unit by transferring within or exiting the organization (Vessey et
Simons (2008) found a significant positive correlation between WPB and intent to leave (r = .51, p < .001). Johnson and Rae (2009) noted nurses who were bullied were three times more likely to express intent to leave employment. However, some nurses may stay on a unit attenuated with WPB behaviors but they experience a loss of interest in the job (Vessey et al., 2009).

Sustained WPB behaviors are psychologically stressful related to loss of control over the situation and lack of resources for appropriate response (Duffy & Sperry, 2014). When WPB behaviors are perceived as threatening (targeted, repeated, unwanted), stress and anxiety increase. The ability to cope through WPB behaviors may become compromised (Lazarus & Folkman, 1984). When exposed to WPB, 90% (n = 191) of nurses reported moderate to severe stress when bullied (Vessey et al., 2009).

Tehrani (2004) noted symptoms of posttraumatic stress disorder were present in 44% (n = 72) of care professionals exposed to chronic WPB behaviors. Matthiesen and Einarsen (2007) explored posttraumatic stress symptoms among WPB targets (n = 180) from a broad range of industries. Targets who experienced WPB were found to have significant correlations (p < .01) between WPB and intrusion, avoidance, and hyperarousal (Matthiesen & Einarsen, 2007). Malik and Farooqi (2014) noted significant positive correlations between general workplace harassment and posttraumatic stress symptoms for female physicians (n=100; r=.58, p<.01) and female nurses (n=100; r=.52, p<.01).

In the U.S., the prevalence for posttraumatic stress disorder is 11.7% (Norris & Slone, 2013). A person must have direct or indirect, witnessed, or repeated exposure to a traumatic event for posttraumatic stress symptoms to occur. Posttraumatic stress symptoms are described as hyperarousal, numbing, and the intrusion of traumatic events through nightmares or
flashbacks, or avoidance of things, persons, or situations reminding them of the trauma (National Center for PTSD, 2014). Almost all humans have had exposure to traumatic events at some point in their lives. However, systematic and persistent WPB may lead to chronic posttraumatic stress symptoms (Tehrani, 2004).

**Study Purpose**

Nurses must successfully address the WPB behaviors directed towards them to stop the internal emotional response to WPB behaviors (Berry et al., 2012). However, the strategies nurses used to maintain employment without psychological distress symptoms are unknown in a work environment attenuated with high frequency of WPB behaviors. Therefore, the purpose of this study was to determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on WPB exposure levels and select nurse characteristics; and explore strategies to manage or stop WPB behaviors. It was hypothesized that there would be a significant difference in perceived stress, anxiety state, and posttraumatic stress symptoms between novice nurses based on WPB exposure levels.

**Methods**

A sequential quantitative dominant (QUANT/qual) mixed method study was conducted with Indiana, Kentucky, and Ohio nurses still employed at the same facility and unit from a prior study conducted in 2010 (Berry et al., 2012). A two-phase research design was used for this study (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). In Phase I, a quantitative web-based survey was implemented with the study sample. In Phase II, semi-structured interviews were conducted with a subset of the Phase I study sample (Figure 3). The mixing of quantitative and qualitative data occurred within the discussion to further describe emergent findings on what constitutes WPB behaviors, why WPB behaviors continue, and how these nurses continued to
cope and reach out for social support as they worked through or stopped WPB in their initial position (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). University Institutional Review Board (IRB) approval was secured prior to study procedures.

**Phase I Survey.** The study sample was obtained from a previous study of novice nurses (n=197) in practice less than three years (reference removed for anonymity). From this previous sample, 148 nurses agreed to further contact for research. Letter invitations to participate were sent with the URL link to an internet survey along with a unique study identification number. After entering the web-based survey, respondents received instructions and a letter detailing their rights as research subjects. Of the 84 respondents who completed the study survey, 37 nurses had described a targeted or observed WPB event in the 2010 study and continued their employment on the same unit at the time of this followup survey composed the analytical study sample. Demographic data from the 2010 study were used in further analysis (i.e., ethnicity, gender, age, educational attainment) along with other categorical variables (i.e., history of bullying prior to RN licensure, working on unit prior to RN licensure).

**Quantitative measures.** Respondents completed a five-component survey. The first component, the Negative Acts Questionnaire (NAQ), is a 22-item inventory measuring exposure to targeted WPB behaviors over a six-month period (Einarsen et al., 2009). The NAQ uses an ordinal scale with items weighted for a six-month exposure frequency (never = 0, now and then = 2, monthly = 6, weekly = 25, and daily = 125) (Berry et al., 2012; Simon, 2008). Summed scores ranged from 0 – 1,302 for the sample data with a Cronbach's alpha .89. A dichotomous categorical variable was developed by using the sum of 49 or less (infrequent WPB behaviors) and 50 or above (frequent to daily WPB behaviors). The cutoff sum of 50 or above was used based on work by Simons (2008) who determined the demarcation point to capture those
respondents exposed to twice weekly WPB.

The second component, the 10-item Perceived Stress Scale, assessed perceived stress in the sample over the past month (Cohen et al., 1983). This ordinal scale (1 = “none” to 4 = “often”) has four positively stated items that were reverse coded. All items then were summed, with scores ranging from 0 – 22 for the sample data. Cronbach’s alpha was .92.

The third component was the state anxiety scale, a 20-item subscale of the State Trait Anxiety Inventory (Spielberger et al., 1983). This component measured how respondents feel “right now”. This ordinal scale (1 = “Not at all” to 4 = “Very much so”) has nine items that were reverse coded and then all items were summed. Scores ranged from 20 – 76 and Cronbach’s alpha .96.

The fourth component, the Posttraumatic Stress Disorder Checklist – Civilian Version (PCL-C), screened for posttraumatic stress symptoms (National Center for PTSD, 2010). The PCL-C is a 17-item ordinal scale (1 = “Not at all” to 4 = “Extremely”) with a total symptom severity score ranging from 17 - 57 for the study sample. Cronbach’s alpha was .95 The PCL-C has a test-retest reliability ranging from .77 to .96, strong internal consistency reliability for the subscales ranging from .85 to .87, and internal consistency of .94 for the instrument as a whole (Blake et al., 1995). A score above 30 indicates the potential for a diagnosis of posttraumatic stress disorder (Bliese et al., 2008).

The final component was a demographic survey. The survey solicited questions about (1) prior work history on unit before RN licensure, (2) prior bullying outside of the work environment, (3) age, (4) gender, and (5) ethnicity.

**Data analysis.** Data were visually screened for missing data points using the Statistical Package for the Social Sciences (PASW Statistics, version 21, SPSS, Inc., Chicago, IL). Values
missing completely at random were identified using SPSS Missing Values Analysis. Data were replaced with the mode for that variable when 1.8% or less of the items were missing at random (Tabachnick & Fidell, 2007). Descriptive statistics described respondent data. Mann Whitney statistics were conducted to determine differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on WPB exposure levels and other nurse characteristics. A posthoc power analysis using GPower (Faul et al., 2009) was performed. Sufficient power (87%) was achieved to conduct the planned analyses based on the study sample size and Mann Whitney statistic for two independent group comparisons. The resulting Cohen’s d effect size was 1.13.

**Phase II Interviews**

The purpose of Phase II was to qualitatively explore the strategies used by nurses who experienced or observed a WPB event, and managed in spite of, or stopped, WPB, while remaining on the same unit with their same employer. All respondents who qualified for the Phase I procedures were asked to participate in a 1:1 interview. Over a period of eight months, 11 nurses completed the interview procedures (Figure 1). Telephone interviews were facilitated by using a semi-structured interview guide. Questions inquired as to why respondents thought WPB behaviors occurred, what they did to cope after, or to stop WPB, and other actions taken to continue working on the same unit after WPB occurred.

**Qualitative rigor and data analysis.** Rigor was established by building trustworthiness using Lincoln and Guba (1985) criteria. Subject matter experts assisted in development and review of the semi-structured interview guide (Lincoln & Guba, 1985). The interviews were conducted by phone, recorded digitally by the primary investigator, then transcribed verbatim by a paid transcription service. The primary author verified the accuracy of the transcripts by listening to the audio recordings, amending transcripts as needed. Verified transcripts were
transferred into NVivo 8 (QSR International, Doncaster, VIC, Australia) for analysis. An audit trail was developed and maintained to document coding discussions, decisions, and dispute resolution between investigators. Lincoln and Guba (1985) state the audit trail is the “single most important trustworthiness technique” (p. 283) for maintaining the truth-value, applicability, consistency, and neutrality of the content analysis. After prolonged contact with narratives, line-by-line content analyses were conducted separately and together by investigators to code responses, and to group findings under themes. Expert member checking occurred periodically for themes and subthemes to safeguard against bias by co-investigators in managing paradigm or contract disjunctions (Lincoln & Guba, 1985). Linkages between narratives were refined into structured themes and subthemes through multiple comparisons and discussion between investigators on coping with, working through, or stopping WPB (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009). The researchers used the qualitative data to make comparisons to the quantitative data for a better understanding of the psychological distress symptoms associated with the continuation of WPB behaviors in healthcare (Morse & Niehaus, 2009).

**Phase I Quantitative Results**

Of the 84 nurses who responded to the survey, 37 respondents met the criteria for Phase I inclusion. Respondents were mostly white (89.2%) and female (91.9%) (Table 1). The mean age was 28.8 years (S.D. 6.3), ranging from 22 to 47 years. Most respondents (n = 22, 59.5%) answered yes to being a target of WPB behaviors with 32% (n= 12) of respondents being exposed to frequent to daily WPB behaviors (Table 7).

The first phase of this study was to determine the differences in perceived stress, anxiety state, and posttraumatic stress symptoms based on WPB behavior exposure and other nurse characteristics (gender, education, ethnicity, age) while maintaining same unit employment.
Respondents (n=12) who experienced frequent to daily WPB exposure scored significantly higher for perceived stress (Md = 11 vs. 3, \( U = 37.0, p < .001 \)), anxiety state (Md = 49 vs. 32, \( U = 43.5, p = .001 \)), and posttraumatic stress symptoms (Md = 37.5 vs. 21, \( U = 45.0, p = .001 \)) as compared to respondents (n = 25) who experienced infrequent WPB behavior exposure. There were no differences for perceived stress or anxiety state when compared by age groups. However, there was a significant difference between respondents 30 years and older (n = 14, Md = 33) and 29 years and younger (n = 23, Md = 21) for posttraumatic stress symptoms (\( U = 86.5, p = .018 \)). No differences in perceived stress, anxiety state, and posttraumatic stress symptoms were noted when comparing groups based on previous work history on the unit prior to RN licensure, history of bullying outside of work, gender, educational attainment, race, or type of social support used.

**Phase II Qualitative Results**

Interviewees were mostly white (90.9%) and female (81.9%) (Table 1). Half of the interviewees (n=5) maintained employment at the same facility after becoming a nurse. The interviewees predominantly used a problem-focused coping style when experiencing work conflict. Three interviewees experienced frequent to daily exposure to WPB behaviors (Table 8). Content analysis based on the interviewee transcripts revealed four themes: (a) Construct of Bullying, (b) Permissive Culture of Bullying, (c) The Toxic Effects of Bullying, and (d) Fostering a Positive Work Culture.

In Construct of Bullying, respondents described behaviors, incidents, and situations by peer and nurse leaders they perceived as bullying. Respondents internally questioned the behaviors of others, but never confirmed aggressors’ intentions. One respondent said, “I've noticed that people are really mean to her. And even – I tend to be aware of it, but sometimes, I
catch myself being short with her. You know, rolling my eyes as I walk away.” Other bullying behaviors included gossiping, broken confidences by nurse leaders, screaming or verbal abuse, “eating their young”, equal opportunity bullying (picking on everyone), tough love, sink or swim, and refusal to assist when asked. Organizational practices considered bullying occurred when perceived as unfair, such as mandatory overtime, no breaks related to patient acuity, or down time away from the unit.

In a Permissive Culture of Bullying, the negative actions, attitudes, or interactions created an environment that enabled, ignored, or rewarded WPB behaviors. Respondents believed nurse leaders and human resources representatives minimized WPB behaviors through a sincere lack of recognition, ignoring, or minimizing their complaints. Perpetrators targeted newer, less tenured employees in general, where the “low man on the totem pole” created an easier target. One respondent stated of an aggressor “…she targets newer nurses and I think she targets less experienced nurses…”

The Toxic Effects of Bullying represented the personal reactions to perceived WPB behaviors. Suppressing emotions, blocking and refocusing on the work, and rationalizing the stressful environment helped respondents to work through WPB behaviors and continue patient care. However, six of 11 respondents were making plans to leave, from applying for licensure in a different state to applying to other facilities. Leaving was difficult for one respondent:

“I will be [leaving] just as soon as I get, as soon as I close on my house, which will be any week now. I have already started applying for other jobs. I haven’t gotten calls yet but I have started looking and kind of preparing myself mentally because as I said before, I do care about my residents. They’re- I’ve actually did clinical at this facility when I was in nursing school so I guess I’ve gotten attached to them. They’re like my friends and family so I’ve been preparing myself mentally that eventually I will be leaving and it might be months down the road but I definitely will be going.”
In Fostering a Positive Work Culture, all respondents provided excerpts on their sources and quality of support. Family support provided an avenue for venting but onsite peer support provided interventions ranging from immediate support by nurses who experienced the same bullying, being listened to by nurses considered friends, and other nurses expressing the behaviors were not only targeted at respondents but also directed towards others. Strategies on confronting aggressors were not always professional. Respondents were told to “fight back” or call the perpetrator “stupid.” However, being prepared for disruptive physicians, being a “team player,” or “buddying up” inside the facility were offered as solutions to maintaining employment and decreasing stressful encounters. Rituals, prayer, music, and maintaining close relationships with coworkers or patients helped to refocus respondents who continued to be targets of WPB behaviors.

Discussion

Of the nurses (n = 64) who documented WPB events in the 2010 study, 27 nurses did not remain on their unit, representing 40% attrition in 18 months. In addition, half of the nurses interviewed were actively looking for other positions or making plans to leave. WPB behaviors continued to be pervasive at the peer level in some healthcare organizations. Unaddressed interpersonal WPB behaviors leading an employee to terminate employment potentially can cost healthcare organizations $22,000 to $64,000 per replacement (Robert Wood Johnson Foundation, 2009), posing a significant burden to the financial viability of any healthcare facility. If a large facility with 1,000 RNs lost 40% of its staff yearly to WPB behaviors, estimated replacement costs would be between $8.8 and $25.6 million annually. Although WPB is not the only reason attrition takes place, half of the nurses interviewed were already looking for positions elsewhere.
One of the most significant findings was that each nurse was susceptible to stress, anxiety, or posttraumatic stress symptoms notwithstanding gender, race, educational attainment, or prior history of being bullied, even if they worked on the unit prior to becoming nurses. By internalizing the emotions, respondents did not confront the more senior peer or address the concerns minimized by peers and nurse leaders. Respondents expressed the futility in reporting WPB behaviors. In addition, nurses were encouraged by their senior peers to use verbal abuse to stop the perpetrator. If these victimized nurses adopted the same level of negative behaviors exhibited by coworkers, WPB behaviors can become normalized (Hutchinson et al., 2010).

Brotheridge, Lee, and Power (2012) found targets responded to aggression by using aggression and required help to stop the aggression constructively. However, emotions and the “stress of the confrontation” make the confrontation ineffective (Brotheridge et al., 2012).

Of those nurses remaining on the unit, 32.4% were exposed to WPB behaviors at least twice weekly with almost 60% feeling targeted and unable to defend themselves. Researchers studying stressful nursing practice endorse problem-focused (proactive coping) as more effective when managing stress from trauma care (Gillespie & Gates, 2013) and patient aggression (Gillespie, Gates, Miller, & Howard, 2010). Use of emotion-focused coping style (e.g., humor, prayer, voicing negative feelings, blaming oneself) may reduce the negative emotional responses to stressful situations, and may be more useful to those needing to accept the reality of that which they cannot change (Lazarus, 1999). Music, prayer, and maintaining close relationships with coworkers and patients helped to distract respondents from WPB behaviors and refocus on patient care. In terms of coping strategies used with peer work conflict, those interviewed avoided the perpetrators and suppressed emotions to focus on patient care.
Nurses need to be empowered with clear professional expectations to stop conflict or WPB behaviors, or ask for help (St-Pierre, 2012). Targets and other employee bystanders need to be educated to speak up when other nurses act inappropriately, unacceptably, or hurtfully. Nurse leaders must coach novice nurses on how to professionally address WPB behaviors. When witnessing WPB behaviors, nurse leaders must intervene and coach perpetrators to stop the WPB behaviors that make an unhealthy work environment (St-Pierre, 2012).

Respondents 30 years or older had a higher median score for posttraumatic stress symptoms. Recovery from any critical incident, trauma, or threat, may take weeks or months but novice nurses exposed to continued, accumulating, and adverse WPB behaviors may develop or exacerbate prior posttraumatic stress symptoms (de Boer, Lok, van’t Verlaat, Duivenvoorden, Bakker, & Smit, 2001). Healthcare professionals also may underestimate the effect of these stressors on their ability to function effectively (deBoer et al., 2001). Taking care of oneself emotionally is essential before posttraumatic stress symptoms impede the nurse’s ability to perform. Employee Assistance Programs may provide some benefit to these employees.

Teamwork is essential in the complex arena of healthcare to help the next group of new employees (Baker, Day, & Salas, 2006). One respondent validated this conclusion by expressing a desire to protect the next group of novice nurses coming into their unit. In addition, respondents gave several proactive steps for working with perpetrators: finding a “buddy to work with”, “knowing the needs” of disruptive physicians, and preparing for difficult persons.

This study was limited by a small sample size. Although adequate power was achieved for the quantitative analyses, the findings are not representative of all novice nurses. In addition, nurses experiencing severe WPB behaviors may have experienced discomfort and opted not to
participate. The study also depended on self-reports of the respondents, potentially creating response bias.

**Conclusion**

All healthcare professionals and the organizations where they work need to collaborate to create a safe and healthy work environment. Nurse leaders need to empower their direct reports to resolve minor intraprofessional conflicts but also must move swiftly to resolve escalating conflict and WPB when novice nurses are ineffective at defending themselves. When confronted with work conflict and WPB behaviors, all nurses need to mindfully consider their stress triggers when responding to perpetrators. Healthcare organizations should implement business practices and education that promote healthcare employees’ physical and psychological safety, health, and wellbeing. Future research should focus on target, observer, and nurse leader empowerment and self-advocacy to create and maintain safe, professional working environments to prevent further victimization and attrition from healthcare.
Table 7
Characteristics and WPB Exposure for Survey (n = 37) and Interview (n = 11) Respondents

<table>
<thead>
<tr>
<th>Characteristics and Variables</th>
<th>Survey, n (%)</th>
<th>Interviewed, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>33 (89.2)</td>
<td>10 (90.9)</td>
</tr>
<tr>
<td>Person of color</td>
<td>4 (10.8)</td>
<td>1 (9.1)</td>
</tr>
<tr>
<td>Female</td>
<td>34 (91.9)</td>
<td>9 (81.9)</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>16 (43.2)</td>
<td>6 (54.5)</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>21 (56.8)</td>
<td>5 (45.5)</td>
</tr>
<tr>
<td><strong>Prior History (positive history)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullied prior to RN licensure</td>
<td>13 (35.1)</td>
<td>5 (45.5)</td>
</tr>
<tr>
<td>Worked in facility prior to RN licensure</td>
<td>13 (35.1)</td>
<td>5 (45.5)</td>
</tr>
<tr>
<td><strong>Target Orientation (Are you bullied?)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>15 (40.5)</td>
<td>4 (36.4)</td>
</tr>
<tr>
<td>Yes, but rarely</td>
<td>15 (40.5)</td>
<td>7 (63.6)</td>
</tr>
<tr>
<td>Yes, now and then</td>
<td>5 (13.5)</td>
<td>0</td>
</tr>
<tr>
<td>Yes, several times a week</td>
<td>2 (5.4)</td>
<td>0</td>
</tr>
<tr>
<td><strong>NAQ weighed score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrequent exposure (0 – 49)</td>
<td>25 (67.6)</td>
<td>8 (72.7)</td>
</tr>
<tr>
<td>Frequent to daily exposure (50 or above)</td>
<td>12 (32.4)</td>
<td>3 (27.3)</td>
</tr>
</tbody>
</table>

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CHAPTER 6: IMPLICATIONS FOR PRACTICE AND RESEARCH

There are enormous physical and psychological costs to employees and employers when human aggression, like WPB, escalates in the workplace (Hill & Joyce, 2013). Given the state of the science, every healthcare worker is at risk of aggression and violence from multiple sources (Gillespie & Fisher, 2014). Unfortunately, these findings indicate that WPB behaviors occur as a socialization process within organizations that ignore, enable, or reward WPB (Hutchinson et al., 2010). Because of the escalating scrutiny of healthcare violence, the Occupational Safety and Health Administration (2015) has issued revised guidelines for preventing workplace violence in healthcare settings and the American Nurses Association is drafting a position statement on incivility, bullying, and workplace violence. In creating position statements, it is highly recommended to include other professional organization (e.g., human resources, psychology, safety, security, social work) for a wider lens to address the complex issue of aggression and violence in the workplace.

A discussion of the study findings was previously presented (see Chapters 4 and 5). This chapter will focus on implications for practice and research for specific stakeholder groups. The target groups are individual nurses, nurse educators in academic settings, nurse leaders, and occupational and environmental health professionals.

Implications for Practice

Implications for Individual Nurses

When WPB behaviors are rationalized, justified, or not addressed in a highly stressful environment by peers, and minimized by nurse leaders, these WPB behaviors become normalized and embedded in the work culture (Hutchinson et al., 2010). As WPB behaviors escalate and individuals react (or reciprocate) in silence or their own negative behaviors, a poor
work environment develops (Duffy & Sperry, 2014; Patterson et al., 2013). When WPB behaviors are pervasive through orientation, even competent novice nurses become powerless when dependent on peers who use WPB behaviors for orientation to facilities and procedures.

**Recommendations for practice.** Nurses must assume responsibility for their own personal and professional growth in order to advocate not only for patients but also for themselves, their colleagues, and their profession. Learning how to professionally and timely confront others who use words to shake confidence or humiliate is essential for personal psychological health. Respondents in this dissertation who continued to work on the same unit after witnessing or experiencing WPB behaviors recommended using a buddy system to reach out for support (Chapter 5). Gillespie, Brown, Grubb, Shay, and Montoya (2015) recommend a trusted nurse mentor for assessing and providing input on clinical competence. Nurses need to professionally confront persons using WPB behaviors instead of being a passive bystander (Griffin, 2004; Patterson et al., 2013). Patterson et al. (2013) promote giving respect, sharing interests in solving the issues at hand, and addressing the behavior, not attacking the person. However, not all nurses are emotionally ready to intervene when WPB behaviors occur. Gillespie et al. (2015) addressed the strength of physically standing behind or next to persons receiving WPB behaviors as a sign of support against an aggressor. In addition, nurses need to recognize that their own behaviors may trigger stress in their mentors who may be over-burdened by orientation (Budin et al., 2013). Personal management of work-life balance can help individual nurses better manage their personal behaviors in the complex environment of healthcare (Weinstein, 2009).
Implications for Nurse Educators in Academic Settings

Oppressed group theory (Fanon, 1963; Freire, 2010; Roberts, 1983) has dominated nursing literature as an explanation of WPB behaviors. However, work stress, job ambiguity, and uncontrollable workload create the fertile ground for emotion-laced, stressed communication leading to silence or WPB behaviors at the peer level. Hutchinson et al. (2010) indicated WPB behavior is normalized within some healthcare cultures. Not all healthcare facilities are healthy workplaces and students coming into these settings are particularly vulnerable and may learn that WPB behaviors are an acceptable form of communication (Hoel et al., 2007). Regardless, student nurses must be educated on professional communication and work behaviors to prevent the normalization of workplace aggression in the next generation of nurses.

Practice recommendations. Nurse educators have powerful voices and can influence students greatly. The expectation of civility starts in nursing school by educating and modeling a stronger, more professional response for dialog (Clark, 2013). Dellasega (2011) states education, reframing, and integration of appropriate professional behaviors are necessary. Additionally, crucially confronting a perpetrator decreases the ambiguity of intent with WPB behaviors (Griffin, 2004). Bystander voice is crucial and should be cultivated in students (Dellasega, 2011; Gillespie et al., 2015). Strategies to accomplish these recommendations include in-depth discussion, education, and practice on professional etiquette, stress management, collaboration, and communication in clinical and didactic classwork (Clark, 2013). Also recommended is role play to enhance the learning experience (Gillespie et al., 2015; Griffin, 2004). Promoting patient cultural care as well as inclusivity, diversity, and tolerance between students and other healthcare collaborators (e.g., medical students, physical therapist students, health and safety students) in clinical and didactic education are recommended. Nurse educators may have to be more selective
on clinical sites and work with organizations on improvements towards a “just” culture. However, if clinical sites are difficult to secure, the use of mentoring programs before, during, and after graduation for novice nurses may provide more transitional support to help move students towards a positive role model. Not all healthcare organizations are able or willing to change so determining the best practice to stop WPB behaviors needs to start at the student level by promoting focus group support programs for safe problem solving as they transition from novice to competent nurse.

**Implications for Nurse Leaders**

When leadership fails to act to support novice nurses to resolve WPB behaviors, nurses may lose trust in leadership. Nurse leaders are responsible for demonstrating support of novice nurses by encouraging, coaching, and assisting them to resolve minor work conflicts (Laschinger & Grau, 2012; Moore et al., 2013; St-Pierre, 2012). When trust in leadership was not present, nurses were less likely to seek help when experiencing WPB behaviors. This finding reflects a gap in nurse leaders’ communication with others.

Attrition was a reported consequence of WPB behaviors in this dissertation. Unaddressed WPB behaviors leading an employee to terminate employment potentially can cost healthcare organizations $22,000 to $64,000 per replacement (Robert Wood Johnson Foundation, 2009), posing a significant burden on the financial viability of any healthcare facility. Approximately 30% of the respondents left their employers in the 18-month period between data collection points. One third of those respondents who left cited environment (bullying, stress, toxic work environment) as the cause. Half of the respondents interviewed were looking for jobs and cited work environment. WPB behaviors continued as a barrier to good employer-employee relationships.
**Practice recommendations.** Nurse leaders need to exceed the Joint Commission’s recommendations to embrace employee engagement, satisfaction, and retention. To lead and manage successfully, skilled-based education on building collaborative relationships, confronting unprofessional behavior, coaching, and conflict resolution are necessary (The Joint Commission, 2008). The lack of trust in nurse leaders by some respondents presents a gap to be addressed. Nurse leaders who address this problem between employees and employers will lead a more effective organization (Cook et al., 2005).

A relational approach will increase the shared purpose and connections in contrast to the authoritarian power that can kill relationships and productivity (Patterson et al., 2013). In addition, successful transition from novice to competent nurse requires tenured nurses to train and mentor novice nurses through the typical daily challenges in nursing (Benner, 1984; Benner et al., 2010; Kramer, 1974; Pellico et al., 2009). Nurse leaders can assure that tenured nurses mentoring novice nurses are appropriately matched and given a reduced workload to foster a mentoring relationship. Hiring and onboarding practices may require auxiliary staffing models as safe nurse-patient ratios become established through government regulation. Some novice nurses take on additional responsibilities such as “charge nurse,” which may be an ambiguous role of more responsibility, but no conferred power or authority. These new charge nurses will need support from nurse leaders in order to build or maintain a better culture and climate.

**Implications for Occupational and Environmental Health Professionals**

Occupational and environmental health professionals focus on workforce health and productivity, tailoring interventional programs to manage healthcare costs (Randolph, Scully, & Bertsche, 2014). These professionals also collaborate with other departments and professionals in order to maintain metrics associated with work injury, illness, and use of sick leave as part of
their position. These professionals can serve as consultants to nurse leaders, human resource professionals, or employees distressed by WPB behaviors. Employees may present to them complaining of somatic complaints (e.g., stomachache, headaches, depression, anger, lost time) that accompany stress and burnout from frequent WPB behaviors (Vessey et al., 2009; Yildirim, 2009).

**Practice recommendations.** Patient care has become more complex, time-consuming, and stressful. Essential job functions and descriptions in healthcare organizations may be outdated to meet current demands. Occupational and environmental health professionals should use injury and illness surveillance to determine at-risk units within healthcare organizations. Using resources on cost benefit studies of health risks associated with WPB behaviors, these professionals may estimate the costs of attrition and benefit use. With this information, they can project the impact that unresolved work conflict and escalated WPB behaviors have to financial status of employers (Randolph et al., 2014). Using cost savings, corporate image, productivity, and business risk as critical business concerns, these professionals can create a case for intervention (Randolph et al., 2014).

**Implications for Research**

Findings from this dissertation indicate that WPB behaviors continue in healthcare organizations at the peer-to-peer level, fueling distrust. When novice nurses distrust leadership, stress and anxiety increase, potentiating posttraumatic stress symptoms and the next generation of perpetrators of WPB behaviors. Further research is needed to more fully understand this problem as well as study interventions to reduce this burden in healthcare.
Research Opportunities for Nurse Educators in Academic Settings

Nurse educators are perfectly situated to conduct longitudinal studies with student nurses prior to their entry into practice. Quasi-experimental studies can be done to evaluate the effectiveness of communication education and simulations in WPB management. Because WPB behaviors increase anxiety state and posttraumatic stress symptoms in novice nurses, testing the effectiveness of student-led peer support groups may lead to valuable contributions to practice once students are novice nurses experiencing WPB behaviors.

Research Opportunities for Nurse Leaders

Future research should be conducted to identify optimal onboarding processes for novice nurses that lead to civil work cultures. Research should be conducted collaboratively with human resources, risk management, nurse leaders, and occupational and environmental health professionals to measure the true costs of work productivity loss in work settings where WPB behaviors are prominent.

Research Opportunities for Occupational and Environmental Health Professionals

As previously stated, every nurse may be affected by WPB behaviors. When WPB behaviors are work stressors, WPB behaviors are detrimental to employee health. Research may be conducted to measure the incidence and financial impact of WPB behaviors related to work productivity, missed days from work, injury, and illness.

Conclusion

Reducing, eliminating, and preventing WPB behaviors in healthcare begins with nurse educators modeling and teaching professional behaviors, boundary setting, and communication. In turn, individual nurses must continue to model professional behaviors, set boundaries, and communicate effectively with nurse peers and leaders in their organizations. All nurses must
recognize the triggers and responses associated with WPB behaviors and alter responses to the behaviors by holding the person or industry accountable. The notion that one individual can challenge, change, and sustain a healthy and safe workplace is unrealistic but one voice added to many can create a movement to change healthcare culture.
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Workplace bullying (WPB) and its behaviors have been linked to decreased productivity, satisfaction, and retention in nursing, hindering safe patient care (Berry et al., 2012). The purpose of this paper is to review and apply the constructs of WPB within the nursing field. Actions for nurse leaders will be discussed on how to recognize, confront, and eliminate WPB behaviors. WPB is defined as the repeated and frequent unacceptable behaviors targeted towards an individual or group. Examples of bullying behaviors include harassment, exclusion, humiliation, belittlement, gossip, and assignment of unfair workloads. In addition, the perpetrator carefully and methodically tailors bullying behaviors in creative and opportunistic ways to reduce a target’s ability to defend against these behaviors (Cleary et al., 2010).

What constitute WPB remains discordant within the multiple meanings through researchers’ prisms and targets’ perceptions (Einarsen et al., 2003; Einarsen.et al., 2011; Vessey et al., 2011). Untargeted and ambiguous acts of WPB behaviors are symptoms of an incivil work environment (Einarsen et al., 2011). Delineating and measuring WPB provides an important linkage to the further understanding of WPB predictors and consequences. Einarsen et al.’s (2011) constructs will be used to increase the clarity between incivility and in recognizing, confronting, and eliminating WPB behaviors.

Recognizing Workplace Bullying, Incivility, and Social Norms

Einarsen et al. (2011) developed WPB constructs through synthesis of European bullying research beginning in the early 1990’s. The five constructs of WPB are target orientation, frequency, duration, intentionality, nature of the behavior, and power imbalance.
**Target Orientation (Self-Labeling).** Targets themselves determine if WPB behaviors are directed toward them (Einarsen et al., 2011). As an example, Berry et al. (2012) asked novice nurses about negative acts directed towards them in the previous six months. Even though 92.9% (n=183) of the participants had exposure to negative behaviors, only 44.6% (n=88) self-identified as having been bullied. This finding reflects that not all accounts of negative behaviors experienced are perceived as WPB.

**Frequency.** WPB is not a single behavioral event. WPB must occur repeatedly, at least once weekly (Einarsen et al. 2011). An example of WPB, within the nursing context, is when a charge nurse assigns an unmanageable workload to a particular nurse compared to other nursing staff (or the charge nurse’s friends) daily or weekly. In Berry et al. (2012), a similar incident was described and coined a “rite of passage” by a novice nurse.

An example highlighting a behavior not easily placed in the frequency category of repeated behavior is the spreading of rumors or gossip (Einarsen et al., 2011). The perpetrator may initiate a rumor to increase their political standing without the intent of harming another employee (Archer, & Coyne, 2005). The initiator does not repeat the rumor, but others do. As the rumor spreads through the organization, changes in peer social support occur, leaving the target socially isolated (Einarsen et al., 2011). The target may be unaware of the rumor until peer or organizational relationships have changed significantly. An example of a rumor is when a nurse alludes to a sexual liaison between two nurses because of a misperceived close friendship during a shared project when there is none. This rumor then causes the manager to separate one of the nurses from the project.

**Duration.** Einarsen et al. (2003) established the six-month time frame to distinguish WPB from incivility and interpersonal conflict. This time frame created a criterion to measure
the behaviors of WPB. The time frame does not mean WPB behaviors go unrecognized before six months or that WPB stops after six months. WPB has been documented to occur on average 18 months, and continuing until nurses took extended sick leave, transferred, quit or were terminated (Vessey et al., 2009; Yildirim & Yildirim, 2007).

**Intentionality.** WPB is intentional from the target’s perspective. Einarsen et al. (2011) assert only the perpetrator can verify intention, giving the perpetrator the power to deny the intent of his or her actions to harm the target. In an incivil environment, a predatory bully may deny any intention to harm until the damage to the target is irrevocable (Einarsen et al., 2003). Because of this, the target’s perception of intention supersedes the perpetrator’s declared intent (Einarsen et al., 2003; Einarsen et al., 2011).

Unintentional harm also may play a larger role in healthcare through the use of instrumental aggression, which is an aggressive act to obtain something of value. Bullying behaviors may be used to increase an aggressor’s political power. Nurses have recognized that bullying behaviors occur for individual, political, and competitive reasons (Ferris et al., 2007; Katrinli et al., 2010; Neuman & Baron, 2011).

WPB perpetrators may be unaware that their actions negatively impact the target. Within nursing, assigning mandatory overtime to nurses who are new, single, or male without asking or rotating the mandatory overtime is an example of WPB behavior. The exclusive assignment of difficult workloads as a way of “making or breaking” a new nurse into the work environment also is WPB. What once was a social norm or tradition in healthcare is no longer acceptable behavior and is now clearly understood as bullying (Bartholomew, 2006; Dellasega, 2011; Griffin, 2004).
**Nature of the Behavior.** WPB and incivility are manifestations of human aggression in the workplace. Einarsen et al. (2011) recognizes that WPB can be divided into conflict-related and predatory bullying. WPB is not a conflict between opponents of equal power, however work conflict can accentuate interpersonal power imbalance (Einarsen et al., 2003; Neuman & Baron, 2011). With predatory bullying, the perpetrator seeks to exert power and control over a target. There are numerous reasons predatory bullying occurs and may be linked to poor self-esteem, personality traits, or simply recreational (e.g. teasing a foreign-born nurse because of her accent) (Neuman & Baron, 2011). However, predatory bullying is purposeful in its selection of a target believed to be unable to defend against the bullying behavior. Targets are vulnerable either from the perceived power differences, inability to push back verbally against the behavior, or the ambiguous intent of the behavior. Incivility poorly resolved between the target and predatory perpetrator can escalate from incivility to WPB to physical violence (Andersons & Pearson, 1999).

**Power Imbalance.** Power differences are present between the perpetrator and the target. There is the perceived power of seniority or the actual power of a position (e.g., charge nurse, nurse educator, supervisor or manager) in comparison to new or novice nurses. Targets believe they are in a powerless position; and, therefore, unable to defend against the bully’s actions (Cleary et al., 2010; Salin, 2003). Salin (2003) states power imbalances align with the overall societal beliefs about powerful (e.g. white male, CEO, government official) or powerless people (e.g. female, ethnic minority, persons with a disability) and these same societal beliefs flow into organizational cultures.

With Social Exchange Theory, the interpersonal power of the perpetrator increases through the imbalance of reciprocity (rewards or exchanges) when the target is dependent on the
perpetrator for job security, knowledge, guidance, job assignments, direction, or support (Blau, 1987). Within an organization, employees must trust that their work will be rewarded. Employee trust can be lost when WPB causes inequality in the exchange between work production and reward (Blau, 1987; Cook, Hardin; & Levin, 2005). WPB may lead to employee organizational mistrust when there is failure to resolve escalating work conflict. Notably, nurse productivity was negatively impacted ($r = -0.322, p = 0.01$) with WPB (Berry et al., 2012).

**Other Considerations in Workplace Bullying**

The constructs forming WPB are target orientation, frequency, duration, intention, and power imbalance. To differentiate between work conflict or incivility and WPB, the target must perceive he or she is the target of intentional, frequent and systematic negative acts for six months with an inability to defend against those acts related to the perceived power difference between the target and the perpetrator (Einarsen et al., 2011).

Social norms also may play a role in shaping or reinforcing WPB behaviors (Neuman & Baron, 2011; Hutchinson et al., 2010; Kramer, 1974). A social norm is a spoken or unspoken rule or particular way of doing things (e.g., everyone facing the door in an elevator) which imposes the expected behaviors among a group (Bicchieri & Muldoon, 2011). WPB may have a long history in an organization (e.g. military, paramilitary, nursing), rooted and unrecognized as socialization through indoctrination or ritualistic initiations of the new employee (Kramer, 1974; Hutchinson et al, 2010). In other words, perceived WPB behaviors may be a culturally supported form of instrumental aggression mingled with the good intentions of molding the novice nurse into the organizational culture.

Hutchinson et al. (2010) found that informal organizational alliances along with organizational tolerance, reward, and misuse of legitimate authority, processes, and procedures
led to WPB in healthcare. Further synthesis of the narratives of WPB studies suggested a socialization process within nursing that normalized bullying behavior (Hutchinson, 2012). Organizational tolerance and reward of WPB in the management of nurses led to silence, minimization, and under-reporting of WPB by nurses (Hutchinson et al., 2010). This same socialization also may cause under-reporting of injuries, violent or verbal attacks from patients, as well as non-payment of lost breaks, lunches, and overtime by nurses.

A strong predictor of engaging in bullying behaviors is having been bullied (Hauge, et al., 2007). Bullied participants in three nursing studies confirmed use of bullying behaviors defensively (Vessey et al., 2009; Yildirim & Yildirim, 2007, Yildirim et al., 2007). Hoel, Giga, & Davidson (2007) noted that student nurses adopt the norm of the nurse collective working group, instead of challenging WPB behavior. Given the adoption of social norms within the group culture, understanding how the nursing culture plays a role in the continuation of WPB is a crucial first step to changing that culture towards a culture of safety and health of nurses.

Confronting and Eliminating WPB

The previous sections provided a description to assist nurse leaders in recognizing and understanding the complexity of WPB behaviors within the nursing culture. The following actions are recommended to confront and eliminate bullying behaviors in nursing.

Target Orientation

The perception of the target is critical. When an employee approaches the nurse leader reporting an interpersonal conflict, address employee concerns immediately. Discuss the conflict to determine if communication and behavior have been addressed between both employees. Griffin (2004) noted tenured nurses were not aware that their behaviors toward novice nurses were perceived as bullying. Increasing verbal communication between the employees will add
clarity and understanding for better interprofessional communication and will assist in avoiding an escalating process.

Based on the recommendations of The Joint Commission (2008), healthcare organizations are encouraged to educate all employees on WPB behaviors and instruct targets and bystanders on reporting these behaviors confidentially. Healthcare organizations should educate new employees in new hire orientation as well as annually with all employees. In addition, what constitutes appropriate behavior and professional communication in the workplace should be communicated and modeled by nurse leaders. Although zero tolerance policies have been recommended at all levels of the organization, structured coaching and progressive corrective action policies that are transparent to all employees is recommended (The Joint Commission, 2008).

Frequency and Duration

From a researcher’s perspective, WPB happens weekly for a minimum of six months; however, an employee may feel bullied within weeks of repeated and frequent unacceptable acts in an incivil work environment. If a culture of disrespect and incivility is endemic to the facility, careful monitoring and increased interventions are needed while working through culture change. Nurse leaders need to be attentive to staff communication on and off their unit as WPB behaviors can occur between units and floors causing reduced participation and productivity. Frequent contact in a non-threatening manner (i.e., open door policy) may provide an opportunity for employees to share with the nurse leader issues arising on and between the units. Additionally, confidential focus groups to share experiences in a safe environment and rehearse individual responses to WPB behaviors have proven helpful (Griffin, 2004). Skilled-based education on building collaborative relationships, confronting unprofessional behavior, coaching, and conflict
resolution are necessary to any nurse leader’s ability to manage staff effectively (The Joint Commission, 2008).

**Intentionality and Nature of the Behavior**

Regardless why WPB behaviors occur, WPB behaviors continue. WPB behaviors have been tolerated, enabled, or rewarded, creating social and cultural acceptance in healthcare (Hoel et al., 2007; Hutchinson et al., 2010; Kramer, 1974). Given most instances of bullying are learned behaviors, responses to stress, or social norms of an organization, the behaviors can be unlearned. Nurse leaders must model professional behaviors and verbalize what those expected behaviors are. In addition, nurse leaders must state to their staff that WPB behaviors are unaccepted, will be confronted, and will be documented. If coaching or corrective action fails, there will be consequences to the bully that include termination (The Joint Commission, 2008; Patterson et al., 2005).

**Power Imbalance**

The reporting structure within a hierarchical organization can create a perceived power imbalance which silences staff as well as nurse leaders in reporting up the corporate structure, leading to the perception of bullying (Patterson et al., 2005; Grubb et al., 2004). To minimize the power imbalance, shared governance within magnet status or other professional practice models have been recommended for effective nurse empowerment by creating a shared responsibility and transparency in decision-making for patient-centered care, increasing nurse satisfaction, retention, and patient safety (Barden, Griffin, Donahue, & Fitzpatrick, 2011).

**Conclusion**

The perception of WPB behaviors within an organization can be minimized by a skilled and interactive-oriented nurse leader who recognizes WPB behaviors, confronts unprofessional
behaviors, and empowers staff to do the same. Corporate officers, nurse leaders, staff nurses, and all other healthcare staff need to work together to manage cultural change in the individual and group responses to stressful workplace triggers that cause WPB. As the root causes of WPB become more transparent through education, collaboration between administration, nurse leaders, and staff will create a shared response to mutually combat WPB.
APPENDIX B

Recruitment Letter (Example)

Peggy Berry, RN, MSN
Gordon Gillespie, RN, PhD
University of Cincinnati College of Nursing
P.O. Box 21-0038
Cincinnati, OH 45221-0038
O: 513.558.5236
F: 513.558.2142

Date:

Dear (participant):

Thank you for your prior participation in the research study “The Effects of Bullying and Productivity and the Novice Nurse.” We are asking you to participate in an additional research study, A Mixed-Methods Analysis of Novice Nurse Coping Strategies after Workplace Bullying, regarding workplace bullying. For your participation, we will send you a $10.00 Starbucks or Target gift card. You will be able to access study survey material and informed consent at: http://www.surveymonkey.com/_________. You’ll need your study ID number:

This survey will only be open through _______. We will be selecting a smaller group for telephone interviews following the survey. The telephone interview will be audio-taped, last approximately 1 ½ hours, and ask additional information on the strategies used after workplace bullying. If you decline to be audio-taped, this will indicate that you decline the interview or you can decline to be interviewed. An additional $20 Starbucks or Target gift card will be paid for participation in the telephone interview. Thank you for your participation in this important study.

Sincerely,

Peggy Berry/Gordon Gillespie
APPENDIX C INFORMED CONSENT

Principal Investigator: Peggy Berry, RN, MSN; email: berrypa@mail.uc.edu
Faculty Advisor: Gordon Gillespie, RN, PhD; email: gordon.gillespie@uc.edu

Adult Consent Form for Research
University of Cincinnati
Department: College of Nursing
Principal Investigator: Peggy Berry, RN, MSN
Faculty Advisor: Gordon Gillespie
Title of Study: Coping Strategies of Nurses Who Are Bullied

Introduction:
You are being asked to take part in a research study. Please read this paper carefully and ask questions about anything that you do not understand.

This research study was supported by the American Nurses Grant #1855.

Who is doing this research study?
The person in charge of this research study is Peggy Berry, RN, MSN of the University of Cincinnati (UC) College of Nursing. Peggy Berry, RN, MSN is being guided in the research by Gordon Gillespie, PhD, RN.

What is the purpose of this research study?
The purpose of this research study is to identify and measure the psychological effects of workplace bullying and coping strategies used by the novice nurse to maintain employment after workplace bullying.

Who will be in this research study?
About 121 people will take part in this study. You may be in this study if you participated in the previous study on the effects of workplace bullying on productivity.

What will you be asked to do in this research study, and how long will it take?
You will be asked to fill out a survey. It will take about 1 ½ hours to complete. The research can be done wherever you have a computer with internet access. You will be asked to rate your life stress, anxiety and post traumatic stress one year after the first study.

Your study participation will be confidential. There are no requirements to participate and your employer will not be notified regarding your study participation.

Are there any risks to being in this research study?
There are no known psychological or physical issues with filling out the surveys but, you will be directed to your Employee Assistance Program or National Suicide Hot line if you experience distress with the recalling of bullying behavior.

Are there any benefits from being in this research study?
You will probably not get any benefit because of being in this study. But, being in this study may help to understand the relationship between the psychological effects of workplace bullying and coping strategies used after workplace bullying.

Will you be compensated or get anything from being in this research study?
You will receive a $10 Target or Starbucks gift card by mail for participating in the study. You will receive the gift card regardless of completion of the entire survey. If selected for a phone interview, you will receive an additional $20 Target or Starbucks gift card by mail following the interview.

Do you have choices about taking part in this research study?
If you do not want to take part in this research study you may simply not participate. How will your research information be kept confidential? Information about you will be kept private by assigning a unique code to your identifying information.

Plans that may be used include, but are not limited to only the PI and mentor having access to the database, roster and matching code key. In addition, any identified data will be locked in the designated area of the UC College of Nursing Center for Nursing Research. After data collection is finished, the code key will be destroyed. Any data storage will be on a secured server through UC College of Nursing and will be kept for up to seven years after the completion of the study. Any electronic data will be deleted and any paper generated data will be shredded. Only de-identified data in aggregate form will be used for all reports and for dissemination. The data from this research study may be published; but you will not be identified by name. Agents of the University of Cincinnati may inspect study records for audit or quality assurance purposes.

What are your legal rights in this research study? Nothing in this consent waives any legal rights you may have. This consent also does not release the investigator, funding agencies, the institution, or its agents from liability for negligence.

What if you have questions about this research study? If you have any questions or concerns about this research study, you should contact Peggy Berry, RN, MSN at berrypa@mail.uc.edu or, you may contact Gordon Gillespie at gillesgl@ucmail.uc.edu.

The UC Institutional Review Board – Social and Behavioral Sciences (IRB-S) reviews all non-medical research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your rights as a participant or complaints about the study, you may contact the Chairperson of the UC IRB-S at (513) 558-5784. Or, you may call the UC Research Compliance Hotline at (800) 889-1547, or write to the IRB-S, 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567, or email the IRB office at irb@ucmail.uc.edu.

Do you HAVE to take part in this research study? No one has to be in this research study. Refusing to take part will NOT cause any penalty or loss of benefits that you would otherwise have. You may skip any questions that you don't want to answer. You may start and then change your mind and stop at any time.

Agreement: I have read this information and have received answers to any questions I asked. I give my consent to participate in this research study. I will receive a printed copy of this consent form.

BY TURNING IN YOUR COMPLETED SURVEY YOU INDICATE YOUR CONSENT FOR YOUR ANSWERS TO BE USED IN THIS RESEARCH STUDY. PLEASE PRINT AND KEEP THIS INFORMATION SHEET FOR YOUR REFERENCE.
APPENDIX D - SURVEY

Survey Introduction

You are being asked to answer questions about your work environment, your stress level, feelings, coping styles, support systems, and additional information about yourself.

We are going to ask you about your work environment and exposure to workplace bullying over the last six months. Even if you have not been a target of workplace bullying now, your answers are important to the researchers. Please completely fill out the survey.

We define workplace bullying as any prolonged, unacceptable overt or covert behavior repeatedly targeted towards an employee or group of employees by one or more employees which is humiliating, belittling, hurtful, excessive, and unwanted. These unacceptable behaviors take the form of verbal abuse (e.g., yelling, insults, teasing, gossip), belittling gestures (e.g., eye rolling, ignoring, terminating conversation by turning away), or unacceptable actions (e.g., sabotaging work, hiding equipment, withholding information vital to work assignment, assigning excessive work load purposely for employee failure). Targeted employee or employees find it difficult to defend against these behaviors. Workplace bullying is not one incident but is sustained over a period of time, at least six months.
Negative Acts Questionnaire

The following behaviors are often seen as examples of negative behavior in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work? Please mark the number that best corresponds with your experience over the last six months.

<table>
<thead>
<tr>
<th></th>
<th>1 – never</th>
<th>2 – now and then</th>
<th>3 – monthly</th>
<th>4 – weekly</th>
<th>5 – daily</th>
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<tbody>
<tr>
<td>1.</td>
<td>Someone withholding information which affects your performance.</td>
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<td>2.</td>
<td>Being humiliated or ridiculed in connection with your work.</td>
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<td>3.</td>
<td>Being ordered to do work below your level of competence.</td>
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<td>4.</td>
<td>Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks</td>
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<td>5.</td>
<td>Spreading of gossip and rumors about you.</td>
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<td>6.</td>
<td>Being ignored, excluded or ostracized.</td>
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<td>7.</td>
<td>Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life.</td>
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<td>8.</td>
<td>Being shouted at or being the target of spontaneous anger (or rage).</td>
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<td>9.</td>
<td>Intimidating behavior such as finger-pointing, invasion of personal space, shoving, blocking/barring the way.</td>
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<td><strong>10.</strong></td>
<td><strong>Hints or signals from others that you should quit your job.</strong></td>
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<td><strong>11.</strong></td>
<td><strong>Repeated reminders of your errors or mistakes.</strong></td>
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<td><strong>12.</strong></td>
<td><strong>Being ignored or facing a hostile reaction when you approach.</strong></td>
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<td><strong>13.</strong></td>
<td><strong>Persistent criticism of your work and effort</strong></td>
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<td><strong>14.</strong></td>
<td><strong>Having your opinions and views ignored.</strong></td>
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<td><strong>15.</strong></td>
<td><strong>Practical jokes carried out by people you don’t get along with.</strong></td>
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<td><strong>16.</strong></td>
<td><strong>Being given tasks with unreasonable or impossible targets or deadlines.</strong></td>
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<td><strong>17.</strong></td>
<td><strong>Having allegations made against you.</strong></td>
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<td><strong>18.</strong></td>
<td><strong>Excessive monitoring of your work.</strong></td>
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<td><strong>19.</strong></td>
<td><strong>Pressure not to claim something which by right you are entitled to (e.g., sick leave, holiday pay, travel expenses).</strong></td>
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<td><strong>20.</strong></td>
<td><strong>Being subject of excessive teasing and sarcasm.</strong></td>
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<td><strong>21.</strong></td>
<td><strong>Being exposed to an unmanageable workload.</strong></td>
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<td><strong>22.</strong></td>
<td><strong>Threats of violence or physical abuse or actual abuse.</strong></td>
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<tr>
<td><strong>23.</strong></td>
<td><strong>Have you been bullied at work?</strong> We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will not refer to a one time incident as bullying. Using the above definition, please mark whether you have been bullied at work over the last six months.</td>
<td><strong>a.</strong> No (continue on to the next questions);</td>
<td><strong>b.</strong> Yes, but only rarely;</td>
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<td></td>
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<td><strong>c.</strong> Yes, now and then;</td>
<td><strong>d.</strong> Yes, several times per week</td>
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</table>
24. Recalling the list of negative acts, have you used the same behaviors towards peers or new novice nurses?
   a. Yes  
   b. No
**Perceived Stress Scale**

The next set of questions will ask about your feelings and thoughts during the last month. Your answers are important to the research. In each case, you will be asked to indicated by marking how often you felt or thought a certain way.

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<tr>
<th></th>
<th>0 – never</th>
<th>1 – almost never</th>
<th>2. - sometimes</th>
<th>3. – Fairly often</th>
<th>4. - Often</th>
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<tr>
<td>1. In the last month, how often have you been upset because of something that happened unexpectedly?</td>
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<td>2. In the last month, how often have you felt that you were unable to control the important things in your life?</td>
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<td>3. In the last month, how often have you felt nervous and “stressed”?</td>
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<td>4. In the last month, how often have you felt confident about your ability to handle your personal problems?</td>
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<td>5. In the last month, how often have you felt that things were going your way?</td>
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<td>6. In the last month, how often have you found that you could not cope with all the things that you had to do?</td>
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<td>7. In the last month, how often have you felt that you were able to control irritations in your life?</td>
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<td>8. In the last month, how often have you felt that you were on top of things?</td>
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<td>9. In the last month, how often have you been angered because of things that were outside of your control?</td>
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<td>10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?</td>
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<td></td>
<td>1 – Not at all</td>
<td>2 – A little bit</td>
<td>3 – Moderately</td>
<td>4 – Fairly often</td>
<td>5 – Extremely</td>
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<td>1.</td>
<td>Repeated, disturbing memories, thoughts, or images of a stressful experience from the past</td>
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<td>2.</td>
<td>Repeated, disturbing dreams of a stressful experience from the past?</td>
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<td>3.</td>
<td>Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?</td>
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<td>4.</td>
<td>Feeling very upset when something reminded you of a stressful experience from the past?</td>
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<td>5.</td>
<td>Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?</td>
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<td>6.</td>
<td>Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?</td>
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<td>7.</td>
<td>Avoiding activities or situations because they reminded you of a stressful experience from the past?</td>
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<td>8.</td>
<td>Trouble remembering important parts of a stressful experience from the past?</td>
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<td>9.</td>
<td>Loss of interest in activities that you used to enjoy?</td>
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<td>10.</td>
<td>Feeling distant or cut off from other people?</td>
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<td>11.</td>
<td>Feeling emotionally numb or being unable to have loving feelings for those close to you?</td>
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<td>12.</td>
<td>Feeling as if your future will somehow be cut short?</td>
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<td>13.</td>
<td>Trouble falling or staying asleep?</td>
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<td>14.</td>
<td>Feeling irritable or having angry outbursts?</td>
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<td>15.</td>
<td>Having difficulty concentrating?</td>
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<td>16.</td>
<td>Being “super-alert” or watchful or on guard?</td>
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<tr>
<td>17.</td>
<td>Feeling jumpy or easily startled?</td>
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</table>
State Trait Anxiety Inventory – State

A number of statements which people have used to describe themselves are given below. Read each statement and then blacken the appropriate circle to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feeling best.

<table>
<thead>
<tr>
<th></th>
<th>1 – Not at all</th>
<th>2 – Somewhat</th>
<th>3 – Moderately so</th>
<th>4 – Very much so</th>
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<tbody>
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<td>1.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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1. I feel calm
2. I feel secure
3. I am tense
4. I feel strained
5. I feel at ease

1Only five questions can be displayed as part of the permission to use the STAI
**State Trait Anxiety Inventory – Trait**

A number of statements which people have used to describe themselves are given below. Read each statement and then mark the appropriate circle to indicate how you generally feel.

<table>
<thead>
<tr>
<th></th>
<th>1 – Almost never</th>
<th>2 – Sometimes</th>
<th>3 – Often</th>
<th>4 – Almost always</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>I feel pleasant</td>
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<tr>
<td>2.</td>
<td>I feel nervous and restless</td>
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<td>3.</td>
<td>I feel satisfied with myself</td>
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<td>4.</td>
<td>I wish I could be as happy as others seem to be</td>
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<td>5.</td>
<td>I feel like a failure</td>
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</table>

1 Only five questions can be displayed as part of the permission to use the STAI.
**Demographic Questionnaire.**

There are just a few more questions. Thank you so much for continuing to answer these questions.

1. What is your primary method for coping with these stressful work situations? Please mark one:
   a. Problem-focused coping (e.g., positive reframing, acceptance, take action to resolve the issue, talk to friends)
   b. Emotion-based coping (e.g., humor, prayer, expressing negative feelings, blaming yourself)
   c. Avoidance-focused (e.g., self-distract to avoid thinking, deny that it is happening, give up, drink alcohol to feel better)

2. Who (or what) has been your primary support during the last year when work issues came up?
   a. Family (spouse, parents, siblings)
   b. Peers (friends, church, outside of healthcare)
   c. Professional peers at your worksite
   d. Supervisor or manager
   e. Other __________

3. When faced with stressful work situations, I trust the management to look out for me at the place where I work
   a. Strongly Agree
   b. Agree
   c. Disagree
   d. Strongly Disagree

4. Month and year of graduation: __________

5. Have you had a previous history of being bullied at another job or outside of the work environment (e.g. high school, siblings, parents, significant other)?
   a. Yes
   b. No

6. Did you have any previous work history outside of nursing before this job?
   a. Yes
   b. No

7. Did you work for the facility before you were a nurse?
   a. Yes
   b. No

8. Are you still employed at the same facility?
   a. Yes
   b. No
   If yes, sent to question 12, if no, continues to 9:
9. If no longer employed, how many weeks were you employed? ______________

10. Why are you no longer working there? ___________________________

11. What is your employment status currently:
   a. Employed in another facility as RN
   b. Unemployed, seeking RN position
   c. Unemployed, return to school
   d. Unemployed, seeking non-nursing position
   e. Unemployed, health condition
   f. Unemployed, family needs

12. If you would like to be contacted for further research in workplace bullying, please type your email and phone number below: ______________________ (sent to closing statement)

13. Are you working on the same unit?
   a. Yes if yes, question 12
   b. No – if no, question 14

14. Why did you transfer from the unit: _________________________________(to question 12)

15. If you would like to take part in the second part of this study for a brief (one hour) telephone interview for further research in workplace bullying, please type your email and phone number below: ______________________

16. Type of facility currently working in:
   a. Hospital- magnet status
   b. Hospital-non-magnet
   c. Nursing home
   d. Public Health
   e. Outpatient clinic
   f. Surgical Center
   g. Other

18. Do you have any other additional comments for the researchers?

____________________________________________________________________

Thank you so much for your participation in this research. If you have any questions or concerns, please contact the investigator through berrypa@mail.uc.edu. Thank you.
## APPENDIX E – AUDIT TRAIL

<table>
<thead>
<tr>
<th>Date</th>
<th>Tasks/Discussions</th>
<th>Decisions or Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/21/2013</td>
<td>Prior to meeting, both PB and GLG separately coded Participant A’s narrative to develop themes</td>
<td>Reached consensus on 14 separate themes for recoding Participant A’s narrative’s.</td>
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<tr>
<td>PB, GLG</td>
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<tr>
<td>06/04/2013</td>
<td>• Email discussion on coding.</td>
<td>Changed (2) from “Talking things through” to “Support from others”</td>
</tr>
<tr>
<td>PB, GLG</td>
<td>• In person discussion on coding and tweaking of the list.</td>
<td>Changed (8) from “Picked for bullying” to “Characteristics of the bullied”</td>
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<td></td>
<td>• Discussion on (7) on the differences between ignoring and minimizing bullying. Ignoring means no action where minimizing means acknowledgement of the behavior, minimizing the effect or actions in situation</td>
<td>Added (15) Disbelief                                                                perimentation</td>
</tr>
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<td></td>
<td>• Determined consistent approach to coding data</td>
<td>Will need to develop a synopsis or definition of the codes at a future date</td>
</tr>
<tr>
<td>06/11/2013</td>
<td>• First discussion was on page 8 line 16: “it’s like we’re the ones being punished.” The question is whether this is an intervention or retribution to acknowledge bullying by displacing the target. “Retaliation means any adverse action against an employee because he or she complained about harassment or discrimination. Retaliation can include demotion, discipline, firing, salary reduction, negative evaluation, change in job assignment, or change in shift assignment. Retaliation can also include hostile behavior or attitudes toward an employee who complains.” (<a href="http://www.nolo.com/legal-encyclopedia/preventing-retaliation-claims-by-employees-29599.html">http://www.nolo.com/legal-encyclopedia/preventing-retaliation-claims-by-employees-29599.html</a>). Punishment is very similar to retribution and retaliation, quite possibly denotes an action taken because of the complaint of</td>
<td>Both the acknowledgement and retaliation can be punishment. Displacing the target is considered both retaliation and acknowledgement of bullying with displacement of the target.</td>
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<tr>
<td>PB, GLG</td>
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bullying. I would argue they are both the acknowledgement and retaliation.

- Discussion on page 10, line 14 -21 “He’s a good listener. He’s a good listener. Before I met him he used to be a CNA so he knows what the health care field is like so, that was way back when but, he’s a good listener and he’ll be like, okay, well have you tried this or have you tried that. I’m always trying to talk things through and sometimes people listen to me and sometimes they don’t and now I have a bunch of support at work” and well as page 11, lines 4-8 “With my coworkers we just talk about the different strategies that we’ve used. There are several that have confronted the bullies and they have stopped and then there’s other people that have confronted and it’s made it worse” These two narratives showed a difference between “Types of Support” and a new theme of “Quality of Support.” Both Support and getting help were combined as (2) Seeking support/getting help from others. The categories of: Coworkers/prior coworkers, Family/friends, and Administration.

- The above brought to light a bias by PAB that those who supervise should not seek support from those they supervise. This bias has followed PB around for a long time in that PB always supported those supervised or managed but did not depend on them for support. From 1977 to 1993, PB moved frequently with spouse’s job so establishing those work “support systems” were not a high priority. Still, trust with those worked with and each group worked as a team to take care of patients when PB worked hospitals as a nurse aid and RN. In addition to the above bias, based on Social Exchange Theory, current coworkers and management support

It is important to distinguish inside facility support from outside facility support in relationship to trust through Social Exchange Theory. Both Support and getting help were combined as (2) Seeking support/getting help from others. Two categories of who provides the support was sought from became: Coworkers/prior coworkers, Family/friends, and Administration.
increases trust, which in turn, increases retention and group cohesion. Likewise, constant negative behavior decreases trust.

- **Page 13, line 7 – 11:** “The most recent one would have been, there’s a lot of things that need done at our facility and have not been done for one reason or another but they had went on a retreat and pretty much came up to some of us and were like, look what we got to do, ha ha” This is a display of one-upmanship: a cycle of trying to one-up or outdo an opponent (http://www.omnidict.com/pages/One-upmanship.html). The discussion was whether this was “power over” or just bragging. PAB argued that this should be included under 12d as power over. This is displaying what the “bully” gets to do (a retreat) and the staff do not. To PAB, bullying is a display of power and control and narrative above indicates a power disparity between the interviewee and the “bully. GLG and PB discussed one-upmanship. GLG believes it is just bragging. PAB argued that this should be included under 12d as power over. This is displaying what the “bully” gets to do (a retreat) and the staff do not. PAB believes bullying is a display of power and control and PAB think those lines indicate a power disparity between the interviewee and the “bully.” PB believes that this is a power play, to be better than, to justify actions as a bully. Will look for additional actions in the next few narratives.

- **Page 19 line 23** “because I’ve let it build and build and build,” 4. Rituals to stay positive, and 9. Response to Bullying. Discussion ensued on combining themes as responses to bullying instead of separate issues. Targets can let emotions build and build to a crying spell, use

<table>
<thead>
<tr>
<th>Role</th>
<th>Response to bullying</th>
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<tbody>
<tr>
<td>Made Theme</td>
<td>Response to bullying a bucket list of behaviors and moved rituals under it. Because of that, I moved “just” accept it to Theme 7</td>
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<tr>
<th>Role</th>
<th>Made Theme</th>
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<tr>
<td>GB</td>
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<td>PB</td>
<td>PB</td>
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<td>GLG</td>
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proactive coping or logical responses, or keep their mode elevated in response to the bullying.

- Avoiding Conflict as a theme was moved from Response to bullying to its own theme. GLG and PAB saw this behavior in all the interviews thus far and it is worth tracking on its own if others say the same thing.

06/25/2013
PB, GLG

- Participant B: As background, all participants selected for interview described a bullying incident, marked they were bullied, or scored as bullied in the preliminary study in 2010. GLG and PAB agreed that Participant B, although bullied as a novice nurse, displays bullying behavior throughout the narrative. She describes she herself “catches herself being short” (p.5, line 104), “rolling my eyes” (p. 5, line 105) in responses. Both GLG and PAB discussed the addition of a new theme to capture what is perceived by the perpetrator or the target as bullying acts. As we perceive these behaviors as negative, it may shed light on why negative behaviors cycle through the workplace.

- Because of Participant B’s reasons why bullying happens, (pg. 8, lines 163-171) “I'll be like, "Oh, this happened today, and so-and-so seems so lazy, and blah, blah, blah. So-and-so said this and it's just so annoying." So, you know, talking to – there's probably a group of five girls that I'm very close with that I work with, and through work they're working, we might step aside, and just get it off our chests, and then, be done with – and try to be done with it.”

- GLG and PAB discussed the need to differentiate between reliving high school and Clique/group behavior. A clique is a small group of people with

Created own Theme 11 Avoiding Conflict with a bucket list of behaviors associated with avoiding the bully.

Added 13 Perceived Acts of Bullying: Bucket list of perceived acts as with rolling eyes, group gossiping, management confidentiality broken, screaming, eating their young

Added Lazy and annoying to the Theme 9 Motivation for Bullying.

Clique/high school: added clarifying statements to the developing themes list.
Clique (clique behavior
shared interests, who spend time together and exclude others (http://www.merriam-webster.com/dictionary/clique). PAB had an epiphany in the company we keep. A bully in clique behavior excludes others and uses this group to make fun of, gossip about, speak poorly of other coworkers or management, creating a negative work environment. Reliving high school has a lot to do with being plain mean or snobby, unwillingness to share or to help out and it may be because of a clique or just plain meanness, burnout, fatigue, stress, instant dislike, jealousy, etc. and nurses call it “high school” behavior possibly because we start to recognize these behaviors in high school.

- Confronting the bully or bullying behavior. This is the immediate action or reaction by the target or perpetrator when bullying occurs – different from retaliation or retribution (e.g. stating to the group “we need to stop” as the participant realizes it is bullying behavior or I am being more verbal in confronting).

- Discussion beginning on page 26, line 588 through page 27, line 600: GLG and PB discussed the need to included lines 596 through 600 “They're just these little gruff men. So – but I love my patients. Everyday working with that type of population is pretty awesome. And then, I've heard horror stories about other hospitals. You know, just even as much as like sometimes it seems my unit has a lot of negativity, in the grand scheme of things, it doesn't seem that bad relatively speaking. And that's a big part of it.

which excludes others and uses these groups to make fun of, gossip about, speak poorly of other coworkers or management, creating a negative work environment) and reliving high school (mean or snobby behavior, unwillingness to share or to help out should remain exclusive from each other).

Added Theme 12 After confronting the bully or bullying behaviors. This is the immediate action or reaction by the target or perpetrator when bullying occurs – different from retaliation or retribution. This may give actions that stop bullying from happening. Stating to group “we need to stop,” filing an incident report on behavior.

Added to (7) rationalization/comparison to the list as participant B stated it's a great group and floor compared to what she has heard elsewhere. Also added “picked on” under (7).
And, for the most part – I think I said in the beginning that – the floor that I work on is pretty good. The people at the site [inaudible] and instances. Overall, everyone gets along really well. Most people are very helpful” under 7 (Response to bullying). The entire comment needs to be added in total and not as separate paragraphs in order to make sense.

- **Stress:** Added a better definition to Stress as identified sources of stress (e.g., management change, staffing issues, workload) that adds to unit stress and frustration

<table>
<thead>
<tr>
<th>Date: 07/02/2013</th>
<th>Participant C: Page 2, lines 31-34 “But I work in psych, and I have to tell you, I have experienced none of this. And I think maybe it's because of the area that I work in, that, you know, we all have to stick together.” After discussing past bullying, the participant discussed that she did not experience peer bullying on the unit, and that everyone “sticks together.” PAB thought this was a good support statement that she uses her peer support but GLG pointed out that this was not seen as in relationship to bullying. GLG and PAB discussed that Participant C was focused more on the support and sticking together related to the violence on the unit rather than bullying.</th>
</tr>
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<tbody>
<tr>
<td>PAB, GLG</td>
<td><strong>07/02/2013</strong> Page 3, lines 60 -62 “(P) Even nurses who he's worked with for 20 years. (I)And he will still behave like that? (P) Yeah, he has very unpredictable behaviors.” GLG and PAB discussed if this was a new category under theme 9 “Motivation for bullying.” “Just the way she is” was added from Participant’s B description and now this same behavior is seen with the perpetrator, who is a physician. GLG and PAB discussed whether to expand the theme to add behavior traits like “unpredictable” to the list. Rather expand the categories, we agreed that it would fit under</td>
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Page 3, lines 60-62 are placed under “That’s just the way he or she is”
Just the way he or she as it is no longer gender specific.

- Page 4, lines 75-78 “I suppose at one time Bev was a floor nurse. Our manager probably hasn't worked on the floor in 20 years. But I've actually recorded a doctor [out of] control, [and] management [treatment of me] along with it, so.” PAB pointed out that this statement was interesting. It is (to PAB) as protective mechanism in response to the bullying, to actually record a doctor and management treatment afterwards as a way of gather evidence of the abusive behavior. PAB wondered where this would go as a coping strategy. Certainly, current target literature recommends recording or keeping a record of workplace bullying in order to justify stress or PTSD claims.

- Page 5, lines 90 - 96 “(I)And who have you told that you were being bullied or you're bullied by these physicians? You've told your manager. You've told this manager? (P)I have on one occasion a doctor. I was advocating for a patient, and he told me that if I said one more thing to him about her, he would send her to the state hospital. Which she was no way a candidate for that. And he left it with me, but then he went back to her and said some other things to her, so that's when I reported him to my manager and reported to Safe Care.” PAB believes this to be theme motivation for bullying where the physician was using his positional power (Theme 9d) to silence Participant C from advocating for the patient but threatening to send the patient to a state hospital instead and also creates a patient safety issue (Theme 10). GLG did not perceive this as a bullying incident. GLG and PAB both have different views of this which will need to be resolved.

- Page 7, lines 136-144 “(I)Okay. So why do you think, or what are the circumstances as to why these two keep bullying staff like this?" Page 7, lines 136-144 not coded. BF needs to determine if it would be
<table>
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<th>Page</th>
<th>Text</th>
<th>Comments</th>
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<tr>
<td>Pg. 7, Line 151 through 154</td>
<td>*(P)*But I think if our manager said – and, you know, I belong to – we have a meeting with – a meet the president, with the president of our hospital, and talked to him about some of it, and if it came from the top, that, look, this behavior isn't tolerated.' PAB had included this as 5c (minimizing), but this was read by PAB as a real action. GLG read this as “wishes she could have done it” and PAB agreed with his interpretation.</td>
<td>Pg. 7, Line 151 through 154. Not included with 5C.</td>
</tr>
<tr>
<td>Pg. 175-194</td>
<td>*(P)*I guess that's about it. As coworkers, though, I have great coworkers. And when we do [forced] medical, because we have to every once in a while when there's [cath] we'll do it. We're not trained in medical, but we'll do, like, one on ones, and we'll do their vitals, and blood sugars, and simple things. I do see it in other departments, though. They're not as much as a team as we are. They don't get along with the [medical floors]? Yeah. I mean, we're all looked down upon. But in medical, it's kind of every man for himself, you know. *(I)*Well, no, I guess I don't understand. Can you broaden – *(P)*There's not a lot of team work. There's not a lot of helping each other out. Where, you know, for us, especially the day shift, I think it's different. But, for us, if somebody's – like, a couple of days ago, we</td>
<td>Pg. 175-194. Merits more discussion. GLG, after you read this, let’s discuss a little more. I am glad you liked the comment but we still need more discussion on this.</td>
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had an admission, one nurse had two discharges herself, so everybody pitches in and helps everybody out. We don't just do our own work, and if it's somebody else's, Oh, well. Whereas in medical, it's kind of that way. If you're behind, but your people are caught, they're not gonna chip in and help you.” GLG and PAB went back and forth with this description. The participant is describing how well her group works together to accomplish medical procedures and share the workload compared to other floors. This is not specific to any bullying incident and GLG does not believe it should be included. It is not having anything to do with bullying but how cohesive the team is in working together. PAB agrees with GLG that it have nothing to do with bullying but PAB believes that a good cohesive workgroup discourages bullying and may be a social support strategy, to work well as a group.. GLG related his experiences with working with a great trauma team on severe trauma but after the work was done, this team went out of its way through behavior that they hated working with each other. This group literally would abandon him creating unsafe patient situations. Although the above does not relate to actual bullying, it relates to how poorly other floors work as teams to even the work flow for safe patient care. Both GLG and PAB have a difference of opinion based on experiences about how comparing/rationalizing helps maintain employment when the bullied nurse can say my floor is much better off than the other floor because we all work together, which also may lead to between floor animosity. Writing this out helped clarify how between unit animosity can erupt.

- Pg. 11, lines 234-236 “(P) Yes. But it has encouraged me to – I'm finishing my bachelor's in December, and starting my master's in January because I'm not gonna live like this for the rest of my life.” In agreement that this line is Theme 1 preparing to leave.
to leave. However, GLG and PAB discussed if the ensuing lines 237-244 were also an indication of leaving or if these lines diluted the effect of 234-236.” Pg. 11, 237- 244 (I) And why it does still affect you. (P) Yeah, it encourages me to do more, I guess, to not be in this situation any longer. (I) Towards upgrading your education to move out of that area or you would move out of that area anyway? (P) It just encourages me to do more so I don’t have to be in this position where I – all doctors are kind of arrogant anyway.” PAB agreed to GLG about the comments did not strengthen the first statement on preparing to leave after rereading aloud. It was almost like she was trying to even out the power by becoming more educated with the MSN.

07/10/2013

PAB, GLG

- Participant D: Discussed pg. 2, lines 34 – 37 “I’ve been a nurse for two years and I’m orientating new nurses. I try not to (bully) I don’t want them to feel like that because it can be scary and discouraging when you’re starting out to be a nurse.”
- Discussion:
  - Lively discussion between PAB and GLG on how to code this. It certainly does not belong under Theme 7 Response to bullying and, if added to 7, it will conflict with Theme 12 This is the immediate action or conscious decision by the target or perpetrator to resolve or prevent bullying. These actions are not retaliation or retribution. These are actions that stop bullying from happening. It may be personal accountability to consciously deciding not to bully or when realizing that negative gossip is taking place to state to group “we need to stop,” as well as filing an incident report on bullying behavior that may affect patient care.
  - . Participant D made a conscious decision to not bully. GLG and PAB

Decision:
Pg. 2, lines 34 – 37 are an exemplar for Theme 7, Creating a subtheme 7i Don’t bully others: Makes a conscious decision to not bully others, to do preceptor role to give a better orientation, to shield from someone else or advocate for someone.
discussed what would be the three words to explain the behavior and “does not bully” was determined. PAB really like that Participant D made a conscious decision based on observation and her own experience to provide a protected environment in orienting new nurses. This specifically answers a specific aim on whether those nurses bullied at Time 1 will bully at Time 2 and she consciously decided, in spite of the bully still present on the floor, to not bully and to precept new nurses.

- Discussion on coding with Pg. 2, lines 43 – 53. “I think sometimes it’s just like an atmosphere, and I know that other nurses that I talk to that kind of started at the same time on some of the nurses on my unit that have been nurses for a very long time just like maybe like condescending remarks and things like that that can – I mean it just kind of can be discouraging and if feel like they’re kind of picking on you and that kind of thing. I don’t think that it happens all the time, but I think that sometimes it does, and it’s usually just certain people it’s not like a whole lot of people. But it’s usually like older nurses that have been there for a long time.”

- Discussion: Read allowed to discuss atmosphere, as driven by people because of their behavior. PAB stated she did not know if a new code was needed for atmosphere or to revise the Code 9f Perpetrator personal or unit characteristic: People create the culture or atmosphere. Examples seen are “that is just the way he or she is,” “that’s just the way it is,” “it won’t change, burned out.”

Determined that this was not a new Theme or code. After some thought, these are personal characteristics of the bully or perpetrator or unit. Given we have a code for target personal characteristics, revised 9f as Perpetrator personal or unit characteristic: People create the culture or atmosphere. Examples seen are “that is just the way he or she is,” “that’s just the way it is,” “it won’t change, burned out.”
• Pg. 3, lines 51 – 53 “I don’t think that it happens all the time, but I think that sometimes it does, and it’s usually just certain people it’s not like a whole lot of people. But it’s usually like older nurses that have been there for a long time.”

• GLG and PAB had discussion on these lines. GLG stated he coded it Theme 13 Perceived Acts of Bullying: Bucket list of perceived acts as with rolling eyes, group gossiping, management confidentiality broken, screaming, eating their young but he was not sure. PAB did not agree to Theme 13 however, this could readily go under Code 9f in its expanded version. Although it is stereotyping the “older nurses” as the perpetrator, this may actually have some generational qualities.

Decision to code it as 9f as Perpetrator personal or unit characteristic: People create the culture or atmosphere. Examples seen are “that is just the way he or she is,” “that’s just the way it is,” “it won’t change, burned out.”

• Pg. 4, lines 85-91: “I have like several close friends that I work with and we kind of just talk to them about it because some of them feel the same way. And it’s just kind of you know kind of talk it through, and we realize that maybe they’re burned out or maybe they’ve been there a while and it’s nothing personal. Just try to I don’t know overlook it and you know go on with doing – trying to be the best nurse that I am.”

• Discussion: PAB double coded the above as 2a/3c. GLG disagreed with this citing boundary issues with coding 7G. So PAB and GLG argued on whether there were boundaries associated with the sentences. GLG drew a Venn diagram to further his point to boundaries. PAB argued that 3c was also part of that process and GLG agreed. GLG and PAB agreed to the additional coding of 7e and 7g. This also led to additional discussion about some boundary issues when nurses use 7g, they may also be describing 9f Perpetrator personal or unit

Decision:
GLG and PAB agreed to code pg. 4, lines 85 – 88 “I have like several close friends that I work with and we kind of just talk to them about it because some of them feel the same way. And it’s just kind of you know kind of talk it through” as 2a/3c
Coded as 7e Block and Refocus “Just try to I don’t know overlook it and you know go on with doing – trying to be the best nurse that I am”
Coded as 7g
Rationalize/comparison “and we realize that maybe they’re burned out or maybe they’ve been there a while and it’s nothing personal.”
Coded 9f “burnout”
characteristic when the group discusses that the other nurses may be burnout.

- Pg. 5, lines 103-110: “One of my best friends that I work with we work most days together, so that kind of helps that she’s there on the same day. But I just try to think of I have a job to do. I’m there for a reason. I’m not there to pick a fight for someone or get in a fight with someone, and I just try to not think about it and get through my day and take the best care of my patients the best that I can at that point in time until I can get to one of my friends and talk to them about it.”

- Discussion: Agreed on coding through these sentences but PAB wondered if this was Code 11 Avoiding the Conflict as the participant states she is not there to pick a fight with someone. GLG argued that the participant is making a decision not to “pick a fight” or go looking for it rather than avoiding a conflict. This further clarified Code 11 for PAB.

- Pg 6, lines 129-132: “And it’s not just with me it’s with other people too, and it irritates me that she does this to other people and that she says this to other people.” Lively discussion on where irritation or anger would go according to the coding. Originally under the theme 7 Response to bullying: The target’s emotional response, feelings, or actions to relief own emotional distress that is not directed towards the perpetrator in response to bullying. However, 7a only listed crying and with this example the target expresses irritation, which is synonymous with frustration and anger. In Lazarus and Folkman (1984) Stress, Appraisal, and Coping, they state emotions help understand the person’s agenda in day to day living. It may also speak to the target’s cognitively appraisal on the interaction as a broken assumption on how others should be treated in a just culture. To some, anger, frustration, “hot

Decision: Agreed not to code 11; agreed on all other coding.

Decision: Revised from just crying to full range of emotional responses to the bullying. Changed to 7a Emotional Response: During the incident or after the incident, becomes teary talking about what happened, irritation, anger, dwelling on the emotion.
“tears” are the emotional responses to that person’s perception of how they or others are treated. PAB stated the emotions are linked to stress and WPB is just one of the stressors nurses have to must cope on a daily basis.

| • Pg. 7, lines 150-157 “Yeah, I think that she’s like the majority of – she’s like the major player and the person that – and it’s not only me it’s other people too that she kind of targets. And I know like the new nurses don’t like to get reports from her just because of the comments she makes during reports and just different scenarios like that that she does towards everyone. She’s an equal opportunity person she doesn’t just pick one person she kind of just does it to everyone.” Discussion of this entire paragraph. GLG believed the whole paragraph is 13, describing the perceived acts of bullying. GLG stated it was open to his interpretation as the subtheme 9f was not clear enough for him. PAB stated she would accept 156-157 “She’s an equal opportunity person she doesn’t just pick one person she kind of just does it to everyone.” as 13 only but PAB believed the characteristics of the bully were being described from 150-155 “Yeah, I think that she’s like the majority of – she’s like the major player and the person that – and it’s not only me it’s other people too that she kind of targets. And I know like the new nurses don’t like to get reports from her just because of the comments she makes during reports and just different scenarios like that that she does towards everyone.”. GLG stated he would not budge on the coding and that Bonnie would be the tie breaker with his. However, this also means that both 9f and 13 need to be expanded with clearer wording to describe what is different about them. |

Decision is for Bonnie to decide. PAB edited the themes and sub themes to create something clearer. Theme 13 are specific acts either overt or perceived covert bullying now reads” Perceived Acts of Bullying: Overt or perceived covert bullying acts as with rolling eyes, group gossiping, management confidentiality broken, screaming or verbal abuse, eating their young, and equal opportunity bully picking on everyone.

Expanded 9f to read Perpetrator personal or unit characteristic: People create the culture or atmosphere. Examples seen are “that is just the way he or she is,” “that’s just the way it is,” “it won’t change, older nurses, burnt out.”

BF: Entire paragraph should be taken it its totality, any one sentence not really enough to code – that said, then theme 13 as described especially part BF highlighted: equal opportunity bully picking on everyone.
<table>
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<tr>
<th>Page</th>
<th>Text Content</th>
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<tbody>
<tr>
<td>8</td>
<td>“As far as management really no one. But I mean just I was preceptor to my manager and then our director is kind of scared of her so I mean really no one. I’m sure they know what goes on because I’m sure people have complained about it, but nothing was ever done about it. So it just kind of seemed a moot point I guess. So other people that I work with they see it. They hear things that she says, and it’s not – and she says it to them and treats us the same way. So I guess the other coworkers that I work with.”</td>
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<td>8</td>
<td>Discussion: GLG and PAB had a debate over assumptions. PAB assumes the manager and director know about the bullying, especially with the comment “our director is kinda scared of her” therefore PAB wanted to code this under Theme 5 Blowing off the bullying: This is the target’s perspective of the reaction that occurs from management or others when reporting a WPB behavior, filing a grievance, reporting the behavior, (HR, nursing directors, manager, and/or bullies under subtheme b Ignoring: not acknowledging that bullying exists. However, GLG posited good arguments that PAB and the participant assumes the managers know and might better be classified as 7g “Just” accept it: Examples would be “taking it with a grain of salt, ““that’s just how she is.” PAB agreed to accept 7g and not Theme 5 because it was assuming the management know there was bullying.</td>
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<tr>
<td>13</td>
<td>“No, actually I try to make them feel – my preceptorship was not a good experience. I kind of was just thrown into it and not really explained a whole lot like here’s the patient go ahead and do what you’ve got to do.”</td>
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<tr>
<td>13</td>
<td>Discussion between GLG and PAB that it was about orientation not bullying.</td>
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This is stressful in itself and PAB felt it was a sink or swim situation but was not focused on bullying.

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<tr>
<th>11/12/2013</th>
<th>Began audit trail immediately on 2, lines 46 through 51: “So over time I think, you know I’ve gotten to – I’m finally building a nicer relationship I should say- professional relationship with the doctors where I’m not scared to death to walk up and ask them a question.” PAB discussed that this might be an exemplar of someone having a bad experience but this may be an issue later in interviews. This may be a victim characteristic or something that the target develops to get better relationships with the doctors for social support:</th>
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<tbody>
<tr>
<td>PAB; GLG</td>
<td>Decided to document this one statement as interesting, may be social support, may be characteristic. Will review after looking at other narratives.</td>
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Page 3, page 53 61: Again discussed issues associated of a single event associated with an aggressive or violent sentinel event may color her approach to other persons. GLG argued that this may be a perceived competence vs. confidence. GLG and PAB discussed back and forth on if this has a real cause and effect. PAB argued the target talked about the sentinel incident and this causes the target stress. GLG agreed to leave it in as 8: “Yeah, But, I just had a really bad experience at the beginning which you know would put me in a panic attack if I’d ever seen a thing where it said-where I had an order to consult somebody. But like I said, it’s so much better. We are a smaller hospital, it’s not where we don’t see a lot of the same physicians over and over again and I always try to make myself unnoticeable and you know- and not. GLG and PAB discussed she is lacking that competency until she gets confidence.

This lead to a continuing discussion on page 3, lines 63-67 as more information would be needed before coding the comment. GLG has some strong beliefs that participant E is introverted and is just avoiding talking to the doctors. He thinks PAB is extroverted but PAB

Agreed to code as 8. This is a stressor for this person.

No code for page 3, lines 63-76
disagrees as she is able to be extroverted when she needs to but then she has to isolate herself to recover. PAB concurred with GLG regarding excluding comment: “Unnoticeable. I wanted to, you know I could never like try to engage in any kind of small talk with any doctor or anything like that. I wanted to get my answer and get away. I didn’t want them to know who I was.”

On page 5, 101 – 105: Interviewee:
Yeah. So, you know just after that I just was – he, you know went in – he started asking me so many questions that I had no idea of, you know answering.

Interviewer: So do you feel like he was doing that in retaliation for getting in trouble for screaming at you?

Interviewee: Well, probably.”

Pg 117 – 137: Interviewee: We – our floor, it is the most demanding floor and we were all talking about it yesterday. It feels like it’s the dumping ground where you – we’re supposed to be medical renal, we deal with all the nephrology, you know all the dialysis patients and all the kidney failures. And then we get all isolations and then we get what everybody else doesn’t want.

So we’re – it’s so demanding and just everybody doesn’t have time to help anybody else. It is, you know sink or swim. And our charge nurses, which are our clinical coordinators and they are the ones that have 25, 35 years’ experience and are extremely knowledgeable and if they had the time to help you they would. But they will have – the charge nurses will have like three patients of their own. A lot of times they’ll be precepting other students or other new nurses, and –“

GLG was adamant but agreed to add it to the themes. **Need to address changing the overarching theme “Permissive Culture of Bullying**
GLG and PAB discussed the issues associated with this entire interchange. We talked about how a person should edit the story but both were adamant about how we both see it. GLG states it is job security and PAB wanted to code this as stress. GLG talked that it should not be coded because it does not relate to bullying. PAB on the other hand argued that workload is a significant factor in workplace burnout and compassion fatigue. That this needs to be coded as a stress. PAB states that all stress needs to be captured into the coding schema. We discussed that we need to change the overarching theme of the permission: Gordon again talked about how people need to be grateful for the job they have in this economic environment. GLG wanted all narratives to directly relate to bullying but PAB again stated that this is a covariance or confounding variable in the quant data and should be addressed in the themes. It is understood that bracketing needs to be addressed as GLG made arguments based on his life, not taking the words as they are off the page from an advocacy lens but from a “manager” lens.

Pg. 7: 150-154: You know I don’t know if it would be – I don’t know, I guess I – you know it’s hard to kind of remove yourself from it and you just – a lot of time you’re busy and you need so much help and you wonder, you know are they doing this on purpose? Do they not have time to help me? Or do they just really just don’t want me to succeed? GLG thought this might be a story but he felt it was the target telling PAB what she thought PAB wanted to say. PAB was not strong on coding but found it interesting as a conversation a target may have in their head on certain situations. If this comes up again, where the conversation occurs in thought on coworker behavior, this might be another pathway to healing or stopping behavior.

Pg 11-12238 – 260 GLG and PAB talked about the perception of disciplinary action flying between shifts, GLG stressed the

Monitor to see if this comes up in any other narratives.

Agreed to stress
importance of the documentation trail to create change on errors where blame is falsely accused.

Pg. 13, lines 293 through p. 14, line 318. GLG and PAB talked to the stress of the unit. GLG does not believe this is stress, just “bitching, moaning and complaining.” GLG is not sure working in a busy department. Is this organizational bullying or just business. PAB looks at what can be eliminated to reduce stress, so busy that they cannot help each other – workload, infrequent rest breaks, long work hours, hectic and or routine tasks that have little meaning. So PAB believes that these things create a stressful environment. GLG and PAB argued this at length. GLG doesn’t want employees off the floor, take lunch or leave. GLG reflects that bullying is reversed when someone needs to take a break and if someone leaves, that person may be bullied for leaving. This was a lively conversation related to wage and hour, needs for break, lunch. In nursing, the laws mandate overtime but if they leave, they can be fired.

Lines 293 - 318 Well, we’re allowed one 30-minute lunch and we have a break room, but it is right there by the nurses’ station, and I tell them it’s like a little closet. It’s not big enough for everybody to crowd in there so I like to get – like if it’s a very nice day out, I always go outside. I mean others go outside too. But we have Voceras, you know those little walkie-talkies?
Interviewer: Yes.
Interviewee: And, you know during our 30-minute lunch they can call us ten times and ask us questions, and if there’s a physician that absolutely needs you to do rounds with them and the charge nurses, you know – of course if they’re too busy, you have to go back up and, you know do what they need.
Interviewer: So there’s no down time?
Interviewee: Not really. Then like we’re supposed to have a 15-minute break in the

Audit item. I would like DG and BF to look at this. Stress is a component of a poor work environment. Poor work environments cause problems with lack of teamwork, scapegoating, verbal abuse. I believe lines 293 through 318 be coded stress (5).
afternoon, but it’s just randomly, like if you can get off the floor and if you’re not busy you can go. And you can’t – you have to make sure, you know that if there’s a few of you going like to the cafeteria, you can’t, you know. It’ll have to be a couple of you because so many are not allowed to be off the floor and none of the charge nurses like you to take that break.

Pg. 23, lines 507 522: And I guess I just – I’ve gotten really – I don’t know – as you do the job more and more you develop your time management skills a lot better – your organization. You know you think ahead, you know okay, I have this podiatrist coming and I know he’s gonna change the dressing and I know he’s gonna want it instantly. So okay, I can handle this by have it, he’s gonna be here around five, so you know around 3:00 so I have to get the supplies in there, you know so he’s not upset.

Interviewer: Oh.

Interviewee: You know what I mean?

Interviewee: I know this nephrologist possibly is gonna want this gentleman’s bladder scanned and so, you know you make sure you have the bladder scanner in the room just in case. You know what I mean?

Interviewer: So you anticipate – you learn to anticipate the physician needs –

Interviewee: Right.

Interviewer: – to decrease any of the conflict that might occur there?

Discussed the need to create a new theme so Theme 4, Coping with bullying behavior or Bullying Prevention, Personal Preventive for Bullying or become Theme 14 General Strategies to prevent bullying

Pg. 25, 565 - 578 Interviewee: But I would also – I would also be very, very supportive. Whenever there’s a new nurse on

GLG asked PAB to look at all *8I in the past to determine if 14 is new or belongs at 8i.

This may not be avoiding but trying to create a healthy work environment.

- Coded 8i

Created a change in Theme 4 and new subtheme 14.
there I know how they feel. I always go up and introduce myself and if there’s anything at all you need, you know you can call me on your Vocera – on my Vocera and I’ll help you with anything, you know. And I always do. Because I see it, I know.

Even when there’s students – when we have a group of students come on the floor, I’m always really helpful with them because I know – I know what they’re going through. And I, you know I wanna make their experience there as pleasant as possible.

- Ending conversation between GLG and PAB, GLG felt she had HR issues and has paranoia about situations. It’s like she is a real whiney person and negative. PAB discussed the need to assure acuity levels were appropriate. PAB is taking an advocacy stance with the new nurses.

11/18/2013
PAB and GLG

- PAB began discussion on how some of these narratives, these ladies or gentleman, felt bullied, tested high on the bullying sum or had a sentinel event. Some are still bullied and some say they are not. GLG said to document on top whether they are female, age, bullying incident, where they work, bully sum or self-identification ion Time 1 or 2.

- Discussed the fact that there is not verbatim narrative where there is sobbing in the voice and that PAB will need to go through and document if sobbing occurred document it in there. GLG and PAB have gone back and forth about gaining the higher truth as a researcher, not as an advocate. GLG stated that if someone needs to be bullied to learn better. The emotions help people to remember. However, do we really need to victimize the nurses to learn? We talk about the need to advocacy on making learning fun. And, although the truth is

Give additional information on top of the remaining narratives.

PAB will go back through the transcripts and recordings to see if this information can be captured into the narratives.

Just as a side for additional learning – single mothers with young children are dependent on wages and the job unless use to using welfare. They need the job,
out there, in discussion, PAB can take that advocacy stand.

- Pg. 2, line 37 – 53: I would say it's a whole new comfort level. I mean I still have days where I feel overwhelmed or might need some extra help but I think that I've always - I've noticed it kind of depends on who I'm working with, whether I walk in and get the vibe that something - if I'm going to be busy that day, I know I'll have somebody there to help me or I'm less hesitant to help certain people than others, I guess and I've definitely gotten over putting off asking for help, I was a little more scared to ask. People would think I was not able to just do my job on my own or thought I was inadequate or something, I don't know. My preceptor that had trained me for the previous 16 weeks was actually like my first day on the floor was her first day on the new job so I didn't have her there either.

- GLG and PAB discussed this as an interesting narrative that may be useful later. Needed to document it in the audit trail with a question as to whether this is transiting to competency “whole new comfort level” which decreases interpretation of being bullied?

- GLG and PAB discussed line 61 – 74. Need to expand 8i as response to bullying, pulling too far from the data.

- Page 8, line 166-173: I don't know if a whole lot has been done. Some managers have said to go to human resources and take it past management and I don't know how many people are willing to do that, I guess. I know that from - they told us that these people have make the best victims, especially in smaller areas where there is only one health facility in the area that hires.

- Document for future review.

Need to expand on 8i to prevention strategies
been spoken to individually but from what I understand in us talking to some other nurses, I don't think this is the first incidents that they've been –

- PAB and GLG discussed this coding at length. Primarily, this stems from the fact that corrective action towards an employee is confidential and the supervisor may be trying to keep it that way. But then she may be discussing past occurrences.

- Discussed the need to list all the various behaviors that should go under #1. Discussed the progression to a toxic or violent workplace that is pervasive through an organization which starts with lack of accountability, incivility, work conflict, disrespect, bullying, mobbing, get into specific behaviors as in ignoring someone’s need for help as a bullying attitude.

- Pg. 18, line 403 – 413. She was basically always there as a resource and said, you're going to be overwhelmed at times and that's okay, and that's that happens to people but we started out, I would have one patient that was kind of less acute once I felt comfortable or even if I didn't feel comfortable but she knew I was capable, she helped you understand that we move up to two patients and she never said, I mean she very much wanted me to become very independent in my work but she never totally pulled herself from the situation and said, you cannot ask me for help, this is all you type stuff. Some of those people I'm talking about actually have - are preceptors to people. They aren't anymore because there have been so many issues but they kind of totally remove themselves from the

Coded it an 11 at this time.

Revise 1. Put more examples of what bullying behavior is. What may be bullying to PAB is not to GLG. It will merit discussing more.

Keep this in the audit trail and this might be able to be pulled in as a positive finding in her orientation.
situation and then you feel like you're drowning a little bit and they kind of just let you drown I guess which isn't a totally bad thing but at the same time it's not what training should be about.

GLG and PAB talked about the potential of using this as an example of an expanded 8i. It is not associated with WPB but with what a good orientation is all about. The challenge is this is not from bullying but it was the example she decided she would use her techniques.

- Need to work on interview prompts to get the participant to talk, like “tell me more about this.”

| 11/25/2013 | Discuss additions to themes and revisions to Theme A Constructs of Bullying to include other components as with organizational bullying. Also looked at no additional theme 14 but 8i was expanded from “don’t bully others” to Proactive Planning: Either through establishing relationship with physicians or peers to anticipate needs, to not bully others, either because of what they have seen others do to others or what was done to themselves during orientation or heavy caseloads: The target makes a conscious decision to not bully others, to do preceptor role to give a better orientation, to shield from someone else or advocate for someone. Expanded 6e to add new employees, novice nurses, and new interns/resident. Very good info in one story beginning page 2 – 3. PAB had this coded as 6f but GLG and PAB went line for line and agreed to added coding. |
| PAB and GLG | GLG and PAB agreed on the changes to the Themes and subthemes. |
| Participant Hilda | Action: Review back transcripts on 8i on other transcripts. |
| | Discussion on including targets (not just the participant) and need to expand that on 7. Preparing to leave. Also discussed Theme C, removing Target from Targets’ response to bullying but it was agreed to leave it in. |
| | 8f add peers, unit “I love the people I work with.” |
| | Action: Go back and review other transcripts regarding other people |
Page 9, 194-205: Peggy: Even the one who throws the monkey wrench in comes in and works well with other when people are going south?

Hilda She will come in, but it feels like it's to take over, not, "What do you need? What can I run and grab you? Is there something I can get you? How's your other patient doing, you want me to keep an eye on him? Are you gonna be in this room for a while? I'll go do your care on your other patients, don't worry about it." It feels like when she steps in the room, it's to take over not to help people. Everybody else, it's, "Don't worry about your other patients. I'll keep an eye on them. I went ahead and turned them. I did their eyes and nose. I know this one is going south, I'll pick the other ones up." Everybody else does that. It just feels like she barges into a room instead of asking what you need or just offering to do something. It feels like more of an intrusion than an offer.”

PAB and GLG talked about the aggression that occurs in a code or critical period of time for a patient and what might seem like aggressive bullying is in actuality “saving the patient.” PAB argued that the behavior is considered bullying by the target even though it might not necessarily be bullying when stress and emotion is high in response to rescuing the patient. After continued discussion.

PAB and GLG had an excellent discussion related to the ambiguity more than real targeted bullying. People use bullying behavior but it does not necessarily mean WPB which is target and intentional. It really is essential for individuals to clarify before.

PAB stated that we needed to discuss the potential of adding additional coding of 14, Confidence-competency connection as there is less bullying as the new nurse becomes more competent and others stop educating them in a bullying way. It was determined that Code 14 confidence-

12/02/2013
PAB and GLG

Just say no (15) really is 11 and new code on 14 confidence-competency. Wording on 14 will need to be more reframed. Undecided
competency has been identified as a finding as confidence in their competency creates less defensiveness and looking over data from time 1 to time 2, with less frequency.

- PAB and GLG discussed the impact to patient care with lines 135-145. Although it may be inferred, it was agreed include it as impacting patient care.

- Page 7, line 146-155: If you’ve got another patient, you feel like you’ve gotta medicate them with something that’s more important than assisting the neuro doctor with his exam or, you know some sort of procedure he’s trying to perform. You know as a nurse in the ER, I feel like I don’t have to do that. It’s my call. I don’t – they aren’t my boss. I mean I’ll certainly help them, but they are not the ones that I really am taking orders from. That’s not really how it works. So I don’t feel like it’s appropriate for them to be bossing around. They’re getting frustrated when I don’t, you know jump up as soon as they same something or run right to their side.

- PAB believed this was an 11 and 14. GLG believed this was the participant talking to self as something he wanted to do but GLG is not sure. It may be iffy but keep it in and reconcile later. Agreed to include it and if needed, trash it out later.

- PAB and GLG discussed double coding on pg. 26 thru 27 lines, 583-591 as classic miscommunication.

- PAB and GLG discussed moving rituals to Theme D. Good discussion about moving 8f after all coding is done.
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| 1/20/2014  | - PAB and GLG met to finish the last two interviews. We went through Interview K (Katie) rapidly.  
- Need to check through exemplars with 4 and 6e to see if these are crossed over and may need to merge these. Will need to strengthen coding, check exemplars to make sure.  
- Need to change the definition of 8h to be more inclusive of rationalization  
- Need to revise codes and strengthen 8i                                                                                                                                                                                                                                                                                                                                                                      |
| 1/28/2014  | - 1 ½ hour discussion on Themes and Coding with next steps of screening qualitative data.  
- Discussed changes to major Theme 1 on the Acts of bullying. GLG and PAB discussed the difference between being said and not assumed for literature.  
- Code 5 Stress: Discussed changes to the stress definition. From the target’s perception, GLG thought in terms of the target’s response, PAB thought it would be the stressor itself that causes increased stress in actions, attitudes, or interactions. PAB used an example where there is stress related to violence from patients which creates as environmental influence. Need to stick with the data. Also wondered about the organizational consideration in financial changes that make jobs harder. PAB wondered about the equipment vs. GLG gave a great analogy regarding airplane crashes to keep things in perspective to just going to the data. Discussed changes in Theme names but need to use enable, ignore or reward (from Hutchinson’s work). Discussed the difference between stressors and responses to stress.  
- Theme A. Constructs of Bullying: Behaviors, incidents or situations which construct workplace bullying in the eyes of the target are documented under this theme. Behaviors, incidents, or situations may not necessarily be WPB but perceived as intentional bullying behaviors or cause internal questioning of others’ behaviors instead of confirming intention.  
- Theme B. Permissive Culture of Bullying: The negative actions, attitudes, or interactions between nursing leadership, the target, and the perpetrator that enable, ignore or reward a distressful culture attenuated with workplace bullying behaviors.  
- Make sure these descriptions are based on data and not assumptions
• Emotional response (crying, angry) during or after the incident is moved to Toxic Effects and gathered under “Emotional response

• Made 8i its own code under 15. Decided that Coping/Social support, Theme D needed to be inclusive. Determined these are behaviors we want to see when bullying occurs. Also determined that after the conflict and Rituals to stay positive should also be moved under Theme D. The goal is to reduce negative behaviors to prevent WPB. Need to create a succinct statement for Theme D.

• GLG questions the difference between rationalization and avoiding the conflict. Avoiding conflict is still under the Toxic effects in that the target avoids the perpetrator but doesn’t make an excuse for the behavior. Rationalizing is used to excuse a behavior. An example would be a nurse who is hearing impaired had to fight to get in and through nursing school and continues to aggressively fight for her rights in angry tones. A target would rationalize

• Discussed placing competency and confidence under proactive planning. May need to revise proactive planning with immunity to the bullying or at least an understanding why it happens. Get all the data merged together prior to renaming the code.

Theme C. The Toxic Effects of Bullying: The target demonstrates or observes responses they or others do when perceive they are bullied. These responses range from preparing to leave, emotional responses, rationalizing behavior, avoiding the bully to confronting the bully.

Theme D. Fostering a Positive Work Culture: Demonstrates behaviors, actions, or attitudes that will break the cycle of WPB through positive coping and meaningful social support, proactive actions to prevent bullying, notification to leadership of bullying behavior, to responding effectively to bullying related to increased comfort in competency and management of patients.
• Discussed moving rituals under Fostering a Positive Culture. Nine people talked about it and moving the taking a break over into rituals.

• Discussed merging confronting the bullying to proactive for merge.

• Also merging coping and social support under one title.

• Given the changes on the Theme content, PAB will review all cases and exemplars. PAB will document any additions for cases in the audit trail and make the changes to the nodes as documented above.

Proactive planning: Anticipating physician needs, plans or active resolution to break cycle of bullying others, by stating a conscious decision to not bully others, to do preceptor role to give a better orientation, to shield from someone else or advocate for someone. Target effectively removes him- or herself from the situation to stop the behavior towards them, the nurse becomes more confident of his or her competence with nursing skills, as there is a “whole new comfort level” in the appraisal of the perpetrator of bullying behaviors.

Positive Action, Reaction, or Proactive Planning: Anticipating physician needs, plans or active resolution to break cycle of bullying others, by stating a conscious decision to not bully others, to do preceptor role to give a better orientation, to shield from someone else or advocate for someone. Target effectively removes him- or herself from the situation to stop the behavior towards them, the
nurse becomes more confident of his or her competence with nursing skills, as there is a “whole new comfort level” in the appraisal of the perpetrator of bullying behaviors. Immediate action, reaction of pushing back comments to perpetrator or up the reporting structure when bullying occurs which may give actions that stop bullying from happening as with stating to group “we need to stop,” or filing an incident report on behavior.

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<th>01/31/2014</th>
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<tr>
<td></td>
<td>Additional coding pulled: Participant A:</td>
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<tr>
<td></td>
<td>We never hear any positive about the things that we do as nurses. Of course none of us are perfect, but when all you hear is negative, negative, it really brings you down, pg 4, line 14 - 17</td>
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<td></td>
<td>Reviewed Participant B</td>
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<td>Reviewed Participant C</td>
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<td>Reviewed Participant D:</td>
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<td>and I just kind of always saw sometimes that new nurses get bullied that nurses that have been there that nurses kind of eat their young, pg 2., 29-32</td>
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<td>Reviewed remainder of cases with no new coding.</td>
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<td>There was one exemplar under 3e. Laughing about bullying. This was moved to 6c Recreational.</td>
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<td>Participant A: Off the top of my head it’s almost like they think that it’s fun.</td>
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<td>Coded 5 Potential stressors leading to bullying</td>
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<td>Coded 4 Characteristics of the bullied</td>
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<td>No new Coding</td>
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<td>Deleted 3e. Laughing about the bullying</td>
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<tr>
<td>3/17/2014</td>
<td>- There was one exemplar under 10c for Social Media. Moved to Listening from others:</td>
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<td>Participant B. People that used to work there, I talk to through Facebook or email and we talk about it and try to help with different strategies.</td>
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<td>- Redid Themes to correct errors and delete and renumber nodes.</td>
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<td>- Working extensively on the NVIVO revisions related to theme and node changes.</td>
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<td>- Revised exemplars to reflect the participant who quoted them and additional changes to the Themes.</td>
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<td>Deleted 10d. Social media</td>
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<td>Revised Node 2. This is the target’s perception of the negative reactions from management or others when reporting WPB behaviors, whether filing a grievance, reporting the behavior to HR, nursing directors, manager, and/or bullies</td>
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becomes angry, frustrated, teary or verbalized disbelief when talking about a bullying incident or feeling picked on. Nodes of disbelief and feeling blamed or picked on were merged in to this one node.

and b. Managing through bullying. Data sets were merged as it actually made those nodes stronger. Block and refocus, just accept it, and avoiding the conflict were merged un this node. As an aside, novice nurses who stay appear to manage through the behaviors and forgo the emotional responses. Unfortunately, suppressing the emotional responses instead of confronting may lead to a blow up – where the target becomes the perpetrator and the roles are reversed.

Went through each node property to make sure the definitions matched to the themes as these have had multiple revisions over the past year.

03/18/2014
GLG/ PAB

- Reviewed exemplars and changes to the themes. Several more revisions were done.
- Node 2: Merged to one heading of “Minimizing the bullying.” I left them under those three titles but they are merged for the exemplar purposes.

Minimizing the bullying:
The target’s perception of reactions after reporting to management or others on WPB behaviors. Behaviors seen include (1) sincere lack of awareness of bullying and its impact to the target; (2) not acknowledging bullying exists; or (3) acknowledging bullying but taking no action, minimal action or displaces the target.
Revised Node 11 After confronting the bully

After confronting the bully:
This is the immediate action in response to bullying to stop bullying. These actions are taken to stop or prevent bullying from happening, as in stating to the group "we need to stop," or filing an incident report on behavior.

Removed exemplar for 8 to reflect a better avoidance behavior that impacts patient care: Respondent B: I stopped asking her questions. I would find [pause] I would go down a different hallway and find someone else to ask because I didn't wanna ask her.
## Theme A. Construct of Bullying: Behaviors, incidents or situations which construct workplace bullying in the eyes of the target are documented under this theme. Behaviors, incidents, or situations may not necessarily be WPB but perceived as intentional bullying behaviors or cause internal questioning of others’ behaviors instead of confirming intention.

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<thead>
<tr>
<th>Node</th>
<th>Exemplar</th>
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<tbody>
<tr>
<td>1. Perceived acts of bullying: These are the overt or perceived covert bullying acts as described by the target or perpetrator, such as rolling the eyes, gossiping, management confidentiality broken, screaming or verbal abuse, eating their young, or equal opportunity bullying (picks on everyone). Additional constructs may be described as tough love, sink or swim, refusal to assist when asked, may also include organizational acts the target verbalizes as unfair, such as mandatory overtime, no breaks r/t patient acuity, or down time away from the unit.</td>
<td>(1) Respondent B: “I’ve noticed that people are really mean to her. And even – I tend to be aware of it, but sometimes, I catch myself being short with her. You know, rolling my eyes as I walk away – joining the conversation &quot;Oh, Jesse called and she –&quot; you know, I was just thinking like, &quot;I'll take out the batteries.&quot; She's calling in seconds and we're all kinda rolling our eyes. And, like I said, I try to be cognizant of it, but – and then I feel like I do it myself or chime in when people are complaining about her.”</td>
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**10 sources with 60 references**
Theme B. Permissive Culture of Bullying: The negative actions, attitudes, or interactions between nursing leadership, the target, and the perpetrator that enable, ignore or reward a distressful culture attenuated with workplace bullying behaviors.

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<tr>
<th>Node</th>
<th>Exemplar</th>
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<tr>
<td>2. Minimizing the bullying: The target’s perception of reactions after reporting to management or others on WPB behaviors. Behaviors seen include (1) sincere lack of awareness of bullying and its impact to the target; (2) not acknowledging bullying exists; or (3) acknowledging bullying but taking no action, minimal action or displaces the target.</td>
<td>Respondent I: “We’ve had people try and go and talk and there’s a token email that gets sent out or something like that. But it doesn’t go much beyond that.”</td>
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<td>3. Characteristics of the bullied: This is the target’s perspective on why he or she is bullied or why others are bullied. This theme is demonstrated through comments such as the target being the “low man on the totem pole,” internalizing the bullying such that the target states she or he lets “it build and build and build,” and being excluded from the group either as a personal choice or a choice of the group (“Don’t hang out with the bullies” and being an “Outcast”).</td>
<td>Respondent B: “I don’t think it was just me, I think that she targets newer, less experience employees in general. I think maybe I’m more sensitive to it, in thinking that it’s a little more towards me than other people.”</td>
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<td>4. Potential stressors leading to bullying: Identifies stressors, scenarios, and sources of stress (e.g., management change, staffing issues, and increased workload) that adds to unit distress and frustration. Other organizational considerations are lack transparency on business plans, miscommunication, no communication, or barely minimal staffing constricting breaks, down time, away time from the unit or vacation.</td>
<td>Respondent I: “They might already have one very sick patient and I’m sending them something that they think is [pause] a lot of times they get frustrated if they feel like they shouldn’t have a type of patient over there. If they feel like [pause] they get mad if the patient’s too stable often and a lot of times they’l give me crap about that. Like, you know why are you ever sending me this patient? And it’s stuff that I don’t have any control over. It’s not my decision if they go to the ICU; it has nothing to do with me. And they know that, so I get frustrated when they start asking me like, well, big deal here, they’ll even try to go to the supervisor to avoid taking a patient if they don’t feel like it’s critical enough and they’ll take that out on me.”</td>
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<td>5. Motivation for bullying: In the words of the target or perpetrator, these are the perceptions as to the motivation of the perpetrator for bullying.</td>
<td><strong>9 sources, 24 references</strong></td>
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**6 sources with 26 references**

**6 sources, 12 references**

**9 sources, 24 references**

**10 sources, 102 references**
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples</th>
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<tr>
<td>a. Bullying for fun and friends</td>
<td>High school, cliques and immaturity continue in the workplace as demonstrated by mean or snobby behavior, unwillingness to share or to help out, cliquish behavior or making fun or joking about the target or behavior.</td>
<td>Respondent A: “It’s several people in management and a lot of us think of them, they act like they’re a clique, like when you’re in high school. You know you have groups of people and sometimes they pick on you and that’s kind of like what it reminds us of.”</td>
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<td>b. Power and control</td>
<td>Describes the use or accumulation of power by the perpetrator for retribution or justification through education, rank differences, or control issues associated with patient care that target can’t control but are being held accountable (either person or situational)</td>
<td>Respondent K: “I think that she targets newer nurses and I think she targets less experienced nurses and again, my best guess is that she was bullied throughout her entire life and now that she’s a 10 year nurse, she feels like she has more power and can turn that around and be the one to present that power over others.”</td>
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<tr>
<td>c. Target personal characteristics</td>
<td>These are descriptors used by a perpetrator as to why the behaviors are used toward a target (e.g., lazy, annoying, new employee, new nurse, new intern/resident).</td>
<td>Respondent B: “And, for some reason, nobody can seem to get along with her. She's very [pause] I don't know what it is about her, but she's annoying I guess. She's just always calling you, not understanding about the heart palpitations, and pestering me about, &quot;Oh, this patient is off monitor. This patient is off monitor.&quot; Within seconds, she kinda freaks.”</td>
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<td>d. Perpetrator personal or unit characteristics</td>
<td>People create the culture or atmosphere. Examples may be &quot;that is just the way he or she is,&quot; &quot;that's just the way it is,&quot; &quot;it won't change,&quot; older nurses are burnt out.</td>
<td>Respondent D: “I mean she has a full-time job as a professor, and then she works two days a week in the ICU. And I don’t know if it’s just that she’s burnt out. I don’t know if it’s just a personality like she’s always had that personality. I don’t really know but I suspect that some of it is that she’s burnt out just by the comments that she makes at work. But she doesn’t really want to work that much anymore and I guess it’s kind of her way of thrashing out. But I don’t know. I’ve only known her for two years, and I don’t think that this is like a new occurrence. So I don’t know if it’s just her personality and the way that she is that she kind of has always been like a dominant personality that she just kind of does that.”</td>
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Theme C. The Toxic Effects of Bullying: The target demonstrates or observes responses they or others do when perceive they are bullied. These responses range from preparing to leave, emotional responses, rationalizing behavior, avoiding the bully to confronting the bully.

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<th>Node</th>
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<tr>
<td>a. Preparing to leave: Although still working at the facilities after 18 months, there may be preparations to leave a facility, mentally and physically (e.g. moving further away, saying goodbye, applying other places). Additionally, target may verbalize the loss of other employees related to bullying.</td>
<td>Respondent A: “I will be [leaving] just as soon as I get, as soon as I close on my house, which will be any week now. I have already started applying for other jobs. I haven’t gotten calls yet but I have started looking and kind of preparing myself mentally because as I said before, I do care about my residents. They’re, I’ve actually did clinical at this facility when I was in nursing school so I guess I’ve gotten attached to them. They’re like my friends and family so I’ve been preparing myself mentally that eventually I will be leaving and it might be months down the road but I definitely will be going.”</td>
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<td>Six sources, 8 references</td>
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<td>b. Target responses to bullying behavior directed towards self: Emotional, feelings, or actions that are not directed towards the perpetrator in response to bullying.</td>
<td>Respondent B: “I am so [pause] maybe the stress of the confrontation brings up hot teary feeling behind my eyes, as opposed to just calm. And so, then, I don't think it's very effective because of those emotions.”</td>
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<td>11 sources, 74 references</td>
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<tr>
<td>a. Emotional Responses: Emotional Responses: During the incident or after the incident, the target becomes angry, frustrated, teary, or verbalized disbelief when talking about a bullying incident or feeling picked on.</td>
<td>Respondent B: “I am so [pause] maybe the stress of the confrontation brings up hot teary feeling behind my eyes, as opposed to just calm. And so, then, I don't think it's very effective because of those emotions.”</td>
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<td>8 sources, 15 references</td>
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<td>b. Managing through the bullying behavior: The target uses a variety of methods to work around the bullying. These methods may include avoiding the conflict, blocking and refocusing at the work at hand and acceptance or rationalization of the environment, perpetrator or self.</td>
<td>Respondent D: “But I just try to think of, I have a job to do. I’m there for a reason. I’m not there to pick a fight for someone or get in a fight with someone, and I just try to not think about it and get through my day and take the best care of my patients the best that I can at that point in time.”</td>
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<td>10 sources, 59 references</td>
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<tr>
<td>c. Patient care affected: Patient care is affected through delayed care trying to find someone to answer the question or patient advocacy blocked. This can include avoiding the perpetrator, hunting down another person, or just doing the task themselves.</td>
<td>Respondent B: “I stopped asking her questions. I would find [pause] I would go down a different hallway and find someone else to ask because I didn't wanna ask her.”</td>
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<td>7 sources, 10 references</td>
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Theme D. Fostering a Positive Work Culture: Demonstrates behaviors, actions, or attitudes that will break the cycle of WPB through positive coping and meaningful social support, proactive actions to prevent bullying, notification to leadership of bullying behavior, to responding effectively to bullying related to increased comfort in competency and management of patients.

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<td>d. <strong>Sources and quality of support:</strong> The target seeks social support after bullying.  <strong>11 sources, 122 references</strong></td>
<td><strong>Respondent I:</strong> “But we all have been in that (bullied) position so we tend to form kind of a tight group and, you know protect each other pretty well too. I certainly had other nurses that I worked with stand up for me when these doctor or, you know other nurses try and do this stuff, which is really helpful. You feel – once you feel that support – I mean your feelings aren’t hurt as much when you have somebody else standing up for you while you’re getting bullied especially if you don’t feel like you can stand up for yourself.”</td>
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<td>a. Inside Facility: Coworkers/management/administration support from inside the facility may be more helpful in maintaining employment and empowerment by building trust in coworkers, management, or administrators.  <strong>11 sources, 57 references</strong></td>
<td><strong>Respondent I:</strong> “You know as much as I like to talk about it and vent, sometimes I wanna go hang with my friends that aren’t in healthcare and know nothing about nursing and tell them like, hey I don’t even feel like talking about work, let’s go out or let’s talk about what’s going on with you. Let’s go somewhere, let’s do something.”</td>
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<td>b. Outside Facility: Family/friends outside support of family and friends may assist with support but do not understand the true nature of being inside the facility or create the trust needed to do the job.  <strong>10 sources, 18 responses</strong></td>
<td><strong>Respondent D:</strong> “So that’s kind of – everyone kind of said you need to find a buddy that you work with so they can help you. And that’s kind of what I did, and there were a lot of people there that were other nurses that were not my preceptor that were really willing to answer my questions.”</td>
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<tr>
<td>c. Strategies or interventions by others to support the target. Examples might be discussing what worked for them; take the phone away, or speaking up towards the perpetrator.  <strong>6 sources, 15 responses</strong></td>
<td><strong>Respondent H:</strong> “One of the more experienced nurses that does like the precepts, kind of pulled me aside one night, and said, “You know, it doesn't have anything to do with you. If you watch her interaction with the new people, it's everybody. She does this to everybody. So she's kind of one of those, You're a young thing. And I'm not of that same philosophy. I help the person I'm precepting. I want to help them. I don't want to tear them down. So she's just like that. So I'm going to interact with her on her level and leave it at that.”</td>
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<td>d. Listening from others: Being listened to, venting, even without a solution, helps the target find meaning in what has happened.  <strong>10 sources, 32 responses</strong></td>
<td><strong>Respondent F:</strong> “I think I'm a good team type player. If I'm caught up on all my stuff, I try and ask people if there's anything they need as much as I can. And I feel like I don't [pause] I mean I'm not necessarily [pause] there's a lot of people on the floor that have been there a long time so I wouldn't say that I'm the most experienced out of the bunch but I think I...”</td>
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comfort level” in the appraisal of the perpetrator or bullying behavior.

| 9 sources, 31 responses |

f. **After confronting the bully:** These are the immediate actions taken to stop or prevent bullying from happening, as in stating to the group "we need to stop," or filing an incident report on behavior.

| 9 sources, 35 responses |

Respondent B: “No, not [pause] no, I didn't get real nasty or anything. Sometimes, currently if she gets like that, I just [pause] I think I tend to respond calmly and just [pause] I'm trying to think of [pause] sometimes, she'll go off about like, "Why isn't this patient discharged yet? We need the bed. And we [pause]" you know? Or, "Why is he doing that?"
She'll just get really on you about something that's out of your control, and trying to make it seem like it's your fault, or, you know, she tries it or something. And I've just kinda taken the stance of, "Well, I don't have control over that discharge order that the doctor hasn't put in. I don't have control over the fact that the patient [inaudible]." or whatever the situation may be and I just kinda calmly state, you know, my side in reply to her comment. And, usually, then, she is like, "Oh, well, yeah, you're right. It's not really your fault." And kinda [pause] it quiets her down.”

| 9 sources, 35 responses |

g. **Rituals:** The target uses rituals or other behaviors to stay positive such as listening to music, using prayer and other faith-based activities, or maintaining a close “attachment to ‘my’ patients,” “peer group,” or the “unit or desk.” May take a break from the floor or to bathroom to calm down.

| 9 sources, 16 responses |

Respondent A: “It may be funny but I actually kind of do a ritual before I go into work to try to stay positive and deal with certain things that I’m dealing with because it’s different at my job from week to week with what we’re dealing with, if that sounds, doesn’t sound stupid. I come from a Christian background, so of course I do a lot of praying and I listen to some of my favorite music. One song in particular is called Outcast so I listen to that every morning on the way to work.”