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Perceptions of Workplace Bullying Among Practicing Registered Nurses

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PERCEPTIONS OF WORKPLACE BULLYING

AMONG PRACTICING REGISTERED NURSES

by

Crystal Regina Threadgill

Abstract of a Dissertation
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

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ABSTRACT

PERCEPTIONS OF WORKPLACE BULLYING

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by Crystal R. Threadgill

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Workplace bullying (WPB) is a social and organizational problem. Within the health care arena, employees, particularly registered nurses, are at risk. WPB has several adverse effects and has been cited in the literature as closely associated with burnout and nurses leaving their positions. This quantitative study examined workplace bullying among practicing registered and its relationship with burnout and nurses' intent to leave their current position.

The surveys utilized were the Negative Acts Questionnaires-Revised (NAQ-R), Maslach Burnout Inventory Survey, Intention to Turnover Scale and a demographic survey. Of the surveys distributed, a total of 185 were returned from one selected hospital in a southeastern state. As part of analyzing the quantitative results, SPSS program version 17 was used. Multiple regressions was used to determine the relationship between the perceptions of WPB among nurses, burnout and intent to leave, as well as WPB and the variables age, race, gender, level of education and years of experience. Based on the research findings, WPB has a significant relationship with the demographic variable gender, likewise with burnout and intent to leave

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DEDICATION

I dedicate this accomplishment to my family. My husband and daughter, Charles and Erinn Graham, have given me their love and support throughout the highs and lows of this tour of duty.

To my parents, Wendell and Beverly Threadgill, I am forever indebted to them both for providing me with a quality foundation for life's struggles, stressing the importance of education and giving their unyielding love.

For all who have contributed to my reality, exposing me to the positive and negative aspects of life, I credit them as well. It is, in part, because of these encounters with each and every one of them, I have endured, persevered and succeeded. They are the individuals who assisted in making me the person I am today.

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CHAPTER I

INTRODUCTION

The concept of horizontal violence or workplace bullying is a complex problem

that is often under reported. According to Dunn (2003), horizontal violence is, "sabotage

directed at coworkers who are on the same level within an organization's hierarchy" and

can take place in any environment as long as unequal power relations exist (p. 977). The

more powerful and prestigious people control and suppress the underprivileged people

(Harcombe, 1999). This type of violence is manifested both in covert and overt hostility

behaviors (Duffy, 1995; Freire, 1972). Duffy (1995) gave a specific account of horizontal

violence among nurses as the "overt and covert non-physical hostility such as criticism,

sabotage, undermining, infighting, scapegoating and bickering" (p. 9). As a result, the

recipient of horizontal violence can experience significant and prolonged emotional,

physiological, and spiritual effects (Wilkie, 1996).

Various terms, such as workplace violence or hostility (Keashley & Jagatic,

2003), incivility (Cortina, Magley, Williams, & Langhout, 2001), mobbing (Zapf, 1999),

lateral violence (Griffin, 2004; Rowell, 2007; Stanley, Martin, Michel, Welton, &

Nemeth, 2007), and horizontal violence (Dunn, 2003; Farrell, 1997; Hastie, 2002; Longo

& Sherman, 2007), have been used interchangeably in the literature. For the purpose of

this study, the term workplace bullying (WPB) was used to refer to the term horizontal

violence (Workplace Bully Institute, 2011). Often, people refer to horizontal violence in

the workplace as WPB. One difference between horizontal violence and WPB is that

WPB generally is a repetitive act by the perpetrator against the same target(s) in the form

of verbal abuse, offensive threatening, intimidating behaviors, and sabotage of the

target's work. Horizontal violence encompasses these same characteristics except that it is not necessarily a repetitive act against the same target (Workplace Bully Institute, 2011).

For this study, the sample include experienced and novice practicing registered nurses who are equal in staff rank but not necessarily equal in age, race, gender, levels of education, or years of experience. When WPB occurs horizontally, the WPB behaviors originate between equally-ranked practicing registered nurses and not from chain of command delegation and rank order directives. The postulation for this study was that WPB is prevalent among novice practicing registered nurses with 3 years or less experience and there is a statistically positive relationship of WPB on the variables of years of experience, burnout, intent to leave current position or shift rotation, age, race, educational level, and a difference between genders. Previous researchers (e. g. Berry, Gillespie, Gates, & Schafer, 2012; Laschinger & Grau, 2012; Simons & Mawn, 2010) have classified registered nurses as inexperienced if they had three years of less of practice experience. This notion was based partially on Benner's (2001) seminal work on novice to expert, which was her theory of skills acquisition. Benner explicated five levels of skills acquisition, with novice being the beginner with no experience. She described each step associated with the transition from the novice graduate nurse to expert caregiver. The perceptions and experiences of novice practicing registered nurses need to be explored to avert further attrition of the nursing workforce.

Infrequently, WPB can be a physical perpetration, such as hitting, shoving, and throwing objects. Researchers have established that WPB has damaging effects within organizations; examples include: (a) development of a toxic work environment (Johnston,

Phanhtharath, & Jackson, 2010), (b) corrosion of morale and job satisfaction (Felblinger, 2009); (c) political reasons for power and self-serving interests (Katrinli, Atabay, Gunay, & Cangarli, 2010), and (d) increased absence and turnover rates (Cleary, Hunt, & Horsfall, 2010; Murray, 2009).

Another effect of WPB is compromised care and safety of patients (e.g. Bae, Mark, & Fried, 2010; Boyle & Miller, 2008; Bush & Gilliland, 1995; Cox, 1991; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007). According to Buerhaus, Auerbach, and Staiger (2009), the registered nurse shortage in the United States (US) will be 260,000 by 2025. Some authors have suggested that abuse in the workplace is a common reason for many nurses to leave their profession (e.g. Aiken et al., 2001; Cox, 1991; Stagg & Sheridan, 2010; Zigrossi, 1992). Quine (1999) reported the results of a large study of 1,100 respondents of the National Health Service community trust in England. In 2001, Quine further explained those findings that related only to the 396 participating nurses and found that the majority of recipients reporting abuse experienced higher job stress and burnout and greater intent to leave the job.

Traditionally, the nursing profession has encountered a deficit of staff nurses. Because of the supply of nurses does not fulfill the demands, it is imperative to attract and retain nurses by creating and maintaining a sustainable work culture. Bowles and Candela (2005) conducted a study on nurses' job experiences within five years after graduating from their program and found that 30% of participants had left their first job within one year of employment and 57% had left by the second year; 22% cited that work environment factors were connected to management issues, lack of support, and too much responsibility caused them to leave. The transition from student to a working professional

is stressful (Delaney, 2003; MacIntosh, 2003; Thomka, 2001), and poor experiences with colleagues can lead to thoughts of leaving nursing (Thomka, 2001). Accordingly, the distinction of a younger and inexperienced generation of nurses coupled with the stress of nursing practice may be a contributing factor to the inadequate supply of practicing registered nurses.

Failure by hospital and nursing administrators to address nurse-to-nurse violence potentially can increase the risk of high turnover and hinder the development of the professional pride. Along this same line of thinking, Sofield and Salmond (2003) reported that health care organizations evaluate workplace issues with a goal of developing an environment that supports nursing in their efforts to achieve and maintain quality care. Recent efforts to tackle this issue included the creation of leadership standards by the Joint Commission on Accreditation of Hospitals (2009) with requirements that leaders create protocols for managing disruptive behaviors and maintain a hospital culture of safety and quality.

The theoretical framework for this study is Freire's (1971) model of oppressed group behavior. This research is an exploration of the relationship between practicing registered nurses' perceptions of WPB and years of experience, burnout, and intent to leave current position or shift rotation.

<div align="center">Problem Statement and Purpose</div>

Historically, nursing literature has substantiated nurses being exposed to patriarchal oppression by hospital administrators and physicians (Ashley, 1976; Muff, 1982; Reverby, 1987), but more knowledge is needed on WPB and practicing registered nurses. The purpose of this study was to examine the relationship between practicing

registered nurses' perceptions of WPB and years of experience, burnout, and intent to leave current position or shift rotation, age, race, educational level, and a difference between genders. Questionnaires for data collection include: (a) Negative Acts Questionnaire-Revised (Einarsen & Hoel, 2001), (b) Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996), (c) Intention to Turnover Scale (Cammann, Fichman, Jenkins, & Klesh, 1981), and (d) Demographic Data Survey. The investigator hypothesized that WPB was prevalent among novice practicing registered nurses with 3 years of experience or less and that there is a statistically significant positive relationship between WPB and burnout and intent to leave current position or shift rotation.

Identifying this study's variables as related to practicing registered nurses' perceptions of WPB will assist hospital and nurse administrators to understand more clearly the effects of WPB. De Marco, Roberts, and Chandler (2005) stated that WPB is considered to be one of the noticeable factors of oppressed group behavior. De Marco et al. (2005) found a relationship between WPB and nurses' feelings of inferiority and stated, "oppression elicits negative behaviors—silence, a lack of voice, poor self-esteem, and the sublimation of the experience of powerlessness through the internal divisiveness known as horizontal violence" (p. 86).

Ignoring this problem could be a factor in the persistent issues of the nursing shortage. Hospital and nursing administrators, who create and implement policy that stipulates a safer work environment, often overlook the issue of WPB among registered nurses, which is a key rationale for conducting this research. Additionally, evidence reveals that shortages are an indication of inadequate policies on recruitment and retention of health care workers (Zurn, Dolea, & Stillwell, 2005). Anthony et al., (2005)

explained that the nursing leadership team, specifically nursing directors, can have a vital role in retaining nurses using their managerial and leadership skills in order to create a positive culture that promotes retention.

Description of Variables

According to Burns and Grove (2007), variables can be described as any object, event, idea, feeling or anything that is measured in a study. Evidence suggests that WPB is related to years of experience, burnout, intent to leave current position or shift rotation, age, educational level, and gender, but the research is not strongly documented; therefore, the researcher will study these variables in relation to WPB. In this researcher's long professional nursing practice, direct observation supports a relationship between WPB and these variables. Perceptions of workplace bullying (WPB) was measured by the Negative Acts Questionnaire-Revised (NAQ-R; Einarsen & Hoel, 2001). Burnout was measured by using the Maslach Burnout Inventory (Maslach et al., 1996); intent to leave current position will be measured by using the Intention to Turnover Scale (Cammann et al., 1981). Demographic data was collected by way of a Demographic Data Survey from the practicing registered nurses participating in the study and included the variables of (a) age, (b) race, (c) years of experience, (d) educational level, and (e) gender.

Nature of Study

WPB is a significant problem facing the nursing profession, and the dearth of literature on WPB experienced by nurses in the workplace serves as a rationale for further investigation. Despite the fact that WPB can occur in any profession, the problem is emerging as a high profile, more prevalent issue in the health care environment (Lyneham, 2001). There is growing evidence that registered nurses experience WPB in

disproportionately higher levels as compared to other workers in environments inside or outside the health care system (Saines, 1999). In 1998, Hewitt, Levine, and Misner reported that workplace bullying (WPB) however was underreported and the actual scope of prevalence is underestimated. Currently, however, there are no formal methods for reporting the incidence of WPB (American Nurses Association, *Bullying in the Workplace*, 2012).

It is apparent that violence has a negative effect on health care finances as a result of low staff and increased patient acuity (Smith & McKoy, 2001). The health care system is burdened by workplace violence, which is correlated with expenditures related to nurse absenteeism, litigation, and compensation, and decreased productivity (Gates, Meyer, & Fitzwater, 1999). It was not until the past few years that workplace violence against nurses was identified as a health hazard—physically, mentally, and emotionally (Katrinli et al., 2010). The human costs related to this kind of violence include chronic pain, depression, emotional trauma, and shifts in functional status (Gates et al., 1999). WPB has been linked to burnout and job stress, in addition to difficulty in attracting and maintaining nurses in positions (Smith & McKoy, 2001).

The International Council of Nurses (2007) accepted the problem of workplace violence as a critical issue in the health care system and created guidelines for appropriate prevention action. Then a few years later, in a 2012 booklet, the American Nurses Association gathered current research findings on recognizing the acts of bullying, identifying causes and consequences, and recognizing expected actions and responsibilities of individual nurses. Duncan, Reimer, and Estabrooks (2000) stated that nurses have a key role in the identification and management of bullying in the workplace.

Because managers and leaders are the culture carriers of an organization, they must be perceptive enough to detect bullying behavior and create a culture that eliminates a bullying culture (Olender-Russo & Mullet, 2009).

All nurses share the responsibility in eradicating WPB (Farrell, 1999). Nurses have the ability to help move an organization from a closed system of secrecy, shame, and silencing behaviors to an environment that is open, kind, and without individual self-serving political motives (Katrinli et al., 2010; Namie & Namie, 2000). The motives for bullying affect the type of response or expectations associated with incidents. Eliminating WPB will depend on the nurse's (a) ability to acknowledge the problem, (b) communication system, and (c) response (Bartholomew, 2006).

<div align="center">Research Questions</div>

The research questions developed for this study were as follows:

1. What is the relationship between practicing registered nurses' perceptions of WPB, and the variables age, race and gender?

2. What is the relationship between practicing registered nurses' perceptions of WPB, and the variables level of education and years of experience?

3. What is the relationship between practicing registered nurses' perceptions of WPB and the burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment?

4. What is the relationship between practicing registered nurses' perceptions of WPB and intent to leave current position or shift rotation?

5. What is the relationship between practicing registered nurses' perceptions of WPB, burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment and intent to leave current position or shift rotation?

Conceptual Framework

Freire's (1971) model of oppressed group behavior was the framework for this study. Freire's model of oppressed group behavior has served as basis for other studies on horizontal violence in nursing, as well as in other disciplines. Freire created the model based on his research with Brazilians who had been dominated by Europeans. These natives were restricted and exploited by those possessing greater influence, reputation, and status, just as nurses in years past were viewed by some physicians as second-rate care takers, unworthy of professional recognition. It is believed that what Freire described in his theory between Europeans and Brazilians is a situation that resembles the once problematic vertical relationship between nurses and physicians. As well, nurse leaders have played their role by taking the baton from the physicians and preserving the dominating behavior, which has generated horizontal violence, or WPB, among practicing registered nurses called WPB. For this study, Freire's model of oppressed group behavior is a justification for the description of WPB.

Originally, Freire (1971) found in his study that influential and dominant Europeans (a) identified their norms and values as the proper ones in society and then used their power to impose them; and (b) determined which attributes (e.g. skin color, language, food, and clothing) were to be respected and rewarded. This same principle can be applied to the past and present relationships between nurse leaders or physicians, and practicing registered nurses. Over a period of time of acclimating to this pattern,

subordinate groups learned to hate their own attributes. Freire concluded that an educational system that propagates the values and beliefs of the dominant group solidifies the continuance of oppression. The oppressed group and the oppressors eventually derive that the oppressed group is inherently inferior. If nursing organizations continue to allow the demeaning acts of WPB among practicing registered nurses, it will maintain this destructive, ritualistic cycle.

As Freire (2003) explained about oppressed groups, "in their alienation, the oppressed wants at any cost to resemble the oppressor, to imitate and follow them" because they believe that internalizing the values of the oppressor will promote acceptance and power (p. 62). Accordingly, those practicing registered nurses who have been the targets of WPB will in turn mimic the characteristics of their perpetrator counterparts to gain recognition and status. The oppressors depict the oppressed as lacking in values, knowledge, and dignity, but view themselves as everything good and valuable in society. The oppressed people view themselves with disdain and reject identification with their own culture, which they view as negatively.

Sometimes oppressors will use humanitarianism as a basis for preserving a profitable situation or will mandate or suggest actions for the safety and good of the people, but they know that the oppressed group will have limited abilities to come up with initiatives to tackle the problems and challenges in the working environment. This system thrives on lack of transformation, creativity, and knowledge of an oppressed group as they become misplaced and misguided within the system. Repetition of this pattern produces a cycle of oppression, reinforces insensitivity in the oppressors, and gives credence to oppressors that they are more knowledgeable than the oppressed. Freire

labeled this phenomenon as the banking concept. Freire explored the banking concept through teacher-student relationships where the oppressors were the depositors, the oppressed were the depositories, and education or information became the act of depositing. The depositor used the depositories as containers to be filled with information and behavior to be received, memorized, and repeated. Just as physicians, nurse managers, and nurses transfer the behaviors to those they have labeled subordinate practicing nurses**.**

In the exploration of this study, identifying the target and perpetrator of WPB was not a primary objective; nonetheless, differentiating the depositories from the depositors could be accomplished; perhaps discovering that the novice practicing registered nurses are the depositories and the experienced practicing registered nurses are the depositors, even though these two populations of practicing registered nurses are equal in rank and in the position of staff nurse. Because of equal rank and position of staff nurses, the depositors (experienced practicing registered nurses) and the depositories (novice practicing registered nurses) form a horizontal relationship and flow of communication with a potential for oppressive, non-constructive behaviors that are characterized as horizontal violence, or WPB. Vertically, practicing registered nurses are delegated to and receive commands from the person he or she perceives as the depositors; in a vertical relationship, the depositor is generally an administrator and the depository is generally the staff nurse. The culture of the healthcare historically has been consumed by images of the nurse as a "handmaiden" in a patriarchal environment (Kelly, 2006, p. 23); this imagery may have become more so true of novice practicing registered nurses (NRN).

Freire (2003) emphasized that the banking concept implies the notion that human beings are adaptable and manageable beings. He illustrated this point in his education research. The more that students worked at storing the effects of those deposits imposed on them, the less they developed the critical thinking to transform their environment. In other words, the more completely practicing registered nurses accept the role imposed on them, the more they tend to adapt to that existing environment and to the disruptive behaviors deposited in them. Roberts (2005) emphasized the notion that nurses in the oppressed group believe they are inadequate and powerlessness in the system, and absent of pride in their own culture—all leading to feelings of low self-esteem and lack of respect for their attributes and each other.

In a healthcare organization, there is a horizontal flow of command, although the vertical flow is where nurses receive instructions from their managers and those same managers receive instructions from their top administrators, and so on. Clearly, the relationship between employers and employees is more defined by policy than is the horizontal relationship between those who occupy the same rank, such as experienced and novice practicing registered nurses. WPB, the acronym being utilized in this study for workplace bullying, and sometimes referred to as horizontal violence, is open to different interpretations, depending on the structural direction of the relationship. For example, in a vertical relationship, WPB can exist but the bullying may not be so defined, sometimes because of the nature of the chain of command with higher-up registered nurses or administrators having power over the practicing registered nurses in a staff nurse position. When WPB occurs horizontally, the WPB behaviors originate between equally-ranked practicing registered nurses and not from chain of command delegation

and rank order directives. The equally ranked practicing registered nurses, however, are not necessarily equal in age, race, gender, levels of education, or years of experience.

According to common practices in the workplace, those with experience have the moral obligation of guiding those who are less experienced, novice practicing registered nurses and in the workplace in order to deliver quality services. However, WPB behaviors tend to interfere, and even contradict, the nurturing the moral behaviors that nursing represents. This guidance is even more important in a practice arena where the mission is to protect and save lives. The ANA *Code of Ethics for Nurses* (2001) serves as a guide to promote quality nursing care and ethical obligations of the profession. In Provision 1.5 of the *Code of Ethics for Nurses* (2001), the ANA discussed on the relationship with colleagues and others by stating:

> The principle of respect for persons extends to all individuals with whom the nurse interacts. The nurse maintains compassionate and caring with colleagues and others with a commitment to the fair treatment of individuals to integrity-preserving compromise and to resolve conflict. Nurses function in many roles, including direct care provider, administrator, educator, researcher, and consultant. In each of these roles the nurse treats colleagues, employees, assistants, and students with respect and compassion. The standard of conduct precludes any and all prejudicial actions, any form of harassment, or threatening behavior or disregard for the effects of one's actions on others. The nurse values the distinctive contribution of individuals or groups, and collaborates to meet the shared goal of providing quality health services. (ANA, 2001, pp. 4-5)

Depending on the oppressor-oppressed (or depositor-depository) relationship, practicing registered nurses should develop their own initiative to tackle the problems and challenges in their work environment. However, it is a collaborative obligation by all nursing professionals to ensure that practicing registered nurses are well guided. The outcome of working as one in a healthcare team moves them toward a common aim. There are experienced practicing registered nurses who exploit nursing's moral duty by using WPB tactics on novice practicing registered nurses, instead of giving guidance and instructions in a clear and concise manner.

<div align="center">Operational Definitions</div>

Age. Age is defined as the length of time that a person has lived or a thing has existed (Oxford online, 2012). Age was measured by way of ratio data.

Bullying. Bullying was measured by scores on the Negative Acts Questionnaire – Revised (NAQ-R) (Einarsen & Hoel, 2001), which was designed to measure perceived exposure to bullying at work. The 22 items are rated on a 5-point Likert Scale, ranging from never to daily, measures the concepts of these three subscales: personal bullying, work-related bullying, and physical intimidating forms of bullying.

Burnout. Burnout is defined as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that occurs among the individuals who do "people work" (Maslach & Jackson, 1986a, p. 1). Burnout was measured by scores on the Maslach Burnout Inventory (MBI) by Maslach et al. (1996). It is a 22-item questionnaire with three subscales that measure concepts of burnout. These subscales are emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA).

Demographic Variables. The demographic variables were measured using the Demographic Data Survey findings.

Depersonalization. Depersonalization is defined as one of the three subscales composing the MBI. "When workers develop cynical attitudes and feelings about their clients" (Maslach et al., 1996, p. 4).

Emotional exhaustion. Emotional exhaustion is defined as one of the three subscales composing the MBI (Maslach & Jackson, 1986a). "Emotional resources are depleted, workers feel they no longer able to give of themselves at a psychological level" (Maslach et al., 1996, p. 4).

Gender. Gender is defined as the state of being male or female (typically used with reference to social and cultural differences rather than biological ones (Oxford Online, 2012). Gender was measured by way of nominal data.

Intention to Leave. The Intention to Turnover Scale (Cammann et al., 1981), a subscale of the Michigan Organizational Assessment Questionnaire (Cammann, Fichman, Jenkins, & Klesh, 1979), was used. The scale is a 3-item index of employees' intention to leave their job.

Level of education. Level of education is defined as a position in a scale or rank (as of achievement, significance, or value) the field of study that deals mainly with methods of teaching and learning in schools (Merriam-Webster Online, 2012). Level of education was measured by way of ordinal data: (a) diploma or associate degree as a score of 1; (b) baccalaureate degree as a score of 2; or (c) master's degree as a score of 3.

Personal bullying. Personal-related bullying is defined as one of the three subscales composing the NAQ-R. Personal-related bullying contains items that are

interpreted as direct or indirect acts of bullying; and personal in nature, such as humiliation, excessive teasing, and being ignored (Einarsen & Hoel, 2001).

Physical intimidating bullying. Physical intimidating forms of bullying are defined as one of the three subscales composing the NAQ-R. Physical intimidating forms of bullying contains items that are interpreted as direct or indirect acts of bullying; menacing in nature, such as yelling while invading personal space; and actual or potential violence(Einarsen & Hoel, 2001).

Race. Merriam Webster online (2012) defined race as "a class or kind of people unified by shared interests, habits, or characteristics." Race was measured by way of nominal data.

Reduced personal accomplishment. Reduced personal accomplishment is defined as one of the three subscales of the MBI and is "the tendency to evaluate oneself negatively, particularly in regard to one's work with client" (Maslach et al., 1996, p. 4).

Work-related bullying (workplace bullying). Work-related bullying characterizes the study variable workplace bullying in this study. Workplace bullying (work-related bullying) is defined as a situation in which people persistently, over a given period of time, perceive themselves as being the subject of negative actions from one or many individuals and has difficulty defending themselves against these actions (Einarsen & Hoel, 2001). Work-related bullying is defined as one of the three subscales composing the NAQ-R. Work-related bullying is interpreted as direct or indirect acts of bullying; occupational in nature, such as being assigned unmanageable or demeaning tasks; and consistent criticism of work patterns.

Years of Experience. Years of experience is defined as a period of 365 days starting from any date practical contact with and observation of facts or events (Oxford Online, 2012). Years of experience was measured by way of ratio data.

Theoretical Definitions

Horizontal Violence. Horizontal violence is defined as aggression, abuse, or injury towards a member of one's peer group (Freire, 1970) or "sabotage directed at co-workers who are on the same level within an organization hierarchy" (Dunn, 2003, p.977). Lateral violence is another term for horizontal violence.

Group Behavior. Oppressed Group behavior is defined as the "work behavior of employees who have low self-esteem and lack of self-confidence (powerless individuals) within a particular work environment" (Roberts, 2005, p. 24).

Assumptions

The assumptions for this study were:

1. Because each nurse does not share the same circumstances, experiences and perceptions may vary depending on the degree of understanding of stressors.

2. Self-reporting on the surveys by practicing registered nurses will be honest and accurate.

Limitations

The identified limitations of the study were:

1. There may not be an adequate representation of non- Caucasian practicing registered nurses.

2. The sample consists of self-reporting volunteers, which could constitute a construct validity threat. Self reporting may be associated with social desirability

response bias, which means the answers to the questions on surveys are to make the participant look good or in a positive light.

3. Participants may freely choose not to answer some of the items, which could obscure the findings of the research.

<div align="center">Delimitations</div>

The plan involved the researcher receiving a sample of approximately 200 practicing registered nurses in one southeastern city of the United States. The support and participation extended by practicing registered nurses would enable the researcher to collect data by using a convenience sample.

There were several pre-identified delimitations of this study. First, practicing registered nurses experience WPB in other geographic areas besides one city in southeastern United States. Because of the time frame and resources available for the study, the sample selection is limited to one southeastern city of the United States. Therefore, the sample may not be representative of the United States population of practicing registered nurses and findings from the study cannot be generalized to the rest of the population of practicing registered nurses. Furthermore, sampling in one area of the United States could decrease representativeness of the population under study and limit the generalization of the findings, which is a potential external validity threat.

Some of the participants involved in the study will have diploma degrees or associate degrees; baccalaureate degrees; or master's degrees. Therefore, the results may not be generalized to practicing registered nurses with any one level of education. According to *2008 National Sample Survey of Registered Nurses,* 50% of the registered

nurse workforce holds a baccalaureate or master's degree while 36.1% earned an

associate degree and 13.9% a diploma in nursing.

Additional pre-identified delimitations were the questionnaires being

administered at multiple sites, possibly by different data collectors, which could obscure

the findings of the research. Also, the scope of the sample may not accurately represent

males and may not represent male registered nurses in the United States population.

<p align="center">Significance of Study</p>

According to Buerhaus, Auerbach, and Staiger (2009), the United States nursing

shortage is projected to grow to 260,000 registered nurses by 2025. Aiken et al. (2001)

discovered that more than 40% of hospital nurses are dissatisfied with their jobs and have

burnout levels that exceed the norms for health care workers. According to study by

Sounart (2008), approximately 90% of nurses have witnessed or were the targets of

workplace bullying, and some experts fear this trend could push more nurses out of the

clinical setting. "Lateral bullying among nurses was also noted in the survey…[which]

include[s] making inappropriate remarks about other nurses' skills in front of patients,

doctors or other staff members, refusing to assist a fellow nurse or making inappropriate

personal comments" (p. 7).

WPB is labeled as a major blemish within the health care organization. WPB does

not only increase employee burnout, it also increases employee turnover rate and the

number of absences and sick leaves. As an end result, the work satisfaction and work

performance of registered nurses are negatively affected. Institutional administrators

being able to comprehend the rationale to and related factors of WPB will provide the

basis for reducing WPB. Significant improvement could result in the profitability of the

health care organization as well as the level and quality of work performance of registered nurses. WPB among practicing registered nurses is hurtful and devalues the recipient of the abuse, both personally and professionally. WPB hinders a process of developing cohesiveness within the nursing profession and institution.

In Namie and Namie (2009), the authors indicate that victims waste time defending themselves and soliciting support, thus becoming demotivated and stressed, and then taking sick leave due to stress-related illnesses. Bullies sabotage their work environment through their own fear, anger, anxiety, and low morale (Canada Safety Council, 2002; Vartia-Vaananen, 2003). A bully's behavior causes other people to suffer shame, humiliation, and depression, which can affect their personal life as well as their job performance (Namie & Namie, 2003).

According to Wilkie (1996), WPB has serious ramifications on the professional, psychological, and physical development of its victims. Individuals experiencing WPB will transition through different specific states that could hinder their emotional composure, their career or job, and their environment. The first stage involves sleep disorders, low morale, impaired self-esteem, and floating anxiety. The second stage encompasses hypertension, nervous conditions, loss of emotional control, burnout, and apathy. The third stage manifests in the form of intolerance, depression, negative effects on personal relationships, disconnectedness, and suicide. These side effects have far more of a negative influence on employee productivity that once believed and are known to be the primary source for employees leaving their job.

Bullying has consequences on the victim, the society, and the organization. As already discussed in this section, the effects on the recipient of WPB can be highly

destructive, ranging from irritation to psychosomatic complaints (Katrinli et al., 2010; Leymann, 1996; Quine, 2001). The Finish researchers, Kivimaki, Elovainio and Vahetera (2000), conducted a study to measure the rate of sickness absence for victims versus non-victims of bullying; 5,000 nurses participated. Two categories were used to describe sickness absence. Medically-certified spells were absences of four or more days and self-certified spells of sickness absence were spells of three days or fewer. These researchers found that medically-certified illness was 26% greater in bullied victims than medically-certified illness of those not bullied.

More research needs to be conducted and more work needs to be done to understand and rectify high turnover rates and to acknowledge and address WPB among hospital nurses. Patients rely on registered nurses to administer safe and high level care. WPB could lead to potentially life threatening errors. WPB among all registered nurses needs to be managed and reduced so that professional unity, retention of registered nurses, and quality health care can exist. As part of increasing our knowledge in terms of main causes of WPB, this study's findings will broaden the reader's understanding of the factors of WPB so that leaders can develop and implement strategies to counter WPB.

<p style="text-align:center">Transitional Statement</p>

As WPB continues to escalate, the strain is felt in areas of recruitment and retention of competent practicing registered nurses. Registered nurses are essential to providing quality health care to the public. The problem of WPB needs to be addressed as one cause of burnout and nursing turnover rates. The investigator of this study addresses an important gap in the literature regarding WPB as a significant problem in nursing and examined WPB of practicing registered nurses as it relates to burnout and nursing

turnover rates. In Chapter II, the investigator presents a comprehensive review of the literature related to the concept of practicing registered nurses, WPB, burnout, nurse retention and turnover. The literature review reveals that WPB is prevalent among practicing registered nurses, both novice and experienced.

CHAPTER II

LITERATURE REVIEW

This chapter is a literature review on workplace bullying, burnout, and intention to leave the current position among practicing registered nurses. The review consists of reliable and valid sources from primary research, sources from renowned organizations, books and other sources. The findings in the selected, relevant sources assists in understanding the scope of the research conducted on the topic of workplace bullying (WPB). The research findings from the literature review assists the researcher in avoiding mistakes committed by previous researchers and also address various issues that have been raised on the subject.

The review includes: (a) history of oppressed group behavior; (b) workplace bullying; (c) workplace bullying in nursing; (d) age, race and gender as related to workplace bullying; (e) educational level and years of experience as related to workplace bullying; (f) burnout, (g) burnout and workplace bullying, (h) intent to leave, (i) intent to leave and burnout; and (j) intent to leave and workplace bullying. The summary includes the justification for this proposed study and existing gaps in the literature.

History of Oppressed Group Behavior

For several years, the oppressed group behavior model has been used to analyze the behavior of nurses and contributes to the explanation of how powerless groups have responded to the domination. Oppressed group behavior (OGB) are initially described in writings about colonized Africans (Fanon, 1963, 1967; Memmi, 1965, 1968), South Americans (Carmichael & Hamilton, 1967), Jews (Lewin & Lewin, 1948), American

women (Miller, 1986), and Brazilians (Freire, 1970). Later, Roberts (1983) provides insight and support to the oppressed group concept as it related to nurses.

Although Fanon (1963) initially discovered oppressed group behavior during the Algeria Revolution, it was validated by Freire in 1970. Lewin and Lewin (1948) a German-American psychologist made some initial contributions and is often recognized as the founder of social psychology and was one of the first to study group dynamics and organizational development. He made suggestions based on the historical persecution of an aggregate group of Jews. During World War II Jewish people acquired some self-hatred; this was from years of abjection and maltreatment. Lewin declared that positive forces such as member encouragement or attainment of personal goals attracted and retained an individual to a certain group, whereas negative or unsavory forces such as undesirable group characteristics averted the individual. Put simply, Lewin and Lewin meant that in seeking to achieve their goals, human beings naturally tend to identify with and pursue those activities that are perceived to add positive value, but avoid those that are deemed negative.

Even though the equilibrium of the two groups was the deciding factor on whether the individual endured or fled a particular group, there would still be tension and frustration; Lewin insisted this resulted in unresolved anger. He suggested that the very forces convincing Jews to disunite from their group offset forces convincing them to remain. Nevertheless, most Jews could not physically leave the group anyway because of their dictator's power and dominating influence. The plight led to aggravation, anger, and self-hated, which resulted in assimilation, marginalization, low self-esteem, and aggression (Lewin & Lewin, 1948).

Frantz Fanon coined the term of workplace bullying (WPB) as *horizontal violence* (Chang & Daly, 2007). He used the term horizontal violence to describe the intergroup conflict that is directed horizontally, where it is perceived as safe to do so instead of at the superior.

> The amalgamation of this is that the leaders emerging from oppressed groups tend not to value the views of their subordinates, while those same subordinates tend not to make their views known because they see no point in doing so—'What's the use, no-one will listen anyway…?' A Catch-22 scenario thus often exists. (Chang & Daly, 2007, p. 98)

Fanon (1963) was a Martinique psychiatrist, philosopher, revolutionary, and writer. He is known as a radical existential humanist. Fanon's works have inspired critical theory, Marxism, and post-colonial studies, thus incited the anti-colonial liberation movement for many decades. Fanon (1963) based his writings on personal experiences as a Black Algerian under French domination. He gave an account of how oppressed people are unable to express hostility and rage toward their oppressors due to submissiveness brought on by self-hatred and low self-esteem. He proclaimed that at an early age the oppressed have been taught they are inferior and that the culture of the oppressor is better and most desired. The feeling of envy by the oppressed then ensues followed by the yearning to take the oppressor's place; however this the envy transforms to anger which is viewed as a long term conquest inevitably leading to violence by the oppressed people to correct or make right their situation.

According to Fanon (1963), not all of the oppressed people turned to violence, but those who did were stimulated by envy and anger in relation to the suffering by the

oppressed under the rule of the oppressor. The alternative to violence was noted by Fanon to be collective auto destruction, assimilation, or fatality. The primary alternative collective auto destruction came about when the oppressed retaliated against another oppressed member instead retaliating against of the oppressor. This action further supported the negative opinions of the oppressor about the disadvantaged group.

Memmi (1965), a Tunisian, viewed economic privilege at the root of oppressive relationships; and those who want to get ahead in the culture feel they need to transform and look more like the oppressor. Memmi asserted that the oppressor formulated a fictitious picture of the oppressed, describing them as "lazy, weak, wicked, backward, evil, and thievish" (p. 87). Memmi explained how this idea is adopted by the oppressed because the oppressor is admired and feared: "Is he not partially right? Are we not all a little guilty after all; Lazy because we have so many idlers? Timid, because we let ourselves be oppressed?" (Memmi, 1965, p. 87). Memmi (1968) asserted that behaviors such as situational inadequacy and assimilation lead to the oppressed participating in their own oppression, but assimilation is only easy when it means learning a different language or changing dress or food. The ability to "pass" is impossible when it involves skin color or gender. Those who are successful at this assimilation are known as marginal, a term coined by Lewin and Lewin (1948). They are marginal because they are between groups, on the border of their own culture, and are not fully belonging to the dominant group. The marginality is a state of uncertainty and does not have a clear culture identity.

Furthermore, political scientists Carmichael and Hamilton (1967) suggested longstanding racism caused oppressed group behavior in African Americans and argue

they became marginal by adopting the culture characteristics of Caucasian Americans and abandoning their roots.

Miller (1986) applied oppression to the female gender. She asserted that historically the male-oriented society resulted in the devaluation of female traits and activities. Miller stated the unequal power balance caused conflict and as a result males ventured in methods of suppression, often through giving threats and engaging in violence. Though Roberts (1983) and Miller (1986) both shared the commonality of the female gender, Roberts addressed the entire nursing profession and was the first to identify oppressive group behavior (OGB) in nursing.

Roberts (1983) argued that dependent and submissive behaviors of nurses evolved in response to a long history of being controlled by medicine. Roberts assumed that oppression in nursing has been immortalized by three mechanisms. These mechanisms are nurses in the medical model, rewards by the hospital administrators and physicians to nurses who exhibited preferred behaviors, and token appeasement to the oppressors in the presence of revolts (Roberts, 1983). Roberts postulated that nurses, as an oppressed group, are decisive and demonstrate self-hate and dislike for each other.

Freshwater (2000) scrutinized the manifestation of WPB within nursing, suggesting that it was a product of unexpressed conflict within an oppressed group. The author examined how the educational system in nursing may contribute to felt oppression by following the cultural narrative. Conveying that the cultural narrative in nursing includes being subordinate and that to go against the cultural narrative would necessitate energy that nurses do not have when recruitment and retention are at their lowest.

Freshwater also argued that "nursing instructors have socialized nurses to have no voice because instructors may feel oppressed" (p. 484).

Promoting a positive work atmosphere and a supportive collegial connection are necessary features to reconstruct the future of the nursing profession. Roberts (1983) proposed understanding oppressed group behavior could assist nurses in focusing on strategies to break the cycle of behavior that keeps them powerless in the health care industry. Although an emphasis on new nurses is not exclusively the answer to the nursing shortage; they were selected as a partial antidote in recognition of this existing issue. Berliner and Ginzberg (2002) reported that the nursing shortage today is actually a tri-fold problem but is related to fewer nurses entering the profession, inability of hospitals to attract and keep new nurses, and nurses who either retire or leave the workforce early. An investigation of practicing registered nurses is one means of contributing knowledge to lend support for change in organizations, and recruit and retain productive nurses.

Freire's (2003) framework was chosen as an expression of oppression in nursing. A review and critique of other theorists' frameworks on oppression, as they apply, to nursing will assist in exploring the relevance of WPB in nursing as related to Freire's framework. A link between socialization and education of nurses through Freire's (1970) model may provide a view that oppressive behavior evolved inconspicuously. The notion that medicine was able to gain control and remain at the helm of nursing may be a gender problem; the thought that oppression was perpetuated may be a social and educational problem. Freire's framework remains popular among researchers studying oppression in nursing. Gender is an unchangeable constant, pedagogy is activating. Hence, the

pedagogical doctrine of Freire's framework supported and explicated oppression in

nursing and Freire's model was chosen for the purpose of this study.

<div align="center">Freire's Oppressed Group Theory</div>

Paulo Freire (1921-1997) was a Brazilian educationalist and author. *Pedagogy of the Oppressed* (1970) is Freire's most well-known work. In it he represents a theory of education in the context of revolutionary struggle. He was able to do this while helping peasants in his country read, write, and think independently. He came to realize and believe ignorance and lassitude of the poor were related to economic, social, and political domination.

The conceptual model for the framework of WPB to be used is Freire's oppressed behavior model. In Freire's revolutionary book *Pedagogy of the Oppressed*, he sought to address lateral oppression, which he labeled horizontal violence (Freire, 1970). The association between nursing as a profession and Freire's pedagogical model is thought to be strong. As determined by Freire (1970), once the oppressive relationship is set, it generates a different way of living for those involved, no matter whether the tormentor or the exploited.

One aspect of Freire's (1970) work is his emphasis on dialogue, an informal tool for education, as opposed to curricula. The dialogical teaching creates a process of learning and knowing. Individuals accomplish this by reflecting on and analyzing the environment in which they live, creating a "group therapy space" for voicing their opinions and grievances (p. 18).

Freire's pedagogy is grounded in a theory of human nature. His dialogue was not only about enhancing understanding but also making a difference in the world. Freire

speaks extensively on human liberation, in which he named this practice "humanization".

Humanization is the notion that every human being, regardless of race, age, culture,

economic class, or any existing disability, is entitled to freedom from exploitation and

oppression. This signifies eliminating harassment and discrimination. Liberation is the

goal when oppression is present. Freire (1970) explained dehumanization afflicts both

those whose humanity has been stolen and those who have stolen it. This distorts the

process of becoming more fully human.

As a humanist and libertarian pedagogy, the pedagogy of the oppressed, has two

outlined phases. In the first, the oppressed uncover the world of oppression and through

the praxis devote themselves to its transformation. In the second phase, when veracity of

oppression has already been transformed, this pedagogy ceases to belong to the oppressed

group and develops into pedagogy of all citizens in the development of everlasting

liberation (Freire, 1970).

Freire argued that "this struggle [for humanization] is possible only because

dehumanization, although a concrete historical fact, is *not* a given destiny but the result of

an unjust order that engenders violence in the oppressors, which in turn dehumanizes the

oppressed" (Freire, 1970, p. 44). In the application of Freire's framework, the oppressed

are depicted as objects subjugated to their own control and domination. The oppressed

suffer from a conflict established in their innermost being. These people realize that they

can't exist authentically without freedom, the one thing they desire most. Though, they

crave this existence, they fear it. Freire (1970) described this dilemma as "Duality" (p.

55). The conflict lies in the choice of being wholly themselves or feeling divided with the

oppressor's consciousness they have internalized. How can the oppressed, as divided,

unauthentic beings, participate in developing pedagogy of their liberation. The oppressed

are contradictory and shaped by and existing in a concrete situation of oppression and

violence. "As long as they live in the duality in which *to be is to be like, and to be like is*

to be like the oppressed, this contribution is impossible" (Freire 1970, p. 48).

Freire stated that an oppressive relationship develops and is upheld through

socialization and educational systems in which the oppressor's values and beliefs are the

proper and right ones. The oppressors use seditious pedagogical techniques to establish

control, possibly with a component of physical violence. Freire noticed that mental

aggression is used to achieve and maintain control over the oppressed. Freire identified

oppressive behavior as: (a) identification with the oppressor, (b) gregariousness and

conformity, (c) horizontal violence, (d) self-depreciation, and (e) emotional dependence.

Workplace Bullying

Lyons, Tivey, and Ball's (1995) defined Workplace bullying as "persistent,

offensive, abusive, intimidating, malicious or insulting behavior, abuse of power or unfair

penal sanctions, which makes the recipient feel upset, threatened, humiliated or

vulnerable, which undermines their self-confidence and which may cause them to suffer

stress, (Lyons et al., 1995, p. 3). Bullying is ideally defined as unwelcomed (Porhola,

Karhunen, & Rainivaara, 2006) and recurring (Dailey, Lee, & Spitzberg, 2007; Einarsen,

1999; Einarsen & Skogstad, 1996; Olweus, 1991; Rayner, 1997; Rayner & Hoel, 1997)

negative acts targeted at one or more individual, involving perceived power inequality

(Einarsen, 1999; Einarsen & Skogstad, 1996; Rayner & Hoel, 1997) and a relative

inability on the part of the victim to engage in self-defense, resulting in some degree of

psychological or work-related harm to the victims (Einarsen, 1999). In recognition of

these facts, novice registered nurses may have an unfair playing field because of their status as a novice in the nursing profession and the responsibility of developing proficient clinical skills. Depending on the coping abilities of each novice registered nurse, he or she may not be able to balance a demanding and negative work environment.

All-encompassing research has investigated the occurrence (e.g., Einarsen & Skogstad, 1996; Jennifer, Cowie, & Ananiadou, 2003; Lutgen-Sandvik, 2006; Porhola et al., 2006; Rayner, 1997; Rayner & Hoel, 1997; Tracy, Lutgen-Sandvik, & Alberts, 2006; Zapf, 1999), and the toxic personal (e.g., Einarsen, Raknes, & Matthiesen, 1994; Hearn & Parkin, 2001; Tepper, 2000) and institutional outcomes (e.g., Ashforth, 1997; Salin, 2003) of bullying. As a result of these international investigations, WPB prevalence ranges from 5% to 38% in the United States, the United Kingdom and Scandinavian (Johnson, 2009; Simons, 2008). Between 30% (Jennifer et al., 2003) and 53% (Porhola et al., 2006; Rayner, 1997) of employees report having felt bullied at some time in their working history. Victims of bullying and observers report psychological problems such as distress, humiliation, anger, anxiety, embarrassment, discouragement, feelings of inadequacy, hopelessness, depression, burnout, lower job satisfaction, a perceived lack of support from colleagues and work-group cohesiveness, eroded attachment to the job and organization, and greater intention to leave (Ashforth, 1994, 1997; Infante & Gordon, 1986; Rayner, Hoel, & Cooper, 2002; Rayner & Keashly, 2005; Sheehan, 1999; Sheehan, Barker, & Rayner, 1999; Tepper, 2000). In fact, Rayner (1997) reported that 27% of victims do leave their jobs.

Communication researchers have just recently become fascinated specifically with workplace bullying (e.g., Lutgen-Sandvik, 2003, 2006; Lutgen-Sandvik, Tracy, &

Alberts, 2007; Porhola et al., 2006), yet "bullying is realized in the processes of

interaction between the parties" and is interconnected "to various communication

processes taking place between individuals and within groups" (Porhola et al., 2006, p.

250). Several characters other than those of victim, observer and bully have also been

acknowledged [i.e., bullies, assistants (those who join in), reinforcers (the onlookers that

laughs or affords other forms of positive reinforcement), outsiders (allow bullying

through silent approval), victims, defenders (victim supporters whether through

comforting the victim or trying to stop the bullying), observers, non-observers (those who

do not notice it), victim/observers, bully/victims, and bully/non-victims (Jennifer et al.,

2003; Porhola et al., 2006; Smith, Singer, Hoel, & Cooper, 2003)], indicating a clear

supposition that bullying behavior is an interactional and communicative phenomenon.

Even though this deduction and the players involved are worthy of further exploration,

for the purposes of this study, only the perpetrator and victim, and a small detail on the

observer, will be discussed. "Workplace bullying is a combination of tactics in which

numerous types of hostile communication and behavior are used;" as such, bullying "is

not limited to active communication but is also perpetrated through passive, nonacts of

social ostracism" (Tracy et al., 2006, p. 152). This characterization generalizes the

isolation, silent treatment, and impersonal interactions used by many registered nurses.

WPB has been described as being, "like childhood bullying…the tendency of

individuals or groups to use persistent aggressive or unreasonable behavior against a co-

worker. Workplace bullying can include such tactics as verbal, nonverbal, psychological,

physical abuse and humiliation..." ("Workplace Options," 2010, para. 2). Johnston et al.,

(2010) project, if WPB is not addressed in a timely manner by the organization, the

consequence of "creating huge problems not only for themselves and other employees,

but also for the victims of the tolerated behavior" (p. 289). De Marco et al., (2005) stated

that WPB is considered to be one of the noticeable factors of oppressed group behavior.

De Marco et al. (2005) found a relationship between WPB and nurses' feelings of

inferiority and stated, "oppression elicits negative behaviors—silence, a lack of voice,

poor self-esteem, and the sublimation of the experience of powerlessness through the

internal divisiveness known as horizontal violence" (p. 86).

  Workplace bullying is a situation whereby systematic stigmatizing attacks are

directed to the victim by fellow workers, thus limiting the victim's civil rights (Quine

2001, p. 74). Wachs (2009) described a scenario in which an inappropriate promotion of

an employee began a subtle presentation of incivility among coworkers, soon becoming a

path of unrestricted negative comments and bullying, leading to absenteeism and lower

retention; this behavior was tolerated by the company. WPB is inherently societal and

organizational in that the perpetrators are supported by workplace culture (Twale &

Deluca, 2008). Bullying must be repeated behavior for it to be considered as such

(Einarsen, 1999; Einarsen & Skogstad, 1996; Rayner, 1997; Rayner & Hoel, 1997),

Single negative acts, such as assigning an employee a task beneath his or her competence

level or yelling once, could be an isolated incident. Notably, the more frequent the

bullying, the more intense and negative the behaviors become (Einarsen & Skogstad,

1996). If employees' perceptions of a deficiency of conflict management skills and an

imbalance of power, or an impairment in confidence, employees may fail to fight off acts

of bullying (Einarsen, 1999; Einarsen & Skogstad, 1996).

There are certain examples of behaviors which are characteristic of bullying, and many of them, although not all, include: being rude, or belligerent; talking in a dismissive tone to subordinates or peers; screaming, cursing, [and] having an arrogant attitude of always being right and everyone being wrong ("Workplace Bullying," 2010). Speedy (2006) articulates this unsolicited behavior towards the victim "is intimidating, humiliating, offensive, and embarrassing" (p. 240).

Other abusive behaviors that reinforce horizontal violence in the workplace include "being quick to criticize and slow to praise; destruction of property or work product; character assassination; spreading malicious rumors; gossiping about others; not providing appropriate resources and amenities in a fair and equitable manner; social ostracism; [and] physical assault" ("Workplace Bullying," 2010). In Longo's (2010) article, some of the same overt and covert conduct is outlined; she reviewed the causes and consequences of these disruptive behaviors and sets out to provide initiatives to resolve the issue. Longo cited Grenny (2009) as declaring administrators should exhibit a concern for the increased occurrence of disruptive behaviors and employ a comprehensible plan.

After extensive evaluation, it is noted that the definitions of workplace bullying have three elements in common: First, workplace bullying is usually defined with reference to impact to the victim; second, most definitions depict the impact to the victim as negative; third, is to do with the consistency of bullying behavior (Einarsen & Hoel, 2001; Lockhart, 1997; Lyons et al., 1995; Randall, 1997; Rayner et al., 2002; Vartia, 2001).

WPB has become an epidemic worse than sexual harassment and physical violence. Recent studies in several European countries declare that the dilemma of violence and harassment in the workplace affect a substantial part of the work place (Di Martono, Hoel, & Cooper 2003; Einarsen & Nielson, 2004; Paoli & Merllie, 2001). These studies make known that psychological violence and harassment, rather than physical violence represents the greatest threat to most workers (Di Martino et al. 2003), about 9% of European workers had exposure to some psychological violence.

A research conducted by Schat, Frone, and Kelloway (2006) representing nearly 47 million United States workers reported that 41.41% of respondents experienced psychological aggression at work at least once, 13% or nearly 15 million respondents suffering from such psychological aggression weekly. Of the five specific psychologically aggressive behaviors evaluated in the survey, being the target of shouted obscenities or being screamed at in anger represented the most frequent forms of psychological aggression being reported by 35% of respondents. Latest research and surveys confirm a similar trend.

In August 2007, The Workplace Bullying Institute (2011) wrote a survey and commissioned Zogby International to collect data for the first representative study of all adult Americans on the topic of WPB. Of the 7,740 respondents, 37% of the U. S. workforce an estimated 54 million Americans, report being bullied at work; with an additional 12% witnessing it. A second representative study of all adult Americans also commissioned by WBI and conducted by Zogby found 8.8% of respondents were direct victims of bullying. Both the 2007 and 2010 surveys indicated that about 35% of workers

in the U. S. experience some bullying. The number of respondents witnessed WPB rose in 2010 to 15.5%.

Another worldwide survey conducted by Monster (2011), the leading job portal, had 64% of all respondents alleging to having been bullied, either physically, or driven to tears, with work significantly affected as a consequence. Though not victims themselves, 16% revealed having witnessed WPB. The survey showed the likelihood of being bullied at work varied by region and culture. Europe recorded the highest instance of bullying, with a shocking 83% of all employees claiming physical or emotional bullying.

Regarding the causes of bullying, research shows that "Previous recurrent emotional problems are not significantly related to future victimization" (Bond, Carlin, Rubin, & Patton, 2001, p. 1). As aforementioned, bullying is usually the cause of someone in power oppressing someone with little or no power. Childers (2004) recognized that in *The Nurses in Hostile Work Environment's 2003 Report* that bullying is highly prevalent in hospitals and organizations to the extent that 70% of victims leave their job, 33% of these victims leave for health reasons and 37% because of manipulated performance appraisals. In the findings from a survey by Cooper and Swanson (2002), the National Health Trust community workers in the UK noted that 38.1% of staff revealed having experienced bulling and would probably quit their jobs as a result. Cooper and Swanson concluded that workplace bullying is significant, under-reported, and under-recognized occupational safety and health problem.

Antecedents of bullying may have origin in individual, environmental, and/or organizational factors. Individual factors include low self-esteem, personal behaviors, female gender employees, lack of coping skills, and substance abuse habits.

Environmental factors include lack of safety measures, working with hostile patients and families and toxic work environment. When employees are bullied, there is deterioration or disabling of organization (Keashly & Jagatic, 2003). Organizational factors are shrinking resources, strict hierarchy, poor working relationships, authoritarian leadership, and increased work load (Cooper & Swanson, 2002; Salin, 2003). These factors indict organizational practices that are oppressive, exploitive, and over-controlling as sowing abuse (Liefooghe & MacKenzie-Davey, 2001). WPB may be seen as developing from several origins but most frequently is identified as emerging from oppressed group behavior (Duffy, 1995; Freire, 1972; Griffin, 2004, Hutchinson, Vickers, Jackson, & Wilkes, 2006; Ratner, 2006; Roberts, 1983).

According to a survey done by the Joint Commission (2009), more than 50% of nurses reported to have experienced bullying and more than 90% say they witnessed the bullying of someone else. Findings by Vega and Corner also indicate that most workplace bullying is done by managers, bosses, or others in positions of authority instead of those who are equal rank to each other. It is estimated that those in positions of authority account for 75% to 89% of incidents of bullying behavior (Vega & Comer, 2005). From these findings, it is clear that it will be difficult for the targets of bullying to step forward and address their concerns. The Workplace Bullying and Trauma Institute (WBTI, 2003) research report found that 33% of the time the targets of bullying quit their job, 37% of the time the targets were terminated from their job, and in only 13% of the cases was the bully terminated or transferred.

Workplace Bullying in Nursing

Investigating bullying behavior among hospitals in Australia, Farrell (1999) established that 30% of the nurses who had experienced humiliation, abusive language and rudeness reported having encountered violence almost on a daily basis. Farrell's study found that more than 50% of these Nurses reported the most distressing aggression to arise out of nurse to nurse aggression, (Farrell 1999). A study by Quine on workplace bullying established that nurses who reported having encountered bullying were more likely to develop negative opinion/perception and lower levels of job satisfaction, exhibit higher depression and clinical anxiety levels and therefore have relatively higher propensity to quit their jobs compared to the nurses who had not reported bullying encounter (Quine, 2001).

An interview by Randle (2003) on pre-registration nursing program students in the United Kingdom (UK) revealed that bullying was a common theme. Other studies, such as one of Massachusetts nurses, 31% of the respondents reported specific incidences of bullying (Simons, 2008). Members of the Washington State Emergency Nurse Association completed a survey with 27% of the respondents reporting they had experienced acts of bullying in the past six months (Johnson, 2009). WPB is prevalent in various health care organizations and demonstrated in these and other studies.

According to the study by McKenna, Smith, Poole, and Coverdale (2003), 34% of first year registered nurses reported to have encountered verbal conflict comprising of abusive language, false criticism, rudeness and humiliation. According to McKenna et al., only 12% of 49% that had reported these incidents to their bosses at work received formal counseling, and established that following these occurrences, the victims suffered

loss or reduction of their self-esteem and personal confidence alongside developing general fear, anxiety, frustration, and depression tendencies. Victims also exhibited other symptoms including; hypertension, fatigue, weight loss and headaches. The study found that these events directly influenced the need for days off duty and intent to leave job as 14% of the nurses reported need for days off duty while 34% reported to have considered leaving job as an option following events of aggression at the workplace, (McKenna et al., 2003).

According to the Bureau of Labor Statistics (BLS, 2008), women comprised 92 % of RNs, With the vast majority of nurses being female, expressly practicing registered nurses, it can be speculated that behaviors are an extension of their childhood. When considering aggression with adolescent girls, research has shown that while some girls use verbal and physical aggression, the most frequent form of aggression among girls is relational (e.g., Cummings & Leschied, 2002; Pakaslahti & Keltikangas-Jarvinen, 1998; Paquette & Underwood, 1999; Simmons, 2002). Relational aggression is expressed by Crick and Grotpeter (1995) as manipulation of others with the objective of causing damage to the relationship and the victim. Through behaviors such as: (a) excluding a girl from a social group, (b) gossiping about another girl so that other girls will reject her, or (c) threatening termination of a friendship unless a girl does what the aggressor wants. WPB among nurses could be interpreted as merely an extension of juvenile relational behavior. Subsequently, with research suggesting cognitive learning of aggression may serve as a catalyst for believing the behaviors are acceptable, purely in view of the fact the behaviors were learned, and it therefore may not occur to the bully that others consider them inappropriate and hurtful.

Alternatively, workplace bullies may very well have exceptional access to and insight of the organization's language and varied interpretations, and exploits them to their advantage, whereas the victim remains uninformed and therefore unable to defensively react. The bully can decide how severely he or she wants to injure the victim, and contrive attacks accordingly (Kinney, 1994).

The following scenario is an example of WPB of a novice practicing registered nurse in her second week of employment devise by this researcher: A novice practicing registered nurse, with one year of experience, is openly ridiculing another practicing registered nurse of equal rank because of a perceived substandard performance of a skill. The novice practicing registered nurse with less than two weeks work experience is known to be passive and had been scolded the day before by a physician. Instead of providing empathy and encouraging the novice practicing registered nurse, the bully practicing registered nurse is finding pleasure and gratification from embarrassing her.

Nursing has a long way to go in creating healthy work environments. Based on a scenario, such as the one in the previous paragraph, fundamental human factors that foster individual health and well-being are still deficient. Healthcare leaders, nurses, and other healthcare professionals need to focus on those basic psychosocial and physical aspects of healthy work environments.

Griffin (2005) described the vulnerability of newly licensed nurses as they are socialized into the nursing workforce; WPB affected their decision of whether to remain in their current position. The study established that one in three nurses will leave a position because of lateral violence. In terms of nurses who are new to nursing, 60% leave their first professional position within six months and 20% leave the profession

permanently (Griffin, 2005). "The impact of this turnover erodes an organization's budget and negatively influences the organization's ability to recruit and hire new staff once reputation of horizontal violence is known among nurses (Bartholomew, 2006). Other costs are a result of the emotional and physical symptom of horizontal violence, which lead to increased use of sick leave, thus affecting staffing patterns and places a strain on the service unit (Rowell, 2007).

Workplace bullying (WPB) among hospital nurses is a serious issue. According to the study by Sounart (2008), up to 90% of nurses have witnessed or were the targets of WPB, and some experts fear this trend could push more nurses out of the clinical setting. "Lateral bullying' among nurses was also noted in the survey…[which] include[s] making inappropriate remarks about other nurses' skills in front of patients, doctors or other staff members, refusing to assist a fellow nurse or making inappropriate personal comments" (Sounart, 2008, p. 7).

Sounart (2008) also stated that nurses who are bullied in the workplace often develop psychological side effects like post-traumatic stress disorder, anxiety, depression, and insomnia, each of which can result in poor work performance. Hutchinson, Vickers, Jackson, and Wilkes (2006) found that WPB persists from six months to as long as seven years of repetitive acts toward the target. Nurses who are singled out by bullies commonly find themselves labeled as stupid or less capable. As a result, these nurses become the center of attention while the bully goes unrecognized, making the action legitimate because the built power structure asserted and maintained by the bully functions to normalize the abuse. Salin (2003) discovered that large organizations with conventional practices and protracted decision making procedures produce outstanding

havens camouflaging and never acknowledging the perpetrators. The victim and others may endure isolation, fear, or stress-related ilnesses; some may even commit suicide.

Current research in this area has suggested that many nurses are leaving the institutional environment due to this peril of WPB, perhaps never to return (Sounart, 2008; Woelfie & McCaffrey, 2007). Quine (2002) found that employees experiencing bullying have a higher propensity to leave the organization; links have been noted between bullying and the current recruitment and retention crisis in the nursing workforce (Jackson, Schwab, & Schuler, 1986). Those exposed to WPB often become unable to perform their duties because of the psychological effect of experiencing bullying; the victim begins to use sick time to alleviate the stress and abuse, resign under pressure or voluntarily, or is fired or forced to retire early (Davenport, Schwartz, & Elliot, 1999; Jackson et al., 1986 Hospital Nurse Staffing and Patient Mortality, Emotional Exhaustion, and Job Dissatisfaction; Tinaz, 2006).

In the early 1980s, nursing professor, Helen Cox (1991), began studying verbal abuse in the medical setting when it appeared to be driving away promising nursing students. Cox correlated oppressed group behavior to the effects of verbal abuse in nursing. Cox found that nurse managers reported higher levels of self-esteem, assertiveness, accountability, control over practice, and autonomy, whereas staff nurses reported higher levels of submissiveness and the need for structure. Cox's (1991) research exemplified many of the features of oppression, including hierarchical power relationships, low self-esteem, submissiveness, and WPB. The meanings of the characteristics and findings that Cox discovered were not revealed.

In contrast, Daiski (2004) performed a study of 20 nurses purposively selected from various Canadian hospitals. The interviewed nurses represented diverse ages, educational preparations, and practice settings. Three men and numerous newly graduated novice nurses were included in the sample. The intention of this descriptive, exploratory study was to include views of staff nurses in the communication of hospital restructuring and to make discernible the processes that contributed to their perceptions of being marginalized. Daiski evaluated the bedside nurses' views on their relationships with other professionals and nursing peers, their perceptions of themselves, and changes needed during the restructuring process. The conclusions of this study were disappointing but did support the features associated with oppression and WPB. The findings indicated that nurses felt relaxed and valued working within a multidisciplinary team, yet this did not automatically render better nursing practice. Nurses tended to discard patient advocacy and go along with the team's directives and choices. All of the participants perceived that their work was significant but lacked appropriate acknowledgment.

Daiski's (2004) research divulged several cases of workplace bullying, including eating their young and resisting the practicing registered nurses' ideas for change. For instance, older, diploma-prepared nurses reported resentment for new baccalaureate degree graduate nurses. These older nurses would relax at the nurses' station and observe their new colleagues labor with difficulty. Young baccalaureate-prepared nurses admitted concealing their educational background to prevent ridicule and obstinacy from the older nurses.

Skillings (1992) published a more comprehensive assessment of WPB as an idiom of oppressive behavior in a qualitative study of six nurses in Northern New England. The

findings revealed three basic themes. The first theme categorized oppression as a multidimensional and socially created reality. Participants expressed their oppression as a combined result of hospital organizational environment and the relationship between nursing and medicine. Unequal gender, class relations, and institutional power composed the organizational environment. These aspects along with the dominant culture of medicine created an environment that was oppressive to nurses.

Skillings (1992) second theme to materialize was that nurses will experience and participate in WPB as a result of institutional oppression. WPB is agonizing for nurses and negatively affects patient care. Lack of peer support, humiliation, sexual harassment, and blaming the victim were all identified as examples of WPB. Each participant pointed out that some nurse managers assumed the behaviors of the administration and physicians, which could be labeled marginal. The nurses generally believed that WPB was associated with differences in gender, values, knowledge, education, and power.

The last theme to surface was personal and collective consciousness raising and transformation, identified by each participant, as they pursued methods to overcome the oppression (Skillings, 1992). The act of nurses telling their stories was educative and gratuitous; they became aware of their role in the perpetuation of oppressed behavior. The experience of telling their stories bestowed them some personal power.

Other studies consistent with Freire's (1970) concept of pedagogy of the oppressed was present in nursing education. Witt (1992) and Rather (1994) studied the function of nursing education for oppressed of nurses returning to school to obtain a bachelor of science in nursing degree (RN to BSN). Witt (1992) analyzed changes in behavior secondary to the education. Using Freire's model, in a quantitative study, Witt

inferred that a baccalaureate education was a stepping stone to prevail over oppressive behaviors and attitudes in nurses, such as the power to advance nursing practice, eliminate low self-esteem, and discourage lack of respect for others. Using the final sample size of 158 entering students and 173 graduates, Witt suggested that low self-esteem and lack of respect resulted in a variation of bullying exhibited as poor affiliation with other nurses and a tendency to form negative characteristics on other nurses.

There were two of limitations to Witt's (1992) study. The broad basis for the assumptions was based on a 90-statement questionnaire, a 52-statement questionnaire, and a demographic question on whether participants were members of the (ANA) American Nurses Association. The first supposition was that an RN to BSN education could have an uplifting effect on the oppressed person, as defined in Freire's (1970) theoretical account of education. One of Freire's primary concerns was dealing with the lack of social knowledge; he did not with certainty equate this with formal school education. With the second assumption, Witt made the inference that a baccalaureate education would prove to increase enrollment in professional organizations, improve self-image, and amplify professional job performance. Despite the limitations the research findings substantiate that education of the oppressed may reduce the behaviors of incidental incompetence and negative attitudes of one's peer group.

Rather (1994) conducted a phenomenological study to expose similar interpretations hidden in the lived experience registered nurses returning to school for their baccalaureate degree. The convenient sample of 15 registered nurses from 3 BSN programs was asked to describe thoughts and feelings about what it was like to be a RN returning to school. Common answers surfaced; such as, feeling coerced to return to

school to be considered as a professional, subjected to controlling faculty that had too much power over the academic situation, and suffered curricular and instructional practices that belittled their present education and experience. Rather concluded that components of pedagogical oppression were present thus identified behaviors of self-hatred and horizontal violence that are congruent with Freire's Framework.

Even though the sample size was appropriate for a phenomenological study, the selection and number of participants in the sample and the study's qualitative design prevented the results from being generalized to the population. Rather admitted to using Freire's (1970) model to influence her understanding of oppression in nurses, which also could have misdirected the data analysis.

Roberts has been coined as one of the pioneers of identifying horizontal violence in nursing as a deterrent in the workplace in that field.

> More than 20 years on from Roberts' article, horizontal violence as a symptom of oppressed group behavior is still seen as a major issue in contemporary nursing…However, many newly graduating nurses will find themselves working in a bureaucracy where work will tend to be guided by adherence to policy and procedure. (Chang & Daly, 2007, p. 98)

Age and Gender

Freire (2003) believed and valued class as a significant theoretical category in search for an enhanced comprehension of conditions of oppression. He asserted the importance of approaching the analysis of oppression through a "convergent theoretical framework" when the oppressed person or group is evaluated by some factors such as race, class, gender, culture, language, and ethnicity (p.15). To maximize the findings

from this study and continue to draw from Freire's theory, the examination of certain variables is vital.

According to Merriam-Webster Online (2012) age is "the time of life at which some particular qualification, power, or capacity arises or rests". Age is an ever-changing demographic of the nursing workforce presenting an obvious challenge for the health care industry to adapt to and manage. In order to examine WPB in its entirety, the review of the literature includes a description and comparison of the perceptions among the three generations of nurses observed in the work industry today. Besides age, other demographic variables addressed in this research are educational level and years of experience of practicing registered nurses. Oxford Dictionaries online (2012) defined gender as "the state of being male or female (typically used with reference to social and cultural differences rather than biological ones)." Regarding gender, the WBI (2011) reported that 38% of females were identified as perpetrators, but overall the female-to-female prevalence (80%) of WPB was at an all-time high; males accounted for a high percentage (42%) of WPB; and perpetrators (62%) of WPB. Additionally, those nurses, ages 30 to 49 years, were the most vulnerable and frequently bullied, with nurses from ages 18 to 29 years as the second highest being bullied and witnessing.

According to the 2010 census, the population of the United States on April 1, 2010, was 308.7 million people, Of the 2010 census population, 157.0 million were female (50.8 %) while 151.8 million were male (49.2 %). The younger working-age population, ages 18 to 44, represented 112.8 million persons (36.5%). The older working-age population, ages 45 to 64, made up 81.5 million persons (26.4 %). As indicated by the 2008 National Sample Survey of Registered Nurses released in September 2010 by

the federal Division of Nursing, the average age of the registered nurse population in 2008 was age 46, up from age 45.2 in 2000; males represented 6.6% of the nursing workforce. The average age at graduation from initial RN education has been increasing over time. More than half of RNs who completed their initial education prior to 2001 did so when they were under age 25; only 34.9% of 2001 to 2004 graduates and 32% of 2005 to 2008 graduates were younger than age 25 at graduation. The mixture of the current nursing workforce crosses three generations, with each generation exhibiting unique work habits, beliefs, and attitudes (Goldman & Schmalz, 2006). The existing intergenerational nursing force consists of three core generations, which are labeled as Baby Boomers (born between 1946 and 1963), Generation X (born between 1964 and 1980), and Generation Y (born between 1981 and 2000) (Duchscher & Cowin, 2004). Work complications arise when each generation is present in any given work environment. Lacking a basic understanding of each generation's value system and interpersonal skills, nurses may fail to function as a unified force causing discord and hostility, and resulting in WPB.

Baby Boomers are service oriented and are defined by their chosen profession. They are often known to criticize views different from their views. In contrast, Generation Xers are self-focused and typically do not identify themselves by their work; often, their job is only one piece of their identity (Jovic, Wallace, & Lemaire, 2006). For example, Generation Xers may pick a lower-paying job if it offers less stringent working hours and allows for a better work-life balance (Glass, 2007). Generation Yers are good listeners, seek new challenges, and are the most adaptable and technologically literate generation. The Xers sometimes have difficulty maintaining a professional image and

have time and attendance issues. Even with this brief and incomplete overview of generational differences, one can begin to see that incorporating a new generation into an existing workforce can produce or intensify conflict.

Currently, the largest generational cohorts in the nursing profession are composed of Baby Boomers and Generation Xers, with the impending loss of Baby Boomers to retirement and the nursing shortage in general, there is an urgent need to understand the novice practicing registered nurses, most of whom are Generation Yers. If this challenge is addressed appropriately, nursing will be in a better position to recruit, retain, and involve novice practice registered nurses.

According to the Workplace Bullying Institute U.S. Workplace Bullying Survey (WBI, 2011), an overwhelming number of employees, ages 50 and older, sought help with the crisis of WPB. The WBI (2011) interpreted the Baby Boomers search for help by contending that employers characteristically seek to force out the more experienced, higher paid, employees. Moreover, a high proportion of nurses, ages 50 to 64 years, reported being bullied. With many in this age group involuntarily forced out, this group represents the lowest rate of bullying.

The *Norwegian Tripartite Agreement on a More Inclusive Workplace* of October 2001 is one of the measures introduced to create a more inclusive workplace, reduce the utilization of disability benefits and sick leave, and retain senior employees longer. This trial agreement lasted a period of four years until December 2005. In 2004, Einarsen & Nielsen sought to support the campaign against workplace bullying as part of the *Tripartite Agreement on an Inclusive Workplace*. In authoring *Workplace Bullying*, their aim was to make the various members in the workplace capable of managing and

preventing WPB. Although age appears to have a correlation to bullying, Einarsen et al. surmised that culture may be a contributing factor, as demonstrated by opposing findings in Norway and Britain. Hoel and Cooper (2001) discovered that younger employees reported more exposure bullying than those, ages 55 years and older, who were the least likely to be bulled. In contrast, Norwegian surveys indicated that younger employees reported being more exposed to concrete, negative acts than older personnel, who reported feeling bullied (Einarsen, Hoel, Zapf, & Cooper, 2003; Hoel, Cooper & Faragher, 2001; Rayner et al., 2002).

Quine (2001) used a modified version of the Negative Acts Questionnaire to study workplace bullying in community nurses in an NHS trust in the United Kingdom. The research objectives were to establish the prevalence of bullying, to scrutinize the association between bullying and occupational health outcomes, and to explore whether support at work could moderate the effects of bullying. Of those nurses who reported being victims of WPB, there was no difference by age or gender in reports of bullying. Nurses who worked full time were more likely to be bullied than those who worked part time. Quine also reported that 38% of cases were WPB on the same level of seniority, and in 3% of cases were perpetrators with less seniority than the victim. In 26% of cases, the bully was male; 66% of cases were female; and in 8% of cases, the victim reported being bullied by individuals of each gender. Frequently, although the bully was older than the victim in 44% of the cases, in 31% of the cases the bully and the perpetrator were of similar in age and in 25% of the cases the perpetrator was younger than the victim.

Pai and Lee (2011) conducted an exploratory study in Taiwan on workplace violence related to age and educational level. Participants were invited to complete the Workplace Violence Questionnaire, an instrument designed to assess types of workplace violence, such as verbal abuse and bullying, the characteristics of perpetrators and victims, and victims' reactions to their abuse. Registered nurses working in hospitals in Taiwan reported high incidences of WPB. More mature nurses (ages 41 and older) and those with a master's degree were thought to be less vulnerable to violence and were used as the reference group in analyses. This assumption was found to be correct. In this study, although patients were the main perpetrators of physical violence, staff members, co-workers, and supervisors often were the perpetrators of psychological violence, with verbal abuse at 52.6% and bullying/mobbing at 42.9%. This finding is in agreement with the outcomes of other recent studies on workplace violence in healthcare settings (Bigony, Lipke, Lundberg et al., 2009; Johnson, Martin, & Markle-Elder, 2007; King & McInerney, 2006; Kwok et al., 2006;). Pai and Lee (2011) identified that a significant risk factor for verbal abuse is a younger age (<30 years), which is consistent with the results of prior studies (Kamchuchat, Chongsuvivatwong, Oncheunjit, Yip, & Sangthong, 2008; Lawoko, Soares, & Nolan, 2004). Younger age may be a reflection of lack of job experience, resulting in a nurse's inability to identify or prevent potentially abusive situations (Kamchuchat et al., 2008; Lawoko et al., 2004). This younger age variable also relates to Privitera, Weisman, Cerulli, Tu, and Groman's (2005) finding that job duration builds a protective factor against violence. Again, years of experience and Privitera et al.'s results are further reviewed in the literature review.

Kamchuchat et al.'s (2008) research involved two parts, a survey and a key informant interview. The survey included not only registered nurses, but also every charge nurse, vocational nurse and nurse assistants of a 500 bed general hospital. Kamchuchat et al. studied three main types of violence that nurses encountered: verbal abuse, physical violence, and sexual harassment. The primary aim was to document the characteristics of workplace violence directed at nursing staff. Ninety seven percent of respondents were females, with almost half under age 30.Though the researchers did not find a significant gender determinant, a significant personal determinant of verbal abuse included younger age. As previously mentioned, immaturity may be a manifestation of work inexperience and those with only basic nursing education, causing Generation Yers not to recognize a prospective bully. King and McInerney (2006) initiated research, qualitative in nature, to survey and describe the hospital workplace experiences contributing to the resignations of registered nurses in the Durban metropolitan area. Thirty interviews were conducted, two per participant, with only two participants being male. Most of the participants were in the group from ages 30 to 40 years, with the youngest participant being age 23 and the oldest being age 52. The greater portion of the participants indicated that they had experienced violence in the workplace. The occurrences of WPB varied from verbal abuse, malicious gossiping and intimidation to an actual physical assault. It was determined that the male registered nurses' experiences of workplace violence differed from their female colleagues. Typical areas of bullying for the participants were verbal abuse and rudeness at the hands of medical practitioners in the private hospitals and from senior nursing colleagues.

Sa and Fleming (2008) studied both the prevalence of WPB among a sample of Portuguese nurses and the relationship between the symptoms of burnout and mental health complaints in the Portuguese Public Health System, in part, because of the central concepts, the instruments NAQ-R and MBI-HSS, and results from a detailed demographic profile of the participants. A 71% response rate of the initial small sample limited generalization of results beyond Portuguese nurses, but the evidence established a relationship between bullying and burnout. The sample included 91 females and 16 males, totaling 107. Thirteen percent (13%) of nurses, with only 1% being male, were identified as having been bullied. The majority of the bullied nurses (57%) were between ages 31 and 40 years; these nurses fit in the category of Generation X.

In 2011, Dumont, Meisinger, Whitacre, and Corbin (2012) studied the occurrence of nurses experiencing or witnessing WPB. Nurses in all age groups reported experiencing and witnessing WPB as often as weekly. However, of the 950 nurses responding, those ages 41 to 51 years reported the highest occurrence. The results revealed a slight overlap of the generations of Baby Boomers and Generation Xers. Regarding gender; only 50 males responded, but the variances in the data were equalized. Males experienced higher occurrences of bullying behaviors than did females.

Leiter, Price, and Spence Laschinger (2010) pursued an exploration of the experience of workplace social environments, specifically job distress and incivility, between generations of nurses. While researchers failed to present data related to gender, they chose generational comparisons without specificity of ages of the nurses. An added limitation, aside from lack of gender information, is that the sample included too few Generation Y nurses with birth dates after 1981 to provide a balanced contrast with the

other two groups; therefore, the Y generation was eliminated. The outcome indicates that

Generation X nurses experienced more incivility than did their Boomer counterparts;

there was a distinction in the three measures: coworker incivility, supervisor incivility,

and team civility. An assessment of separate correlations for the two generations

identified no meaningful differences, but cynicism and exhaustion were equally

correlated with turnover intention, which confirm the importance of civility and incivility

in relation to burnout measurements for both generations—Baby Boomers and

Generation Xers. The researchers did not represent burnout and WPB adequately as it

relates to novice practicing registered nurses, but researchers need to investigate novice

nurses and Generation Yers nurses' perceptions of WPB.

Laschinger and Grau (2012) utilized a cross-sectional design to survey 165

Ontario nurses with 1 year or less experience in nursing. The primary intent of the

researchers was to analyze a model derived from Leiter and Maslach's (2004)

questionnaire titled Six Areas of Worklife Model, which linked six areas workplace of

factors, experiences of bullying and burnout, and a personal dispositional factor

(psychological capital) to the mental and physical health of new graduates in their first

year of practice. Bullying was measured using the Negative Acts Questionnaire-Revised

(NAQ-R) (Einarsen & Hoel, 2001). Laschinger and Grau (2012) found that 26.4% of

nurses reported being bullied, with work-related bullying accounting for the greatest

frequency (23.3%). The same was predominantly female (93.2%), with the average age

of novice practicing registered nurses at age 28 and 10 months experience in nursing.

Laschinger, Grau, Finegan, and Wilk (2010) conducted research in a Canadian

hospital on new graduate nurses' experiences of bullying and burnout in hospital settings.

Using Kanter's work empowerment theory, the researchers tested a model linking new graduate nurses' perceptions of structural empowerment to their experiences of WPB and burnout in Canadian hospital work settings. Using the Negative Acts Questionnaire-Revised, Laschinger et al. (2010) reported that one-third (33%) of the new graduates reported being bullied. Novice practicing registered nurses were 95% female with the mean age of 27 years.

Efe and Ayaz (2010) aimed to determine if the Turkish nurses had been exposed to mobbing or not, and to reveal the causes of the mobbing. The primary difference in WPB and mobbing is the deliberate intention to drive an individual out of a current position. Mobbing is the activity of a person to force someone out of the workplace through rumor, innuendo, intimidation, humiliation, discrediting, and isolation (Davenport, Schwartz, & Elliott, 2003). Just as other researchers have documented certain links relating to WPB, Efe and Ayaz did as well. Of the 33% exposed to mobbing, those nurses 26- 30 years (19.5%) reported being exposed more frequency than others. Some nurses reported decreased work performance (15.05%) because of the hostile behavior and caused unhappiness in their private life (18.4%).Some nurses reported feelings of hopelessness (11.6%) and then identified the victim as the one who would be punished, not the bully.

In 2008, Simons surveyed newly licensed U.S. nurses to measure the frequency and intensity of workplace bullying. The theory of oppressed group behavior served as the theoretical framework for the study (Freire, 2000). Based on the bullying criteria in the NAQ-R instrument, 31% of nurses reported at least two bullying behaviors on a

weekly or daily basis from a colleague during a six month period. Of the 511 participants, 93.3% were female, with ages ranging from ages 22 to 24, with a mean age of 33 years.

Berry et al. (2012) sought to determine the prevalence and effects of WPB on the work productivity of novice nurses. Approximately 91% of the sample was female and under age 30 years, with ages ranging from 21 to 59 years. Results indicated that the majority (72.6%) of novice nurses reported a WPB event within the previous month, and 21.3% reported daily WPB.

A vital necessity exists about what Generation Y nurses want from the profession. If there is a better understanding of what matters most to this emerging cohort of nurses, then the profession will be in a better position to employ, retain, and engage novice practicing registered nurses in order for nurses to have a positive future. The future of nursing rests with the extent to which future research studies generate data on Generation Y nurses, both separately and collectively, with other generations in the workplace. With the growing number of novice practicing registered nurses expected to replace retiring Baby Boomers, there is a growing interest in understanding the distinctiveness of the Generation Yers in the workplace (Lancaster & Stillman, 2005; Palese, Pantali, & Saiani 2006). Now more than ever, the high rate of turnover requires that researchers discover and understand the communal environment of the workplace.

Race

Merriam- Webster online (2012) defined race as "a class or kind of people unified by shared interests, habits, or characteristics." In general, WPB occurs among equal ranking nurse colleagues, who have been depicted as the oppressed group, but despite equal rank it is highly plausible to identify a majority group within this oppressive

system. This is demonstrated in Freire's experiences; the dominant group is portrayed as the primary perpetrator against the minority group. There is the belief that not only due to social and economic disparities, a cultural inferiority may be seen as a justification of dominant treatment. Although this may be viewed as a revisited historical debate of societal power between the races, it is merely an additional piece to fully expand the analysis of WPB. There is inadequate information in the literature concerning the relationship of WPB and certain ethnic groups. Therefore, in order to expand data on this subject and more accurately reflect those practicing registered nurses enduring perceived WPB; race is more closely analyzed.

According to the 2008 National Sample Survey of Registered Nurses, with the US population being 83.2% White, non-Hispanic, racial/ethnic minority groups remain underrepresented in the RN population. Registered nurses from minority racial groups represent only a meager 16.8% of all nurses. There is a difference in the age contour of the registered nurse by racial/ethnic group. White, non-Hispanic registered nurses are the oldest racial group of registered nurses working however they were the youngest group at the time of their initial licensure. Virtually all other racial groups were slightly older at the time of initial licensure but were slightly younger than White, non-Hispanic nurses in the 2008 workforce.

Although there is likely an adequate representation of employee diversity in most health care organizations, there is the inquiry of whether minority registered nurses have been adequately represented in WPB research. WBI (2011) revealed Hispanics (25.3%) and African Americans (27.6%) had the highest incidence of WPB. However, for reasons unknown, most of the studies on WPB among registered nurses have yielded a lack of

minority participation, as evident by some investigators including race as a demographic; nonetheless, omitting racial differences in the key findings. Therefore, this further justifies investigating WPB as it relates to minority and other culturally diverse individuals that comprise the nursing workforce.

Education Level and Years of Experience

Educational level is defined as a position in a scale or rank (as of achievement, significance, or value) in a field of study that deals mainly with methods of teaching and learning in schools (Merriam-Webster Online, 2012). Years of experience is defined as a period of 365 days starting from any date of practical contact with and observation of facts or events (Oxford Online, 2012). This researcher evaluates the two variables based on their relationship with WPB.

There are a few options available when electing to pursue a nursing degree. Nursing can be divided into categories like education level, specialty, work environment, and so on. The nursing profession allows graduates extensive opportunities because there are multiple areas of practice and demand for qualified nursing professionals exist in light of the nationwide shortage of registered nurses. For the purposes of this research, types of nursing education and years of experience may be significant factors; therefore, the following discussion provides information about educational levels and years of experience, both in relation to WPB and practicing registered nurses. Specialty areas of practice are not a demographic variable for this study.

There are three types of entry into practice educational programs from which a person can choose for pursing basic registered nurse education. A diploma registered nurse completes a three-year program at a hospital, which was a more common route for

students over 20 years ago than currently. An associate degree (ADN) registered nurse has a two-year nursing degree from a community college. A professional registered nurse holds a four-year Bachelor's of Science in Nursing (BSN) from an accredited college. Once the entry into practice degree is obtain, additional degrees are available, including advanced nursing practice degrees (MSN, DNP) and the Doctor of Philosophy degree (PhD).

 As indicated by the 2008 National Sample Survey of Registered Nurses released in September 2010 by the federal Division of Nursing, 2008 graduates were more apt to have received initial registered nursing education in a bachelor's or master's level nursing program than were registered nurses who graduated before 2001. About 39% of registered nurses who graduated after 2000 held a BSN as their initial nursing education, and about 1% entered with a master's degree. Diploma nursing education was rare among recent graduates (3%). More than 10% of registered nurses who completed their initial nursing education between 2001 and 2004 later completed additional higher degrees. BSN degrees were completed by 9.6% of graduates from diploma or ADN programs; 10% of BSN graduates and 2% of diploma or ADN graduates earned a master's or doctorate degree. The amount of hours worked weekly and annually by full-time registered nurses in 2008 was parallel across the graduation cohorts. However, among registered nurses who worked part-time, the most recent cohorts worked more hours than did registered nurses who graduated before 2001. Registered nurses graduating between 2005 and 2008 who worked part-time averaged 27.1 hours per week and 1,318 hours per year in their primary nursing positions. Part-time registered nurses who graduated from 2001 to 2004 averaged 24.9 hours per week and 1,232 hours per year, while part-time

registered nurses who graduated before 2001 worked an average of 23.8 hours per week and 1,162 hours per year.

Blickenderfer (1996) explained that resistance to nurse-physician collaboration involves status and education. The researcher suggested that a balance of power issue maintains a negative relationship. Additionally, Benner (1984) and several other researchers provided a persuasive argument that the presence of expert, experienced nurses are vital to quality care and are essential to help new nurses progress through the learning stages; but conflict in the work environment continues. Due to unsettling work atmospheres, coupled with the status of novice practicing registered nurses, a decline in retention numbers is expected. Perhaps an overwhelming level of stress leads to other issues, as well. In support of these thoughts, Cowin and Jacobsson (2003) suggested that work environments not fostering or supporting novice practicing registered nurses are at the heart of high attrition rates. Additionally, a great potential exists for turmoil, stress, and burnout among new nurses (Boychuk Duchscher, & Cowin, 2006). Novice practicing registered nurses' stressors include: (a) not feeling confident or competent, (b) making mistakes because of increased workload, (c) encountering situations that have not been faced beforehand, and (d) having inconsistent expectations from preceptors (Oermann & Garvin, 2002).

Evidence of emotional stress having physiological ramifications, O'Shea and Kelly (2007) investigated experiences of 10 new Irish nurses; some reported they had physiological disturbances such as insomnia and weight loss because of work-related stress. According to Cho, Laschinger, and Wong (2006), novice practicing registered nurses with less than two years' experience reported experiencing symptoms of burnout,

mental exhaustion, and depression. Boychuk-Duchscher (2011) found that new registered nurses described work environments as authoritarian. Boychuk- Duchscher & Cowin (2004) studied the relationship between high rates of attrition and role-transition difficulties of new nurses and pointed out that senior practicing registered nurses reject the new registered nurse colleagues—a phenomenon known as new nurse marginalization. The new nurses reported their first few months of practice as being chaotic, agonizing, and traumatic—nurturing feelings of isolation, defenselessness, and uncertainty that can result in low self-esteem, lack of self-confidence, and a sense of failure.

Pai and Lee (2011) discovered that nurses with a master's degree are less susceptible to being bullied. Privitera et al. (2005) also found that lower education is a risk factor for physical violence. Based on the research from these two studies, Kamchuchat et al. (2008) suggested that an increase in the level of education decreases the chances that a nurse will be a victim of violence.

In an attempt to develop a strategy for transforming a hostile work environment into a healthy one, Vessey, DeMarco, Gaffney, and Budin (2009) studied U. S. staff registered nurses' perceptions of frequency and patterns of bullying. The findings exposed novice staff registered nurses as being bullied the most by senior staff registered nurses and charge nurses in order for them to gain power over the novice staff registered nurses. Vessey et al. categorized the bullying negative experiences into seven categories: (a) humiliation in front of others; (b) isolation, exclusion, and gossiping/telling lies about the one who is bullied; (c) excessive criticism; (d) unreasonable requests; (e) verbal abuse or name calling; (f) exaggerated reports made to supervisors; and (g) being denied

opportunities or resources. Staff registered nurses who worked five years or less reported experiencing WPB; as compared to staff registered nurses working more than five years.

Lewis and Malecha (2011) conducted a correlational comparative study using a sample of 659 Texas registered nurses. The main objective was to explore the impact of workplace incivility on staff nurses, as related to cost and productivity. Nearly half of the sample (48%) held a BSN and a majority of the sample (85.7%) with more than six years' experience as a nurse. A majority of the nurses experienced WPB in the last year (84.8%, n = 553). Some nurses in the sample (36.7%, n = 239) admitted that they had instigated WPB toward another person in the last year. At this point, the authenticity of oppression evolves; the value of self within the nurse is decreased, and the cycle of bullying begins

In Simons' (2008) descriptive study of registered nurses in Massachusetts, 403 non-managerial registered nurse participants were licensed for 0 to 36 months and 107 were licensed greater than 36 months. There was no statistical difference in bullying rates between nurses licensed 0 to 36 months and those licensed more than 36 months. Experienced nurses (> 36 months) were targets of bullying behavior just as frequently as novice nurses (36 months or less). However, Simons found BSN and ADN nurses (45.2% and 38.1%, respectively) to be targets of bullying behavior more frequently than other nurses in the study.

Kanai-Pak, Aiken, Sloane, and Poghosyan (2008) conducted a cross-sectional survey of 5,956 staff registered nurses on 302 units in 19 acute hospitals in Japan. The analysis provided a correlation between burnout and novice practicing registered nurses; in fact, 56% of nurses scored high on burnout. Almost two-thirds of novice practicing

registered nurses was under the age of 30 and one-third had less than four years of experience working as a nurse. Kanai-Pak et al. (2008) proposed that nurse burnout is associated with workplaces that have larger percentages of inexperienced nurses.

In another study conducted at a health care facility in Wisconsin, Thomka (2001) studied experiences of 16 nurses during their first year of employment as a registered nurse. The rationale of this investigation was to depict the occurrences and perceptions of registered nurses' interactions with colleagues during their time of role transition from nursing school graduation through the first year of professional practice. The novice nurses described a variety of positive and negative experiences during interactions with other professional nursing staff. Some of the nurses (82%) reported being treated very well; then there were those nurses (72%) described experiences as less than optimal and a sink or swim environment. There majority of the nurses (58%) reported encountering open criticism in front of others, including patients; some of the participants reported they would contemplate abandoning the nursing profession.

<div align="center">Burnout</div>

Burnout as a concept was first introduced by Freudenberger (1974) to describe a state of fatigue and frustration among human service professionals. The first empirical research on burnout was reported in the early 1980s by Maslach and Jackson (1981), Iwanicki and Schwab (1981), and Maslach (1982).

Those nurses who are unfortunate enough not to have authoritative leadership may have the tendency to experience burnout. Burnout is defined as "a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed and unable to meet constant demands" (Smith, Segal

& Segal, 2012, p. 1). Burnout also may be described as "a process in which a previously committed professional disengages from his or her work in response to stress and strain experienced in the job" (Cherniss, 1980, p. 18). Various factors are recognized in the literature as having a negative impact on burnout, which include: (a) incongruent work status (Burke, 2004), younger age (Ilhan, Durukan, Tanner, Maral, & Bumin, 2008); (b) new graduates (Cho et al., 2006; Ilhan et al., 2008); (c) greater than 40 hours worked per week (Ilhan et al., 2008; Kanai-Pak et al., 2008); and (d) nurse staffing and resource adequacy are significant predictors (Kanai-Pak et al., 2008). Arikan, Koksal, and Gokce (2007) pointed out that workplace issues, such as not working the night shift, fewer workplace changes, and increased voluntary choice of the workplace may decrease burnout.

Burnout is considered a probable outcome of oppression and has, therefore, been included in this review (Tinsley & France, 2004). Staff nurse burnout has been correlated negatively with patient satisfaction and quality of nursing care (Aiken, Clarke, & Sloane, 2002; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Burnout is also a factor of nurse dissatisfaction and intent to leave the profession (Aiken et al., 2001; Aiken et al., 2002; Fletcher, 2001; Janseen, De Jonge, & Bakker, 1999; Shader, Broome, Broome, West, & Nash, 2001). Maslach, Schaufeli, and Leiter (2001) showed that prolonged stress leads to burnout that is not a problem attached to individuals, but to the social environment in which they work. It is not the individual but the workplace or social environment that is the quandary and needs to be changed.

Over the last several years, the interest in burnout among both academia and management has grown drastically as they have begun to understand its significant

negative impact on employees (Halbesleben & Buckley, 2004). Workplace stress has

been highly noted in the literature as a serious issue for employees and for the

organizations for which they work (Dewe, Leiter, & Cox, 2000). In fact, occupational

stress has been cited as a significant health problem (Caplan, Cobb, French, Van

Harrison, & Pinneau, 1980; House, 1981; Pelletier, 1984). Burnout is a central feature of

occupational stress (Beckstead, 2002), which has been demonstrated to impact on patient

care, employee health, and organizational effectiveness (Akroyd, Caison, & Adams,

2002). Health care staff members are especially at high risk of burnout (Pico, 2006). It

may lead to patient dissatisfaction, decline in nursing care, and aggravation of the nursing

shortage. So, the detection, management, and prevention of burnout are vital. Burnout,

however, has not yet been directly correlated with oppressed behaviors.

In 1974, Freudenberger & Richelson (1980) coined the term *burnout* to explain

workers' responses to the chronic stress common in occupations involving several direct

interactions with people. The psychologist delineated burnout as human service workers'

physical and emotional exhaustion where they gradually become indifferent towards their

clients. Freudenberger and Nort (1985) later identified 12 phases of burnout that are not

necessarily sequential in presentation, but include: (a) a compulsion to prove oneself; (b)

working harder; (c) neglecting one's own needs; (d) displacement of conflicts (unknown

source of problem and physical symptoms); (e) revision of values (any source of pleasure

is eliminated including people); and (f) denial of emerging problems (pessimism,

hostility). Phases 7 to 12 of burnout included: (a) withdrawal (isolation and possible the

beginning of alcohol or other substance abuse may occur); (b) behavioral changes

become obvious to others; inner emptiness; depression; and (c) burnout syndrome (Kraft, 2006).

Burnout is customarily conceptualized as a syndrome characterized by the three components, which will be used for this study, that include emotional exhaustion, depersonalization, and reduced personal accomplishment (Maru, 2009; Maslach, 2003). The first component is emotional exhaustion, which results from having high intensity, long-term contact with service recipients; it measures feelings of being emotionally overextended and exhausted by one's work. The second component of burnout is depersonalization, which refers to showing a detachment beyond the requirements of professional distance from service recipients, seeing the recipients as objects and being indifferent when dealing with them. Depersonalization measures an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction. The last component, personal accomplishments, measures feelings of competence and successful achievement in one's work; when damaged, it is the feeling of low self-significance and self- worth that leads to inefficiency and possibly withdrawal from making an effort.

According to Maslach (1976) "Burnout is a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people work of some kind" (Maslach, 1982, p. 2). Maslach explained that emotional exhaustion is an antecedent to depersonalization and depersonalization is an antecedent to diminished personal accomplishment. According to the model, emotional exhaustion will only lead to the feeling of reduced personal accomplishment through the mediating variable of depersonalization (Lewin & Sagar,

2007). Cordes and Dougherty (1993) cited the following symptoms: depression, irritability, lowered self-esteem anxiety, and helplessness. Of the three variables, Maslach and Leiter (2005) and Maslach, Schaufeli, & Leiter (2001) emphasized that exhaustion and depersonalization as the more empirically distinct. Research has demonstrated ore intelligibly fact emotional exhaustion is the core feature of burnout, (Barnett, Brennan, & Gareis, 1999; Kristensen, Borritz, Villadsen, & Christensen, 2005; Shirom, 2005) and that depersonalization and inefficacy can be considered as the closest consequence of exhaustion. In accordance with the thought that Maslach and Leiter (2005) mentioned, researchers have offered that inefficacy is a consequence of exhaustion or depersonalization, rather than a co-existing shaping element of burnout.

Lee and Ashforth's (1996) studies discovered that characteristics of burnout, emotional exhaustion overlaps with a comparable increase in depersonalization. Originally presented to be different ideas, both were positively correlated with measures of psychological and physical strain. Personal accomplishment seeming stands alone in co personal to emotional exhaustion and depersonalization. More over some have proposed that these two features build on a single factor and therefore all manifestations of a mutual implicit phenomenon.

According to Cordes and Dougherty (1993), burnout in a workplace can lead to increases in turnover, absenteeism, greater intentions to quit, reductions in productivity. Burnout is likely to result in lower levels of quality and decreased production of quantity (Maslach & Leiter, 1997). Burnout is an increasingly alarming trend, which is unfortunately commonplace in nursing settings. The causes of burnout are obvious. "As nurse workloads increase, nurse burnout and job dissatisfaction become greater factors in

the voluntary turnover that leads to understaffing of hospitals. Healthcare consumers rank this understaffing as a major threat to patient safety" (Vahey et al., 2004, p. 57).

Newly qualified and inexperienced nurses are at particular jeopardy of suffering emotional exhaustion and burnout in unsupportive practice environments (Cho et al., 2006; Kanai-Pak et al., 2008; Laschinger, Leiter, Day, & Gilin, 2009). Despite practicing registered nurses' potential vulnerability, development of burnout post-graduation rarely has been studied in relation to preceding factors during education (Crow & Hartman, 2005; Duchscher, 2009; Watson, Gardiner, Hogston, Gibson, Stimpson, Wrate, & Deary 2009). As younger age has been associated with higher burnout levels, practicing registered nurses may be especially vulnerable to burnout (Maslach et al., 2001; Poncet & Joullic, 2007; Schaufeli & Enzmann, 1998). For example, novice practicing registered nurses feel inadequately prepared for their role and experience conflict with the harsh daily reality at work (Cherniss, 1980; Duchscher, 2009; Maben, Latter, & Clark, 2006; Mackintosh, 2006). This new work environment, work overload and role stress will predictably put the practicing registered nurses in a vulnerable position; the new graduate nurse may be inundated by feelings of failure and aggravation (Duchscher, 2009). In circumstances in which ineffective socialization to the nursing role develops into early career burnout, energy turns into exhaustion, and involvement into cynicism (Cherniss, 1980; Kramer, 1974; Mackintosh, 2006).

In this cohort of newly graduated nurses, the average burnout levels were fairly constant across time. However, it was established that deviating developmental prototypes underlying this mean-level stability at group level. The results point out that during the first three years of career life, almost every fifth nurse will at some point have

extremely high levels of burnout. Amazingly enough, some practicing registered nurses have these high levels after the first year and then recover, while others develop them over the first three years. For a majority of the practicing registered nurses, the second year of practice appears predominantly stressful, as considerable increases in burnout levels were noted for four out of eight development prototype during this period (and the total average value reached its highest point here). Most changes in burnout levels were accompanied by concurrent changes in depressive symptoms and intention to leave the profession.

The results of burnout are relentless for nurses. At least one study done, "illustrates empirical evidence that nurse burnout is a significant factor influencing patient satisfaction with care, and it identifies modifiable characteristics of nurses' work environments that contribute to nurse burnout" (Vahey et al., 2004, p. 59).

Different studies and researchers have associated burnout to poor work conditions. For example, Cho et al. (2006) established that 66% of new graduate nurses reported having experienced severe burnout resulting mainly from disempowering workplace conditions. Spooner-Lane and Patton (2007) similarly found that age was a statistically significant predictor of cynicism. According to this research therefore, cynicism was higher in younger nurses implying that the younger novice practicing registered nurses are likely to be at a higher risk for burnout. Aiken et al. (2002) discovered that a positive correlation existed between levels of emotional exhaustion and patient: nurse ratios, meaning that a change in this ratio has a significant influence on burnout levels. According to this research, a one patient per nurse increase caused a 23% increase in burnout score as well as a 7% patient mortality increase, (Aiken et al., 2002).

In another study, Greco, Laschinger, & Wong (2006) findings fully a mediated theoretical model that linked nurse manager leadership behaviors to nurse burnout through structural empowerment and perceived person-job fit in terms of manageable workload, collegial working relationships, fairness and values.

A study of International Hospital Outcomes (IHOS) in an initial group of five countries (USA, Canada, England, Scotland and Germany) found that nurse burnout and job dissatisfaction were common among nurses working in direct care in hospitals (Aiken et al., 2001). Nurse burnout in these countries (Aiken et al., 2002) and in other studies (Aiken & Sloane, 1997, Leiter & Laschinger, 2006) has been found to be associated with deficiencies in the quality of the nurse practice environment including inadequate nurse staffing. In a study on nurses in U. S. hospitals, Aiken et al. (2002) reported that each additional hospital patient that was added to the average work load of a nurse was associated with a 23% increase in the odds of high nurse burnout and a 15% increase in the likelihood of job dissatisfaction (Aiken et al., 2002).

<center>Burnout and Workplace Bullying</center>

Although such issues as staffing shortages, recruitment, and job satisfaction have been addressed extensively in the literature, little has been known about WPB and its relationship to burnout. Nurses experiencing bullying have significantly descending levels of job satisfaction, increased job induced stress, and a greater intent to leave a position (Quine, 1999). Pricewaterhouse Coopers' Health Research Institute (2007) found the average nurse turnover rate in hospitals was 8.4% and the average voluntary turnover for first year nurses was 27.1%. The Voluntary Hospitals of America discovered that the annual turnover rate is about 21% for all nursing positions (Cope, 2003).

In another study of 286 nurses, all female respondents, Yildirim (2009) found that 21% had been exposed to bullying behaviors. It was concluded that WPB is a measurable problem that leads to the decreased ability to concentrate, lack of work motivation and commitment, poor productivity, and poor relationships with patients, managers and colleagues.

WPB is a critical situation looming. Research has suggested that WPB and related disruptive behaviors are on the rise. Rosenstien and O"Daniel (2006) revealed that problems occur, such as disruptive behaviors between physicians, nurses, and other members of health care team. It was surmised that disruptive behaviors negatively affect communication and team dynamics, which can lead to adverse occurrences such as burnout. Subsequently, it was revealed disruptive behaviors by nurses were witnessed on a daily basis 7% of the time and on a weekly basis 21 % of the time.

Disruptive behaviors increased stress and frustration levels, altered concentration, and obstructed communication. The Joint Commission on Accreditation of health care organizations found support of the effects of disruptive behaviors. They reported that 60% of all adverse events are linked directly to communication error. As seen with WPB, patient information among nurses may be withheld or ignored causing undo stress on the victimized nurse, a breakdown of the work environment, and poor patient outcomes.

In France, Poncet and Toullic (2007) conducted a study using the Maslach Burnout Inventory (Maslach et al., 1996) by investigating determinants of burnout syndrome (BOS) in critical care nursing staff. Of the 2,392 respondents, 80% were nurses with 82% being female. It is presumed by the researchers that BOS is frequent in

intensive care units and a poor workplace climate is a determinant. Severe BOS (MBI <-9) was noted in 785 (32.8%) of the respondents, with no significant differences between nurses, nursing assistants, and head nurses: Furthermore, perceived conflicts with patients, families or other staff members increase the risk of BOS. Both perceived conflicts and perceived poor relationships with other staff members were strong independent risk factors for severe BOS.

Workplace bullying creates several adverse effects on the nurse and the work environment. WPB is a potential antecedent of burnout and intent to leave. For example, in a study of Portuguese nurses, there was a significant relationship between bullying and burnout, with symptoms of burnout at a higher level and more frequent among those reported having been bullied (Sa & Fleming, 2008). Additionally, researchers report verbal abuse contributes to 16%-24% of staff turnover. Studies by Aiken et al. (2001) and Zigrossi (1992) cite verbal abuse as one reason for many RNs leaving their job or the profession altogether.

<center>Intent to Leave</center>

From a research perspective, intentions are of practical value and are the most immediate determinants of actual behavior (Igbaria & Greenhaus, 1992). Intentions are of practical value because once individuals enforce their decision/behavior to leave, there is limited possibility to reach them in order to establish what their initial position was, (Igbaria & Greenhaus, 1992).

In a longitudinal study of salespeople, Sagar (1994) found that the intention to quit effectively differentiate between leavers and non-leavers. This particular research can be used as the basis (validity) for studying intentions at the workplace. Whereas

intentions may accurately predict subsequent behavior, not much is known about what triggers/determines such intentions, (Firth, Mellor, Moore, & Loquet, 2004). In attempts to answer this question, many researches have tended to investigate into the likely antecedents of employees' intentions to leave, (Kalliath & Beck, 2001; Kramer, McGraw, & Schuler, 1997).

Moore (2002) acceptable research established that one of the reasons people want to quit their current positions (jobs) is the lack of job satisfaction. Job satisfaction itself consists of various factors. Therefore, it is important that the particular factors that were associated with job dissatisfaction be identified if a resolution mechanism is to be reached at the workplace. Wood, Chonko, and Hunt (1986) provided a comprehensive widely applied measure for job satisfaction, which comprises six major facets of job satisfaction. These facets are satisfaction with supervisor, satisfaction with variety, satisfaction with closure, satisfaction with compensation, satisfaction with co-workers, and satisfaction with management and HR policies (Wood et al., 1986).

Intent to leave depicts a serious ongoing issue in the nursing profession. What is turnover?

> In a human resources context, turnover or labor turnover is the rate at which an employer gains and loses employees. Simple ways to describe it are 'how long employees tend to stay….Turnover is measured for individual companies and for their industry as a whole" (*Turnover*, 2011).

This unresolved problem adds to the general cost of health care (Jones, 1990). Several studies have attempted to explain nurse turnover behavior.

The nursing industry would do well to try to prevent high turnover within its ranks. According to Jones and Gates (2007), "Nurse Turnover is a recurring problem for health care organizations. Nurse Retention focuses on preventing nurse turnover and keeping nurses in an organization's employment" (p. 1).

The cost of deliberately attempting to change the work conditions obviously is not considered important enough by the nursing industry to deliberate changing work conditions. Meanwhile, "…decisions about nurse turnover and retention are often made without the support of full and complete knowledge of their associated costs and benefits" (Jones & Gates, 2007, p. 1).

This unsolved problem adds to the general cost of healthcare and compromises the quality of patient care (Jones, 1990). Several studies have attempted to explain nurse behavior. Hinshaw and Atwood (1983) distinguish two categories of turnover: voluntary and involuntary. Voluntary turnover is marked as a person initiating termination or quitting an agency; while involuntary is identified as an organization initiating the turnover or dismissing the employee (p. 134). Retirement and death are another cause of involuntary turnover. In addition, promotions and transfers to other departments are not seen as voluntary turnover, because it takes place within that organization (Price & Mueller, 1981a).

<div align="center">Burnout and Intent to Leave</div>

Several issues in the work environment can influence burnout levels of practicing registered nurses, and ultimately cause them to change jobs. Evidence exists to imply negative factors can have a major influence on nursing turnover (Borda & Norma, 1997; Irvine & Evans, 1995; Price & Mueller, 1981b). According to (Zurn et al., 2005), the area

of shortages is an indication of lack of organizational support and poor management. Such shortages lead to heavy workload hence are the precursor to job stress and burnout that are associated with discontent in career choice, (Zurn et al., 2005).

This discontentment is not the only predictor of nurses' intent to leave /quit their current job. Other reasons include lack of involvement in decision-making, poor relationship with management, low salaries and poor benefits, lack of job security, poor recognition and lack of flexibility in scheduling (Albaugh, 2003). According to Aiken et al. (1997), some of these factors may results from emotional exhaustion and burnout and these may significantly impact on patient outcomes. In a study in the U. S., Shields and Ward (2001) established that nurses who were frustrated with their jobs were 65% more likely to have intent to leave compared to their counterparts.

As it stands, the first type of turnover with health care organizations is not the only kind of turnover. The second type of turnover, which happens in hospitals as well, is also a nightmare for them. Many hospitals are experience significant problems with nursing turnover. High turnover rates are measured in terms of increased cost of recruitment and relocation for new staff, as well as agency fees and overtime. Costs from all factors can easily exceed $25,000 for every recruited nurse (*Nursing Retention*, 2009). Turnover from healthcare organizations means that nurses leave various institutions that provide health care, including nursing homes, but in this case excludes hospitals. In turnover from hospitals means that nurses leave jobs in hospital settings for a non-hospital setting.

Many studies have been conducted on intervention programs for novice practicing registered nurses. Only a few empirical studies have been conducted on Japanese

practicing registered nures' turnover or interventions for preventing it (Suzuki, Kanoya,

Katsuki, & Sato, 2007). The present study is an effort to find out possibilities of

developing effective intervention programs for preventing turnover in Japanese hospital

novice nurses. It is usually hard for hospital novice nurses to have a precise perspective

of their profession and to obtain job satisfaction (Mori, 2001; Wakasa, 1999; Whitehead,

2001). It is imperative to support them during the process of acquiring specialized skills

in nursing (Ichikawa, Sato, & Oozono, 2003; Messmer, Jones, & Taylor, 2004;

Whitehead, 2001). In Japan, approximately 4% of novice practicing registered nurses quit

their jobs within the first 9 months of employment (Suzuki et al., 2006), and 8.5% within

one year (Japanese Nursing Association Survey and Research Section, 2005). Decreasing

such high turnover rates is a critical matter in nursing management. An unsatisfactory

atmosphere in the hospital setting (Duncan, 1997) and dissatisfaction with their salary

(Cowin 2002) have been reported to be the main factors for novice practicing registered

nurses quitting their jobs within the first 12 months of employment.

Social workers have challenging jobs. In a recent report on the complexities of the

social work profession, job demands included increasing paperwork, unmanageable

caseloads, and problems with difficult clients, as well as staff shortages and reduced

availability of adequate supervision (Center for Workforce Studies, NASW, 2006).

Previous literature on burnout has suggested that these demanding job conditions are

significant antecedents of social worker burnout (Söderfeldt, Söderfeldt, & Warg, 1995).

In addition, workers who felt burned out and frustrated with their jobs are more likely to

have higher turnover and be absent from work (De Croon, Sluiter, Blonk, Broersen, &

Fringes-Dresen, 2004). Social worker turnover is a serious problem for social work

administration because social worker turnover negatively affects the quality, consistency, and stability of client services (Mor Barak, Nissly, & Levin, 2001). Specifically, worker turnover not only causes psychological distress in remaining staff members or in new and inexperienced workers who fill vacated positions (Powell & York, 1992), but it leads to client mistrust of the system (Geurts, Schaufeli, & De Jonge, 1998) and financial problems for the organization (Kompier & Cooper, 1999). In view of the implications of burnout and high turnover rates in the social work researchers arise: How do we prevent burnout among staff and how do we retain workers?

Based on the literature review, the researchers developed the relationship between job conditions, burnout and turnover intention and hypothesized: Burnout will be positively associated with turnover intention.

A key source of turnover among nurses is related to unsatisfying workplaces (Hayes et al. 2006). Pearson and Porath (2005) discovered that employees who experienced uncivil behaviors at work deliberately reduced their work efforts and the quality of their work, thereby diminishing overall unit effectiveness. Cortina et al. (2001) also connected WPB to decreased job performance and job dissatisfaction. Lim, Cortina, & Magley (2008) found significant relationships between incivility and employee health and wellbeing as well as turnover intentions. In a study of staff nurses, Dion (2006) found that perceptions of WPB were significantly linked to feeling sustained by their superiors and positively related to feelings of occupational stress and turnover intentions.

Balogun, Titiloye, Balogun, Oyeyemi, and Katz (2002) found significant relationships between allied health professionals' relationships with peers and supervisors and two primary elements of burnout. They found that support from supervisors

explained 7% of the variance in emotional exhaustion, whereas support from colleagues accounted for 9.6% of the variance in cynicism. Hemodialysis nurses in a U.S. sample who reported higher workloads were five times more apt to experience burnout. Still, respondents who reported leaving three or more necessary patient care activities undone during their shift were more than twice as likely to report burnout. For those nurses who reported burnout, they were three times more likely to leave their current position (Flynn et al., 2009). There are numerous studies that show an association between burnout and intention to leave the job. Nurses who experience burnout are less committed to their organization (Cho et al., 2006; Laschinger et al. 2009) and are more likely to leave their position (Leiter, Harvie, & Frizzell, 1998).

Although a serious issue, burnout is not always the primary cause of nurse turnovers. VHA research has found that dysfunctional, unhealthy hospital cultures are one of the primary reasons nurses leave their jobs, not burnout. Lack of confidence and respect for hospital management; especially the front-line supervisor, is a key reason cited for leaving. (Gelinas, 2003, p. 5)

Tinsley and France (2004) applied a hermeneutic phenomenological design to investigate why experienced registered nurses chose to leave the profession. The exact question was "Why did experienced registered nurses choose to leave the active practice of nursing?" Participants were asked to "describe their earliest dreams of becoming a nurse" (Tinsley & France, 2004, p. 8). They were also encouraged to tell their story about entering nursing, their career path, and reasons for leaving the profession. Tinsley and France (2004) identified three fundamental structures: (a) "I loved it…this is what I want to do…," (b) suffering, and (c) exodus from the profession (p. 8). This structure was

characterized by nurse abuse, and subsequent burnout; then, "searching to recapture what once I loved…" (Tinsley & France, 2004, p. 9).

Analysis uncovered that the amalgamation of unity for the participants was oppression and became known prior to all fundamental structures emerged (Tinsley & France, 2004). The researchers concluded that the participants would not have abandoned nursing if they had been encouraged, supported, coached, mentored, and valued. The nurse participants sought opportunities to influence decisions about workplace environment and desired acknowledgment of accomplishments and a job well done. Perhaps if healthcare organizations as well as hospitals took into account the opportunity cost of losing their nursing staffs, they would realize how foolhardy it is to allow staff members to mistreat one another, cause burnout, and thus cause nurse turnover.

> Determining the costs of turnover and therefore the benefits of decreasing turnover is more straightforward. What is important to remember is that the costs of turnover include…the effect short staffing has on the remaining staff and the decreased productivity of new staff. (Finkler & McHouh, 2001, p. 94)

Intent to Leave and Workplace Bullying

In the foregoing sections, attention has been drawn to evidence provided by research to show that WPB is a problem that evolves into stresses (burnout) among victims and as such may lead to frustration, which in turn has been associated with intent to quit among employees. Current research in this area suggests that many nurses are leaving the institutional environment due to this peril, perhaps never to return (Sounart, 2008; Woelfie & McCaffrey, 2007). Quine (2002) found that employees experiencing bullying have a higher propensity to leave the organization; links have been noted

between bullying and the current recruitment and retention crisis in the nursing workforce (Jackson, Schwab, & Schuler, 1986). Those exposed to WPB become unable to perform their duties because of the psychological abuse inflicted. Moreover, the victim begins to use sick time to alleviate the stress and abuse, resign under pressure or voluntarily, or are fired or forced to retire early because of psychological violence (Davenport, Schwartz, & Elliot, 1999; Jackson, Clare, & Mannix, 2002; Tinaz, 2006).

According to Sa´ and Fleming (2008) and Matthiesen, Aasen, Holst, Wie, & Einarsen (2003) research with Portuguese nurses and retail employees respectively, bullying exposure was significantly related to all aspects of burnout, although most strongly related to emotional exhaustion. A study by Quine (2001) on workplace bullying established that nurses who reported having encountered bullying were more likely to develop negative opinion/perception and lower levels of job satisfaction, exhibit higher depression and clinical anxiety levels and therefore have relatively higher propensity to quit their jobs as compared to the nurses who had not reported bullying encounter.

McKenna et al. (2003) established that following these occurrences, the victims suffered loss or reduction of their self-esteem and personal confidence alongside developing general fear, anxiety, frustration and depression tendencies. Victims also exhibited other symptoms including; hypertension, fatigue, weight loss and headaches. The study found that these events directly influenced the need for days off duty and intent to leave job as 14% of the nurses reported need for days off duty while 34% reported to have considered leaving job as an option following events of aggression at the workplace.

Griffin (2005) established that one of three nurses leave a position because of lateral (horizontal) violence. In terms of nurses who are new to nursing, 60% leave their

first professional position within six months and 20% leave the profession permanently (Griffin, 2005). In a British study of 462 nurses, Hadikin and O'Driscoll (2000) found that 46% reported being bullied and, of these, 55% were contemplating leaving within the year (Hadikin & O'Driscoll, 2000).

A study of International Hospital Outcomes (IHOS) in an initial group of five countries (USA, Canada, England, Scotland and Germany) found that nurse burnout and job dissatisfaction were common among nurses working in direct care in hospitals (Aiken et al., 2001). Nurse burnout in these countries (Aiken et al., 2002) and in other studies (Aiken & Sloane, 1997, Leiter & Laschinger, 2006) has been found to be associated with deficiencies in the quality of the nurse practice environment including inadequate nurse staffing. For instance, in a study of nurses in the U.S. hospitals, Aiken et al. (2002) reported that each additional patient added to the average workload of a nurse was associated with a 23% increase in the odds of high nurse burnout and a 15% increase in the likelihood of job dissatisfaction.

Kivimaki et al.'s (2000) found that workplace bullying is associated with a significant increase in sickness absenteeism. In a similar study, Kivimaki, Virtanen, Elovainio,Vahtera, & Keltikangas-Jarvinen, (2003) found a strong relationship between workplace bullying and subsequent depression; an indication that bullying is an antecedent factor for mental health issues. In a study on nurses in the United Kingdom, Quine (2001) reported that 8% of those experiencing bullying had used their sick time to deal with the problem. Simons (2008) used the NAQ-R bullying scale to establish that the intention to leave the organization increased with increase in the bullying scores.

Conclusion

In this literature review, several facets of workplace bullying (WPB) were

examined, which included: (a) an in-depth look at an introduction to workplace bullying

(WPB); and (b) the theoretical underpinnings of Paulo Freire's work *Pedagogy of the*

Oppressed, which serves as the basis for this research on practicing registered nurses'

workplace bullying. Other sections included: (a) workplace bullying in nursing; (b) age,

race and gender as related to workplace bullying; (c) educational level and years of

experience as related to workplace bullying; (d) burnout, (e) burnout and workplace

bullying, (f) intent to leave, (g) intent to leave and burnout; and (h) intent to leave and

workplace bullying.

Oppression has its foothold in nursing, as evidenced by nurses who exploit other

nurses or hinder their pursuit of self-affirmation. The bullying cycle launches at this

point. WPB represents violence, even if overt behaviors are not present (Freire, 2003).

"Violence is initiated by those who oppress, who exploit, who fail to recognize others as

persons" (Freire, 2003, p. 55). Power struggles between the oppressor and oppressed

sustain destructive relationships that sooner or later hinder collaboration and professional

status. Freire's oppressed group concept supports this notion. The researcher purports that

years of experience of practicing registered nurses, those who are experienced with more

than 3 years of experience and those who are novice with three years or less of

experience, leads to an oppressor-oppressed cycle that results in WPB perpetrated by the

experienced nurses toward novice practicing registered nurses. The researcher's intent

also is to examine if there is a significant relationship between perceptions of WPB and

years of experience, burnout, intent to leave current position or shift rotation, level of

education, and age. Perceptions of WPB may also be affected by gender and race.

CHAPTER III

METHOD

Introduction

The purpose of this exploratory correlational study was to determine if there was

a relationship between WPB, burnout, intent to leave current position and the

demographic variables. Again, WPB is unsolicited and undeserving negative acts towards

a collegue that is repetitive. This investigator studied the variables: (a) WPB, which was

measured by using the Negative Acts Questionnaire-Revised (NAQ-R) (Einarsen & Hoel,

2001); (b) nurse burnout, which was measured by using the Maslach Burnout Inventory

(Maslach et al., 1996); (c) intent to leave current position, which was measured by using

the Intention to Turnover Scale (Cammann et al.,1981); and (d) demographic data by way

of a Demographic Data Survey was collected from the registered nurses that participated

in the study and included years of experience, age, race, level of education, and gender.

The chapter provides a description of the methodology for this study,

development of the instrument, research design, target population and sample, and data

collection method is explained. The theoretical framework, Freire's oppressive group

theory, serves as the basis for the research.

Research Design

A quantitative exploratory descriptive correlational research design was used as

the research design. Correlational research "involves the systematic investigation of

relationships between or among variables….the researcher measures the selected

variables in a sample and then uses correlational statistics to determine the relationships

among the variables" (Burns & Grove, 2005, p. 25). This design is used to develop

theory, identify issues with current practice, justify current practice, make judgments, or identify how others in similar situations respond (Babbie, 1986). The exploratory descriptive correlational design allows the researcher to explore and determine the relationship of the selected variables for the study. Different correlation techniques can be applied in correlation design, but the survey system is used mostly when the statistical relationship between two variables is being tested. Some other studies on job satisfaction and nursing shortages (Aiken, Clarke, & Sloane, 2002) reported that self-administered questionnaires were preferable over interviews because they did not take away from clinical duties and could be done out of view of the nursing manage.

Variables to be studied were: practicing registered nurses' perceptions of WPB, years of experience, burnout, intent to leave current position or shift rotation, and the demographic variables of age, level of education, and gender. Evidence has suggested that WPB, novice practicing registered nurses, burnout, and intent to leave current position or shift rotation may be related (e.g., Cortina et al., 2001; Kanai-Pak et al., 2008; Kivimaki et al. 2000; Leiter, Price, & Spence-Laschinger, 2010; Lutgen-Sandvik et al., 2007; Simons, 2008; Laschinger, Grau, Finegan, & Wilk, 2010) , but because these findings are not strongly supported by research, this investigator explored the extent to which these variables are related.

<center>Sampling and Setting</center>

The target participants for this study were practicing registered nurses, who are currently employed in the eight selected practice settings in a southeastern city of the United States. With the use of the Internet search engines like Yahoo and Google, the researcher was be able to gather a list of locations within the researcher's preferred

geographical area. Given that each healthcare organization has its own culture; it was advisable for the researcher to conduct a primary assessment of the pre-selected health systems official website. The researcher visited each selected practice setting to learn more about its environment. A personal visit to the practice settings enabled the researcher to coordinate well and build a good professional relationship with the different facilities administrators and nurses. By doing so, the researcher had a greater chance of being able to get a verbal approval rather than simply trying to call them. IRB approval from the chosen health care system was obtained prior to initiate the research. The health care system requests that any student researcher provide a letter requesting approval from the Institutional Review Board (Appendix E), a one page synopsis (Appendix F), a copy of the protocol (Appendix H) and any supporting documentation, such as information on surveys to be utilized (Appendix G), and student's signature on research request form. One state was chosen for this study, as opposed to a national study, to decrease rival hypotheses such as management and policy differences, geographical issues, and to ensure a large enough sample.

A nonprobability quota sampling method was used for selecting the sample of from practicing registered nurses, who currently work as registered nurses for one of the eight selected practice settings. Quota sampling is a convenience sampling technique but with the strategy of ensuring representation and inclusion of the types of variables for the study (Burns & Grove, 2005). The geographic location was chosen because of the density of population and the researcher's knowledge of the region and population. Babbie (1986) emphasized this may be appropriate because of knowledge of the population's elements, environments, and nature of the research intentions. The use of any

nonprobability sampling method does not always provide a foundation for inferences or generalizations to the larger population.

Sample Size

For this study, the estimation for sample size was more than 200 participants. However, in estimating sample size for this study, Cohen's table of statistical power estimations were employed (Cohen, 1992). Alpha was set at .05 and beta at .20. Cohen (1992) proposed that the maximum acceptable probability of a type 2 error would be 20% with a corresponding level of power of 80%. Therefore, the power value was .80; with the necessary sample size needed being 85.

Many nursing studies do not have sufficient power to detect significance in findings, given that significance could be found, due to a very small sample size (Polit & Beck, 2004). The effect size strengthens the power of the research findings and is linked to the probability level at which an effect is accepted as being statistically significant.

Eligibility Criteria

To be eligible for participation in this study, subjects were to meet the following criteria:

1.   Participants are currently employed as practicing registered nurses.

2.   Participants must work at least part-time work, or 24 hours per week.

3.   Participants must write, read, and understand English.

Instrumentation and Materials

Data for this study was obtained by using four questionnaires that measured practicing registered nurses' perceptions of workplace bullying, years of experience, burnout, intent to leave current to leave current position or shift rotation, and the

demographic variables of age, educational level, and gender. The instruments include

NAQ-R (Einarsen & Hoel, 2001), Maslach Burnout Scale (Maslach et al., 1996),

Intention to Turnover Scale (Cammann et al., 1981), and the Demographic Data Survey.

Reliability and validity of the NAQ-R, the Maslach Burnout Inventory, and the Intention

to Turnover Scale is presented in the next section.

Negative Acts Questionnaire-Revised

Permission to use the Neagative Acts Questionnaire (Appendix A) was

obtained.The Negative Acts Questionnaire-Revised was designed to measure perceived

exposure to bullying on the job, (Einarsen & Hoel, 2001). Since items in this measure are

presented with reference to negative behaviors, they do not make reference to the term

bullying. Original NAQ-R scale was created and tested in a limited Scandinavian context

hence there emerged concerns with cultural bias, face validity, and factor structure during

first attempts to translate it in English, (Einarsen & Raknes, 1997; Matthiesen &

Einarsen, 2001). The intention of coming up with NAQ-R scale was therefore to develop

a valid and reliable scale that would be suitable for use with the Anglo-American

cultures.

Through conceptual reasoning, the original version of the NAQ-R was adjusted to

cover 11 focus groups and sample size of 61 participants drawn from different

occupations and positions over organizational hierarchies (Hoel, Cooper, & Faragher,

2001). The response to the items is a 5-point Likert scale that ranges from 'never' to

'daily'. The approach was such that three interrelated factors were measured. These were;

factors associated with personal related bullying (12 items), work related bullying (7

items) and physically intimidating bullying (3 items); however, only the total score was

used. Applying the Cronbach's alpha of 0.92 to the NAQ-R scale, it was established that the "Cronbach's alpha was correlated with measures of both mental and physical health, intention to quit the job, and overall job performance (-0.24, -0.36 and -0.24 respectively)" (Einarsen & Hoel, 2001).

Maslach Burnout Inventory

The most well received and studied calculation of professional burnout is MBI (Appendix B). Maslach and Jackson developed the scale in 1981. Permission was obtained to use the MBI survey which is now recognized as the leading measure of burnout. The items for the MBI were developed for the purpose of assessing hypothetical aspects of the burnout syndrome. Therefore during explanatory research, interview and questionnaire data that was gathered was useful in providing sources regarding characteristic feelings and attitudes of burned-out workers. Other than these, a review was done on numerous established scales to establish useful content material without outright borrowing of items, (Maslach, 1976; 1982).

The preliminary form consisting of 47 items was administered to a sample of 605 people (56% male and 44% female) drawn from various health and service occupations that were considered to have high potential for burnout based on previous research findings (Maslach, 1976; 1982). The two assumptions that were made included were; first, workers in all the occupations must be interacting directly with people regarding either problematic or potentially problematic issues; secondly, there is possibility that strong emotional feelings will emerge in the work environment leading to chronic emotional stress, which is responsible for burnout.

Principle factoring with iteration and an orthogonal (varimax) rotation was used to carry out a factor analysis to the data from the first sample. In this analysis, 10 factors accounted for more than three quarters of the variance. Applying a set of selection criteria to the items, the items were reduced from the previous 47 to 25. For a factor to be retained, it had to have a factor loading greater than .40 on only one of the factors, high item-total correlation, a large range of subject responses, and a relatively low percentage of subjects checking the "never' response" (Maslach, 1976; 1982).

The 25-item form was then administered to a new sample consisting of 420 people in order to derive confirmatory data for the factor patterns. The new sample consisted of 31% male and 69% female. Since the factor analysis results for the first and second tests, the two samples were then combined such that (N=1,025). Using the same approach, a four-factor solution was developed from factor analysis of the 25-items based on the new combined sample. Of the four factors, three had eigenvalues greater than unity and therefore became the subscales for the Maslach Burnout Inventory (Maslach et al., 1996), and have been replicated in many other countries with many different samples of human service occupations (Enzmann, Schaufeli, & Girault, 1995; Golembiewski, Scherb, & Boudreau, 1993).

Reliability of MBI. In order to avoid any improper inflation of the reliability estimates, reliability coefficients were premised on samples that were not used in item selection. Cronbach's coefficient alpha (N=1,316) was used in the estimation of internal consistency and the three subscales and reliabilities were: 0.90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment with the standard error

of measurement for each subscale being: 3.80 for Emotional Exhaustion, 3.16 for

Depersonalization, and 3.73 for Personal Accomplishment.

Convergent validity of MBI. Various approaches were applied to demonstrate

convergent validity. One way was to correlate individuals' MBI scores with behavioral

ratings independently generated by a person such as a spouse or coworker to whom the

individual is familiar. The second way was to correlate individual MBI scores with the

existence of specific job characteristics that were expected to have contributed to the

burnout experienced. The third way was to make a correlation between MBI scores and

measures of the different outcomes that were hypothesized to be related to burnout.

Substantial validating evidence was derived from all these three approaches.

Validating evidence from independent assessments of individual's experiences

made by outside observers corroborated the individual's self-rating. In the organizational

context, the knowledgeable observer would be the individual's coworker. It was

established as expected, that those individuals who were rated by coworkers as being

emotionally drained by the job actually scored higher in terms of emotional exhaustion

and depersonalization. More so, it was established also as expected, that individuals who

were rated to appear physically fatigued scored higher in terms of emotional exhaustion

and depersonalization. Finally, there was established a correlation between high scores on

depersonalization and more frequent complaints about clients, (Maslach et al., 1996).

With respect to the coworkers themselves, human services staff who scored low

on measures of peer and co- worker satisfaction scored high on Emotional

Exhaustion and Depersonalization and low on Personal Accomplishment.

Subsequent research found that nurses who had unpleasant contacts with their

supervisor scored higher on Emotional Exhaustion, whereas those who had

pleasant contacts with co-workers scored higher on Personal Accomplishment.

(Leiter & Maslach, 1988, p. 301).

Intention to Turnover Scale

The Intention to Turnover Scale (Cammann et al., 1981) was adapted from the

Michigan Organizational Assessment Questionnaire (Cummann et al., 1979). Permission

was obtained to use the adapted version. The MOAQ is a 184-item questionnaire

intended to provide information about the perceptions of organizational members. It is

designed to gather information ranging from objective reporting of direct employee

observation of workplace events to subjective reports of employees' own judgments and

opinions. An analysis was done using a non-multidimensional scale and a principle-axis

factor analysis with a varimax rotation. As a result items were clustered with other items

intended to measure the same construct.

The Intention to Turnover Scale (Appendix C) is a 3-item index of employees'

intention to leave their job (Cammann et al., 1981). A representative item is "I will likely

actively look for a new job in the next year." A coefficient alpha for the turnover

intention was .76. Finally brief information was obtained about the respondents. A 7-

point Likert scale was used ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) for

the all measures. Internal consistency and validity of the scale is provided for by a

reported coefficient alpha of .83. The questionnaire will be modified to complement a 5-

point Likert scale.

Demographic Data Survey

Demographic data was collected by way of the Demographic Data Survey (appendix D) on the variables of practicing registered nurses' years of experience, age, educational level, race and gender. Some of the variables were chosen because of their importance in the health care literature, but some were based on this researcher's direct observation in many years of experience.

Data Collection Procedure

Data was collected from four questionnaires: the NAQ-R, Maslach Burnout Inventory, and Intent to Turnover Scale, and the Demographic Data Survey. Each participant completed the four questionnaires only once. Dates and times were coordinated with administrative personnel. There were four scheduled dates for data collection at the various sites. One week prior to the administration of the survey, at each facility, an announcement (Appendix M) was sent to all practicing registered nurses by way of the organizations intranet system; a second announcement followed three days prior (Appendix K). Flyers (Appendix L) were displayed on the day prior to the start of data collection. This method ensured that those registered nurses working days, evenings, nights and 4-, 8-, 12-, and 16-hour shifts would have ample opportunity to participate. An incentive of three separate $5.00 (lunch) meal tickets and two separate $25.00 gift card drawings for nurses returning completed surveys were offered. This was done by using standard double coupon tickets with matching numbers. The end of the ticket with the participants name and contact information went into a smaller box and the opposite end of the ticket was kept by participant to claim the meal ticket or gift card. The participants

were instructed to use any contact number they felt comfortable with giving and the address section on the ticket could be left blank.

It is often appropriate for researchers to collect their own data; however, due to the varied locations of the participants, this may not feasible. Two data collectors were to be selected based on their experience, congruency with participant characteristics, appearance, and availability. Overall, the selected research data collectors should be impartial representatives whose personal characteristics do not compromise the data collection or the research in general and have no affiliation with the participating health care organization.

A training session was provided for the data collectors. This included general information about the study and the data collection protocol (Appendix H). They were required to follow a rigorous data collection assistant protocol (Appendix I). The data collectors' procedure included:

1. Providing an information summary to a potential participant who did not view or receive information about the research.

2. If the potential participant refuses, thank them for their time and reading the information, if they agree provide them with a research packet and a pencil, explain that the demographic information is for descriptive purposes only and the packet should take approximately 10 minutes to fill out.

If not already sealed by the participant, seal the envelope and place in the lock box, and offer the participant a ticket for the gift card drawing.

3. At no time would the assistants be allowed on the patient care units to solicit research participants.

Once this task was completed, a "trial run" of demonstrating a data collection session will be performed between the primary researcher and the data collectors. This confirmed that the data collectors understand and follow all necessary steps and comply with their responsibilities of collecting the data.

Pre-coding was not be implemented for anonymity, assuring that nurse participants are not identifiable. Every effort was made to ensure privacy and confidentiality. A letter of introduction (appendix M) from the researcher that included the purpose of the study, a letter of statement confirming the approval of both the health care system and University of Southern Mississippi's IRB, a hard copy of the information summary about the research that was sent through the organizations intranet system, the surveys and a manila envelope was be given to the participant. Also, at this time, the primary researcher offered the potential participant an oral presentation clarifying any statements on the documents and giving providing them with an opportunity to ask questions. Because a signed consent form would be the only documentation connecting the registered nurse participant with the WPB research, and potentially infringing confidentiality, the participants' willingness to participate served as their consent. After returning the research packet, it was appropriately coded, but only the researcher had access to this information. The purpose of the study, participant requirements, risks, and benefits was explained. All eligible participants were to be recruited for the study. The researcher had the participant placed the sealed envelope in the box provided. At that time the participant was offered a ticket for the gift drawings.

Before data analysis began, preliminary steps were performed. These steps were done after each scheduled day of data collection. The researcher evaluated the

questionnaires collected by the data collectors to determine if the content was viable. Once opened, the surveys required additional coding, which involved the assignment of an identification number. Good record keeping facilitated the close monitoring of response rates and decreasing the possibility of ineffective data collection. In the process of coding, the information was changed into symbols or numbers to be compatible with computer analysis.

Human Subjects Consideration

This study was submitted for approval to the Institutional Review Board Human Subjects Protection Review Committee at The University of Southern Mississippi. IRB approval was obtained from one health care system that encompasses all practice settings. Each practice setting received an introductory letter and an attachment of the participant packet that includes: a letter of introduction with the purpose of the study, the instructions and the oral presentation. The human subjects protection measures implemented were: (a) participation in the study is completely voluntary; (b) there are no untoward effects from participating in the study; (c) confidentiality will be assured to all participants; (d) complete anonymity will be maintain as there will be no questions or coding identifying the participants on the survey; (e) only data findings in a collective format will be reported and disseminated; and (f) participants will be advised that their participation will benefit nursing by identifying factors to increase professional unity. Only the researcher had access to the information, and will maintain all forms and surveys under lock and key for a period of five years; then, data will be destroyed.

Data Analysis

The SPSS program, Version 20, supported data analysis from the questionnaires by way of descriptive and inferential statistics.

Ratio data (scores on perceptions of WPB, burnout, and intent to leave current position or shift rotation, years of experience, educational level, and age) and nominal data (gender and race) were collected for the demographic questions. Frequencies, means, and standard deviations were analyzed for the perceptions of WPB, burnout, intent to leave current position or shift rotation, years of experience, age, and educational level. Gender frequencies were analyzed in two groups (male, female) and race in three groups.

The inferential statistical analysis was Multiple Regression and Pearson's Product-Moment Correlations for all correlations: perceptions of WPB with age, race and gender ; perceptions of WPB and years of experience with educational level (diploma or ADN, BSN, or MSN) ; perceptions of WPB with burnout subscales emotional exhaustion, depersonalization and reduced personal accomplishment; perceptions of WPB and intent to leave current position or shift rotation;perceptions of WPB, burnout subscales emotional exhaustion,depersonalization and reduced personal accomplishment and intent to leave current position or shift rotation. Males and females, and African Americans, Caucasians (non- Hispanics), and Native American were examined separately and then compared by way of an ANOVA. Additionally, Cronbach's' coefficient alpha was the statistical analysis for internal consistency among the scores of the Negative Acts Questionnaire (NAQ-R) and the scores of the Maslach Burnout Inventory.

Age and years of experience are ratio levels of measurement, but, once collected and analyzed, findings were separated into four groups of practicing registered nurses:

those with three years or less of experience, 31/2 to nine years, 10 to 19 years and those

with more than 20 years or more of experience. Questions with nominal data alternative

responses were assigned numeric codes. For educational level, the code for a diploma

degree or an associate's degree is 1; for a baccalaureate degree, a code of 2; for a

master's degree or higher, a code of 3. For gender, males were given a code of 2 and

females a code of 1. For race, Caucasians were given a code of 1, African Americans a

code of 2 and Native Americans were given 3.

<div align="center">Research Hypotheses</div>

Based on the research questions, the seven null hypotheses were:

H1: There is no significant relationship between practicing registered nurses'

perceptions of WPB and the variables age, gender and race.

H2: There is no significant relationship between practicing registered nurses'

perceptions of WPB and the variables level of education and years of experience.

H3: There is no significant relationship between practicing registered nurses'

perceptions of WPB and burnout subscales (EE) emotional exhaustion, (DP)

depersonalization and (PA) personal accomplishment?

H4: There is no significant relationship between practicing registered nurses'

perceptions of WPB and intent to leave current position or shift rotation?

H5: There is no significant relationship between practicing registered nurses'

perceptions of WPB, burnout subscales (EE) emotional exhaustion, (DP)

depersonalization and (PA) personal accomplishment, and intent to leave current position

or shift rotation?

Summary

Bullying is an inherent problem in the workplace, and therefore, practicing registered nurses perceptions of WPB and it relationship to nurse burnout and intent to leave current position or shift rotation was investigated in this study. Using the Freire's model of the oppressed, the study looked into the historical issue of bullying in hospital setting especially among the nurse. An exploratory correlational design was used for this study. A nonprobability quota sampling method was used to ensure representation of both novice and experienced practicing registered nurses. One hundred and ninety-six nurses participated in the study answering a total of 55 questions regarding their bullying perceptions and burnout in the workplace. Variables for the study included workplace bulling, burnout intent to leave current position, years of experience, age, race, educational level, and gender. Instruments used in the study included: Negative Acts questionnaire (Einarsen & Hoel, 2001), Maslach Burnout Inventory (Maslach et al., 1996), and Intention to Turnover Scale (Cammann et al., 1981).

CHAPTER IV

RESULTS

Introduction

Workplace Bullying (WPB) is a great concern in health care organizations today. It is the nurse leaders and administrators responsibility to ensure an environment conducive to patient safety and creating a bully free culture. Additionally, WPB has been hypothesized as an associate factor of burnout and higher turnover rates among registered nurses (Smith & McKoy, 2001). WPB should be explored methodically and with sustenance to expunge its negative effects on organizations. WPB is persistent and continuous over a given period of time. Einarsen, Hoel, Zapf, and Cooper (2003) define WPB as harassing, offending, socially excluding someone, or negatively affecting someone's work.

The study investigated WPB among practicing registered nurses. The study was proposed for one city located in the Southeastern part of the United States and was conducted over a period of more than three days. All participants were employed at the hospital granting permission, yet ten practicing nurses elected and noted on their surveys that answers were based on another part-time job.

The purpose of the study was to establish if there was a relationship between nurses' perception of WPB, and its relationship with burnout and intent to leave their current position. The experience of WPB, burnout and intent to leave on different demographic factors was analyzed by comparing the average frequency scores among seven different demographic variables: age, gender, race, level of education, years practicing, nursing certification and practice setting. The data gathering tools were: The

Negative Acts Questionnaire-Revised (NAQ-R) (Appendix A); The Maslach Burnout

Inventory- Human Service Survey (Appendix B); The Intention to Turnover Scale

(Appendix C); Demographic Data Survey (Appendix D).`A total of 185 viable

questionnaires were collected. Some of the participants totally completed one

questionnaire and chose specific questions to answer on the others or eliminated relevant

information such as age, level of education or race. Some of the participants skipped

around and did not answer all questions completely, or drew arrows and wrote lengthy

comments instead of answering the questions. In effect, some surveys were unable to be

utilized due to the distortion of the original material. A couple of repeated comments

were employed as an addition to ancillary findings.

Table 1

Demographics 1

	Frequency	Percentage
Age		
< 30 yrs.	36	19.4
Between 30- 39	70	37.7
Between 40-49	43	22.6
> 50 yrs.	37	19.8
Gender		
Female	160	86.0
Male	25	13.4
Race		
White/ non- Hispanic	103	55.4
African American	80	43.0
Native American	1	.5

In this study, Table 1 presents frequency and percentage of participants by age, gender, and race. There were a total of 185 participants who completed the questionnaires. There were 160 females (86%) and 25 males (13.4%). The largest percentage of the participants was age 30-39 years (37.7%), with 103 (55.4%) being White, non-Hispanic.

Table 2

Demographics 2

	Frequency	Percentage
Educational level		
Diploma or ADN	111	59.7
Bachelor's	54	29.0
Master's	20	10.8
Years practicing		
3yrs or <	49	26.4
3.5- 9 yrs.	53	29.1
10- 19yrs.	56	29.5
20 yrs. or >	27	14.5
Nursing certification		
Yes	51	27.6
No	134	72.0
Practice setting		
Medical-Surgical	115	61.8
Intensive care	14	7.5
Psychiatric services	13	7.0
Nursing education	9	4.8
Other	34	18.3

In this study, Table 2 presents frequency and percentage of participants by educational level, number of years as practicing nurses, if a special nursing certification is held and current area of practice. The vast majority (59.7%) held an associate's degree and did not hold a nursing certification (72 %). The largest practicing age group was 10-19 years (29.5%). The most frequently noted area of practice was medical-surgical (61.8%).

Table 3

Descriptive Statistics of age and years of experience

	Min	Max	(M)	SD
DQ1 age	21	63	39.17	10.69
DQ5 years RN	.5	43.0	10.24	9.29

The participants' ages ranged from 21 to 63 years old, with a mean age of 39.17 (SD= 10.69). The number of years of practicing ranged from 6 months to 43 years. The mean of practicing registered nurse was 10.24 (SD=9.29). This reveals most of the participants were middle age females with about ten year's of experience.

Table 4

Descriptive Statistics by variables

	Min	Max	(M)	SD
Negative acts	23.00	97.00	42.13	15.42
Turnover intent	3.00	21.00	13.10	5.53
Emotional exhaustion	2.00	52.00	28.34	10.76
Depersonalization	.00	26.00	8.30	6.06

Table 4 (continued).

Personal accomplishment	16.00	48.00	34.94	6.58

The Negative Acts Questionnaire was used to determine the participants' perception of

bullying over a six month period. The NAQ-r is the sum of 23 questions on a five point

scale. The scale starts with never, assigning a score of 1point, and goes to daily assigning

a score of 5 points. The highest possible score is 115. The frequency score of WPB was

calculated by adding the number of negative acts a participant experienced. The

minimum score reported was 23, with the maximum being 97; the mean score was

42.135. Essentially, this group of participants has not reported a high perceived

experience of workplace bullying.

The intent to leave questionnaire was acquired by summing the answers of three

questions associated with the nurses' perceived intention to leave their employing

organization. Scores ranged from 3-21 with a mean of 13.1081(SD=5.537).

The Emotional Exhaustion subscale of the Maslach Burnout Inventory (MBI)

consists of 9 questions about behaviors that distinguish feelings of emotional exhaustion.

The nurse participants were asked to rate how often they experienced these job related

feelings from 0-6 (0= never-6=daily). A concluding score of 0-16 is categorized as low;

17-26 is moderate and 27 or higher is considered high exhaustion. The rating of this

subscale among the participants established a minimum score of 2 and a maximum of 52,

with a mean of 28.34, placing them at a high-average category of burnout. Similarly, Lin,

St. John, and McVeigh (2009) noted burnout among Chinese hospital nurses in the age

group of 31-35 years experienced emotional exhaustion (M=28.3) as well, with nurse

consultants having a M= 28.7. In the same study, reduced personal accomplishment (M=35.3) was expressed in those ages 36-40 years and among medical surgical units (M= 34.5).

The Depersonalization subscale of the MBI consists of five questions about behaviors related to detached feelings towards other people. The range of possible scores is 0 to 30, with a score of 7-12 within the average category. Nurse participants' scores in this study, M= 8.30, rank them in a low-average range of depersonalization. Adali and Priami (2002) disclosed burnout among Greek nurses with a depersonalization subscale score of M=9.12 ranging from a reported 0 minimum to 28 maximum, slightly above the participants in this study.

The subscale of personal accomplishment of the MBI consists of 8 questions which sum totals can range from 0 to 48. Scores of 38 to 32 indicate average personal accomplishment. With that being said, the participants' exhibited M=34.94, with a minimum score of 16.00 and a maximum of 48.00. In the study completed by Spooner-Lane and Patton (2007) personal accomplish was scored with M=34.6. As well, Adali and Priami (2002) disclosed personal accomplishment with an M= 34.7, with a minimum of 14 and a maximum of 48.

Statistical Analysis

The following hypotheses were formulated for this study:

H1: There is a significant relationship between practicing registered nurses'perceptions of WPB and the variables age, race and gender.

Table 5

Regression Analysis

Variables	B	Std. Error	Beta	t	Sig
Age	-.111	.109	-.077	-1.015	.311
Gender	-7.067	3.411	-.158	-2.072	.040
Race	2.533	2.293	.082	1.104	.271

Regression modeling was used to correlate the variables to WPB? Using a multiple regression this hypothesis was rejected with an F (3,179) = 2.069, p=.106, R^2 =.034. The data in table 5 revealed that the participants' age and race did not have a significant association with WPB, however gender did. There were 160 female and only 25 male participants. It was conceptualized and found that female nurses perceived WPB more frequently than males. So, there is a statistically significant relationship between the variable gender and WPB.

H2: There is a significant relationship between practicing registered nurses' perceptions of WPB and the variables level of education and years of experience.

Table 6

Regression Analysis

Variables	B	Std. Error	Beta	t	Sig
Educational level	2.04	2.59	.060	.789	.431
Years practicing	.005	.125	.003	.039	.969
Practice setting	3.41	2.79	.069	.899	.370

Using a multiple linear regression his hypothesis was rejected with an F (3,181) = .397, p=.755, R^2 =.007. The data in table 6 revealed that these demographic variables were not significant.

H3: There is a significant relationship between practicing registered nurses' perceptions of WPB and burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment?

Table 7

Regression Analysis

Variables	B	Std. Error	Beta	t	Sig
EE	.355	.120	.248	2.952	.004
DP	.596	.216	.234	2.754	.006
PA	.128	.173	.055	.104	.460

The correlation coefficients for the EE and DP subscales were strong. Personal accomplishment was without significance. Presented in table 7 is the hypothesis accepted with an F (3,181) = 12.145, p<.001, R^2 =.168; both EE and DP are statistically significant.

H4: There is a significant relationship between practicing registered nurses' perceptions of WPB and intent to leave current position or shift rotation?

Table 8

Regression Analysis

Variables	B	Std. Error	Beta	t	Sig
Turnover intent	.730	.199	.262	3.671	.000

The hypothesis was accepted with an F (1,183) = 13.479, $p<.001$, R^2 =.069 as shown in table 8.

H5: There is a significant relationship between practicing registered nurses' perceptions of WPB, burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment, and intent to leave current position or shift rotation?

Table 9

Regression Analysis

Variables	B	Std. Error	Beta	t	Sig
Turnover	.354	.223	.128	1.586	.115
EE	.248	.136	.174	1.817	.071
DP	.608	.215	.240	2.820	.005
PA	.131	.172	.056	.762	.447

The hypothesis was accepted with an F (4,178) = 9.565, $p<.001$, R^2 =.177. The data in table 9 shows the relationship between WPB, the MBI subscales and intent to turnover is statistically significant; however, intent to leave is not as strongly related to WPB as depersonalization.

Table 10

Correlation of Intent to Turnover and Years practicing

		Turnover Intent	Years RN
Turnover	Pearsons Correlation	1	-.290**
	Sig. (2-tailed)		.000
	N	185	185
Years RN	Pearson Correlation	-.290**	1
	Sig. (2-tailed)	.000	
	N	185	185

Ancillary Findings

      A supplement to the research was the discovery of years as a practicing RN is related to intent to leave in a negative way(r = -.290, p<.001). The nurses with fewer years of experience are thinking about leaving, those with more experience are not.

      Participant comments made on the MBI and the NAQ-R were note worthy and credible comments, specifically those statements made on the demographic questionnaire. Nurse participants explicitly cited nurse managers as the primary acting bully on their units. Additionally, comments were written next to negative act statements # 14 and 21 of the Negative Acts questionnaire. Statement 14 read: having your opinions and views ignored, 68 of 185 participants (37%) reported daily (5) to monthly (3). Statement 21 read: being exposed to unmanageable workloads, 85 of 185 participants (46%) reported daily to monthly. There were 39 surveys with comments, ten of which had to be excluded due to nearly 20 questions on the NAQ-R and MBI combined not

being answered and/ or substituted with comments with missing answers on the demographic survey.

Participants also believed that the study should have inquired about how the status of WPB and burnout affected the capabilities of the nurse and the safety of the patients. As well, the participants continued to make references to another hospital mandated survey concerning leadership. One final comment, seen more than once, referred back to a team leader or nurse manager being the bully and witnessing the ways in which nurse colleagues began to treat the targeted nurse after the alleged behaviors occurred from leader to subordinate.

Summary

Workplace bullying (WPB) remains an enormous professional blemish. The study confirmed that WPB continues to be an issue with participants rating burnout subscales and intent to leave higher than age, race, level of education and year's experience. The consequences of WPB can have long term effects on the nurse and hinder patient safety and professional success. The results of this study revealed three main findings:

1. The strongest finding of this study was the relationship of WPB and the MBI subscales of emotional exhaustion and depersonalization.

2. WPB occurs more frequently among female nurses than male.

3. There are just as many novice nurses with 3 years or less experience contemplating quitting their jobs, perhaps for different reasons, as those with more than three years.

CHAPTER V

DISCUSSION

Summary

This chapter reviews and discusses the results of the study based on the following research questions:

1. What is the relationship between practicing registered nurses' perceptions of WPB, and the variables age, race and gender?

2. What is the relationship between practicing registered nurses' perceptions of WPB, and the variables level of education and years of experience?

3. What is the relationship between practicing registered nurses' perceptions of WPB and the burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment?

4. What is the relationship between practicing registered nurses' perceptions of WPB and intent to leave current position or shift rotation?

5. What is the relationship between practicing registered nurses' perceptions of WPB, burnout subscales (EE) emotional exhaustion, (DP) depersonalization and   (PA) personal accomplishment and intent to leave current position or shift rotation?

Discussion

This study shares incidents of WPB, burnout and intent to leave current position amongst practicing registered nurses. The variable WPB has been experienced by this researcher and is a topic of predicament by several nurse colleagues. For that reason, the study was conducted to evaluate the status of WPB and its relationship with burnout and intent to leave. In addition, the researcher analyzed the data to determine the impact of bullying by certain demographic variables. The data revealed interesting, yet questionable

findings. As it relates to age and race, with this group of nurses, there was not

statistically significance in the relationship of WPB ($p=.106$). Furthermore, level of

education and years of experience had similar findings ($p=.755$). However, the

statistically significant relationship between WPB and the MBI subscales was evident

($p=<.001$). As well, the relationship of all primary variables: WPB, MBI subscales;

emotional exhaustion, depersonalization and personal accomplishment, and intent to

leave current position or shift rotation were proven to have statistically significant

relationship.

WPB has so many covert presentations and can be difficult to prove; reporting it

only attaches a probable increase of mental disequilibrium within the victim or witness.

WPB can affect a nurse psychologically and impair work performance. Workplace

bullying (work-related bullying) is defined as a situation in which people persistently,

over a given period of time, perceive themselves as being the subject of negative actions

from one or many individuals and has difficulty defending themselves against these

actions (Einarsen & Hoel, 2001). Bullying among nurses has gained national attention

over the last several years and lends a retrospective thought to the depth and extent of its

consequences on the widespread nursing shortage. Moreover, the negative behaviors that

coexist with bullying, this even further compounds the view of nurses being an oppressed

group.

Influential outcomes to be discussed were why race, age, level of education and

experience were not significant among this group and does this lack of significance

actually contest the presence of WPB. As well, should it be automatically assumed that

WPB is a female problem? Also, were there some other possibilities or thoughts that may

have been influencing these nurses' responses to the questionnaires, and if so, what does this mean? Statistics are a powerful tool for discovering patterns in data and making an argument irrefutable because the numbers are without falsehood; however, people may be more prone to distort the truth, especially if it is connection with a negative connotation. Might these nurses' careful responses even further support the cycle of oppression or is it that they genuinely believe that there is not a cycle present and this is apart of who they are as nurse. Let it be recalled, the cycle of oppression or WPB is a learned behavior. Just as nurses learn the accepted culture of the organization they are taught nurses are expected to be caring individuals and help others.

Research Question 1

What is the relationship between practicing registered nurses' perceptions of WPB, and the variables age, race and gender? For this study registered nurses in a southeastern city responded to a series of questions that illustrated WPB. WPB is a damaging behavior by one nurse towards another of equal status. Essentially, the aim is to control the nurse by ignoring, disrespecting and weakening his or her value as a person. With female-to-female WPB having a prevalence of (80%), it is obvious the gender noted as having significance in this study would be female. On the other hand, the review of the literature has defined that males accounted for a high percentage (42%) of WPB; and perpetrators (62%) of WPB. There may be a couple of reasons for these high numbers related to WPB among men and why similar numbers were not seen in this nursing study.

There was a poor representation of males in this study (13.4%). It is the researcher's thought that males may have trouble, through no fault necessarily of their

own, engaging in work and interacting with female cohorts in a traditionally feminine

profession. In support of this researcher's application, a survey for the US National

Student Nurses Association, Hart (2005, p. 33) states 56% of the males surveyed

experienced difficulties in their nursing education, recalling that they were frequently

perceived as "muscle" and uncaring by their females counterparts. The men reported

these assumptions were made merely on the basis of gender. In addition, 50%

experienced the same issues in their workplace due to the fact that they were gender

minorities in their chosen profession. Consequently, those males found it at times

difficult to communicate with female colleagues. In contrast to this researcher's previous

thought, seeking and claiming membership to a globally viewed oppressed professional

group might be a career move to acquire and preserve hegemony. Simpson (2004)

interviewed 15 male nurses and learned of their strong desire to work in nursing, several

with previously unsuccessful careers. Simpson discovered during working hours these

men sought to focus on re-establishing their masculinity; as a man, how might they have

set out to do this, could interacting with masculinity in order to regain something you

believe you have loss include WPB? Accordingly, might there be more male nurses that

are involved in WPB and because of the small sample size the data did not reveal this? In

order to uncover if there are more males on the perpetrating end of WPB, a larger sample

size and more direct questions are necessary.

The results of age and race as it relates to WPB may be a surprise to some

researchers and nurse colleagues in general. Age did not have a statistically significant

relationship with WPB in this study. Nonetheless, the mean age of the study was 39, and

according to the 2010 WBI U.S. Workplace Bullying Survey, it has emerged that the 30-

49 year age group is the most susceptible and found to be the most frequently bullied. If this is in fact true, even in the health care setting, the core generation represented as victims would be the Generation Xers.

According to Jovice et al. (2006), Generation X nurses do not identify themselves by their chosen career. Perhaps they are potential targets based on this and other facts that categorize them as Generation Xers; they are not defined by their chosen careers as are the Baby boomer nor do they resemble the Generation Yers and seek the challenge of their chosen nursing career. These nurses would be between the ages of 33 and 49; this is a 16 year span and almost exactly represents the age group labeled as vulnerable by the 2010 WBI. Hutchinson et al. (2006) found that WPB persists from six months to as long as seven years of repetitive acts toward the target; this may account for the variation in age. Though it is likely the age of the nurse is not the underlying factor, but the accepted culture between the novice and experienced nurses. Sa and Fleming (2008) found that the majority of the bullied nurses (57%) were between the ages of 31 and 40 years, again aligning with the WBI statistics and the Generation Xers; however, Berry et al. (2012) established that age among the novice nurses in their sample was a factor. More than half of the novice nurse participants were under the age of 30 years. Nearly half of the 197 participants identified themselves as being targets of WPB (44.7%); this would be the younger group, the Generation Yers. Once more, perhaps it is not the young age, but the "new nurse" accepted WPB culture of initiation.

Though race did not show a statistically significant relationship with WPB in this study, in the same study by Berry et al. (2012), race was investigated and displayed obvious importance. An important interaction was noted between WPB, work

productivity and ethnicity. What has been labeled as interesting to these investigators is viewed as a lived tradition and survival mechanism for this researcher; the findings are plausible based on "the minority life experience".

Berry et al. (2012) uncovered Non-Caucasian novice nurses (African American and Hispanic) work productivity was not significantly associated with WPB, however there was a negative relationship to productivity for Caucasian novice nurses ($r= -0.38$, $p<.001$). These investigators believed their result reveal the ability of non-Caucasian (African American & Hispanic) novice nurses to adjust to taxing work environments that are hierarchical in nature and, at times, oppressive. The supposition supports this researcher's lived experience. Furthermore, political scientists Carmichael and Hamilton (1967) suggested longstanding racism caused oppressed group behavior in African Americans and argue they became marginal by adopting the culture characteristics of White Americans and abandoning their roots. This perhaps gives a partial explanation of why race was not significant.

According to the 2010 WBI U.S. Workplace Bullying Survey, Hispanics (51.4%), African Americans (51.5%), Caucasian (49.6), and Asians (48.9%) did not have any bullying experience. Perhaps just as all nurses do not see it as bullying neither does all ethnicities but viewed as a part of the working arena. Additionally, it may be due to some other antecedent or characteristic present in the environment or persons involved. Conceivably, most Southern African American nurses in this sample may not fully view negative behaviors as such, at least not coming from their white counterparts, but rather as a test of aptitude and belonging. As an African American, one may feel this is a part of what is normally encountered. Therefore, assuming as southern African American

nurses to have had a life long experience, separate from the nursing career, with a cycle of negative behavior to belong and excel make it more or less difficult to participate? Does each nurse, whether Caucasian or African American; feel as though they are justified in playing their role in this accepted "cultural initiation"?   It is plausible that the data is correct and it is not yet another racial issue to short through, but a nursing problem to correct.

While there is possibly a sufficient representation of nurse diversity in most health care organizations, there is the inquiry of if minority registered nurses have been adequately represented in WPB research. WBI (2010) revealed Hispanics (25.3%) and African Americans (27.6%) had the highest incidence of WPB. Nevertheless, research on WPB among registered nurses has yield a lack of minority participation, or their experiences have not been construed as negative. The omission of racial differences should be avoided. Researchers should even go as far as to deliberately seek a large sample of African Americans and Hispanics to offer a more insight into specific feelings related to their jobs and the nursing profession.

In summary, the data indicated that age and race did not play a major role in WPB for the nurses in this organization, yet gender was significant. Nursing administrators, managers and team leaders; all nursing affiliates and nurses themselves should unite to ensure that nursing has a flourishing culture free of negativity.

Research Question 2

What is the relationship between practicing registered nurses' perceptions of WPB and the variables level of education and years of experience? In this study, the sample did include experienced and novice practicing registered nurses who were equal

in staff rank but not necessarily equal in age, race, gender, levels of education or years of

experience. The postulation was that WPB is prevalent among novice practicing

registered nurses with three years or less experience and there is a statistically positive

relationship of WPB on the variables of years of experience and level of education.

However, less than 1% of WPB in this study is explained by level of education and years

of experience. The findings reject the thought: the longer a nurse practices, the more he

or she will display negative behavior.

There are various reasons the data may not have shown a significant relationship.

In retrospect, as an exploratory study, identifying the target and perpetrator of WPB

should have been a primary objective even though it was originally thought not to be

necessary. Consequently, the data could not officially differentiate the depositories from

the depositors. Though, it is conceivable that the novice practicing registered nurses

were the depositories and the experienced practicing registered nurses, the depositors. By

knowing their status as it relates to Freire's banking system, the two populations of

practicing registered nurses' position as staff nurse could have given more support to the

theory. Of course, it is still very likely the pattern of bullying goes from experienced to

novice nurses, and in turn, the novice nurses demonstrate bullying towards another

novice nurse. At some point, would it be reasonable to say after a year to a year and half,

the novice nurse has completed her initiation into this accepted culture and if she has

chosen to remain in her position she may in turn victimize as well. The example given in

the literature review of the novice nurse with one year of experience belittling the novice

nurse with two weeks of experience expresses the possibility of this theory and hence,

there would be a great variation in years of experience as well as the other changing variables excluding gender and race.

Another thought as an endorsement of defining target vs. perpetrator and the nurse participants not acknowledging themselves as such is due to the choice of the bullying questionnaire (NAQ-R) or the exclusion of identifying with the victim or perpetrator on the demographic survey. The NAQ-R refers to the nurse as the victim or target. It does not give recognition to the bully or perpetrator. Consequently, if the nurses are in fact the bully or have become marginalized, there would not be a confession of victimization. They are the aggressor and not the defender. In justifying this theory, Boychuk, Duchscher, and Cowin (2004) evaluated the relationship between high rates of attrition and role-transition difficulties of new nurses and noted that senior practicing registered nurses reject the new registered nurse colleagues—a phenomenon known as new nurse marginalization. The new nurses reported their first few months of practice as being chaotic, agonizing, and traumatic—nurturing feelings of isolation, defenselessness, and uncertainty that can result in low self-esteem, lack of self-confidence, and a sense of failure. As well, Vessey et. al (2009) exposed novice staff registered nurses as being bullied the most by senior staff registered nurses and charge nurses in order for them to gain power over the novice staff registered nurses. There were only three master's prepared RN's in the study, under these circumstances, confirming Pai and Lee (2011) discovery that nurses with a master's degree are less susceptible to being bullied was not possible, as well, with Kamchuchat et al. (2008) suggesting that an increase in the level of education decreases the chances that a nurse will be a victim of violence.

Finally, an additional reason for the failure of association with level of education and years of experience is one of the greatest conceptions of Freire's pedagogy of the oppressed, the "culture of silence". This cultural initiation or system of social relation implants a negative self-image. Instead of being encouraged, the oppressed are submerged in a state dependence and silence. The nurses are convinced of their inferiority and are unable to develop critical thinking and respond, subsequently maintaining this culture of silence. With this in mind and nurses being portrayed as a caring and noble profession, it is surmised that some nurses are not likely to admit this behavior. Lewin and Lewin (1948) professed that in seeking to achieve goals, human beings naturally tend to identify with and pursue those activities that are perceived to add positive value, but avoid those that are deemed negative.

Research Question 3

What is the relationship between practicing registered nurses' perceptions of WPB and the burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment? The sample of registered nurses in this Southeastern city demonstrated there was a statistically significant relationship between WPB and the MBI subscales. In fact, the strongest predictors of WPB were emotional exhaustion and depersonalization. This means the findings were parallel with the MBI-HSS measurement of the three facets of burnout syndrome. As well, burnout is not "an all or nothing" concept, it is a constant variable with a defined range. According to the assessment, a high level of burnout is reflected in high scores on emotional exhaustion and depersonalization and low scores on the personal accomplishment subscale. With this

group of nurse participants, reduced personal accomplishment was not visible; the PA

scores were moderate to high.

Given the meaning of depersonalization it supports the oppressed group

framework. Depersonalization involves a negative attitude towards and/ or withdrawal

from your job and everyone around you. It is characterized by cynicism, apathy and

depression. Depersonalization coexists with oppression. Within the cycle of oppression is

self- depreciation and depersonalization; they are interrelated. For the most part,

predictors of depersonalization and burnout in general involve the burdens of work and a

deficiency of positive resources. The burden of a nurse's position includes not only

giving good patient care but the process of becoming a member of the "culture of

silence". To put it simply, first a nurse must assimilate by rejecting responsibility and

autonomy which occurs anyway as a novice. Novice nurses, or in some instances nurses

in new positions as previously stated, are rule governed according to Benner's level of

experience, that nurse wants to know what is it you want them to do and they express

their willingness to it. The nurse is dependent on another nurse's guidance. Next, the

social phenomenon of duality or marginalization occurs. With marginalization, the

envisioned benefit by the nurse transitioning into the profession predicates an uncertainty

of acceptance. Then, low self-esteem and dislike of self will occur, what is known as self-

depreciation. Freire pronounced as people hear and are made to feel they are good for

nothing and unproductive, those people become convinced of their own unfitness, at this

point depersonalization is likely (Freire 2001, p.63). If a nurse is made to feel

incompetent, their counterparts as well as their recipients will suffer. So essentially, the

patient will suffer as well from the cycle of initiation this nurse is enduring. Supporting

evidence of this interpretation is in the study of 286 nurses, all female respondents; Yildirim (2009) found that 21% had been exposed to bullying behaviors. It was concluded that WPB is a measurable problem that leads to the decreased ability to concentrate, lack of work motivation and commitment, poor productivity, and poor relationships with patients, managers and colleagues.

The nurse carrying this indifference and pessimism will soon have their work affected as seen in burnout. The very first statement of the MBI-HSS to confirm depersonalization says "I feel I treat some recipients as if they were impersonal objects". The method in which the nurse has been treated spills over into patient care. Freire explicates an emotional dependence (Freire 2001, p.65), describing the targeted nurse as having no power, no autonomy and no voice, this finally builds into WPB.

In summary, the data has established that the more WPB is seen, the higher the burnout level, specifically EE and DP and vice versa. WPB may not have been noted as significantly related to some other variables, but this relationship speaks volumes.

Research Question 4

What is the relationship between practicing registered nurses' perception of WPB and intent to leave current position or shift rotation? Among this group of nurse participants, with only one male nurse specifying leaving his shift rotation, WPB and intent to leave was significantly positive in a confirmatory style. Meaning, if a nurse leaves, it's because they are seeing negative acts; if he or she remain in their position, they are not seeing negative acts. The higher the sum of negative acts the higher the attrition rate. This confirms the hypothesis. Likewise, Griffin (2005) found that one of three nurses leave a position because of WPB and those new to nursing, 60% leave their

first professional position within six months and 20% leave the profession forever. Also, in support of this study's finding, Hadikin and O'Driscoll (2000) found that 46% reported being bullied and of these, 55% were contemplating leaving within the year (Hadikin & O'Driscoll, 2000). Additionally, it affords meaning and enhances the list of reasons other researchers have investigated into the likely antecedents of employees' intentions to leave, (Kalliath & Beck, 2001; Kramer et al. 1997).

According to Fanon (1963), not all of the oppressed people turned to violence, but those who did were stimulated by envy and anger in relation to the suffering by the oppressed under the rule of the oppressor. The alternative to violence was noted by Fanon to be collective auto destruction, assimilation, or fatality. The primary alternative collective auto destruction came about when the oppressed retaliated against another oppressed member instead retaliating against of the oppressor. According to Freire, oppression dehumanizes both the oppressed and the oppressor. It is the nurse who recognizes and defeats the situation of oppression, so that through transforming action, leaving the negative environment, they can generate a better situation, one which makes humanity more achievable. In effect, these nurses decided not to participate in this cultural initiation and become exhausted or burnout by the effort and simply moved on.

Research Question 5

What is the relationship between practicing registered nurses' perceptions of WPB, burnout subscales (EE) emotional exhaustion, (DP) depersonalization and (PA) personal accomplishment and intent to leave current position or shift rotation? This sample proved that there is a relationship among WPB, the burnout subscales and intent to leave current position. As a matter of fact, once again depersonalization is the variable

with the higher association. Intent to leave was not as strongly related to negative acts.

Though unable to determine causation with the data, it has been confirmed that the higher

the depersonalization the more the negative acts. It is known based on the literature

review and the conclusions of this study that there is a relationship between WPB,

burnout and intent to leave; however we cannot say burnout caused WPB or WPB caused

burnout, despite the relationship that exist between the two variables. There is a

functional or associative relationship present rather than a casual relationship. There are

several studies citing a correlation between burnout and WPB, and WPB, burnout, and

novice nurses but relatively none citing which came first or the cause and effect aspect.

Ancillary Findings

Berliner and Ginzberg (2002) reported that the lack of nurses is a tri-fold crisis

but is correlated to fewer nurses entering the workforce, inability of health care

organizations to attract and keep new nurses, and nurses who either retire or leave the

profession early. With that being said, it prompts a contemplation of all the potential

antecedents or influencing factors which leads back to the relationship of the primary

variables. Based on the first ancillary finding, the longer an individual has been a nurse

the less apt they are to leave, in part, supports the postulation of novice nurses

experiencing more WPB and consequently, a greater possibility of departing from their

positions. It also gives meaning to Freire's oppressed theory. Freire witnessed and

declared an imbalance of power resulted in the creation of a dominate group (experienced

nurses) and a subordinate group (novice nurses). At any time there are two groups and

one has more power than the other, he contended, oppression occurs when the values of

the subordinate culture are repressed. This is the basic premise of oppression theory. It

is understood that what Freire defined in his theory between Europeans and Brazilians is a condition that is similar to the once problematic vertical relationship between nurses and physicians.

    With nurses of fewer years experience considering leaving their positions, other probabilities come to mind. If the nurse participants were honest and forthcoming in their responses, especially based on hypothesis four, which disclosed significance between WPB and intent to leave in an affirmative method, what else might be deduced from this result? Is it simply the direct experience of or witnessing WPB that is motivationing thoughts to depart from their jobs or is it another ancillary discovery of RN's feeling WPB and burnout directly effects professional growth and patient safety.

    There were four nurses with more than 10 years experience who commented that with so many new nurses, it was "not safe" for the patients nor the experienced nurses taking the "slack". These comments give relevance to the high numbers from statement 21 involving unmaneageble workloads. Also, five nurses explicated witnessing vertical bullying from team leaders and nurse managers towards the staff nurses. The effects of both horizontal and vertical bullying can have an impact on all employees, particularly witnesses. From the researchers point of view it is highly conceivable that witnessing these negative acts may result in the witness feeling sorry for the victim thereby causing an increase in the nurse witnesses stress level. The thought of becoming the next victim would be frightening causing nurses to change jobs to avoid conflict, working diligently not to become the next victim or merely becoming a member of the bullying culture.

    As well, nurse leaders have played their role by observing the behavior of the physicians and preserving the dominating behavior, which has generated WPB among

practicing registered nurses. This gives consideration to another ancillary finding. The team leader or nurse manager being the perpetrator of negative acts and when observed by the witnessing colleagues it jolts a trickling effect. The results of Bowles and Candela (2005) study on nurses' job experiences within five years after graduating from their program found that 30% of participants had left their first job within one year of employment and 57% had left by the second year; 22% cited that work environment factors were connected to management issues, lack of support, and too much responsibility caused them to leave. The finding of Bowles and Candela (2005) study is partially validated by the comments written on the questionnaires citing unmanageable workloads placing the patients and the nurses' license at risk.

Burnout and WPB have several inferences specifically turnover intent, unmanageable workload and reward-effort imbalance increases the risk for both WPB and burnout. Of great concern and noted among ancillary findings are safety outcomes as it relates to care with high patient to nurse ratio, especially from nurses affected by bully's behavior causing other nurses to suffer shame, humiliation, and depression, which can affect their personal life as well as their job performance (Namie & Namie, 2003).

In summary, WPB is a common and serious issue within the nursing profession since bullying does not only potentially increase employee burnout which could increase employee turnover, number of absences and sick leaves aside from negatively affecting the work satisfaction and work performance of the nurses. Being able to identify the most effective way of controlling workplace bullying could significantly improve not only the profitability of the healthcare organization but also increase the level of the nurses' work performance.

Limitations

One study limitation was a relatively small size (N=185). Of the 500 participants eligible in the selected hospital in a Southeastern state, only 196 elected to participate. The views and experiences of the remaining nurses may have impacted the findings.

The sample was limited to one southern geographical area in one location instead of the 8 as originally hoped for, so the inquiry can be raised related to the ability to generalize results to registered nurses in other parts of the state and other parts of the country.

Though the study design does not preclude strong statements of cause and effect, participants may have underreported the bullying acts to which they were exposed. Additionally, the demographic survey did not include potential personal characteristics, such as low self-esteem, and situational or environmental variables that could have influenced the relationship between WPB, burnout and intent to leave.

Finally, there was a survey all nurses were encouraged to participate in and many participants assumed the researcher was collecting data surreptitiously for their employing organization. Apparently, the survey that was mandated encompassed thoughts on leadership, treatment of nurses by management and general work conditions. Nurses voiced being afraid and not wanting to participate in the study for fear their managers would find out what their responses were.

Recommendation for Education, Policies and Practices

At present, there is a breach of information concerning individual tactics used by novice nurses experiencing WPB. These nurses need to be provided with strategies to avert WPB and provide safe and competent care in a positive environment. WPB can

have a devastating effect on the victim; therefore, it is important that health care organizations have the policies and practices in place to detour the problem. Due to tight market competition within the healthcare industry, human resource management is being challenged to improve the organization's employee retention strategies that can effectively reduce the high costs associated with high rate of employee turnover. The unnecessary costs associated with nurse turnover are usually related to the costs of hiring new employees and training them so as to increase their work productivity and patients' safety. As a result of not being able to satisfy, motivate, and retain employees; the organization is expected to lose some of its valuable patients to other healthcare providers around the area.

Prior to licensure and employment, nursing students should be provided with a component on WPB during their last semester under a professional and leadership objective. Education is an important strategy and should begin while in nursing school and preceding active employment. Nursing educators would be doing students a disservice by not including instruction on the theory of oppression and WPB in the curricula. As well, creating a venue for students to report negative behaviors by faculty and staff members especially during preceptorship, and promoting and enforcing a zero tolerance for WPB in student's clinical areas.

Since work motivation does not only increase employees' retention rate but also their productivity rate, staying focus on motivating nurses becomes a crucial factor in terms of increasing the work satisfaction of each nurse and enabling the entire hospital team members to reach the optimal levels when it comes to accomplishing the organizational objectives. Once a nurse is very much satisfied with their current health

care facility, there is a higher chance for he or she to remain employed with an organization for a very long period of time.

In general, effective work motivation, job satisfaction, high productivity, better business profit, and improved nurse retention are all interrelated matters. For this reason, most of the modern human resource managers today who are working in large- and medium-scale hospitals are being challenged to search for different ways on how they can improve the effectiveness of their motivational and retention strategies at work.

The ability of the human resources department and nurse managers in being able to provide the nurses with a safe working environment is being challenged by the aggressive behavior of some employee. Not only does the practice of workforce bullying negatively affect the work performance of the nurses, the negative emotional consequences of being often bullied within the working environment could also causes the health care workers to experience being burnout from work (Rocker, 2008). Because of the negative impact of bullying and burnout in the profitability and efficiency of the hospitals, the issue behind workplace bullying is one of the most critical issues that need to be resolved within the healthcare organization (Hutchinson, Jackson, Wilkes & Vickers, 2008). The ability of the nurse manager to control the practice of bullying within the hospital area could eventually strengthen its employee retention rate and overall work performance.

Once the chosen policies and procedures are implemented by a given facility, there are certain continuing educational approaches that should occur in collaboration with the hospital's education department, preceptors, nurse managers, directors and so on. Impromptu visits and short scheduled meeting to reinforce learned preventative and

any unresolved issues or questions that may occur during novice nurses or nurses that are

experienced and newly employed. The zero tolerance campaign would include monthly

newsletters and periodical webinars reminding nurses of the positive and caring culture of

the organization.

Commonly used Management Techniques that will Increase Employee Retention and Professionalism within the Workplace

The ability of the human resources department to satisfy employees with their

existing jobs will result in a higher chance that the business organization will be able to

control employee turnover and increase the rate of employee retention (Tas, Spalding &

Getty, 1989). With regards to the use of effective retention strategies in addressing the

bullying concerns of the nurses, some of the common techniques that were adopted by

the human resources management includes: (1) providing the nurses with education,

support and counseling; (2) strengthening the hospital policy against bullying acts; (3)

effective career management and the promotion of equal gender rights.

Providing the Nurses with Adequate Education, Support and Counseling and Strengthening the Hospital Policy against Bullying Acts

Measuring the incidence of bullying within the workplace is important in terms of

measuring the behavior of the oppressed groups and allowing the head nurse to break the

cycle of bullying acts within the workplace culture. (Roberts, Demarco, & Griffin, 2009)

In line with this matter, the head nurse has the responsibility in providing the nurses with

adequate knowledge, support, and counseling with regards to the proper way of dealing

with workplace bullies.

In general, teaching the nurses how to effectively deal with bullies could

significantly decrease the incidence of bullying act within the workplace. Aside from

supporting one another within the working environment, Beech suggests that nurses

should be active in becoming involved with the development of anti-bullying programs which could increase their knowledge and skills on managing bullies (Beech, 2000). For instance: Knowing the legal and non-legal guidelines with regards to the anti-bullying act could protect the nurses from becoming a victim of malicious and violent acts.

With regards to developing a strong organizational policies related to the anti-bullying acts, the head nurse should make a way to get each nurse to participate in the development of the program. By doing so, nurses who were a victim of bullying acts could offer effective ways on how to counteract such unprofessional work practice. Likewise, engaging the nurses to participate in the development of anti-bullying policy could eventually increase the nurses' self-respect and dignity aside from developing the feeling of being safe at work (Tehrani, 2005).

Effective Career Management and the Promotion of Equal Gender Rights

Career development program (CDP) is referring to the actual organizing, formalizing, and planning on employees' career growth based on the specific job requirements needed by the organization(Lips-Wiersma & Hall, 2007). Some employees developed a negative perception with regards to career management because of its paternalistic nature which means that men in general have a higher chance of being promoted at work as compared to women (Maume, 1999). For this reason, even in nursing, most of the male employees are able to reach higher managerial positions than female employees (Cassirer & Reskin, 2000).

Aside from improving the company's overall performance, a positive work satisfaction highly affects an employee's decision to stay loyal with a company. As part of the positive impact of promoting and implementing an effective career program,

several studies conclude that promoting a career management program within the organization is an effective work motivating strategy in terms of making employees deliver a good work performance and higher business profitability return (Chen, Chang & Yeh, 2006; Crabtree, 1999; Eby, Allen & Brinley, 2005).

It is equally important to promote the equal rights of men and women, even in this predominately female profession. Basically, allowing male and female employees to manage their own career growth is a good strategy since most modern human resource managers who have personally applied the strategy found it to be effective in terms of improving the employees' work performance regardless of the gender issues (Dreher, 2003). As a result of giving employees the power to control their career path, competition between male and female employees increases.

Contrary to the positive impact of effective career management and the promotion of equal gender rights on decreasing the turnover rate of employees, each employee has the right to desire to have several careers all at the same time. Since each employee has a tendency to become less committed in a single occupation, career, or even an industry (Parker & Arthur, 2000), the implementation of an effective career management and the promotion of equal gender rights may not always be effective as retention strategy.

Recommendations for Future Research

This study was conducted in a Southeastern city hospital and several questions warrant further investigation.

1. The study should be repeated in another geographical area of the United States such as Atlanta, GA, Chicago, IL, Los Angeles, CA or New York, NY and a comparison made to see what the relationships of the variables are: WPB, burnout and intent to leave.

There are cultural and other meaningful differences of people living in different geographical areas. An individual from a certain area of the United States are thought in some instances to take on the lifestyle and social habits of those they live among. If this is true, the presence of WPB and burnout responses may manifest differently.

2. The study also should be repeated in a government run facility and the findings compared. An agency such as the Veterans Affairs (VA) is one of the largest integrated health care systems with a variety of specialty areas. The VA has long been associated with great employee benefits and comprehensive care for its military personnel. Overall, the operating procedures for the veterans and employees are said to have many differences from a standard acute care medical facility. Again, because of the cabinet level status the VA holds, the presentation of WPB, burnout and intent to leave may vary from the findings of the southern area acute care organization in this study.

3. Further studies should include qualitative data specifically of the non-white nurse and male population. As noted in the review of the literature, minorities are under-represented, this includes males as well. The true prevalence and affects of WPB may not ever be discovered if further steps are not taken to seek out this particular population.

4. Further studies should include specific influential factors such as using a tool to measure the participants' self-esteem. Characteristics of the victim and perpetrator are noted in the literature and these distinctions are probable variables lending to the status of victim or perpetrator. Additionally, there may be personal, economical or psychological issues accumulating to the equation of WPB.

5. Developing a WPB scale geared towards or specifically designed for nurses. Despite nurses being known as traditionally nurturing individuals, they still are

individuals with positive and negative qualities that may or may not support the culture of the organization they aspire to practice for. Just as other organizations such as law enforcement or federal agencies have psychological exams, would it be prudent to develop a short survey at the time of applying for a nursing position then annually. This would assist or allow employers to better screen nurses' personal characteristic. This could in fact be a positive practice. For example, there may be a problematic practice area within the organization and it has been determined that a particular leadership style is needed, without revealing to the applicant what qualities are being sought, why not establish the nurse applicant's inherent qualities. As many are aware, countless applicants are prone to say what is desirable to be selected for a particular position. Having a hard copy of what an applicant filled out prior to the interview may alert an employer to conflicting or scripted responses for the purposes of obtaining the position and the applicant not truly possessing the preferred leadership traits. So, the created short survey could actually work in a nurse applicant's favor.

One portion of the study's finding that showed being exposed to unmanageable workloads was a concern. Of the 185 participants, 85 nurses (46%) reported daily to monthly to this statement, this was a high scoring statement among the nurses and a focus of the ancillary comments. An unmanageable workload may not undeniably infer that a nurse is being bullied; it may indicate a part of the nursing job that is overwhelming to the nurse and a risk for the patients' progression of health. A workload is only a piece of the bullying experience and having this insurmountable patient load does not necessarily dictate bullying if it is common across the spectrum of nursing care within that particular

organization. However, with such a large percentage and the comments revealed related to the statement the problem needs to be explored.

The overall goal of this study was to evaluate the relationship of WPB, burnout and intent to leave among registered nurses in a Southeastern state. This research will bring an awareness of a prevalent problem that occurs among nurses today and provide answers. Many nurses suffer daily from WPB. It is should be no longer acceptable for administrators, managers and nurses to ignore this problem and hope it goes away. The old cliché of "nurse eating their young" should be a saying and an act of the past. As the literature review in this study and the data revealed, words, rumors, concealing information, intimidation, etc., really do affect nurse victims of WPB. This unwanted attention should not be occurring in such a caring profession and WPB should stop.

APPENDIX A

NEGATIVE ACTS QUESTIONNAIRE

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

1	2	3	4	5
Never	*Now and then*	*Monthly*	*Weekly*	*Daily*

1) Someone withholding information which affects you performance   1 2 3 4 5

2) Being humiliated or ridiculed in connection with your work   1 2 3 4 5

3) Being ordered to do work below your level of competence   1 2 3 4 5

4) Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks   1 2 3 4 5

5) Spreading of gossip and rumours about you   1 2 3 4 5

6) Being ignored, excluded or being 'sent to Coventry'   1 2 3 4 5

7) Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life   1 2 3 4 5

8) Being shouted at or being the target of spontaneous anger (or rage)   1 2   3   4   5

9) Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way   1 2   3   4   5

10) Hints or signals from others that you should quit your job   1 2   3   4   5

11) Repeated reminders of your errors or mistakes   1 2   3   4   5

12) Being ignored or facing a hostile reaction when you approach   1 2   3   4   5

13) Persistent criticism of your work and effort   1 2   3   4   5

14) Having your opinions and views ignored   1 2   3   4   5

15) Practical jokes carried out by people you don't get on with   1 2   3   4   5

16) Being given tasks with unreasonable or impossible targets or deadlines   1 2   3   4   5

17) Having allegations made against you   1 2   3   4   5

18) Excessive monitoring of your work   1 2   3   4   5

19) Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)   1 2   3   4   5

20) Being the subject of excessive teasing and sarcasm   1 2   3   4   5

21) Being exposed to an unmanageable workload   1 2   3   4   5

22) Threats of violence or physical abuse or actual abuse   1 2   3   4   5

APPENDIX B

MBI-HUMAN SERVICES SURVEY

How Often

0-6 Statements:

1. _____ I feel emotionally drained from my work.

2. _____ I feel used up at the end of the workday.

3. _____ I feel fatigued when I get up in the morning and have to face another day on the

job.

4. _____ I can easily understand how my recipients feel about things.

5. _____ I feel I treat some recipients as if they were impersonal objects.

6. _____ Working with people all day is really a strain for me.

7. _____ I deal very effectively with the problems of my recipients.

8. _____ I feel burned out from my work.

9. _____ I feel I'm positively influencing other people's lives through my work.

10. _____ I've become more callous toward people since I took this job.

11. _____ I worry that this job is hardening me emotionally.

12. _____ I feel very energetic.

13. _____ I feel frustrated by my job.

14. _____ I feel I'm working too hard on my job.

15. _____ I don't really care what happens to some recipients.

16. _____ Working with people directly puts too much stress on me.

17. _____ I can easily create a relaxed atmosphere with my recipients.

18. _____ I feel exhilarated after working closely with my recipients.

19. _____ I have accomplished many worthwhile things in this job.

20. _____ I feel like I'm at the end of my rope.

21. _____ In my work, I deal with emotional problems very calmly.

22. _____ I feel recipients blame me for some of their problems.

APPENDIX C

INTENTION TO TURNOVER SCALE

This variable was measured using the Intention to Turnover Questionnaire (Cammann,

Fichman, Jenkins, & Klesh, 1979).

1. How likely is it that you will actively look for a new job in the next year?

   ___ Extremely likely (7)

   ___ Likely (6)

   ___ Fairly likely (5)

   ___ Probably likely (4)

   ___ Probably unlikely (3)

   ___ Unlikely (2)

   ___ Not likely at all (1)

2. I often think about quitting.

   ___ Strongly agree (7)

   ___ Agree (6)

   ___ Fairly agree (5)

   ___ Probably agree (4)

   ___ Probably disagree (3)

   ___ Disagree (2)

   ___ Strongly disagree (1)

3. I will probably look for a new job in the next year.

   ___ Strongly agree (7)

   ___ Agree (6)

   ___ Fairly agree (5)

   ___ Probably agree (4)

   ___ Probably disagree (3)

   ___ Disagree (2)

   ___ Strongly disagree (1)

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

INSTRUCTIONS- Please fill in or circle information where appropriate.

1. What is your age: ___
2. Gender:

   ___ Female
   ___ Male

3. Race/Ethnicity:

   ___ White, non- Hispanic

   ___ African American

   ___ Native American or Native Alaskan

   ___ Asian or Pacific Islander

4. Highest educational degree:

   ___ Diploma or Associate degree
   ___ Bachelor's degree in nursing
   ___ Master's degree or higher in nursing or
      in another field

5. Number of years as a practicing Registered Nurse: ___

6. Do you hold a nursing certification?

   ___ Yes
   ___ No

   If "Yes" please specify:

   _____

7. Current practice setting:

   ___ Medical-Surgical
   ___ Intensive care
   ___ Psychiatric services
   ___ Outpatient surgery
   ___ Physician office/clinic
   ___ Hospice care

___ Nursing education
___ Other (please specify) _____

8. Please add any comments or information that you believe would be beneficial to this research.

APPENDIX E

WORKPLACE BULLYING

September 30, 2012

XXXX Institutional Review Board
XXXXXX XXXXXX Circle

XXXXXX, XXXXXXX 00000

XXXX IRB:

I am a PhD candidate (nursing leadership) at The University of Southern Mississippi. I also, practice as a "flex" registered nurse in Psychiatric Services at XXXX and am employed as faculty at Mississippi Gulf Coast Community College. I am engaged in the dissertation phase of my program of study under the direction of Dr. Janie Butts, Professor of Nursing. I would like to be given permission to utilize XXXX facilities to conduct my research.

 My dissertation focus is workplace bullying (WPB) experienced by practicing registered nurses. The purpose of this study is, first, to examine practicing registered nurses' perceptions of WPB and the various bullying behaviors experienced; and second, to examine if there is a significant relationship between WPB and burnout and intent to leave the current position. With WPB being an organizational problem within the health care arena that is often overlooked, an investigation would be beneficial.

I have read the research activity policy and promise to adhere to the stated guidelines. My research is very important to me, and if IRB approval is granted, the results may prove beneficial in enhancing XXXX's professional image and retaining quality nurses I would greatly appreciate XXXX's support in my research, and will be glad to provide any additional information as needed.

Respectfully,

Crystal R. Threadgill, MSN, RN-BC
70XXXXXXXXXXXX
MXXXXe, XX 3XXXX
XXX-6XXX or 3X7-XXX0

APPENDIX F

RESEARCH ACTIVITY SYNOPSIS

Workplace bullying (WPB) is a social and organizational problem. Within the health care arena, employees, particularly registered nurses, are at risk. The concept of horizontal violence or workplace bullying is a complex problem that is often under reported. For this study, the sample will include experienced and novice practicing registered nurses who are equal in staff rank but not necessarily equal in age, gender, levels of education, or years of experience. When WPB occurs horizontally, the WPB behaviors originate between equally-ranked practicing registered nurses and not from chain of command delegation and rank order directives. The theoretical framework for this study is Freire's (1971) model of oppressed group behavior. The postulation for this study is that WPB is prevalent among novice practicing registered nurses with 3 years or less of experience and there is a statistically positive relationship of WPB on the variables of years of experience, burnout, and intent to leave current position or shift rotation, age, educational level, and gender. Three self- administered questionnaires will be distributed: (a) Negative Acts Questionnaire-Revised (NAQ-R; Einarsen & Hoel, 2001); (b) Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996); (c) Intention to Turnover Scale (Cammann, Fichman, Jenkins & Klesh, 1981), which is a subscale of Michigan Organizational Questionnaire (Cammann, Fichman, Jenkins & Klesh 1979), and (d) Demographic Data Survey (Threadgill, 2012). To guide this study, the following research questions are posited:

APPENDIX G

INFORMATION ABOUT SURVEYS TO BE UTILIZED

Instrumentation and Materials

Data for this study will be obtained by using four questionnaires that will measure practicing registered nurses' perceptions of workplace bullying, years of experience, burnout, intent to leave current to leave current position or shift rotation, and the demographic variables of age, educational level, and gender. The instruments are NAQ-R (Einarsen & Hoel, 2001), Maslach Burnout Scale (Maslach et al., 1996), Intention to Turnover Scale (Cammann et al., 1981, and the Demographic Data Survey (Threadgill, 2012). Reliability and validity of the NAQ-R, the Maslach Burnout Inventory, and the Intention to Turnover Scale is presented in this section.

Negative Acts Questionnaire-Revised

The Negative Acts Questionnaire-Revised was designed to measure perceived exposure to bullying on the job, (Einarsen & Hoel, 2001). Since items in this measure are presented with reference to negative behaviors, they do not make reference to the term bullying. Original NAQ-R scale was created and tested in a limited Scandinavian context hence there emerged concerns with cultural bias, face validity, and factor structure during first attempts to translate it in English, (Einarsen & Raknes, 1997; Matthiesen & Einarsen, 2001). The intention of coming up with NAQ-R scale was therefore to develop a valid and reliable scale that would be suitable for use with the Anglo-American cultures.

Through conceptual reasoning, the original version of the NAQ-R was adjusted to cover 11 focus groups and sample size of 61 participants drawn from different occupations and positions over organizational hierarchies. (Hoel et al., 2001). The response to the items is a 5-point Likert scale that ranges from 'never' to 'daily'. The approach was such that three interrelated factors were measured. These were; factors associated with personal related bullying (12 items), work related bullying (7 items) and physically intimidating bullying (3 items). Applying the Cronbach's alpha of 0.92 to the NAQ-R scale, it was established that the Cronbach's alpha was correlated with measures of both mental and physical health, intention to quit the job, and overall job performance (-0.24, -0.36 and -0.24 respectively) (Einarsen & Hoel, 2001).

Maslach Burnout Inventory

The most well received and studied calculation of professional burnout is MBI. Maslach and Jackson developed the scale in 1981. The items for the MBI were developed for the purpose of assessing hypothetical aspects of the burnout syndrome. Therefore during explanatory research, interview and questionnaire data that was gathered was useful in providing sources regarding characteristic feelings and attitudes of burned-out workers. Other than these, a review was done on numerous established scales to establish useful content material without outright borrowing of items, (Maslach, 1976; 1982a).

The preliminary form consisting of 47 items was administered to a sample of 605 people (56% male & 44% female) drawn from various health and service occupations that were considered to

have high potential for burnout based on previous research findings (Maslach, 1976; 1982a). The two assumptions that were made included were; first, workers in all the occupations must be interacting directly with people regarding either problematic or potentially problematic issues; secondly, there is possibility that strong emotional feelings will emerge in the work environment leading to chronic emotional stress, which is responsible for burnout.

Principle factoring with iteration and an orthogonal (varimax) rotation was used to carry out a factor analysis to the data from the first sample. In this analysis, 10 factors accounted for more than ¾ of the variance. Applying a set of selection criteria to the items, the items were reduced from the previous 47 to 25. For a factor to be retained, it had to have a factor loading greater than .40 on only one of the factors, high item-total correlation, a large range of subject responses, and a relatively low percentage of subjects checking the "never" response" (Maslach, 1976; 1982a).

The 25-item form was then administered to a new sample consisting of 420 people in order to derive confirmatory data for the factor patterns. The new sample consisted of 31% male and 69% female. Since the factor analysis results for the first and second tests, the two samples were then combined such that (n=1,025). Using the same approach, a four-factor solution was developed from factor analysis of the 25-items based on the new combined sample. Of the four factors, three had eigenvalues greater than unity and therefore became the subscales for the Maslach Burnout Inventory (Maslach et al., 1996), and have been replicated in many other countries with many different samples of human service occupations (Enzmann, Schaufeli, & Girault, 1995; Golembiewski, Scherb, & Boudreau, 1993).

Reliability of MBI

In order to avoid any improper inflation of the reliability estimates, reliability coefficients were premised on samples that were not used in item selection. Cronbach's coefficient alpha (n=1,316) was used in the estimation of internal consistency and the three subscales and reliabilities were: 0.90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment with the standard error of measurement for each subscale being: 3.80 for Emotional Exhaustion, 3.16 for Depersonalization, and 3.73 for Personal Accomplishment.

Convergent Validity of MBI

Various approaches were applied to demonstrate convergent validity. One way was to correlate individuals' MBI scores with behavioral ratings independently generated by a person such as a spouse or coworker to whom the individual is familiar. The second way was to correlate individual MBI scores with the existence of specific job characteristics that were expected to have contributed to the burnout experienced. The third way was to make a correlation between MBI scores and measures of the different outcomes that were hypothesized to be related to burnout. Substantial validating evidence was derived from all these three approaches.

Validating evidence from independent assessments of individual's experiences made by outside observers corroborated the individual's self-rating. In the organizational context, the knowledgeable observer would be the individual's coworker. It was established as expected, that those individuals who were rated by coworkers as being emotionally drained by the job actually

scored higher in terms of emotional exhaustion and depersonalization. More so, it was established also as expected, that individuals who were rated to appear physically fatigued scored higher in terms of emotional exhaustion and depersonalization. Finally, there was established a correlation between high scores on depersonalization and more frequent complaints about clients, (Maslach, Jackson, & Leiter, 1996).

"With respect to the coworkers themselves, human services staff who scored low on measures of peer and co- worker satisfaction scored high on Emotional Exhaustion and Depersonalization and low on Personal Accomplishment. Subsequent research found that nurses who had unpleasant contacts with their supervisor scored higher on Emotional Exhaustion, whereas those who had pleasant contacts with co-workers scored higher on Personal Accomplishment" (Leiter & Maslach, 1988).

<div align="center">Intention to Turnover Scale</div>

The Intention to Turnover Scale (Cammann, Fichman, Jenkins & Klesh, 1981) was adapted from the Michigan Organizational Assessment Questionnaire (Cummann et al., 1979). The MOAQ is a 184-item questionnaire intended to provide information about the perceptions of organizational members. It is designed to gather information ranging from objective reporting of direct employee observation of workplace events to subjective reports of employees' own judgments and opinions. An analysis was done using a non-multidimensional scale and a principle-axis factor analysis with a varimax rotation. As a result items were clustered with other items intended to measure the same construct.

 The Intention to Turnover Scale (Cammann et al., 1981) is a 3-item index of employees' intention to leave their job. A representative item is "I will likely actively look for a new job in the next year." A coefficient alpha for the turnover intention was .76. Finally brief information was obtained about the respondents. A 7-point Likert scale was used ranging from 1 (strongly disagree) to 7 (strongly agree) for the all measures. Internal consistency and validity of the scale is provided for by a reported coefficient alpha of .83. The questionnaire will be modified to complement a 5- point Likert scale.

APPENDIX H

RESEARCH PROTOCOL

- Data will be collected from four questionnaires: The NAQ-R, Maslach Burnout Inventory, and Intent to Turnover Scale, and the Demographic Data Survey. Paper copies will be utilized for prompt response time and to avoid using XXXX's terminals for a non- organizational activity.
- The term Workplace Bullying will *not* be presented to the participants. A phrase such as negative behaviors may be used in the place of WPB. This is to avoid any type bias associated with the word "bullying".
- Dates and times will be coordinated with administrative personnel. This will be done as not to disrupt any operations of care. There will be four scheduled dates for data collection with one make-up day. I would like every nurse working days, evenings, nights and 4-, 8-, 12-, and 16-hour shifts to have ample opportunity to participate.
- One week prior to the administration of the survey at XXXX facilities, an announcement will be sent to all practicing registered nurses by way of the organizations intranet system or TAO.
- A second announcement will follow three days prior to collecting data through the intranet system, and flyers displayed on the units the day before disseminating questionnaires.
- A letter of introduction from the researcher, the purpose of the study, participant requirements, demographics, consent form and the 3 surveys will comprise the research packet.
- A research assistant may be utilized sparingly at a given site; this individual will be briefed on the research, XXXX's expectations, and complete a training session prior to data collection.
- A research assistant or I will verify all areas of the packet are filled in; the envelope is sealed, and placed in a secure designated box.
- When the envelope has been placed in the box, the participant has the option of registering for a free gift card.
- The findings will be reported to XXXX in a collective manner.
- As standard procedure, all data will be kept under lock and key for a period of 5 years, then will destroyed by shredding.
- Every effort will be made not to disrupt the daily operations of *any* XXXX site.

APPENDIX I

PROTOCOL FOR RESEARCH ASSISTANTS

- Research Assistant will be briefed on general information concerning the study, complete a data collection training session and informed of expectations of XXXX administrators.
- At no time will an assistant be allowed on a patient care unit to solicit participation in the research. They are to remain in an assigned area such as the research table set up outside of the cafeteria.
- Recruitment- If participant did not view or receive information about the research, provide them with an information summary.
- If they *refuse* to participate. Thank them for time and reading the Information Summary.
- If they *agree* to participate: provide them with a research packet and a pencil, explain that the demographic information is for descriptive purposes only and the packet should take approximately 20 minutes to fill out.
- Verify all information in the packet is complete, seal the envelope and place in the designated box, and allow the participant to fill out a slip for the gift card drawing.

APPENDIX J

INFORMATION SUMMARY TO PRACTICING REGISTERED NURSES

Dear Nurse Colleagues,

I am a graduate student conducting research on negative workplace behaviors experienced by practicing registered nurses under the direction of Dr. Janie Butts at The University of Southern Mississippi. This letter is written to request your participation in my research study which will involve completing three short surveys.

Your participation in this study is voluntary and if you choose not to participate, there are no consequences. Though the results of this study may be published, your responses will be anonymous. There will be two separate gift card drawings for those returning completed research packets.

Please look for a second correspondence through the intranet system in the next 3-5 days to include specific instructions, the administering area, dates, and times that the study will be conducted.

If you have any questions concerning this study, please contact me at 251-3xxxxx80 or crystal71@bellsouth.net.

Sincerely,

Crystal R. Threadgill, MSN, RN-BC

APPENDIX K

PARTICIPANT REMINDER LETTER

A few days ago a correspondence was sent informing you all of upcoming data collection on negative workplace behaviors among nurses. My research has been approved by XXXX's IRB and your responses will remain anonymous.

I would like to have every nurse participate. In sharing your experiences, we can learn more about negative workplace behaviors and make positive changes. This will allow us to continue cultivating the nursing profession.

Next week, on October—xxxxx, 2012 will be the first day the questionnaires will be available to you. The first scheduled time will be before shift change at 0530- 0730 on 4th and 5th floors, at lunch on the ground floor outside the cafeteria, from 1100- 1300, and again on 4th and 5th floors before evening shift change at 1730- 1930. .. Any concerns by XXXX's administration or IRB will be communicated, and times and locations will be modified based on general consensus. As well, the remaining dates and times can be modified on the letter….

Sincerely,

Crystal R. Threadgill, MSN, RN-BC, PhD(c)

APPENDIX L

INVITATION FLYER ON WORKPLACE BULLYING

YOU ARE INVITED TO PARTICIPATE IN NURSING RESEARCH!

Investigator:

Time:

Place:

HAVE A VOICE AND REPRESENT YOUR PROFESSION!

APPENDIX M

LETTER OF INTRODUCTION

Dear Nurse Colleagues,

I am a PhD candidate conducting research on negative workplace behaviors experienced by practicing registered nurses under the direction of Dr. Janie Butts at The University of Southern Mississippi. I thank you for participating in my research.

The purpose of the study is to determine if there is a statistical significance relationship between negative behaviors in the workplace and other variables such as burnout, intent to leave current position or shift rotation, and certain demographics. You must be a practicing registered nurse working a minimum of 24 hours a week and proficient in the English language.

Please, if at all possible, fill out all of the information requested. If you have any questions, I or one of the research assistants will be glad to help you. Again, this research is anonymous and comes without risk of managerial reprimand.

If there are any questions or concerns about the research, please feel free to contact me at 251-3774880 or email at crystal71@bellsouth.net. Thanks again for your support.

Crystal R. Threadgill, MSN, RN-BC, PhD (c)

APPENDIX N

LETTER OF APPRECIATION

THANK YOU

Because of your participation in my study on negative behaviors among registered

nurses, it was successful. I thank you all for supporting this nursing research. The two

winners of the $25.00 gift cards are XXXXXXXXX (name) of XXXXXXX (practice

site) and XXXXXXXX (name) of XXXXXXX (practice site).

Crystal R. Threadgill, MSN, RN-BC, PhD (c)

APPENDIX O

IRB APPROVAL

THE UNIVERSITY OF SOUTHERN MISSISSIPPI.

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.6820 | Fax: 601.266.4377 | www.usm.edu/irb

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

The risks to subjects are minimized.

The risks to subjects are reasonable in relation to the anticipated benefits.

The selection of subjects is equitable.

Informed consent is adequate and appropriately documented.

Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.

Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.

Appropriate additional safeguards have been included to protect vulnerable subjects.

Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".

If approved, the maximum period of approval is limited to twelve months.

Projects that exceed this period must submit an application for renewal or continuation.
PROTOCOL NUMBER: 12121204
PROJECT TITLE: Perceptions of Workplace Bullying Among
Practicing Registered Nurses
PROJECT TYPE: Dissertation
RESEARCHER(S): Crystal R. Threadgill
COLLEGE/DIVISION: College of Nursing
DEPARTMENT: Systems Leadship & Health Outcomes
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL:
Lawrence A. Hosman, Ph.D.
Institutional Review Board

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