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Nurse Managers, Work Environment Factors and Workplace Bullying

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NURSE MANAGERS, WORK ENVIRONMENT FACTORS AND WORKPLACE BULLYING

by

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ABSTRACT

The purpose of this dissertation is to explore relationships between authentic leadership style, global social power, job demand, job control, and workplace bullying of nurse managers in acute care settings across the United States.

Over 30 years of workplace bullying research exists. Consequences are linked to intent to leave, turnover, and harmful emotional and physical effects. Published studies identifying nurse managers as targets of workplace bullying and work environment factors that contribute to nurse managers being recipients of workplace bullying either, downward from their leaders, horizontally from their nurse manager peers, and upwards from their clinical nurses were not identified.

A descriptive, cross-sectional design using an online survey was utilized. Descriptive, inferential, and multivariate analyses were used to identify relationships and the likelihood of workplace bullying occurring.

Thirty-five percent (n = 80) of nurse managers reported being a target of workplace bullying. Managers sustained occasional (56%, n = 45) and severe (44%, n = 35) levels of workplace bullying, 65% (n = 43) identified their executive nurse leader as the predominate perpetrator. Authentic leadership, job demand, job control correlated significantly (p = <.01) with workplace bullying and job demand demonstrated the strongest likelihood (OR = 3.9) for predicting workplace bullying. Nurse Managers are four times more likely to be a recipient of workplace bullying when their job responsibilities are classified as demanding.

This study expanded the science and demonstrated that nurse managers, the backbone of organizations, are recipients of workplace bullying emanating predominately from executive nurse leaders, but also from clinical nurses and their nurse manager peers. Given the harmful

consequences of workplace bullying, as ‘guardians’ of and ‘advocates’ for their teams, executive nursing leaders, have an ethical and operational responsibility to ensure nurse managers are able to practice in a safe environment.

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
ANA	American Nurses Association
AONE	American Organization of Nurse Executives
ALI	Authentic Leadership Inventory
CAS	Complex Adaptive System
CLT	Complexity Leadership Theory
DV	Dependent Variable
FONE	Florida Organization of Nurse Executives
FTE	Full time equivalent
GSP	Global Social Power
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IV	Independent Variable
JC	Joint Commission
NAQ-R	Negative Acts Questionnaire-Revised
RN	Registered nurse
NM	Nurse Manager
UBS	Upwards Bullying Scale
U.S.	United States
WPB	Workplace bullying
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Overview

This chapter presents an overview of the work environment of healthcare organizations, describes the relationship of the nurse manager in the work environment, and introduces the phenomenon of workplace bullying. Likewise, the chapter introduces the concepts for the study, purpose, specific aims, and research questions that guided this doctoral research study.

Work environments of healthcare organizations are high pressured, chaotic, complex, and ever changing due to multiple transitions to new models for delivery of care, fluctuating reimbursement practices, integrated technology requirements, and incessant planning for shifting workforce needs (Needleman, 2013; Porter-O'Grady, 2003). Workplace bullying (WPB) is part of the overarching construct of injurious, antisocial workplace behaviors (Branch, 2008; Hershcovis, 2011). These behaviors are recurring, intimidating, and offensive verbal and non-verbal actions that damages or harms the physical and emotional wellbeing of individuals (Lutgen-Sandvik, Namie, & Namie, 2009). For more than 30 years researchers have examined the work environment of various organizations and described the phenomenon of WPB (Einarsen, Cooper, Hoel, & Zapf, 2011). During this time, researchers from the disciplines of nursing (Vessey, Demarco, & DiFazio, 2011), communications, organization development, psychology, sociology, anthropology, and medicine have concentrated their studies on identifying occurrences, precursors, and the consequences of WPB (Samnani & Singh, 2012). Consequently, there is consensus from researchers that the phenomenon of WPB is of a global nature, is pervasive, and complex with a multitude of associated dynamics that involve individuals, groups, the organization, and society (Einarsen et al., 2011). The Joint Commission (JC) suggests that all types of disruptive behaviors weakens the safety culture of healthcare

organizations (The Joint Commission [JC], 2008). Furthermore, the World Health Organization (WHO) acknowledges bullying as a multifaceted major public health problem that demands the scrutiny of families, health-care organizations, and policy makers (Srabstein & Leventhal, 2010). Due to the severe impact of its consequences on individuals, groups, organizations, and society, WPB continues to generate interest.

Contributing factors for WPB that focus on leadership behaviors and other dynamics within the work environment have been identified. Leadership factors include, behaviors by the leader that are described as unfair and unsupportive by their teams (Hauge et al., 2011) and the presence of non-relational building leadership styles (Nielsen, 2013). Conversely, a leadership style that is focused on relationship building, such as authentic leadership has been linked to lower incidence (Spence-Laschinger & Fida, 2013) and decreased exposure (Nielsen, 2013) to WPB. Other workplace dynamics, like a demanding workload along with control over job responsibilities (Baillien, De Cuyper, & De Witte, 2011), power dynamics (Branch, Ramsay, & Barker, 2007), changes within the organization (Baillien & De Witte, 2009) along with a stressful work setting (Jenkins, Zapf, Winefield, & Sarris, 2012) are also contributory factors for WPB.

In acute care settings, the nurse manager (NM) is the defining link between front line nurses and upper management. NMs work to enable the attainment of organizational goals, set the tone for healthy work environments (Duffield, Roche, Blay, & Stasa, 2011), and are accountable for the achievement of high quality patient outcomes (Squires, Tourangeau, Spence-Laschinger, & Doran, 2010). Specifically, the role of the NM is described as stressful, emotionally draining, with high work demands, 24-hour accountability, and numerous interruptions (Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010). Defined as the

stabilizing force for nurses (Anthony et al., 2005), positive quality relationships between NMs and their teams have been correlated with higher levels of empowerment (Spence-Laschinger, Finegan, & Wilk, 2009) and retention (Ritter, 2011). Likewise, as the stabilizing force, the role of the NM and the ability to create a supportive work environment has been linked to autonomous decision making of nurses (Heath, Johanson, & Blake, 2004), positive patient safety outcomes such as decreased mortality (Aiken, Clarke, Sloane, Lake, & Cheney, 2008), patient falls, medication errors, and hospital acquired infections (Spence-Laschinger & Leiter, 2006).

Furthermore, studies of nurse managers have identified key factors that are central determinants to their job satisfaction and their subsequent retention. Included are: (1) support from their leaders; (2) organizational factors such as decentralization of resources and increased span of control (Lee & Cummings, 2008); (3) relational building leadership behaviors (Spence-Laschinger et al., 2008); (4) empowerment from their leaders to impact change (Brown, Fraser, Wong, Muise, & Cummings, 2013) and; (5) effective communication with their leaders (Parsons & Stonestreet, 2003). Thus, leadership behaviors, aspects of the NM role, and work environment factors could serve as a catalyst for placement of the NM in a vulnerable position to be a recipient of WPB.

Workplace Bullying

For more than 30 years, the phenomenon of WPB has received worldwide exposure, with the majority of the research conducted in European countries (Hershcovis, 2011). However, the North American culture, in comparison to some European countries, is described as highly assertive, competitive, with high power distance, and low in-group collectivism (Jacobson, Hood, & Van Buren, 2014). Likewise, in several European countries, WPB is illegal, while in

the U.S. it is not (Yamada, 2011). Consequently, research performed on the North American continent though rich, is disjointed, and inconsistent in the operationalization of the concept (Keashly & Jagatic, 2011). For example, most of the North American studies have examined related concepts like: abusive supervision (Tepper, 2000), workplace aggression (Baron & Neuman, 1998), horizontal violence (Duffy, 1995), workplace incivility (Andersson & Pearson, 1999; Cortina, Magley, Williams, & Langhout, 2001), and workplace violence as described by Campbell et al. (2011). Descriptions of North American and other European concepts used in the WPB literature are listed in Table 1.

Table 1. Definitions of Counterproductive Workplace Behaviors

Attribute	Domain	Definition	Perpetrator
Abusive supervision	Psychological Indirect	"Sustained display of hostile verbal and non-verbal behaviors excluding physical contact" (Tepper, 2000, p. 178).	Supervisors Managers, Executive leaders
Workplace aggression	Physical Psychological Indirect	"Efforts by individuals to harm others with whom they work, or have worked, or the organizations in which they are presently, or were previously, employed. Any form of deviant behavior directed toward the goal of harming or injuring someone physically or psychologically" (Neuman & Baron, 1998, p. 395).	Individuals Peers Supervisors Managers Executive leaders
Workplace bullying	Psychological Indirect	"Harassing, offending, or socially excluding someone or negatively affecting someone's work. In order for the label of bullying (or mobbing) to be applied to a particular activity, interaction or process, the bullying behavior has to occur repeatedly and regularly (e.g., weekly) and over a period of time (e.g., about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal strength are in conflict" (Einarsen et al., 2011, p. 22).	Individuals Peers Supervisors, Managers Executive leaders

Attribute	Domain	Definition	Perpetrator
Horizontal or lateral violence	Physical Psychological Indirect	"Nurse to nurse aggression, verbal, physical, emotional abuse that is designed to control, humiliate a peer and can consist of a one-time occurrence" (Embree & White, 2010, p. 168).	Peers
Workplace harassment	Physical Psychological Indirect	"Irreverent types of behavior that put victims at risk physically, psychologically, and or sexually. Psychological harassment begins with sporadic, hostile, humiliating conduct of an unethical kind by one or more persons" (Fornés, Cardoso, Castelló, & Gili, 2011, p. 186).	Individuals Peers Supervisors Managers Executive leaders
Incivility	Psychological Indirect	"Low intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (Andersson & Pearson, 1999, p. 457).	Individuals Peers Supervisors Managers Executive leaders
Mobbing	Physical Psychological Indirect	"Social interaction through which one individual (seldom more) is attacked by one or more (seldom more than four) individuals almost on a daily basis and for periods of many months, bringing the person into an almost helpless position with potentially high risk for expulsion" (Leymann, 1996, p. 168).	Individuals Peers Supervisors Managers Executive leaders
Workplace ostracism	Psychological Indirect	"The exclusion, rejection, or ignoring of an individual (or group) by another individual (or group) that hinders one's ability to establish or maintain positive interpersonal relationships, work-related success, or favorable reputation within one's place of work" (Hitlan, Cliffton, & DeSoto, 2006, p. 217).	Individuals Peers Supervisors Managers Executive leaders
Workplace violence	Physical Psychological Indirect Direct	"The use of physical force against another person or group, or threat of physical force, that results in physical, sexual or psychological harm" (Campbell et al., 2011, p. 83).	Individuals Peers Supervisors Managers Executive leaders

Note. Attribute – type of behavior; Domain – areas of focus; Perpetrator – individual or groups responsible for the negative behaviors.

Considered to be part of the overarching construct of antisocial workplace behaviors (Branch, 2008; Hershcovis et al., 2007), four characteristics are considered germane to the definition of WPB: (1) undesired negative acts; (2) regularity and persistency of behaviors; (3)

methodological nature of the negative acts; and (4) powerlessness of the recipient to stop the negative acts (Einarsen et al., 2011). In addition to the four defining characteristics, three distinct pathways of workplace bullying are noted, they are: downward, upwards, horizontal or lateral bullying. Downward bullying consists of acts that are perpetrated by an administrator, director, manager, or supervisor to an individual in a lesser rank or position, this pathway is most commonly identified in the literature (Branch, Ramsay, & Barker, 2013). Upwards bullying is described as bullying of the manager by a subordinate or someone in a lesser position than the manager (Branch et al., 2013; Salin, 2001). Finally, horizontal or lateral bullying is between peers of equal rank or position (Branch et al., 2013). In this study, all directional components, downward, upwards, and horizontal bullying targeting NMs were examined.

In conclusion, more than 30 years of research exists for the phenomenon. Though characterized as a major public health problem by WHO, little is known about work environment factors that contribute to NMs being recipients of negative acts emanating downward from their leaders, upwards from their teams, and horizontally from their peers. Given the complexity of the NM's role, the increasing demand for NMs to attain organizational goals, the multidimensional nature of WPB, and the complicated, changing work environment where NMs practice, the probability that NMs could be on the receiving end of workplace bullying must be considered.

Specific Aims

The purpose of this study was to examine relationships between work environment factors and workplace bullying of nurse managers in acute care settings across the United States (U.S.). The study aims were:

- Aim 1: Describe the relationship between authentic leadership, global social power, job demand, job control and workplace bullying of nurse managers in acute care settings across the United States.
- Aim 2: Determine whether nurse managers are targets of WPB and identify the severity level of WPB.
- Aim 3: Describe the directionality of workplace bullying (downward, horizontal, and upwards) directed toward nurse managers.
- Aim 4: Describe the identity of perpetrators and determine if nurse managers are observers of workplace bullying that impact their nurse manager peers.
- Aim 5: Identify global social power behaviors directed to nurse managers by nurse leaders and clinical nurses.
- Aim 6: Determine if work environment factors of authentic leadership, global social power, job demand, and job control can predict workplace bullying of nurse managers.

Key Terms

Throughout this paper, the term 'clinical nurse' is used to describe the registered nurse (RN) who is given an assignment to care for patients on an inpatient unit located in an acute care hospital. The term 'nurse manager' is used to identify any registered nurse in a middle manager position with direct reporting to an executive nurse leader and with 24-hour accountability for their nursing unit. Other job titles such as clinical manager, supervisor, unit manager, department manager, resource manager are included in this definition. Likewise, the term 'nurse leader' is used to describe registered nurses who are in executive leadership roles in acute care settings. Various titles to include: director, administrator, chief nursing officer, and chief nurse executive

are also used, these titles are included in the term 'nurse leader'. 'Peer' is the term that is used to designate another nurse manager who has the same title and or position and who works in the same organization as the study participant. Rather than 'victim', the term 'target' is used to define the individual who is on the receiving end of WPB, as 'target' is consistently used throughout the literature. 'Perpetrator' is the term used to describe the individual who instigates the negative behaviors. 'Observer' represents individuals or nurses, who witness the negative acts. 'Authentic leadership' describes relational building leadership behaviors that utilize high moral and ethical standards for the promotion of positive work environments (Gardner, Cogliser, Davis, & Dickens, 2011). 'Job demand' speaks to the environmental forces that pushes the capabilities of an individual to achieve their job responsibilities (Karasek, 1979). 'Job control' describes the latitude or autonomy that an individual has to make decisions related to their job (Karasek, 1979).

Implications for Nursing

The occurrence of counterproductive workplace behaviors was identified in various groups in the nursing profession, including nursing faculty (Mintz-Binder & Calkins, 2012) and clinical nurses (Vessey, Demarco, Gaffney, & Budin, 2009), but specifically novice or graduate nurses (Spence-Laschinger, Grau, Finegan, & Wilk, 2010). However, though extant literature has identified managers as the predominate perpetrators of workplace bullying (Johnson & Rea, 2009; Zapf, Escartín, Einarsen, Hoel, & Vartia, 2011) none of the published studies have exclusively examined NMs as targets of WPB emanating from their peers, clinical nurses, or nurse leaders.

The profession of nursing is in the midst of an unprecedented, extensive shortage of registered nurses (American Association of Colleges of Nursing [AACN], 2014). Recent forecasts suggests that between the timeframes of 2009 and 2030, the RN shortage will reach proportions that will exceed 900,000 RNs (Juraschek, Zhang, Ranganathan, & Lin, 2012). Nurse managers, key initiators for stabilizing the work environment, are challenged and will continue to be challenged with high turnover of staff and shortages that are associated with poor quality impacting the delivery of care to patients (American Nurses Association [ANA], 2014; Wong & Cummings, 2007).

In addition to the challenges associated with the NMs role, in the State of Florida, the position of the unit/department nurse manager, is ranked fifth as one of the most sought after specialty positions in the acute care setting (Florida Center for Nursing, 2014). As noted by the Bulmer (2013) team, approximately 75% of RN respondents did not aspire to leadership positions. The Spence-Laschinger and Grau (2012) duo found a scarcity of clinical nurses aspiring to middle management positions particularly as they mature into their roles. In Canada, managers account for almost 7% of the RN population (Canadian Health Institute for Health Information, 2012) and by the year 2022, Canada will need close to 4,000 nurse managers (Canadian Nurses Association, 2009). Results from a survey published in 2002, identified the nurse manager vacancy rate in the U.S. as 5.6% (The HSM Group, 2002). However, in 2007, one hospital in the U.S. cited their nurse manager turnover rate closer to 15% and recognized that these middle manager positions went unfilled for over 100 days (Wendler, Olson-Sitki, & Prater, 2009).

In one of the first studies to examine retirement plans of nurse managers, the Hader, Saver, and Steltzer (2006) team found between the years of 2011 to 2020 more than 50% of

respondents (n = 978) had plans to retire from the nursing profession. Furthermore, after 2020, another 25% of respondents also had retirement plans. Similarly, findings from an international study identified more than 50% of the population of NMs are of retirement age (Hader, 2010). This supports the results of the earlier Hader et al. (2006) study which suggests NMs may have approximately 5 to 10 years left in the workforce (Hader, 2010). Also, with the impending exodus of NMs, organizations and the nursing profession stands to lose valuable experiential knowledge that cannot be quantified once these experienced NMs retire (Sherman, 2008).

Various factors as noted in Table 2 have been identified as contributory to NM turnover and can be correlated with WPB. Researchers have linked the proliferation of WPB with non-relational building leadership styles (Nielsen, 2013), high pressured, changing work environments (Stouten et al., 2010), and increased workload and lack of control over job responsibilities (Baillien, De Cuyper, et al., 2011). Thus, healthcare environments also described as turbulent (Needleman, 2013) are not only contributory to NM turnover but also to WPB.

Table 2. Factors Contributing to Nurse Manager Turnover

Factors	Findings
Societal Factors	Current and projected shortage of RNs (American Association of Colleges of Nursing [AACN], 2014)
	Lack of qualified and or 'available' RNs that seek nursing management positions (Sherman, Schwarzkopf, & Kiger, 2011)
Organizational Factors	Lack of formal leadership development, orientation to the role, and experience with leading teams (Parsons & Stonestreet, 2003)
	Organizational changes and lack of support from their leader (Skytt, Ljunggren, & Carlsson, 2007)
	Organizational culture or climate (Mackoff & Triolo, 2008)
	Decreased quality patient care (Parsons & Stonestreet, 2003)
Individual Factors	Diverseness of the nurse manager's job responsibilities (Baker et al., 2012)
	Span of control and workload (Spence-Laschinger et al., 2008)
	Decreased empowerment (Mackoff & Triolo, 2008)
	Stress associated with excessive responsibilities (Kath, Stichler, Ehrhart, & Sievers, 2013)
	Leadership behaviors and non-transformational style of their leaders (Strelioff, 2007)

Note. Factors equate to: individual – micro level; organization – macro level; society – mundo level

Consequences of workplace bullying are multifactorial and encompass all levels to include individuals, groups, organizations, and society. At the micro or individual level, decreased job satisfaction and productivity (Berry, Gillespie, Gates, & Schafer, 2012; Spence-Laschinger et al., 2010) and increased levels of stress manifested through emotional and physical symptoms (Bartlett & Bartlett, 2011) are identified. However, few studies exist that examined consequences at the group or meso level. Of those studies, Coyne, Craig, and Chong (2004) in their study of 288 fire-fighters consisting of 36 teams, identified isolation of perpetrators and targets of WPB, along with decreased success of the team. Furthermore, Ramsay, Troth, and Branch (2010) suggest bullying identified in groups potentiates more bullying.

For the macro or organizational level, high turnover (Berthelsen, Skogstad, Lau, & Einarsen, 2011), excessive financial expenditures and damage to the reputation of the organization are also implicated as consequences of workplace bullying (Hoel, Sheehan, Cooper,

& Einarsen, 2011). Similar to the group or meso level, few studies were identified that studied the consequences at the societal or mundo level. However, it is postulated that WPB can impact or increase costs associated with medical, social, and legal services (Bartlett & Bartlett, 2011) along with rates of unemployment and early retirement (Vega & Comer, 2005).

WPB has been documented in various nursing groups. Yet, to date, no published literature has been found that studied the NM population. Given the complexity of the NMs role, the aging NM workforce, and other work environment factors that could contribute to the turnover of NM and WPB, it would be important to identify if NMs are targets of WPB. If nurse managers are indeed targets, then executive nurse leaders have an ethical responsibility to be informed about contributing factors and an operational imperative to seek measures to craft the NM role to potentially eliminate the harmful consequences of WPB. Thus, NMs could be retained in the workforce longer. Therefore, the purpose of the study is to examine the understudied population of nurse managers to determine associations between authentic leadership style, global social power, job demand, and job control characteristics and WPB. Knowledge and insights stemming from this study could potentially advance nursing science surrounding WPB and ultimately may lead to heightened identification and prevention of this phenomenon.

CHAPTER 2: LITERATURE REVIEW

This chapter includes an expansive overview of workplace bullying to pinpoint the empirical foundation and rationale for examining the research question from an ontological perspective. Specifically, this section discusses facets of bullying since its identification in the workplace 30 years ago, the work environment, power dependency factors, contributing leadership behaviors, the nurse manager's role, and the theoretical framework used to guide the study.

Workplace Bullying Definition

Workplace bullying is described as a multidirectional, interrelated, and multifaceted phenomenon (Heames & Harvey, 2006). Thus, three directional pathways for workplace bullying are noted: Upwards (Hoel, Cooper, & Faragher, 2001; Salin, 2001), downward, and horizontal (Branch et al., 2013). However, regardless of the directional pathway, the gold standard definition for workplace bullying made popular by European researchers and frequently cited in the literature is:

> Bullying at work, means harassing, offending, or socially excluding someone or negatively affecting someone's work. In order for the label of bullying (or mobbing) to be applied to a particular activity, interaction, or process, the bullying behavior has to occur repeatedly and regularly (e.g., weekly) and over a period of time, (e.g., about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal strength are in conflict (Einarsen et al., 2011, p. 22).

Descriptions of Workplace Bullying

The negative behaviors of WPB include but are not limited to: personal, professional attacks, and attacks on the role and responsibilities of the individual (Hutchinson, Vickers, Wilkes, & Jackson, 2010). Personal attacks comprise: persistent criticisms or insults, remarks that are personally offensive, being badgered, humiliated, or teased incessantly, physical attacks, and subtle acts such as, excluding or isolating individuals from peers or work activities (Hutchinson, Vickers, Wilkes, et al., 2010; Zapf et al., 2011). Attacks on the professional capability of the individual are: public disparagement, undermining, negative performance assertions, and restricting opportunities for career advancement (Hutchinson, Vickers, Wilkes, et al., 2010). Lastly, attacks on the role and responsibilities of an individual are: making work life difficult by not allowing for breaks, having a bigger workload in comparison to others, denying requests for leave, and instilling financial sanctions (Hutchinson, Vickers, Wilkes, et al., 2010).

Operational Definition Confusion

Even with the gold standard definition for workplace bullying, concept confusion exists and appears to be more prevalent throughout the North American literature. Confusion surrounds the timeframe for the negative acts along with the number of acts that should be counted as WPB. Likewise, the intentionality of the acts and inclusion of the overarching construct of counterproductive behaviors with the phenomenon (Keashly & Jagatic, 2011; Zapf et al., 2011) have also added to the confusion. This lack of agreement with an operational definition for WPB has contributed to methodological differences that impact the measurement of the concept, but specifically its incidence and prevalence rates (Agervold, 2007; Nielsen, Notelaers, & Einarsen, 2011).

Occurrences

A recent national Zogby poll requested by the Workplace Bullying Institute (2014) reported approximately a quarter of the U.S. population experienced or are currently experiencing WPB (27%). Of that number, 11% was upwards, 56% was downward, and 33% was from peers. Lutgen-Sandvik, Tracy, and Alberts (2007) identified approximately 46% of their U.S. sample as receiving one bullying act per week over a timeframe of six months. A meta-analytical review of WPB studies performed in healthcare, education, manufacturing, retail, and service organizations located in European countries, reported the frequency of bullying acts ranged from 3% to 20% (Zapf et al., 2011). Business professionals in management roles in Finland were surveyed to explore the existence of WPB. The presence of downward, upwards, and horizontal bullying were recounted by managers at rates of 40% from superiors, 33% by colleagues, and approximately 16% from subordinates. Of those in the sample, 9.2% of middle managers reported experiencing WPB over a span of months and years (Salin, 2001). Wallace, Johnston, and Trenberth (2010) identified more than 70% of post graduate students and employee participants from academic and work settings in New Zealand reported bullying their boss within a timeframe of six months.

In a national study performed in the U.S., approximately 70% of clinical nurse participants and 6% of nurse managers reported being targets of workplace bullying (Vessey et al., 2009). Johnson and Rea (2009) in their study of clinical nurses acknowledged that more than a quarter of these clinical nurses were on the receiving end of bullying behaviors that consisted of 1 to 11 different acts administered daily, weekly, and over a timeframe of more than six months. Approximately 33% of associate degree nursing program directors reported being victims of upwards bullying and 43% reported WPB emanating from peers (Mintz-Binder &

Calkins, 2012). Chipps, Stelmaschuk, Albert, Bernhard, and Holloman (2013), in their study of perioperative registered nurses, surgical technologists, and unlicensed perioperative workers in two academic medical centers, found 34% of participants were targets of WPB and 49% witnessed WPB.

The differences with the incidence rates observed in these studies reflect measurement and methodological issues that are inherent with the operational definition of workplace bullying (Keashly & Jagatic, 2011; Nielsen, Matthiesen, & Einarsen, 2010). However, regardless of the measurement issues, three directional pathways and the identification of WPB as a universal problem in the work environment were supported.

Status

Studies have identified leaders in the position of nurse manager as frequent perpetrators of WPB of clinical nurses (Chipps et al., 2013; Johnson & Rea, 2009; Vessey et al., 2009). However, in addition to leaders in nursing, individuals in management and supervisory positions in other disciplines like public administration, education, and finance were also implicated as perpetrators of workplace bullying (Zapf et al., 2011). This view of a 'top down' pathway has been widely studied and corroborated by many researchers (Ortega, Hogh, Pejtersen, & Olsen, 2009; Zapf et al., 2011). Conversely, the 'at risk' population of NMs has not been exclusively studied from the standpoint of being a target of WPB.

Antecedents

Studies identified antecedents impacting individuals and emphasized personality and coping skills (Baillien, Neyens, De Witte, & De Cuyper, 2009), gender (Hauge, Skogstad, & Einarsen, 2009; Hintz Klein, 2012), and ethnic characteristics (Paice & Smith, 2009) of the

target. Hauge et al. (2009) explored individual factors of the perpetrator and identified gender, exposure to occasional and frequent WPB, and conflict surrounding the role as contributory. In their grounded theory study, Tracy, Lutgen-Sandvik, and Alberts (2006) characterized perpetrators as "demons, evil, and narcissistic dictators" (p. 159).

The group and organizational studies identified the climate of the work environment (Skogstad, Torsheim, Einarsen, & Hauge, 2011), leadership styles (Nielsen, 2013), workload (Baillien, De Cuyper, et al., 2011) and interactions between individuals within the groups (Branch et al., 2007; Hauge et al., 2011). Studies at the societal level generated agreement that cultural factors played a role in the development of WPB (Loh, Restubog, & Zagenczyk, 2010; Power et al., 2013).

Consequences

Literature supports the identification of workplace bullying and connects the phenomenon to a myriad of effects that impact the individual, groups, organizations (Bartlett & Bartlett, 2011) and society (Vega & Comer, 2005). For example, the qualitative study using a grounded theory methodology from the Hallberg and Strandmark (2006) team described emotional suffering that resulted in the theme being labeled as 'marked for life'. Likewise, as the bullying persisted, opportunities to leave current positions did arise, but were not realized due to rejections based on less than desirable job recommendations from supervisors or managers (Hallberg & Strandmark, 2006).

In a meta-analysis of cross-sectional and longitudinal studies conducted between 1989 and 2011, health effects of post-traumatic stress disorder, mental health disorders such as anxiety and depression and physical health issues were examined. Job related effects like increased

absenteeism, a resolve to exit the organization, and decreased job satisfaction (Nielsen & Einarsen, 2012) were identified. However, a limitation of Nielsen and Einarsen (2012) analysis was the inclusion of longitudinal studies with only two measurement points, rather than three or more points. Two data points may not have been an adequate timeframe to recognize the outcome variables and could have led to the identification of the weak relationship between absenteeism and workplace bullying.

Likewise, in a longitudinal study, Danish healthcare helpers and assistants were followed from the time of graduation to two years post-graduation (Hogh, Hoel, & Carneiro, 2011). Respondents who reported frequent and occasional bullying, had a two to three times higher risk of leaving their positions at all times points when compared to those who were never bullied (Hogh et al., 2011). In a second longitudinal study, researchers examined intent to leave and exit from the organization. Findings determined that the desire to leave the organization was significant (OR = 4.62) and evident over two measurement points within a time span of two years (Berthelsen et al., 2011). Furthermore, while participants who were bullied were two times more likely to change positions within a two year time frame compared to those who were not bullied. The majority of respondents continued in their roles for up to 24 months after the first reports of workplace bullying. Additionally, sick absences were related to the severity of workplace bullying; the higher the severity, the greater the number of sick absences (Berthelsen et al., 2011).

The effect of infrequent and repeated bullying on absences due to illness was examined longitudinally. Participants who reported frequent exposure to workplace bullying, had a higher risk (95%) of continuous absences because of illnesses (Ortega, Christensen, Hogh, Rugulies, & Borg, 2011). A limitation of the Ortega et al. study is the use of only an operational definition for

examining WPB. According to Nielsen et al. (2011) the standard for measurement of WPB should include both a behavioral and a self-labeling approach with a WPB definition, as this method captures all the theoretical aspects of the concept. The omission of the recommended standard, could have resulted in the under reporting of data.

Novice nurses reported a change in their work output when confronted with WPB. More than half of the nurses reported a decrease in productivity after only one negative act of WPB and acknowledged that when the negative behaviors were generated from someone in a leadership role, the impact on their productivity was strong (Berry et al., 2012). However, the impact of the consequences of workplace bullying on delivery of care to patients was not explored in this study.

Resident physicians (n =33,329) in the United Kingdom reported making potential or serious medical errors when caring for patients as compared to those who were not recipients of WPB (Paice & Smith, 2009). Though this study had a large sample size, the type of reported medical errors and the reliability and validity of the survey instruments were not noted. Spence-Laschinger (2014) investigated the relationship between WPB, incivility and the perception of Canadian nurses on patient safety risk, assessment of nursing quality, and adverse events. Though WPB and incivility exposure rates of nurses was not high (M =1.45, SD = .59; M =1.52, SD = .70), results revealed bullying and incivility were significantly related to perceptions of patient safety risk, assessment of nursing quality, and adverse events. This study is one of the first published studies to actually link patient outcomes to WPB. However, Spence-Laschinger (2014) utilized perceptions of nurses rather than actual organizational patient outcomes data.

Recurring effects of WPB on organizations include: decreased productivity (Berry et al., 2012), increase absences due to illnesses (Ortega et al., 2011), intent to leave and exiting the

organization (Hoel et al., 2011). Also, researchers identified: increased legal and healthcare costs, concerns with engagement and commitment of staff, and decreased productivity (Hoel et al., 2011). Collectively, organizational effects of WPB could impact the financial bottom line, organizational culture, and reputation of the organization (Bartlett & Bartlett, 2011).

A paucity of research studies investigated the financial costs of WPB on organizations and society. Yet, when cost estimates are reported they are based on conservative, inconsistent prevalence data that is more than 14 years old (Hoel et al., 2011). Estimates for financial expenditures to the organization for one person perpetrating bullying behaviors though conservative, are reported to be higher than two million dollars annually (Lieber, 2010). Given the complexity of the healthcare environment, the effects of workplace bullying on individuals, groups, organizations, and society (Hoel et al., 2011; Nielsen & Einarsen, 2012), fluctuating reimbursements from government and private payers (Needleman, 2013), the potential for serious medical errors (Paice & Smith, 2009), and the perceived patient safety risk (Spence-Laschinger, 2014), workplace bullying could be a financial impediment to organizations and society at large.

Work Environment Factors

A predominate theme noted in the WPB literature is work environment. Work environment integrates surroundings in the work setting, decision making structures, along with processes that influences the physical, emotional, cultural, and social dimensions of employees (American Association of Colleges of Nursing [AACN], 2002; The Free Dictionary, 2013). Thus, Warshawsky, Rayens, Lake, and Havens (2013, p. 251) defines the work environment that

supports the practice of nurse managers as: “the organizational context that affects the ability of the nurse manager to achieve optimal staff, patient, and organizational outcomes”.

Therefore, for this study, the concept of work environment will include interrelated and interactional subthemes of leadership behaviors (Agervold, 2009; Hauge et al., 2011; Hoel, Glasø, Hetland, Cooper, & Einarsen, 2010), disparity of power (Baillien et al., 2009; Branch et al., 2007; Salin, 2001), and job demand and control (Baillien, Rodriguez-Munoz, Anja, & De Witte, 2011; Stouten et al., 2010). WPB researchers have studied these subthemes separately and in combination but, with a synergistic framework and have linked them as contributory factors of WPB. This section will discuss three aspects of the work environment, describe the relationship to workplace bullying, and outline job characteristics of nurse managers that may set them up as targets of workplace bullying.

Leadership Behaviors

The importance of effective leadership behaviors in the creation of positive work environments has been cited as a necessary ingredient by groups (Institute of Medicine [IOM], 2003) and researchers (Cummings et al., 2010). In a phenomenological study of managers and supervisors accused of workplace bullying, themes of ineffective leadership styles and aspects of the work environment such as inadequate resources and increased workload that contributed to high levels of stress were uncovered (Jenkins et al., 2012). Most importantly, this study identified the crucial role of the leader in creating an effective work environment. Hauge, Skogstad, and Einarsen (2007), in their study of the Norwegian labor force not only identified the destructive leadership style of tyrannical leadership behaviors as a relatively strong predictor

of workplace bullying but also identified an interaction with job stressors as a factor for 'inviting' workplace bullying.

The association between ratings from direct reports from 70 organizations about the leadership styles of their supervisors with exposure to and the observation of workplace bullying was examined (Hoel et al., 2010). Differences were identified between respondents who received negative acts and those who reported just observing the negative acts. The presence of laissez-faire leadership style, non-contingent punishment, autocratic leadership behavior, and the absence of participative leadership styles were highly correlated with workplace bullying. Specifically, respondents who designated themselves as targets identified the supervisor's leadership style of laissez-faire and non-contingent punishment as significant contributing factors (Hoel et al., 2010).

Nielsen (2013) surveyed over 800 maritime crew members and captains to determine the impact of leadership styles on workplace bullying. Transformational, laissez-faire, and authentic leadership styles were explored along with perceptions of safety and group cohesion. Crew members who identified their leader as demonstrating a high degree of laissez-faire leadership style, had a three times higher risk for receiving workplace bullying when compared to leaders with decreased levels of laissez-faire leadership style. On the other hand, the leadership styles of transformational and authentic, demonstrated a lower risk of exposure to workplace bullying. Lastly, a full and partial mediating effect of safety perceptions between the relationship of transformational and authentic leadership styles and workplace bullying was noted (Nielsen, 2013).

Using two-time points over a span of one year, Spence-Laschinger and Fida (2013) collected data from questionnaires to examine the experiences of graduate nurses with WPB,

burnout, authentic leadership, and intent to leave. Authentic leadership, a positive relational leadership style predicted decreased levels of burnout and workplace bullying. Conversely, increased levels of work related bullying resulted in higher levels of cynicism and emotional exhaustion of graduate nurses one year later.

In addition to leadership styles, also noted in the literature is the personality of the perpetrator. Mathisen, Einarsen, and Mykletun (2011) examined characteristics of the leader's personality, levels of stress, and workplace bullying among both supervisors and team members in the restaurant industry. Higher levels of supervisor stress resulted in reports of workplace bullying from their team members. Specifically, leaders who classified themselves as displaying characteristics of neuroticism and low conscientiousness had higher reported rates of workplace bullying from their teams. When the leader demonstrates low levels of stress, the personality attribute of low agreeableness was correlated with workplace bullying. Likewise, when the leader exhibited high levels of stress a strong correlation with workplace bullying was also present. This study is important because of its linkage of workplace bullying to high stress and the personality characteristic of low agreeableness.

The Hauge et al. (2011) team studied over 10,000 Norwegian employees at 65 different organizations to determine if work characteristics, such as role stress, role ambiguity, fair, and supportive leadership practices at the department level could be contributory factors for WPB. A strong association between work environment conditions, specifically leadership practices, role conflict, and WPB at the level of the department was noted. Findings from this study suggest WPB comprises a multifaceted dimension to include a group level element, in addition to the individual level dimension. Importantly, this perspective, implicates leaders within an organization as they are responsible for environmental conditions within the organization.

Two studies, Nielsen (2013) and Hoel et al. (2010) associated the laissez-faire leadership style as a contributing factor for workplace bullying. Both studies utilized large samples, randomization, and had response rates that were acceptable. However, the Nielsen study had a predominance of males as study subjects. Therefore, generalization of findings to other population groups is problematic particularly as it relates to the female dominated population of nurse managers. The Spence-Laschinger and Fida (2013) team focused on the population of novice nurses, used self-reported data rather than specific scores from leaders, and lacked actual turnover data. Still, the importance of authentic leadership behaviors and or practices were linked to WPB and suggests these behaviors play a major role in creating supportive environments that could decrease the prevalence of WPB (Spence-Laschinger & Fida, 2013). Likewise, the Hauge et al. (2011) team proposed a direct connection to WPB due to the increased work related stressors generated by unsupportive leadership practices that create an environment conducive for WPB.

Disparity of Power

Power is a comprehensive, multidimensional term that highlights the inherent dependency between two individuals along with the ability of one individual to achieve their own agenda even though there is resistance (Kim, Pinkley, & Fragale, 2005). Consequently, an imbalance is achieved when hierarchical differences resulting from formal or informal structures are present. Likewise, the concept of power can include threats, withholding of information or skills, and access to a network of informal sources of power (Salin, 2001). According to Raven (2008) all human interactions emanate from power sources or bases that are used to influence or change the views, attitudes, and actions of individuals. Though the concept of power is included

as part of the definition of workplace bullying, few studies have examined the concept as an independent variable.

Researchers reported that a formal position is not necessary for bullying to occur as individuals in formal and informal positions reported bullying behaviors (Branch et al., 2007; Hintz Klein, 2012; Strandmark & Hallberg, 2007). Furthermore, Salin (2001) identified a higher incidence of bullying in individuals in lower positions when compared to leaders. In a mixed methods study, Hutchinson, Vickers, Jackson, and Wilkes (2006) supported the positional aspect of power through thematic analysis. Informal relational networks within work groups that acted as conduits to exploit, conceal, and proliferate workplace bullying not only within departments but extending across and up the organizational hierarchical ladder were found (Hutchinson et al., 2006).

Using grounded theory, Strandmark and Hallberg (2007) identified the theme of 'struggling for power' between two individuals, the perpetrator and target due to conflict as the initial phase of WPB. This occurs due to a perceived threat of the target's higher qualifications (Strandmark & Hallberg, 2007), their level of experience (Hintz Klein, 2012), contradictions between personal and organizational ethics (Hintz Klein, 2012), or due to resistance for imminent changes (Jenkins et al., 2012). As the conflict continues, the power struggle intensifies, and is manifested by the target being watched and subsequently mistreated (Strandmark & Hallberg, 2007). In their qualitative, explanatory case study, Baillien et al. (2009) corroborated the findings of Strandmark and Hallberg by also identifying a pathway of power versus powerlessness as a result of relational conflict. These researchers noted that the imbalance of power stems from influences emanating from teams, groups, or the organization.

In the exploratory interview portion of their mixed methods study, Branch et al. (2007) acknowledged the theme of power, specifically the aspect of imbalance for all directional pathways of WPB. Sub themes identified the absence of support from superiors, disregard for the role of the middle manager, and the reliance or dependency of managers on their teams to meet the needs of the department. Both Baillien et al. (2009) and Branch et al. (2007) reported that an imbalance of power occurs when subordinates recognize the manager is unsupported, isolated, and or without legitimate power. Through multiple methods, Hodson, Roscigno, and Lopez (2006) analyzed organizational data to determine power patterns. They found that interchanges of relational powerlessness and organizational chaos were linked to the identification of WPB. Findings suggest, when relational powerlessness is absent and the organization is stable, bullying is reduced (Hodson et al., 2006). In summary, a power struggle which is not able to be stymied is one of the hypothesized factors for WPB bullying (Strandmark & Hallberg, 2007).

Job Characteristics – Demand and Control

Workload and work strain, were identified in the early WPB research as contributing factors (Einarsen, Raknes, & Matthiesen, 1994). Since that time, few studies have examined the relationship between workload and job demand or work strain and WPB. In their study of Australian police officers, Tuckey, Dollard, Hosking, and Winefield (2009) found that job demand was positively associated with workplace bullying while job control had a negative association. In other words, high levels of demanding work and decreased levels of job control contributed to a higher probability of workplace bullying of police officers.

A six month study using two time points explored the relationship between workload and job autonomy as contributing factors for exposure to workplace bullying from the perspective of

both the perpetrator and the target (Baillien, De Cuyper, et al., 2011). At the initial time point, a positive association between workload and being a target of workplace bullying was found. Increased job autonomy led to decreased workplace bullying. An interaction effect between job autonomy and workload was noted at the final time point; when workload was high and job autonomy was low, perpetrator bullying was evident (Baillien, De Cuyper, et al., 2011).

Employees in various occupations and positions in Belgium were examined to ascertain if there was a distinction between (low, very low, high, and very high) levels of job demand and control over work activities and workplace bullying (Notelaers, Baillien, De Witte, Einarsen, & Vermunt, 2013). Respondents had an increased likelihood of experiencing workplace bullying when job demand was rated high and very high as compared to low and very low levels. Furthermore, the likelihood of experiencing bullying was four times higher with low and very low levels of job control as compared to high and very high levels.

The strength of the reported studies is their identification of job demand and control or autonomy with work related activities. However, the Tuckey et al. (2009) study utilized a cross sectional design, a WPB definition, one question for measuring WPB, along with a triangulation approach from observer reports of workplace bullying. This did serve as a means for strengthening the weak methodological design. Likewise, the Notelaers et al. (2013) team used a cross-sectional design, therefore, the lack of causality for the results along with the ability to determine if the results can be distinguished between correlates, consequences, or predictors of workplace bullying remains suspect.

Role of the Nurse Manager

A report from the IOM (2003) described the work environments of nurses as a serious threat to patient safety due to ineffective leadership, management practices, availability of employees, poorly designed work processes, and retaliatory organizational cultures. Furthermore, leadership was identified as the essential ingredient or originator for effective work environments and the delivery of safe patient care. By using effective leadership behaviors, leaders are able to engage, interact, and build positive relationships with their teams to implement initiatives, policies, and processes for the achievement of organizational goals IOM (2003). However, the inability to effectively lead their teams and manage the complexities of the role, as well as a lack of effective orientation, ongoing professional development (Zwink et al., 2013) and mentoring by seasoned nurse leaders (Wong et al., 2013) contributes to the already demanding responsibilities of nurse managers.

Twenty-one nurse managers reported being 'sandwiched' between the demands of their team, organizational performance goals, and the desires of other interdisciplinary partners. Themes such as increased workload, decreased coping, and the lack of necessary resources as contributory factors of nurse manager stress emerged (Shirey et al., 2010). Also, Lee and Cummings (2008) in their systematic literature review of 14 quantitative and qualitative studies found factors that impact the job satisfaction of nurse managers included workload, number of units/departments within their oversight, involvement in decisions, and support from their leaders. Following thematic analyses of Canadian nurse manager reports, 'a power struggle' between previous and current management's leadership style, sabotage behaviors from members of the team, the perception of being isolated, and drowning in work were identified (Udod & Care, 2013).

Nurse manager turnover and its effects on the rates of pressure ulcers (an inflamed, open, confined injury to the skin and tissues, located over a bony part of the body, (Black et al., 2007)) and patient falls on intensive care and medical surgical patients was explored (Warshawsky, Rayens, Stefaniak, & Rahman, 2013). Findings from the Warshawsky et al., 2013 study indicated that intensive care units were significantly predictive for unit/department and turnover of NMs. Patients in intensive care units where NM turnover was a problem were two and half times more likely to develop two or more pressure ulcers when compared to patients in medical-surgical units. Likewise, medical-surgical patients were greater than three times more likely to develop one or more pressure ulcers when compared to intensive care units with no NM turnover (Warshawsky et al., 2013).

Consequently, there is agreement from researchers that the nurse manager's role is perhaps one of the most influential and overworked roles in healthcare (Zwink et al., 2013). Dynamics such as the changing and competing organizational priorities, the stressful, emotionally draining, demanding 24-hour accountability of the role (Shirey et al., 2010), along with negative leadership behaviors rooted in the work environment are contributory. As a result, these dynamics could serve as an impending storm to set the nurse manager up to be a recipient of WPB.

Theoretical Framework

Researchers have identified a multi-dimensional aspect of workplace bullying. This suggests a complexity of contributing factors that intertwines individual, group, organization, and societal dynamics within the systematic nature of workplace bullying (Einarsen et al., 2011). Contributory factors include: personality characteristics of the target and or the perpetrator (Zapf

& Einarsen, 2011); interactions or conflict between the target and the perpetrator (Strandmark & Hallberg, 2007); organizational factors (Agervold, 2009; Stouten et al., 2010); group factors (Hutchinson et al., 2006), and societal dynamics (Power et al., 2013; Sidle, 2010).

Though many theories have been used to explain WPB, due to its multi-dimensionality, the application of leadership and power dependency theories could assist with understanding the various processes that are part of the phenomenon. This section describes two theories, complexity leadership theory and social power theory and relates the concepts to WPB of nurse managers.

Description of Framework

Complexity Science**.** A new theoretical framework Complexity Science, is the "study of the behavior of large collections of …simple, interacting units, endowed with the potential to evolve over time" (Coveney, 2003, p. 1058). Consisting of concepts from physics, mathematics, systems thinking, and nonlinear dynamics, Complexity Science posits that relationships with involved entities, individuals or organizations are integrated networks that create different patterns or systems of functioning (Byrne & Callaghan, 2014).

Leadership theories for decades have included concepts that focus on complex, top-down bureaucratic, chaotic environments such as healthcare organizations. However, with the current economic age of information seeking, the bureaucratic, top-down theories used in the Industrial Age are not useful (Uhl-Bien, Marion, & McKelvey, 2007). To bridge the gap between leadership theories that were applicable for the Industrial Age and the new Information era, concepts from Complexity Science were used to develop complexity leadership theory.

A major component of Complexity Science is a unit, department or organization referred to as Complex Adaptive Systems (CAS). These systems are comprised of individuals, or representatives with the capacity to organize, interact, collaborate, and network together across boundaries for a common purpose (Burns, 2001; Uhl-Bien & Marion, 2009). The CAS obtains knowledge and quickly creates new paths that generate an interdependent bonding for influencing the functioning of the system, even in fluctuating, chaotic, and unpredictable settings (Uhl-Bien & Marion, 2009).

Complexity Leadership Theory

Complexity leadership theory is represented as the framework for leading in dynamic, highly interactive, and unpredictable smaller complex adaptive systems that are part of another larger system or organization. Serving as the structure for leaders, complexity leadership theory (CLT) focuses on behaviors that are inherent in the system, attainment of knowledge both externally and internally, relational resourcefulness, and the spontaneous adaptation to changes (Crowell, 2011; Weberg, 2012). Three essential components of CLT are noted: (1) informal and formal leadership interactions identified within CASs; (2) embeddedness of leaders within the system, and; (3) entanglement that is interwoven together throughout the functioning of the three levels of leadership (micro, meso, and macro). This entanglement serves to exert an influence on the entire system (Uhl-Bien et al., 2007).

CLT suggests that leadership occurs throughout all levels of the organization and utilizes both formal and informal structures, a relationship building leadership style, along with the ability to become embedded into the 'action' to influence and guide the work of the CAS (Crowell, 2011; Livingston & Lusin, 2009). Bureaucratic organizations such as healthcare

organizations consist of three distinct leadership functions that are observed and entangled throughout the micro, meso, and macro levels. At the macro level, the administrative function aligns and incorporates the mission of the organization, determines strategic pathways, develops policies, and defines reporting structures (Livingston & Lusin, 2009; Uhl-Bien & Marion, 2009). The meso level, represented by the middle manager, is termed the enabling function and consists of stabilizing, balancing, and integrating various processes that are developed from either the macro and or the micro levels (Uhl-Bien & Marion, 2009; Warshawsky, Lake, & Brandford, 2013). At the micro level or adaptive function, front line teams take the strategic plan and adapt the processes to fit the dynamics of their micro system or CAS (Uhl-Bien & Marion, 2009). In order for operational effectiveness to occur, all leadership levels, macro, meso, and micro are dependent on each other and must interact together. This description of entanglement is the third essential component CLT. Finally, what emerges throughout the process of entanglement are outcomes that propel the CAS to improve, decrease, or maintain their status (Uhl-Bien & Marion, 2009).

Social Power Theory

Emerson (1962), theorized that social relationships consist of mutual dependency that is beneficial to individuals. This mutual dependence involves exchanges between individuals and suggests the ability to potentially influence by either hindering or propelling the actions of another, creating an imbalance or a balance of power. As defined, power is the force over another (Emerson, 1962) and emphases the capability or the potential of one individual or group to influence, affect, or psychologically change the opinions, attitudes, and actions of another person (Raven, Schwarzwald, & Koslowsky, 1998). Inherent in the definition are three specific

components of power. They are: potentiality, the perception of one person that the other individual has a particular resource that is needed to attain specified goals, and a dependence or countervailing imbalance of one individual over another (McShane & Von Glinow, 2014). In addition to the components of power, Bacharach and Lawler (1980) postulated that power can be differentiated directionally, laterally, upwards, and downwards. Furthermore, in their seminal work, French and Raven (1959) identified five power bases. These power bases were expanded to incorporate six multidimensional, interpersonal power bases or sources that include: (1) informational – access to information; (2) coercive – punishment, or threats; (3) reward – financial or non-financial benefit; (4) legitimate – position, equity, dependency; (5) expert – experience, knowledge, skill; (6) referent – empathy with the person (Raven et al., 1998). Likewise, Mechanic (1962, p. 352), claims power dependence occurs by "controlling access to information, persons, and instrumentalities", while Yukl and Falbe (1991), suggest power is gained through three sources: position, personal attributes, and the relationship between individuals.

Over the course of 30 years, the power taxonomy as described by French and Raven's earlier work was further refined to ascertain power and the source of influencing tactics used by individuals. Raven (1992), suggests influence tactics help to prepare or set the stage for individuals to utilize their base of power. Also, influence tactics serves as a catalyst for identifying underlying motivation for pursuing the particular power base that generates the subsequent effect on the target. Leaders in formal or informal positions utilize power forces individually or through social networks by pulling from their power bases. Likewise, social networks due to their interdependency, utilize power forces (informational, coercive, referent, expert, legitimate) that are embedded within the network to interconnect, thus influencing the

attitudes, behaviors, and actions of others (McShane & Von Glinow, 2014). Finally, bases or sources of power represent the range or amount of freedom individuals have to conform or not conform to the power force. Legitimate position, coercive, and reward bases restrain the individual's freedom while referent and expert bases are described as open, inviting, and appealing to individuals (Pierro, Raven, Amato, & Bélanger, 2013).

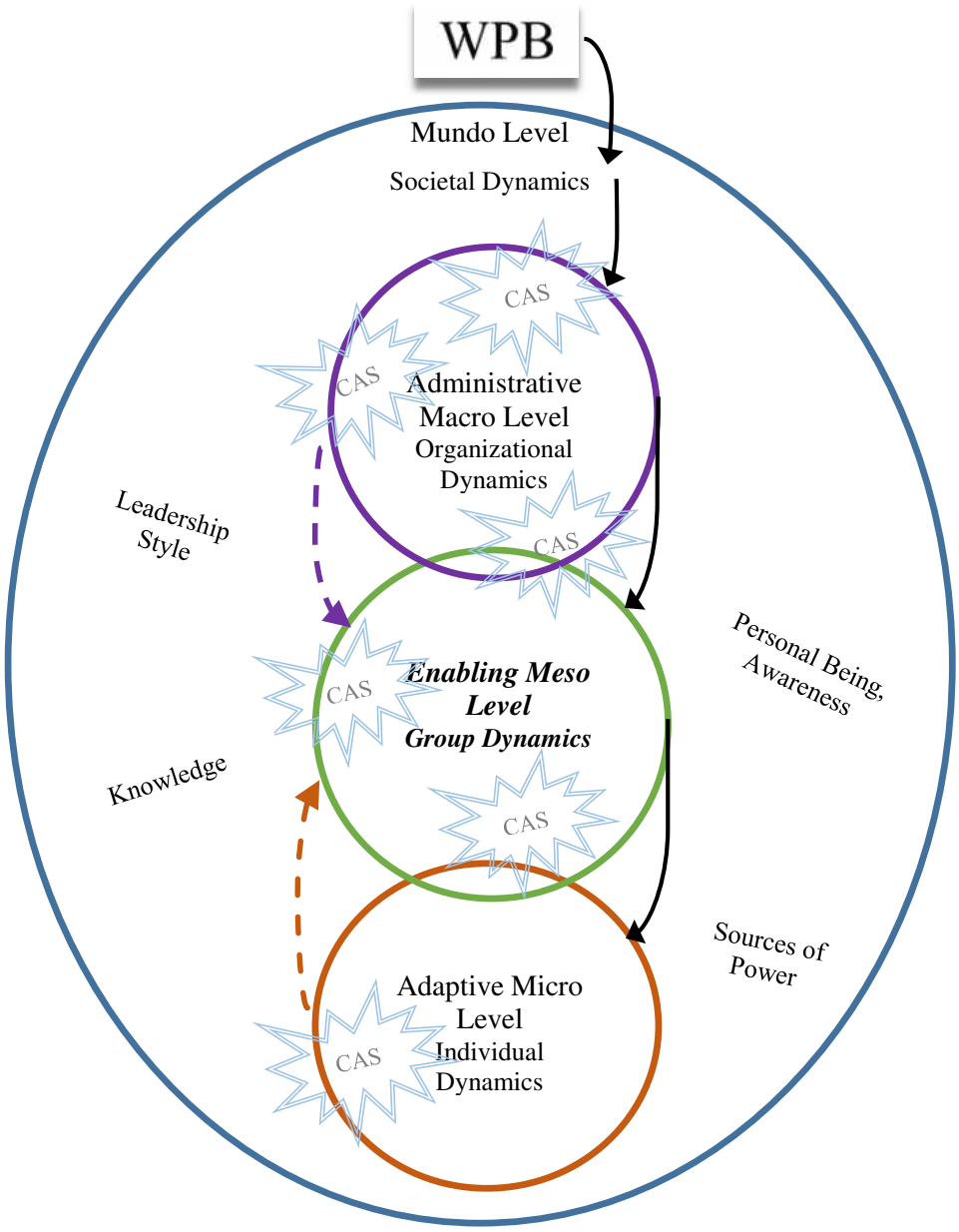
Application of Theoretical Framework

The framework of CLT incorporates the philosophical assumption of Ontology which emphases differing realities that are "out there" yet not clearly understood (Byrne & Callaghan, 2014; Polit & Beck, 2012). Complexity Science, the foundation for CLT is based on systems theories, interrelationships and interdependency of the dynamics of the CAS. Both theories, complexity leadership theory and social power theory are dependent on each other.

According to Raven (2008), all human interactions contain power tactics that can be used to influence or change views, attitudes, and actions. Individuals who are embedded into the CAS function as either formal or informal leaders at all levels (micro, meso, and macro) of the organization and society (mundo). Though the notion of the societal or mundo level is missing from the descriptions of CLT, the impact of societal norms on and throughout all levels cannot be overlooked and must also be considered. Leaders, due to their mutual dependency on each other have the capacity or potential to pull from their source of power. This results in interacting, influencing, and stimulating behaviors that could propagate WPB.

Representatives at the enabling function or meso level are identified between the micro and macro levels. By virtue of this positional level and the multi-level, multidimensional phenomenon of WPB (Heames & Harvey, 2006), antecedents and or consequences shared by

one level impacts or influences the functioning of other levels. However, the possibility exists that leaders, whether in formal or informal positions, could utilize non-relational building leadership behaviors/styles and power sources (Lindberg, Nash, & Lindberg, 2008) thus cultivating WPB. Furthermore, the embeddedness of leaders into the action within the CAS, the need for self-awareness, and the capacity to exist and function in a demanding work environment, suggest control over work responsibilities and characteristics of a relational building leadership style (see Figure 1, complexity leadership theory, social power, and workplace bullying diagram). However, though CLT focuses on the interdependence of three leadership functions, it fails to specifically describe the impact of job demand and control over work responsibilities at each of the leadership functions. Yet, it is postulated that the concepts of job demand and control could be intrinsic throughout all levels.



Note. Dotted arrows signify interactions between the levels; solid arrows signify WPB impacting each level; circles signify the interdependency of all levels. Adapted from: Crowell (2011), Einarsen et al. (2011), Raven et al. (1998), and Uhl-Bien and Marion (2009).

Figure 1. Complexity Leadership Theory, Social Power, and Workplace Bullying

Significance

For over 30 years, the phenomenon of WPB has been identified in the literature. Researchers suggest three different directional pathways for the occurrence of these negative acts. However, upwards bullying, one of the three pathways, has received little attention. Also, a specific definition has been applied to the negative behaviors, but due to confusion surrounding the operationalization of the concept of WPB, measurement issues exist, this has resulted in variances with the reported incidence and prevalence rates.

Different groups are identified as perpetrators and targets of WPB, but there is a lack of studies that have exclusively examined the population of nurse managers. Conversely, researchers have recognized leaders, but specifically nurse managers, as contributing to and or perpetrating the negative acts to clinical nurses. On the other hand, nurse managers are also perceived as key drivers for the creation of work environments that are conducive to the attainment of positive patient outcomes, retention of staff, increased job satisfaction, and productivity of teams. These opposing thoughts place the NM in a vulnerable position to be a recipient of workplace bullying.

Literature is replete with examples of consequences of workplace bullying that impacts four aspects: individuals, groups, organizations, and society. These consequences include harmful effects on the emotional, physical, social, financial, and most importantly, increased risk of harm to patients. Yet, a dominant contributing factor for WPB is the work environment. Included as part of the overarching work environment theme are: leadership behaviors, power disparity, demanding work, and control over aspects that impact the role. Inherent in this work environment theme are relationships between clinical nurses, executive nurse leaders, physicians, and the overall supportive culture of the organization. Therefore, if the practice environment of

the NM is unhealthy, then the interrelated and interactional aspects identified in the work environment have been associated with the promotion of WPB. If NMs are indeed recipients of WPB, then the ability of the NM to build positive relationships that either creates an optimal practice environment for their team or allows NMs to work in a safe practice environment that fosters the delivery of quality care to patients could be in jeopardy. Likewise, if NMs are indeed targets of WPB, then executive nurse leaders not only have an ethical responsibility to be informed about contributing factors, but an operational obligation to pursue processes that can redesign the role of the NM. Thus, potentially minimizing or eliminating WPB and in the long run, could improve the practice environment of NMs and perhaps the quality outcomes of patients.

Finally, with the impending shortage of nurses, the aging population of NMs, the lack of clinical nurses aspiring to leadership positions, along with the essential role of the NM that is responsible for creating positive work environments, it would be beneficial to determine if WPB is a concern that should be addressed by executive nurse leaders. Therefore, the purpose of this study was twofold. First, this study sought to utilize the understudied population of nurse managers to examine relationships between authentic leadership style, global social power, job demand, and job control and WPB generated toward them. Second, the study determined whether these work environment factors are predictors of WPB targeting NMs whose practice is in acute care settings throughout the U.S.

CHAPTER 3: METHODOLOGY

Workplace bullying has been identified as a problem in the work environment of various types of organizations. In healthcare organizations, nurse managers have been implicated as perpetrators of workplace bullying. Yet, NMs have not been studied from the perspective of being targets. Furthermore, scant information exists related to the identification of predictors for WPB of NMs. The purpose of this study was to examine relationships between the work environment factors of: authentic leadership, global social power, job demand, and job control and WPB of nurse managers. By examining these variables, strategies could be developed to impact the functioning, wellbeing, and retention of nurse managers. This chapter describes the methodology for the study including: research questions, study design, sample, procedures for collecting the data, measurement instruments, and the plan for analysis of data.

Specific Aims, Research Questions, and Hypotheses

- Aim 1: Describe the relationship between authentic leadership, global social power, job demand, job control and workplace bullying of nurse managers in acute care settings across the United States.
    - RQ 1.1. What is the relationship between authentic leadership, social power dynamics, job demand, job control and workplace bullying of nurse managers.
        - Ha 1.1. Authentic leadership is negatively associated with WPB.
        - Ha 1.2. Increased global social power is positively associated with WPB.
        - Ha 1.3. Job demand is positively associated with WPB.
        - Ha 1.4. Increased job control is negatively associated with WPB.

- Aim 2: Determine whether nurse managers are targets of WPB.
    - RQ 2.1. Does workplace bullying exist in a population of nurse managers?
        - H_a 2.1 Nurse managers will be positively identified as targets of WPB.
    - RQ 2.2. What is the severity level of workplace bullying directed toward nurse managers as evidenced by severity scores ranging from a baseline of ≥ 33?
- Aim 3: Describe the nature of workplace bullying (downward, horizontal, and upwards) directed toward nurse managers.
    - RQ 3. What is the directionality of workplace bullying (downward, horizontal, and upwards) experienced by nurse managers?
        - H_a 3. Nurse managers who self-identified as targets of WPB, will classify the directionality of WPB as: downward, horizontal or upwards.
- Aim 4: Describe the identity of perpetrators and determine if nurse managers are observers of workplace bullying that impact their nurse manager peers.
    - RQ 4.1. What is the identity of perpetrators of workplace bullying directed toward nurse managers?
        - H_a 4.1. Perpetrators of nurse manager WPB will be identified as either nurse leaders of NMs, clinical nurses, or peer of NMs.
    - RQ 4.2. Are nurse managers observers of workplace bullying directed toward other nurse manager peers by clinical nurses, executive nurse leaders, and nurse managers?
        - H_a.4.2. Nurse managers will identify executive nurse leaders, clinical nurses, and their nurse manager peers of workplace bullying directed toward other nurse manager peers.

- Aim 5: Identify global social power directed to nurse managers by nurse leaders and clinical nurses.
    - RQ 5.1. What is the relationship between global social power and workplace bullying directed toward nurse managers by nurse leaders?
        - H_a 5.1. Global social power will be positively related to WPB of nurse managers when directed by nurse leaders.
    - RQ 5.2. What is the relationship between global social power and workplace bullying directed toward nurse managers by clinical nurses?
        - H_a 5.2. Global social power will be positively related to WPB of nurse managers when directed by clinical nurses.
- Aim 6: Determine if work environment factors of authentic leadership, global social power, job demand, and job control can predict workplace bullying of nurse managers.
    - RQ 6. To what extent does the work environment factors of authentic leadership, global social power, job demand, and job control predict workplace bullying of nurse managers?
        - H_a 6.1. Work environment factors of authentic leadership, global social power, job demand, and job control will predict WPB of nurse managers.
            - H_a 6.1.1. Authentic leadership is a strong predictor of WPB.
            - H_a 6.1.2. Global social power is a predictor of WPB.
            - H_a 6.1.3. Job demand is a predictor of WPB.
            - H_a 6.1.4. Job control is a predictor of WPB.

Design

An exploratory, descriptive, cross-sectional design using an online survey was utilized to examine the research questions with a population of nurse managers located in the United States. The Qualtrics® web based platform was used to access the survey.

Variables

Demographic data consists of continuous and categorical variables, Table 3 describes the variables. The dependent variable, workplace bullying is categorical, while the independent variables: Authentic leadership, global social power, job demand, and job control are continuous.

Table 3. Variables Table

Variables	Type of Data	Statistical analyses
Dependent		
Workplace bullying	Categorical-ordinal	Descriptive statistics Pearson's Correlation Spearman's Rank Correlation Logistic regression
Independent		
Authentic Leadership style	Continuous-ordinal	Descriptive statistics Pearson's Correlation Spearman's Rank Correlation Logistic regression
Global Social Power	Continuous-ordinal	Descriptive statistics Pearson's Correlation Spearman's Rank Correlation Logistic regression
Job Demand	Continuous-ordinal	Descriptive statistics Pearson's Correlation Spearman's Rank Correlation Logistic regression
Job Control	Continuous-ordinal	Descriptive statistics Pearson's Correlation

Variables	Type of Data	Statistical analyses
		Spearman's Rank Correlation Logistic regression
Demographic Data		
Age	Continuous- ratio	Descriptive statistics
Gender: Male; female	Categorical-nominal	Descriptive statistics
Ethnicity: Hispanic, Latino or Spanish; not of Hispanic, Latino or Spanish; Mexican, Mexican American, Chicano; Puerto Rican; Cuban; Another Hispanic, Latino or Spanish	Categorical-nominal	Descriptive statistics
Race: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian/Other Pacific Islander; White; Other	Categorical-nominal	Descriptive statistics
Geographical location of participant	Categorical-nominal	Descriptive statistics
Years of experience as a manager	Continuous- ratio	Descriptive statistics
Years of experience as a registered nurse	Continuous- ratio	Descriptive statistics
Employment status: Fulltime >40 hrs; part-time <40 hrs; interim; fulltime interim; part time interim	Categorical-nominal	Descriptive statistics
Length of time with the organization	Continuous- ratio	Descriptive statistics
Highest level of education level: Diploma, associate degree in nursing, bachelor of science in nursing, bachelor's degree outside of nursing, master's degree in nursing, master's degree outside of nursing, doctorate in nursing, doctorate outside of nursing	Categorical-nominal	Descriptive statistics
National specialty certification	Categorical-nominal	Descriptive statistics
Type of unit managed: Critical care, medical-surgical, medical, surgical, emergency room, intermediate care, pediatrics, obstetrics, oncology, operating	Categorical-nominal	Descriptive statistics

Variables	Type of Data	Statistical analyses
room, post anesthesia care unit, other		
Number of full time equivalents (FTEs)	Continuous-interval	Descriptive statistics
Type of organization: Magnet®, non-Magnet, Pathways to Excellence®	Categorical-nominal	Descriptive statistics
Hospital bed size	Continuous-interval	Descriptive statistics
Geographic location of the organization	Categorical-nominal	Descriptive statistics
Hospital area	Categorical-nominal	Descriptive statistics

Sample

A nurse manager is defined as a registered nurse who is the 1st line leader, a middle manager of an acute care inpatient unit. The NM has direct authority and 24-hour responsibility for one or more inpatient units to include fiscal, operational, and accountability for performance outcomes for clinical nurses and other healthcare workers who directly report to them. Though the middle management position uses the title of 'nurse manager', other job titles such as clinical manager, unit manager, supervisor, and resource manager that fit the role definition are also applicable.

Nurse managers who are members of the American Organization of Nurse Executives (AONE) were recruited from the AONE membership lists of approximately 9000 plus members (see Appendix A, membership agreement). Then, participants who met the inclusion criteria were enrolled into the study. Inclusion criteria were: *(*1) current employment in the role of NM on an acute care inpatient unit for a minimum of 6 months; (2) past employment, not to have exceeded six months in the role of a nurse manager of an inpatient unit in an acute care hospital;

(3) 24-hour accountability for one or more inpatient acute care units; (4) budgetary responsibilities for the unit; (5) full time or variable full time hours; (6) adult (above 18 years of age). Exclusion criteria are: (1) registered nurses who are not in a nurse manager role; (2) nurse managers of outpatient and non-patient care units or departments in an acute care hospital; (3) lack of 24-hour accountability for an inpatient unit; (4) nurse managers in non-hospital based units or departments; (5) participants younger than 18 years of age, i.e., infants, children, and teenagers.

An effect size of .05; response probability of 0.10; $p = .05$; power of .80 was calculated for 295 participants ($n = 295$) (Hintze, 2013). Typically, online surveys garner response rates that are less than 30% (Nulty, 2008). Consequently, to acquire a response rate equal to or greater than 30%, an a priori goal of 1180 participants or approximately four times the number of suggested participants was set.

Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained from the University of Central Florida (see Appendix B, UCF IRB approval letter). Upon accessing the Qualtrics® platform, participants were asked to read the informed consent form describing the study, involvement of participants, risks of the study, confidentiality procedures, and contact information for the UCF IRB and the principal investigator (PI). Consent for all participants was required and completed online. The consent form contained an overview of the study, informed potential participants that their participation in the study was completely voluntary, and notified participants that there was no obligation on their part to consent (see Appendix C, study consent form). Completion or partial completion of the questionnaire was accepted as informed consent, therefore, no written

documentation of consent was obtained. Estimated completion time for the online survey was approximately 20-30 minutes and no long-term follow-up for data was requested. No health, personal, and school records were obtained and no audio or video recording of study participants was utilized. Due to the sensitive nature of the topic, study participants were advised at the start of the study and then again mid-way through the questionnaire, that personal discomfort could be experienced. Individuals who did not read, speak, and understand the English language were not able to enroll in the study. Therefore, additional language accommodations were not made. Monetary compensation was not offered or given to study participants.

Measurements

Data were collected using an online questionnaire consisting of six scales: Negative Acts Questionnaire Revised (NAQ-R); Upwards Bullying Scale (UBS); Authentic Leadership Inventory (ALI); Global Social Power (GSP); and Health and Safety Executive Management Standards Work-related Stress Indicator Tool (HSEMS IT). Permission to use all scales was obtained. However, the HSEMS IT is an open access instrument, therefore permission for use from the authors was not warranted (Cousins et al., 2004), (see Appendix D, permission letters).

Workplace bullying. The Negative Acts Questionnaire Revised (NAQ-R) comprises 22-items. Data are scored as, never, now and then, monthly, weekly, daily and is measured using a 5-point Likert scale (1=never, 2= now and then, 3=monthly, 4=weekly, and 5=daily). This instrument focused on three dimensions of the phenomenon, person related, physical intimidating, work related bullying, includes a WPB definition and incorporates both the self-labeling and behavioral methods. The utilization of both methods is the recommended process for examining WPB (Einarsen, Hoel, & Notelaers, 2009). Researchers have utilized the NAQ-R

in Europe, Asia, New Zealand, United Kingdom, and in the United States with groups of managers in the business sector, registered nurses, surgical technicians, police officers, graduate students, and crew members in the maritime industry. Even with the tool being translated into multiple languages, its use in various populations, high Cronbach's alpha scores were consistently reported and ranged from the mid 80's to mid-90s (Einarsen et al., 2009).

Upwards bullying. The Upwards Bullying Scale consists of 12 questions with data scored as, never, now and then, monthly, weekly, and daily. Measured on a 5-point Likert scale (1=never, 2= now and then, 3=monthly, 4=weekly, and 5=daily), the UBS focuses on person related and work related aspects of upward bullying. The UBS has not been tested extensively and only used by one researcher in a dissertation study of managers in the business sector. Even though this scale lacks extensive use, Cronbach's alpha scores were satisfactory at .81 (Branch, Ramsay, & Barker, 2006).

Authentic Leadership Style. The 14-item Authentic Leadership Inventory (ALI) consists of data obtained from a 5-point Likert Scale (1=disagree strongly, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=agree strongly). This instrument measures the dimensions of self-awareness, relational transparency, internalized moral perspective, and balanced processing of authentic leadership, a relational based leadership style. Used in a population of management executives and graduate students, this instrument demonstrated strong support for discriminate and convergent validity and Cronbach's alpha scores were in the mid-70s to mid-80s (Neider & Schriesheim, 2011).

Global Social Power. The 4-item Global Social Power scale examines the potential or ability to influence. Data are measured using a 5-point Likert scale (1=disagree strongly, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=agree strongly). Utilized in a population of

management graduate students, Cronbach's alpha scores ranged into the mid to high 70's, and convergent and discriminate validity were substantiated (Nesler, Aguinis, Quigley, Lee, & Tedeschi, 1999).

Job Demand and Job Control. Two scales that measure Job Demand and Job Control consists of 14-items from the 35-item Health and Safety Executive Management Standards Work-related Stress Indicator Tool (HSEMS IT). This instrument has been used extensively in Great Britain by organizations and researchers in populations of police officers, civil servants, teachers, supervisors, doctors, and nurses. Job Demand and Job Control measures aspects of a demanding role and autonomy with work responsibilities. Data are measured on a 5-point Likert Scale (1=never, 2=seldom, 3=sometimes, 4=often, and 5=always). However, 2-items from the Control sub-scale are scored using the ranking of (1=strongly disagree, 2=disagree, 3=unsure, 4=agree, and 5=strongly agree). Cronbach's alpha scores ranged from high-70's to high-80's (Cousins et al., 2004; Edwards, Webster, Van Laar, & Easton, 2008) and support for discriminate validity was identified (Edwards et al., 2008), (see Appendix E, study questionnaire).

Procedures

The survey instrument was placed in Qualtrics®, a password protected, online survey platform which is housed through the Information and Technology Department at the University of Central Florida. The instrument was pilot tested by a team consisting of three nursing professionals in the roles of an executive nurse leader, a nursing academic, and an advanced practice nurse; together this team had more than 75 years of nursing experience. The pilot testing team assessed survey length, time for completion, and clarity of scale items. At the conclusion of the pilot testing, appropriate grammatical changes were made to the instrument. Enrollment into

the study began after Institutional Review Board (IRB) approval and continued for eight weeks (see Table 4, study timeline).

Table 4. Study Timeline

2015	Apr	May	Jun	Jul
UCF IRB Approval	X			
Participants enrolled into study		X	X	
Perform study activities	X	X	X	X

Note. Study enrollment began on May 11, 2015 and ended July 3, 2015

The 9000 plus membership list from AONE was reviewed, filtered for position titles, and complete postal addresses. AONE members who were employed outside of the acute care setting were removed from the list. Initial contact was sent to nurse managers using a recruitment letter. Included in the recruitment letter was information about the length of the study and the distinctive, unique URL link for access to the Qualtrics® web based platform (see Appendix F, recruitment letters). Likewise, a snowball sampling technique was used to obtain additional potential participants from executive nurse leaders who were members of AONE and all members of Florida Organization of Nurse Executives (FONE). AONE nurse leaders were contacted using an invitation letter while the 2013-2015 FONE chapter president was contacted by email. A formal request was made to the FONE chapter president to distribute the nurse manager invitation letter to the FONE chapter membership and to place a link to the invitation letter on the FONE website (see Appendix G, FONE email request for distribution). At the beginning of and continuing until the end of the recruitment phase of the study, advertisements

for the purpose of increasing awareness of the study and soliciting participants were placed in the AONE weekly electronic newsletter (see Appendices H and I, newsletter advertisement agreements and AONE membership access agreement). Data collection was monitored throughout the 8-week enrollment period. Post cards were mailed to nurse managers on days: 15, and 30. The electronic link to the survey was included in the follow-up postcard messages (Dillman, Smyth, & Christian, 2014). At the end of the enrollment period, data were downloaded from the Qualtrics platform into a password protected computer for analysis.

Data Analysis

All variables were downloaded into IBM® SPSS® Statistics for Windows, Version 23 (IBM® Corporation, 2014), assigned numeric codes, and recoded as necessary. Analysis consisted of screening for errors, data cleaning, and the use of descriptive statistics to identify means, missing items, outliers, normality, frequencies, and standard deviations. Missing data were assessed and the exclude cases pairwise function in SPSS was applied for data greater than 10% for any variable. Outliers were identified by standard residual values equal to or above 3.3 or less than -3.3. Cronbach alpha coefficient was calculated for all workplace bullying, authentic leadership, global social power, job demand, and job control instruments, a detailed description of the data analysis plan is listed in Table 5, research questions and data analysis plan.

Table 5. Research Questions and Data Analysis Plan

Type of Analysis	Variables	Statistical Test
Demographic data	Age; sex; ethnicity; race; state of residence; length of experience; employment status; length of employment; education; certification; type of unit/department; number of FTE's; type of hospital; hospital bed size; location of hospital	Means, median, frequencies, standard deviations
Descriptive & inferential RQ 1. What is the relationship between authentic leadership, global social power, job demand, job control and workplace bullying of nurse managers in acute care settings across the United States?	DV-Workplace bullying IV-Authentic leadership, global social power, job demand, job control	Means, median, frequencies, Standard deviations Spearman's Rho Correlation
Descriptive & inferential RQ 2.1. Does workplace bullying exist in a population of nurse managers?	DV-Workplace bullying	Summed raw scores ≥ 33 to < 45, ≥ 45 Independent *t*-Test
RQ 2.2. What is the severity of workplace bullying directed toward nurse managers as evidenced by severity scores ranging from ≥ 33 to ≥ 45?	DV-Workplace bullying	Summed raw scores ≥ 33 to < 45, ≥ 45 Independent *t*-Test
Descriptive & inferential RQ 3. What is the directionality of workplace bullying (downward, horizontal, and upwards) directed toward nurse managers?	DV-Workplace bullying	Means, frequencies
Descriptive & inferential RQ 4.1. What is the identity of perpetrators of workplace bullying directed toward nurse managers?	DV-Workplace bullying	Means, frequencies Kruskal-Wallis H

Type of Analysis	Variables	Statistical Test
Descriptive & inferential RQ 4.2. Are nurse managers observers of workplace bullying directed toward other nurse manager peers by clinical nurses, nurse leaders, and nurse managers?	DV-Workplace bullying	Means, frequencies Chi-square
Descriptive & inferential RQ 5.1. What is the relationship between global social power and workplace bullying directed toward nurse managers by nurse leaders?	DV-Workplace bullying IV-Global Social Power	Means, frequencies Pearson' correlation Spearman's Rho Correlation
Descriptive & inferential RQ 5.2. What is the relationship between global social power and workplace bullying directed toward nurse managers by clinical nurses?	DV-Workplace bullying IV-Global Social Power	Means, frequencies Pearson's correlation Spearman's Rho Correlation
Descriptive & multivariate RQ 6. To what extent does the work environment factors of authentic leadership, global social power, job demand, and job control predict workplace bullying of nurse managers	DV-Workplace bullying IV-Authentic leadership, global social power, job demand, control	Means, frequencies Multiple regression Logistic regression

Note: DV – dependent variable; IV – independent variable

Raw scores from all of the scales for the dependent and independent variables were summed. Correlations were run to identify relationships between the dependent and independent variables. Cohen's definition for effect size or the strength of the relationship of the variables (small – r =.10 to .29; medium – r=.30 to .49; large – r =.50 to 1.0) was followed (Cohen, 1988). Means and an independent t-test statistic were used to determine differences between nurse managers who identified as targets and those who did not. A workplace bullying severity score

(≥ 33 but < 45 and ≥ 45) was obtained from the summed raw scores from the NAQ-R (Notelaers & Einarsen, 2013). Using the cutoff score of ≤ 33; ≥ 33 but < 45, ≥ 45 three groups were identified, they are: not bullied (≤ 33), occasionally bullied (≥ 33 to < 45), and severely bullied (≥ 45). A Kruskal-Wallis H test was used to determine the differences between the three groups.

Frequencies were used to evaluate the numbers for the nurse manager observer categories: clinical nurses, nurse manager peers, and nurse leaders. A Chi-square test for independence was utilized to evaluate differences between the three groups.

Logistic regression was used to identify predictors of WPB. Since the dependent or outcome variable is categorical (not bullied or 0 = ≤ 33, bullied or 1 = ≥ 33), logistic regression assumes linearity of the log outcome of the variable and predicts the probability of Y based on X (Field, 2013). Descriptive statistics were used to screen for missing data, outliers, and sample size. Predictor variables were examined for goodness of fit using chi-square statistics. The overall model fit was evaluated using the Hosmer and Lemeshow Goodness of Fit test which compares the observed to the predicted probabilities (Plichta Kellar & Kelvin, 2013). Cox and Snell R^2 and Nagelkerke R^2 were assessed for variance between the dependent and independent variables. Regression coefficients were evaluated using the baseline log likelihood ratio, Wald statistic, odds ratios, Baysian information criterion (BIC), and significance values. A multiple regression analysis was performed to identify multicollinearity of the variables.

A statistical assumption of logistic regression is an adequate sample size so that variable categories are not limited in number. A 95% to 5% split in the distribution of the dependent variables (Plichta Kellar & Kelvin, 2013) and a range of 15 to 20 cases for each independent variable was applied (Vittinghoff & McCulloch, 2007). Residuals were examined for the identification of outliers or variables that are not explained by the model (Pallant, 2013).

Multicollinearity between the independent variables was assessed through the use of collinearity diagnostics obtained from a multiple regression analysis. Tolerance levels greater than .60 and a variance inflation factor (VIF) value < 10 were considered absence of multicollinearity (Pallant, 2013).

Methodological Limitations

One of the limitations of the study is the non-experimental, descriptive design. This is problematic due to the weak ability of this design to inform about causal relationships (Polit & Beck, 2012). Likewise, this design was selected due to the potential for breaching ethical principles that are inherent with the phenomenon of WPB. However, the descriptive design is beneficial in explaining relationships between variables that have not previously been elicited.

Relevant Threats to Internal Validity

Design

The present study design, descriptive correlational, is prone to threats of validity. Temporal ambiguity suggests that causation cannot be inferred because of the improbable ability to determine the sequence, which event came before the other and extraneous or confounding variables that could compete with the dependent variable (Polit & Beck, 2012; Shadish, Cook, & Campbell, 2002). However, descriptive correlation studies serve to describe, observe, and subsequently develop evidence for other higher level, more rigorous studies (Polit & Beck, 2012). Given the understudied population of nurse managers, and the unknown aspect of WPB that could be perpetrated on them, the design fits.

Selection

This study utilized a convenience sample without randomization. This technique also poses a threat to internal validity because of the increased risk for obtaining a non-homogenous sample that is not representative of the entire population of nurse managers. Variances found, may not be a result of the dependent variable but due to the differences in the groups (Polit & Beck, 2012). Strategies to decrease this threat include: (1) using multivariate statistical comparisons of respondents within the sample, i.e. nurse managers who report bullying, those who are occasionally bullied, and those who do not; (2) refining the screening criteria so that a homogenous sample is obtained; (3) ensuring that the research question is focused on the intended variables, as this could limit the possibility of other confounding variables (Polit & Beck, 2012).

Nonresponse Error

An a priori goal of 1180 participants was set. However, it is not known what the percent of nonresponses were for the study. According to Sivo, Saunders, Qing, and Jiang (2006) nonresponse error occurs when respondents either inadvertently fail to answer, choose not answer an item, or their attributes are different than those who made the decision not to reply to the survey. For example, if there were more study participants who reported being recipients of WPB than those who are not, then nonresponse bias could be introduced into the study findings (Dillman et al., 2014).

Measurement Challenges

Participants were asked to complete an online survey that consisted of self-reported data. Due to the sensitive and ethical concerns that surround WPB, the use of self-reports is the most

appropriate and a feasible method to obtain data. However, the possibility exists that respondents may not be totally truthful with their answers or there may be issues with recalling specific events. Since this study is entirely voluntarily, participants can elect to exit the survey at any time. Therefore, to compensate for the possibility of attrition and social desirability response bias (Polit & Beck, 2012), a sample, four times the recommended sample size (n = 1190) was recruited. Length of the survey, format, and comprehensibility of items also pose additional measurement challenges. To address this, the instrument was pilot tested for comprehension, flow, and overall length with a small group of nursing professionals before enrolling participants. Grammatical errors were corrected and no content changes were made to the instruments. However, the category of race and ethnicity located in the demographic section was subdivided to reflect the definitions of the U.S. Census Bureau for racial and ethnic minorities (Humes, Jones, & Ramirez, 2011). Then, one of the WPB scales, the UBS was only identified in one published study. Though this scale demonstrated moderate internal consistency (α=.81)(Branch et al., 2006), it does not have extensive historical use. Internal consistency was determined during the analysis process.

External Validity

Due to the population and setting, external validity was an issue for this study. Even though other research projects have correlated WPB in a multitude of settings, with a variety of individuals in different populations, the difference is the population. No published studies were identified that examined the phenomenon of WPB specifically in a sample of nurse managers. Results obtained may not be representative of all nurse managers across all regions of the U.S. and may not be able to be replicated with a sample of nurse managers in other settings.

Conclusion

Registered nurses, located in acute care hospitals across the U.S., who are in the position of a nurse manager were studied using an online survey with a non-experimental, descriptive design. Data were collected over an 8-week period using a password protected web based questionnaire consisting of six instruments. The questionnaire was accessed by study participants via a direct URL link sent to them via a mailed invitation letter. Using descriptive, inferential, and multivariate statistics, data were evaluated to determine relationships between work environment factors that contribute to WPB of nurse managers.

CHAPTER 4: RESULTS

Overview

This chapter presents the analyses for the workplace bullying of nurse managers and work environment factors study. Descriptive findings for the demographic variables are presented first, followed by the results related to each of the six research questions and their associated statistical tests. To close, the chapter will end with a summary of the findings.

Analysis

Prior to the analysis, data were downloaded from the Qualtrics® online survey platform into IBM® SPSS® Statistics for Windows, Version 23 (IBM® Corporation, 2014). All variables were assigned numeric codes, examined for errors, missing values, and outliers. Data were recoded, assessed for normality, and assumptions needed for correlations, *t*-Tests, Chi-square test, Kruskal-Wallis test and Logistic Regression method. Two questions from the Job Control scale were worded in a negative manner; this resulted in the re-coding of the variables to follow the positive item responses of the other scales. Finally, an alpha level of .05 was used.

Einarsen et al. (2009), reported that the NAQ-R has good internal consistency with a Cronbach alpha coefficient of .90. In this study, the Cronbach alpha coefficient for NAQ-R was .92. For the UBS, Branch et al. (2006), reported a Cronbach alpha coefficient of .81, for this study, the Cronbach alpha coefficient for UBS was .89. Neider and Schriesheim (2011), reported that the Authentic Leadership Scale (ALS) had good internal consistency, with a Cronbach alpha coefficient of .85. In this study, the ALS had a Cronbach alpha of .95. Nesler et al. (1999), identified the Cronbach alpha coefficient for the Global Social Power Scale as .75. In this study, the Cronbach alpha coefficient for Global Social Power Scale was .78. Cousins et al. (2004),

reported that the Job Demand and Job Control scales demonstrated good internal consistency .89 and .78 respectively. In this study, the Job Demand and Job Control scales obtained Cronbach alpha coefficient ratings of .88 and .84 respectively.

Description of Sample

Of the 9430 names identified in the AONE membership database, 1193 potential participants had identifiable position titles of nurse manager, manager, director, supervisor, and a designated postal address. During the month of May 2015, a total of 1193 recruitment letters were mailed to the AONE nurse manager group (see Appendix E, Recruitment letter for nurse managers). Furthermore, 6496 invitation letters were mailed to AONE nurse leaders that were identified by the titles of vice president, chief nursing officer, chief executive officer, chief operating officer, and nursing administrator. The letters to nurse leaders requested assistance with distributing the survey information to their nurse managers (see Appendix E, Invitation letter for nurse leaders). Of the 1193 invitation letters mailed to the nurse manager group, 37 came back as undeliverable and of the 6496 invitation letters mailed to the nurse leader group, 15 were returned as undeliverable. Due to the use of snowball sampling via open access to participate in the study, additional non-AONE, FONE, and non-FONE members could have been included in the sample. Specific numbers of participants generated from the use of the snowball sampling were not able to be quantified.

Though there were 304 individuals who responded to the survey, only 241 finished the survey. Of those, 214 questionnaires were completed satisfactorily and were included in the analysis. Thirty-nine percent of nurse managers (n = 90) ranked their age between 45 to 54 years and 29% (n = 67) identified their age range between 55 and 64 years. Eighty-nine percent were

female, 97% were employed full time, and 25% of respondents listed a Bachelor of Science in Nursing as their highest degree. Forty-five percent identified the Master of Science in Nursing as their highest degree and 73% of nurse managers reported the attainment of a national specialty certification. The majority of the respondents (n = 39) practiced in the State of Florida, 7% in Texas, and 5% practiced in California and Carolina. Eighty-nine percent were white, 6% were of the African American race, and 1.2% of the sample were of either Hispanic, Latino, Spanish, Mexican, Chicano, or another Hispanic, Latino, Spanish ethnicity. Thirty-two percent of the sample had < 5 years of experience as a nurse manager, but > 25 years as a registered nurse. Respondents had responsibility for approximately 25 to 50 direct reports with medical-surgical units (27%) identified as the most frequent type of unit or department where they practiced. The majority of participants were from hospitals located in urban areas, were from non-Magnet® hospitals, and practiced in hospitals with bed sizes of 200-399, see Table 6, Demographic Characteristics of all Study Participants for additional details.

Table 6. Demographic Characteristics of all Study Participants

Characteristics	*n*	%
Age		
25 – 34	21	9
35 – 44	46	20
45 – 54	90	39
55 – 64	67	29
65 or over	7	3
Sex		
Male	24	10
Female	208	90
Ethnicity		
Hispanic, Latino, Spanish	1	0.4
Not Hispanic, Latino, Spanish	219	94
Mexican	1	0.4
Another Hispanic, Latino, Spanish	1	0.4

Characteristics	*n*	%
Race		
Asian	3	1.3
Black or African American	14	6
Native Hawaiian/Other Pacific Islander	1	0.4
White	207	89
Other	3	1.3
Location where nurse manager practices		
Northeast	50	23
Southeast	79	37
Midwest	34	16
Southwest	28	12
West	29	14
Length of experience as a registered nurse		
0 to 5 years	4	2
5+ to 10 years	22	10
10+ to 15 years	31	14
15+ to 20 years	36	16
20+ to 25 years	30	13
25+ to 30 years	46	20
30+ to 35 years	30	13
35+ to 40 years	19	8
40+ to 45 years	7	3
45+ to 50 years	2	0.9
Length of experience as a nurse manager		
0 to 5 years	73	32
5+ to10 years	64	26
10+ to 15 years	35	15
15+ to 20 years	25	11
20+ to 25 years	20	9
25+ to 30 years	6	3
30+ to 35 years	4	2
35+ to 40 years	1	0.4
Employment status		
Fulltime	224	97
Interim	6	3
Length of employment with organization		
0 to 5 years	79	34
5+ to10 years	43	19
10+ to 15 years	33	14
15+ to 20 years	22	10
20+ to 25 years	16	7
25+ to 30 years	22	10
30+ to 35 years	9	4
35+ to 40 years	6	3
Highest education		
Associate of Science in Nursing	5	2.2
Bachelor of Science in Nursing	58	25
Bachelor's degree outside of Nursing	4	2

Characteristics	*n*	%
Master of Science in Nursing	103	45
Master's degree outside of Nursing	44	19
Doctoral degree in Nursing	9	4
Doctoral degree outside of Nursing	7	3
National specialty certification		
Yes	167	73
No	63	27
Type unit or department		
Critical care	54	24.3
Emergency	19	8.6
Medical	12	5.4
Medical-surgical	62	27.9
Obstetrics	21	9.5
Oncology	7	3.2
Operating Room	11	5.0
Pediatrics	13	5.9
Post Anesthesia Care Unit	5	2.3
Surgical	17	7.7
Other	1	0.5
Number of Full time equivalents		
1 – 25	30	13
25 – 50	69	30
50 – 75	65	28
75 – 100	35	15
100 – 125	12	5
125+	18	8
Type of hospital		
Magnet®	88	40
Non-Magnet®	133	60
Pathways to Excellence®	26	14
Hospital bed size		
1 – 199	62	27
200 – 399	69	30
400 – 599	46	20
600 – 799	26	11
800+	27	12
Location of Hospital		
Northeast	49	23
Southeast	75	35
Midwest	35	16
Southwest	26	12
West	29	14
Hospital area		
Rural	46	20
Suburban	82	36
Urban	101	44

Note: $n = 214$; due to rounding, percentage totals do not sum to 100.

From the overall sample (n = 214), 38% of nurse managers (n = 80) who self-identified as targets of WPB were between the ages of 45 to 54, 95% were of the female gender, 97% were employed fulltime, approximately 94% were white, and 45% listed their highest level of education as a Master's of Science in Nursing. Seventy-one percent had a national specialty certification, 33% worked in a medical surgical area, almost 21.3% of nurse manager targets had <1 to 5 years of experience in their role and 34% had > 5 years of experience as a nurse manager. Also, 33% had approximately 25 to 50 individuals reporting to them and 28% of the sample reported having oversight for 50 to 75 full time equivalents, additional details are listed in Table 7, Demographic Characteristics of Nurse Manager Targets.

Table 7. Demographic Characteristics of Nurse Manager Targets

Characteristics	*n*	%
Age		
25 – 34	8	10
35 – 44	15	19
45 – 54	30	38
55 – 64	22	27.8
65 or over	4	5.1
Sex		
Male	4	5.0
Female	76	95
Ethnicity		
Hispanic, Latino, Spanish	0	0
Not Hispanic, Latino, Spanish	77	96.3
Mexican	1	1.3
Another Hispanic, Latino, Spanish	1	1.3
Missing response	1	1.3
Race		
Asian	1	1.3
Black or African American	3	3.8
Native Hawaiian/Other Pacific Islander	0	0
White	75	93.8
Other	1	1.3
Location where nurse manager practices		
Northeast	17	22
Southeast	23	29

Characteristics	*n*	%
Midwest	14	18
Southwest	11	14
West	14	18
Length of experience as a registered nurse		
0 to 5 years	1	1.3
5+ to 10 years	8	10
10+ to 15 years	10	12.5
15+ to 20 years	12	15
20+ to 25 years	9	11.3
25+ to 30 years	15	18.8
30+ to 35 years	13	16.3
35+ to 40 years	7	8.8
40+ to 45 years	4	5.0
45+ to 50 years	1	1.3
Length of experience as a nurse manager		
0 to 5 years	18	22.5
5+ to10 years	27	33.8
10+ to 15 years	14	17.5
15+ to 20 years	11	13.8
20+ to 25 years	4	5.0
25+ to 30 years	3	3.8
30+ to 35 years	2	2.5
35+ to 40 years	1	1.3
Employment status		
Fulltime	78	97.5
Interim	2	2.5
Highest education		
Associate of Science in Nursing	2	2.5
Bachelor of Science in Nursing	17	21.3
Bachelor's degree outside of Nursing	0	0
Master of Science in Nursing	36	45
Master's degree outside of Nursing	17	21.3
Doctoral degree in Nursing	5	6.3
Doctoral degree outside of Nursing	3	3.8
National specialty certification		
Yes	57	71.3
No	23	28.7
Type unit or department		
Critical care	21	26.6
Emergency	4	5.1
Medical	5	6.3
Medical-surgical	26	32.9
Obstetrics	8	10.1
Oncology	1	1.3
Operating Room	5	6.3
Pediatrics	3	3.8
Post Anesthesia Care Unit	3	3.8
Surgical	2	2.5

Characteristics	*n*	%
Other	1	1.3
Number of Full time equivalents		
1 – 25	8	10.1
25 – 50	26	40.8
50 – 75	22	26.7
75 – 100	12	15.3
100 – 125	3	3.8
125+	8	9
Type of hospital		
Magnet®	29	37.7
Non-Magnet®	32	45.7
Pathways to Excellence®	10	14.9
Missing response	3	1.7
Hospital bed size		
1 – 199	26	32.5
200 – 399	19	23.8
400 – 599	19	23.8
600 – 799	6	7.5
800+	10	12.5
Hospital area		
Rural	18	22.8
Suburban	30	38.0
Urban	31	39.2
Missing response	1	1.3

Note: $n = 80$; due to rounding, percentage totals do not sum to 100.

Research Questions

Research Question One

The first aim of this research is to describe the relationship between authentic leadership, social power dynamics, job demand, job control factors and workplace bullying of nurse managers in acute care settings across the United States. The following research hypotheses were tested to answer the first research question, what is the relationship between authentic leadership, global social power, job demand, job control and workplace bullying of nurse managers.

- H_a 1.1. Authentic leadership is negatively associated with WPB.
- H_a 1.2. Increased global social power is positively associated with WPB.

- H_a 1.3. Job demand is positively associated with increased WPB.
- H_a 1.4. Increased job control is negatively associated with WPB.

Preliminary analyses using scatterplots and descriptive statistics to check violations of assumptions for using Pearson's correlation, normality, and homoscedasticity were completed. Due to the nature of the data, the Spearman's correlation was utilized on data for 214 participants to determine the relationship between the four independent variables and the dependent variable, workplace bullying.

Results revealed a statistically significant, negative relationship between Authentic Leadership (r_s (214) = -.44, p < .0001) and WPB, with a medium or moderate effect size. The variable job demand demonstrated a statistically significant, positive correlation (r_s (214) = .54, p < .0001) with WPB along with a large effect size. A statistically significant, negative correlation was found between job control (r_s (214) = -.41, p < .0001) and WPB along with a medium effect size. Therefore, hypothesis 1.1, 1.3, and 1.4 were supported. However, the correlation between global social power and WPB was not significant (p = .19). On the other hand, global social power did demonstrate a statistically significant, positive correlation with authentic leadership (r_s (214) = .33, p < .0001) with a medium effect size. Likewise, authentic leadership demonstrated a statistically significant, negative correlation with job demand (r_s (214) = -.25, p < .0001) along with a small effect size. Furthermore, authentic leadership revealed a statistically significant, positive relationship with job control (r_s (214) = .43, p < .0001) with a medium effect size. Global social power did not demonstrate significant relationships with job demand and job control. The coefficient of determination for the three variables: Authentic leadership, job demand, and job control demonstrated 19%, 29%, 16% shared variance, respectively. In general, results suggest that when authentic leadership style is high, nurse managers reported less WPB

and when the nurse manager role is demanding higher instances of WPB were reported. Furthermore, when nurse managers reported more control over job responsibilities, less WPB was reported. Additional details on Spearman's correlation, means, standard deviation between the independent and dependent variables are presented in Table 8.

Table 8. Spearman's Rho Correlation, Means, Standard Deviations, and Intercorrelations between measures of workplace bullying, authentic leadership, global social power, job demand, and job control

Measure	*M*	*SD*	1	2	3	4	5
Workplace Bullying	34.12	11.54	-				
Authentic Leadership	3.6	.87	-.44**	-			
Global Social Power	4.18	.50	-.09	.33**	-		
Job Demand	3.44	.64	.54**	-.25**	.07	-	
Job Control	3.70	.71	-.41**	.43**	.11	-.42**	-

Note: ** Correlations are different from zero with $p < .01$

Research Question Two

The aim of research question two was to determine whether nurse managers are targets of WPB and to identify the severity level of WPB. The following research hypotheses were tested to answer the second research question of the existence of workplace bullying in a population of nurse managers and to identify the severity level of WPB.

- H_a 2.1. Nurse Managers will be identified as targets of WPB.

- $H_{a.}$ 2.2 The severity level of the WPB will be ≥ 33 as determined by the summed raw score.

To test the research hypothesis that nurse managers will be identified as targets of WPB, the percentage of those who answered yes to the question, 'have you been subjected to WPB during the last six months and the sum raw score of ≥ 33 was assessed (Notelaers & Einarsen, 2013). From the overall sample (n = 214), 35% percent (n = 80) of nurse managers in the sample, self-identified as a target of WPB. To test if there were differences between the mean scores of the group of nurse managers who are targets and those who are not, an independent samples t-test was performed. The assumptions for performing a t-test were met, as distributions were skew = 1.3 and kurtosis = 1.1. The assumption of homogeneity was confirmed with Levene's F test. However, results indicated that homogeneity was violated, $F(204) = 9.0$, $p < .05$. Therefore, a t statistic of equal variances not assumed was computed. A significant difference in the score of the two nurse manager groups ($t(89) = 9.5$, $p < .0001$) was identified. The nurse manager WPB target group (n = 80) had a significantly higher mean score (M = 43.5, SD = 13.8), than the non WPB target nurse manager group (n = 134) (M = 28.89, SD = 5.88). Using a calculated eta squared statistic, the magnitude of the differences in the means (mean difference = 14.6, 95% CI: 11.4 to 17.8) was small (eta squared = .02). Though the proportion of effect is small, a statistically significant difference between the WPB nurse managers group and the non-WPB nurse manager group was identified, giving credence to hypothesis 2.1.

To test the research hypothesis for identification of the severity level of workplace bullying directed toward nurse managers, summed raw scores will be greater than the baseline scores of ≥ 33 to < 45, and ≥45. Described as a systematic process with varying degrees of intensity, researchers suggest WPB should not be explained as an absent or present, either-or,

phenomenon (Notelaers & Einarsen, 2013). Thus, the raw scores from the NAQ-R were summed and the following cutoff scores ≥ 33 and < 45 (occasionally bullied) and ≥ 45 (severely bullied) were utilized to describe the variables. Descriptive statistics and frequencies were calculated, data exhibited scores ranging from 33 to 72. Fifty six percent (n = 45) of nurse managers who reported being a target, had scores that were classified as occasionally bullied (≥ 33 and < 45) and 44% of the nurse manager (n = 35) scores ranked as severely bullied (≥ 45) with a Mean score of 46.5, *SD* 10.25, see Figure 2, Histogram of Total Workplace Bullying Severity Scores.

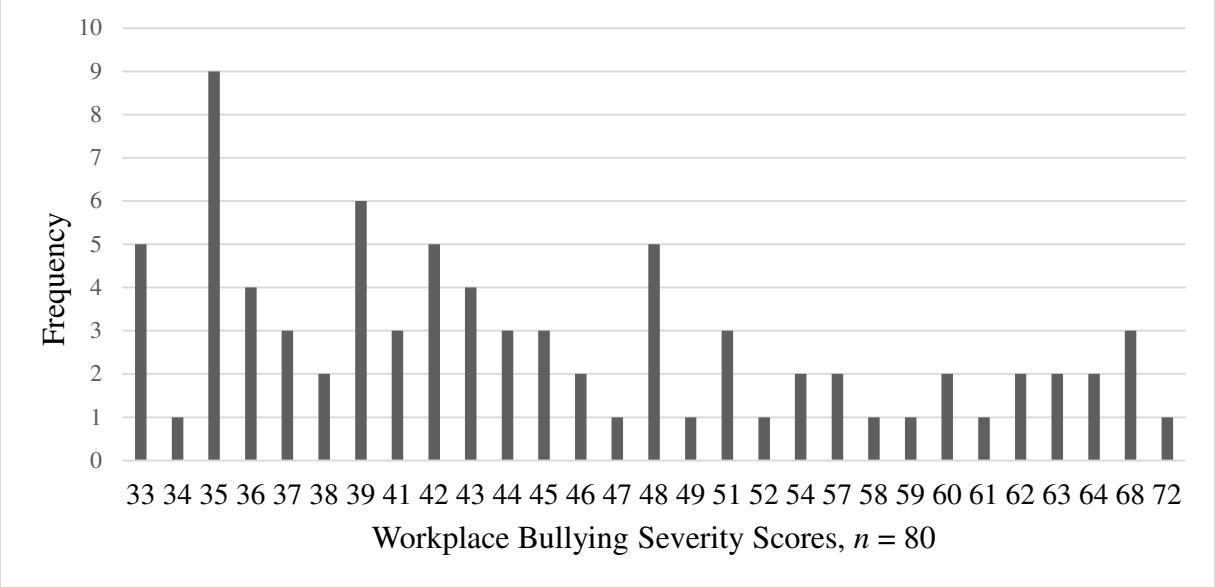


Figure 2. Histogram of Total Workplace Bullying Severity Scores

Research Question Three

The aim of research question three was to describe the directionality of workplace bullying (downward, horizontal, and upwards) directed toward nurse managers. The following research hypothesis was tested to answer the research question of what is the directional pathway (downward, horizontal, and upwards) of workplace bullying experienced by nurse managers?

- H_a 3. Nurse managers who self-identified as targets of WPB, will classify the directionality of WPB: downward, horizontal and or upwards.

Nurse managers who self-identified as targets of WPB were asked to classify the directional pathway of WPB. Data were collapsed into three groups that demonstrated directionality: Nurse Leaders, nurse manager peers, and clinical nurses. Descriptive and frequency data were assessed to determine directional pathways. All three pathways or directions (downward, upwards, and horizontal) were identified. However, the downward pathway was identified as the most prominent (n = 43, or 64%), this was followed by upwards (n = 19 or 28%), and finally horizontal (n = 5 or 7.5%). Therefore, there is support for hypothesis 3, see Figure 3, Histogram of Directionality of WPB.

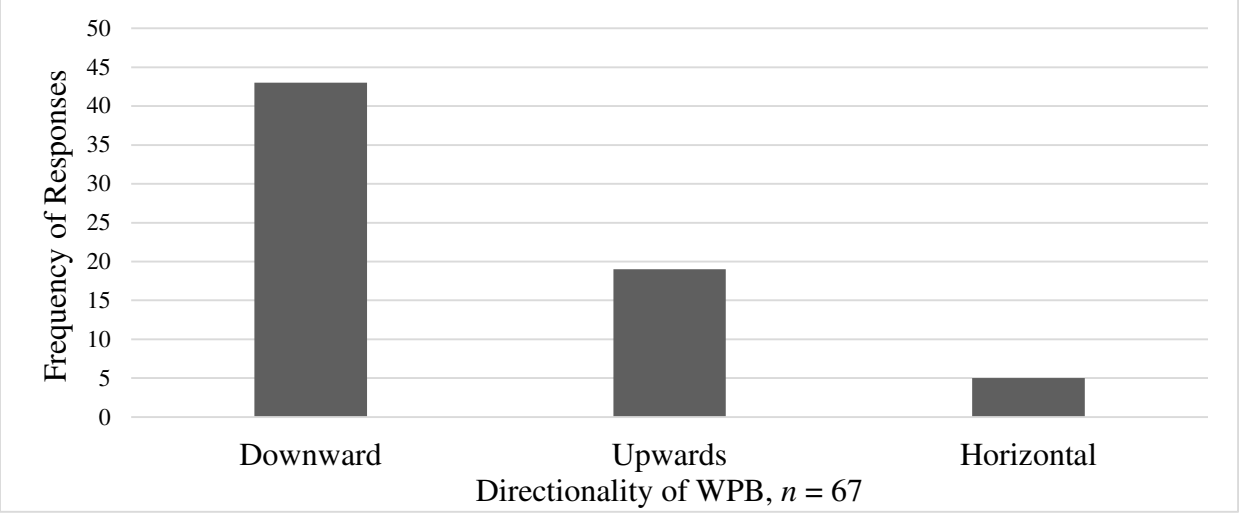


Figure 3. Histogram of Directionality of WPB

Research Question Four

The aim of research question four was to describe the identity of perpetrators and observers of workplace bullying that impact nurse managers. The following research hypotheses

were tested to answer the research question of what is the identity of perpetrators of workplace bullying and determine if nurse managers are observers of WPB demonstrated to their nurse manager peers?

- H_a4.1. Perpetrators of nurse manager WPB will be identified as either executive nurse leaders of NMs, clinical nurses, or peer of NMs.
- H_a.4.2. Nurse manager observers will identify executive nurse leaders, clinical nurses, and their nurse manager peers of workplace bullying directed toward other nurse manager peers.

Of the respondents who indicated they were targets of WPB (n = 80), three groups were identified as perpetrators, they are: executive nurse leaders (64.2%, n = 43), nurse manager peers (7.5%, n = 5), and clinical nurses (28.4%, n = 19). Executive nurse leaders who have nurse managers directly reporting to them received a higher percentage ranking for perpetrating WPB. Tests for normality were executed. Histograms and Q-Q plots demonstrated lack of normality, the Shapiro-Wilk test was not significant ($p > .05$). A non-parametric Levene's test was used to test homogeneity of variances and the result was significant ($F(2) = 64$, $p < .05$). Therefore, a Kruskal-Wallis test was conducted to evaluate whether there were differences between the three groups. Using corrected rank scores, the Kruskal-Wallis test showed a highly statistically significant difference for WPB among the three groups (nurse leaders, nurse manager peers, and clinical nurses) ($H(2) = 17.69$, $p < .0001$). Nurse leaders had a mean rank score of 41.22 (n = 43), nurse manager peers a mean rank score of 29.50 (n = 5), and clinical nurses a mean rank score of 18.84 (n = 19). Further analyses of pairwise comparisons with adjusted p-values did not demonstrate a significant difference between clinical nurses and peers (p = .82, r = .22) or peers

and nurse leaders (p = .68, r = .18). However, there was a statistically significant difference between clinical nurses and nurse leaders when looking at the severity of WPB (p = .001, r = .53). Consequently, there is evidence to suggest support for hypothesis 4.1.

To test the research hypothesis that nurse manager observers will identify nurse leaders, clinical nurses, and their nurse manager peers of workplace bullying directed toward other nurse manager peers, descriptive, frequency data were assessed and a Chi-square test was performed. Data from the overall sample of nurse managers (n = 201) to include both those who self-identified as targets and those who did not self-identify as targets, revealed three groups of individuals who were identified as perpetrators of WPB toward their nurse manager peers, they are: executive nurse leaders, nurse managers, and clinical nurses. Thirty percent (n = 61) of nurse managers identified executive nurse leaders, 23% (n = 46) nurse managers, and 31% (n = 63) identified clinical nurses as perpetrating WPB to their nurse manager peers, see Figure 4, Histogram of Observers of WPB.

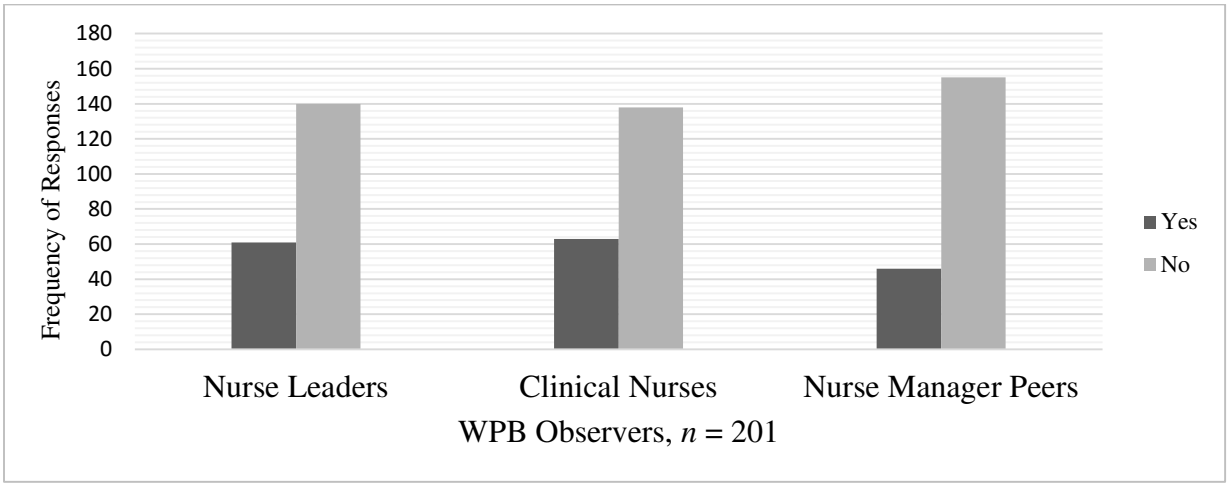


Figure 4. Histogram of Observers of WPB

To determine if there was a significant association among the three groups, a Chi-square test for independence was performed, no significant association was confirmed, *p*-value = 0.12. Therefore, there is evidence to suggest support for hypothesis 4.2.

Research Question Five

The aim of research question five was to identify global social power directed to nurse managers by nurse leaders and clinical nurses. The following research hypotheses were tested to answer the research question: what is the relationship between global social power and workplace bullying directed toward nurse managers by nurse leaders and clinical nurses.

- H_a 5.1. Global social power will be positively related to WPB of nurse managers when directed by nurse leaders.
- H_a 5.2. Global social power will be positively related to WPB of nurse managers when directed by clinical nurses.

Data were filtered for participants who identified nurse leaders as perpetrators of WPB. Pearson's correlation was utilized to determine if there is a linear relationship between social power and workplace bullying directed to nurse managers by nurse leaders. Spearman's correlation was computed due to the violations of assumptions for Pearson's correlation. Results from the analysis were not significant, so no additional inferential statistics were performed. Therefore, no correlation between global social power and workplace bullying of nurse managers was confirmed.

To test the research hypothesis that global social power will be positively related to WPB of nurse managers when directed by clinical nurses Spearman's correlation was performed. Data were filtered for participants who identified clinical nurses as perpetrators of WPB. Spearman's

correlation was computed due to the violations of assumptions for Pearson's correlation. No significant findings were determined from the analysis, thus, no additional inferential statistics were conducted. Therefore, hypothesis 5.2 was not supported.

Research Question Six

The aim of research question six was to determine if the work environment factors of authentic leadership, global social power, job demand, and job control can predict workplace bullying of nurse managers. The following research hypotheses were tested to answer the research question of: what extent does the work environment factors of authentic leadership, global social power, job demand, and job control predict workplace bullying of nurse managers?

- H_a 6.1. Work environment factors of authentic leadership, global social power, job demand, and job control will predict WPB of nurse managers.
    - H_a 6.1.1. Authentic leadership is a strong predictor of WPB.
    - H_a 6.1.2. Global Social power is a predictor of WPB.
    - H_a 6.1.3. Job demand is a predictor of WPB of WPB.
    - H_a 6.1.4. Job control is a predictor of WPB.

Logistic regression was used to determine whether the four covariates: Authentic leadership, global social power, job demand, and job control were significant predictors of workplace bullying of nurse managers. Descriptive statistics for the dependent variable workplace bullying revealed: 13% missing data, a mean value of 1.37, (*SD* = .48), and skew of .53. Mean values for the independent variables are listed in Table 9, Means, SD, and Skew for Independent Variables.

Table 9. Means, SD and Skew for Independent Variables

Variable	*Mean*	*SD*	Skew	*n*
Authentic Leadership	3.67	.87	-.56	214
Global Social Power	4.18	.50	-.24	214
Job Demand	3.44	.64	-.24	214
Job Control	3.70	.71	-.78	214

Note: SD = Standard Deviation

The dichotomous item responses for no WPB, revealed (n = 127, and 63% = 0 or no ≤ 33), and for the yes responses (n = 75, and 37% = 1 or yes ≥ 33). Predictor variables (authentic leadership, global social power, job demand, and job control) were examined for adequacy of sample size. Sample criterion for logistic regression was met with > 10 cases per independent variable (n = 214) (Plichta Kellar & Kelvin, 2013). A preliminary multiple regression was utilized to examine the dependent and independent variables for multicollinearity. Tolerance statistics exceeded .1 and the variance inflation factor (VIF) was < 10 suggesting that multicollinearity was not identified (Pallant, 2013).

Logistic regression captured 63% of cases and identified a fit with a -2 Log Likelihood result of 201.28. The Hosmer and Lemeshow Goodness of Fit statistic (X^2 (8) = 9.86, p =.27) was not significant, suggesting data was a good fit. The entire model explained 37.7% Nagelkerke R Square of the variance in WPB and 76.7% of cases were correctly identified or approximately 23% were misclassified. When all four predictor variables were evaluated together there was a significant effect on WPB (X^2 = 65.2, df = 4, n = 202, p < 0.001) indicating that the model was able to distinguish between no WPB ≤ 33, and yes WPB ≥ 33. As presented in Table 10, Logistic Regression, Predicting Likelihood of Workplace Bullying, only three of the

independent variables: authentic leadership, job demand, and job control are statistically significant.

Table 10. Logistic Regression, Predicting the Likelihood of Workplace Bullying

Predictor	B	S.E.	*p*	*OR*	95% C.I.	
					Lower	Upper
Authentic Leadership Style	-0.66	0.23	0.001	0.51	0.32	0.81
Global Social Power	-0.17	0.37	0.64	0.84	0.40	1.74
Job Demand	1.36	0.34	0.001	3.93	2.00	7.72
Job Control	-0.68	0.30	0.02	0.50	0.27	0.91

Note: CI = confidence interval for odds ratio (OR)

The variable with the strongest likelihood for predicting WPB among nurse managers was job demand, with an odds ratio of 3.9. This suggests that nurse managers are four times more likely to report being a target of WPB when the job role is deemed demanding than those who do not report WPB. Also, authentic leadership and job control demonstrated an OR of .51 and .50 respectively. BIC values for the independent variables were: Authentic leadership = 2.87 (positive); Job demand = 10.7 (very strong); Job control = .32 (weak) (Pampel, 2000). Approximately three cases (127, 171, and 223) had values of ± 3, and three cases (151, 178, and 225) of + 2, these were identified as outliers. Furthermore, a comparison test with the independent variables, identified that deleting global social power did not significantly improve the fit of the model ($X^2 = 63.9$, $df = 3$, $n = 202$, $p < 0.001$). Thus, there is evidence for partial support for hypothesis 6.1.1, support for hypothesis 6.1.3 and 6.1.4, but hypothesis 6.1.2 is not supported.

Conclusion

An online survey was distributed to over 1193 nurse managers across the United States. Various statistical descriptive, inferential, and multivariate tests were conducted to determine relationships between authentic leadership, global social power, job demand, and job control and workplace bullying. Data violated the assumptions for utilizing Pearson's correlation, thus a Spearman's Correlation was conducted. Results suggest there is a significant relationship among authentic leadership, job demand, job control and workplace bullying, but global social power did not demonstrate a correlation with workplace bullying. When high levels of Authentic Leadership style are displayed, less WPB was reported. Likewise, when job control was high, less WPB was reported. Job demand demonstrated a large correlation, suggesting a strong relationship with WPB. Data supported the identification of nurse managers as recipients of WPB from their nurse leaders, with severity scores ranging from 33 to 72. Finally, utilizing logistic regression, the variable job demand, was identified as having the strongest likelihood for predicting WPB of nurse managers.

CHAPTER 5: DISCUSSION

Overview

The overarching purpose of the study was to determine relationships between authentic leadership style, global social power, job demand, job control and workplace bullying in a population of nurse managers whose practice is in acute care settings across the United States. It was hypothesized that the work environment factors of: authentic leadership, global social power, job demand and job control would be predictors of WPB. Furthermore, a primary contribution of this study is the nationwide focus and the inclusion of an understudied group of middle managers. Thus, this chapter discusses pertinent findings and relates the findings to the literature and the study's guiding theoretical framework. Study limitations, along with implications for practice, policy, education, and opportunities for future research are also outlined.

Discussion of Findings

The demographic data for gender of all study participants revealed 10% of respondents were male in comparison to 90% who were female. This is consistent with the known demographics of the nursing population and with other published data (Buerhaus, Auerbach, Friedman, & Staiger, 2014; Florida Center for Nursing, 2011; U.S. Department of Health and Human Services, 2013). Likewise, the finding of 10% males identified in nursing is consistent with results from the AONE salary and compensation study. Of the males that were identified in the AONE study, 26% identified as a nurse manager, 35% at the director level, and approximately 21% were at the chief nursing officer level (AONE, 2013).

Since a higher percentage of females responded to the nurse manager survey, the assumption cannot be made that females have a higher propensity for perpetrating WPB. A predominance of females who are perpetrators of WPB was not consistent with the literature; as perpetrators of bullying are identified from both genders (Workplace Bullying Institute, 2014; Zapf et al., 2011). Due to the fact that both genders are accountable for perpetrating WPB, the finding of 90% female in the nurse manager study, is not suggestive of females being responsible for more bullying across all populations.

The demographic data points, age and years of experience as a nurse manager demonstrated relevant findings. Though this study did not ask for the retirement plans of nurse managers, it is common practice in the U.S. that once individuals attain a certain age, then the typical next step, is to retire. Conversely, recent nursing workforce projections indicate registered nurses are delaying their retirement by approximately 2.5 years and are expected to move out of the acute care settings into nonhospital based roles (Auerbach, Buerhaus, & Staiger, 2014). In the nurse manager study, approximately 32% of respondents identified their ages as higher than 55 years of age. Even with the delay in retiring, given the designated retirement age in the U.S. of 65 to 67 years (Social Security, 2015), it could be plausible that within a short timeframe, nurse managers could be moving into non-hospital roles or could leave the profession entirely.

Second, close to 68% (n = 214) of the entire sample of nurse managers had > 5 years of experience in the nurse manager role. Though it is not known what the leadership competency levels are for these nurse managers, given the number of years of experience in the role, it is posited these nurse managers do possess some degree of proficiency with the responsibilities associated with their role. This thought is consistent with Dreyfus's Model of Skill Acquisition

that was adopted by Patricia Benner and re-named as the Novice to Expert model (Benner, 1982). Furthermore, based on the data, the majority of study participants who self-reported being a target of WPB, had > 5 plus years of experience in their role, suggesting they were 'seasoned' nurse managers (77%, $n = 62$). Consequently, WPB is not relegated to just new or novice nurse managers but was recognized across the continuum of new and seasoned managers. In the literature, a predominant nursing group identified as recipients of WPB are novice nurses (Berry et al., 2012; Simons & Mawn, 2010). This finding, of being a 'seasoned nurse manager' who is a target of WPB is not consistent with the literature.

The results of the study demonstrated that nurse managers are targets of workplace bullying. Summed raw scores from the NAQ-R displayed a range of severity levels from 33 to 72, with ≥ 45 noted as severely bullied. Although nurse managers were not recognized as targets of WPB in other published studies, managers from the areas of business management, government agencies, healthcare, and education have been studied and were identified as targets of WPB (Branch et al., 2006; Hoel et al., 2010; Jenkins et al., 2012; Mintz-Binder & Calkins, 2012). Similarly, studies were found that identified nurse managers as perpetrators of WPB (Chipps et al., 2013; Johnson & Rea, 2009; Vessey et al., 2009). To date, this nurse manager study is the only identified study that exclusively examined nurse managers as being targets of WPB. Furthermore, other published studies identified incidences of WPB from 1% for healthcare workers in psychiatric organizations (Agervold, 2007); 28% for U.S. workers from nine professional and nonprofessional industries (Lutgen-Sandvik et al., 2007); then, 35% for clinical nurses to as high as 70% (Johnson & Rea, 2009; Vessey et al., 2009). In the nurse manager study, 35.7% of nurse managers reported experiencing WPB over a timeframe of six months, this is consistent with other published studies that examined clinical nurses (Berry et al., 2012),

managers in the business sector (Montes, Gutiérrez, & Campos, 2011), and nursing program directors (Mintz-Binder & Calkins, 2012).

When evaluating the severity levels for WPB, the nurse manager study identified WPB as occasional to severe using a specific cutoff score. Other published studies utilized the counting of negative acts that occurred over a specified time and or yes/no responses to identify targets of WPB (Agervold, 2007; Nielsen et al., 2011). Subsequent research studies surrounding this practice found highly skewed distributions to 'never' and 'occasional' responses. Means and standard deviations of the 'never' and 'occasional' response scores were small, subsequently more emphasis could be given to data of non-targets vs targets, thus minimizing the exposure of and severity of WPB (Notelaers, Einarsen, De Witte, & Vermunt, 2006). This suggests that individuals who are categorized as non-targets, could be experiencing some exposure to WPB even when categorized as a non-target. The nurse manager study used a specific cutoff score to determine the severity levels of WPB. This practice, newly identified in the literature allows for the differentiation of severity which is challenging to distinguish if just an arbitrary count number is used (Notelaers & Einarsen, 2013).

This study also sought to identify the directionality of WPB, either downward from executive nurse leaders, upwards from clinical nurses, or horizontal from nurse manager peers. Findings contribute to the science regarding the directionality or pathway of WPB directed toward nurse managers. All three pathways were identified, with the downward pathway recognized as the most prominent. The finding of a downward pathway in the nurse manager study is consistent with results of other researchers (Branch et al., 2013; Salin, 2001; Samnani & Singh, 2012; Zapf et al., 2011). However, what is not consistent with previously mentioned published studies is the percentage ratings for the horizontal and upwards pathways. For

instance, the horizontal pathway in the nurse manager study is less (NM = 7.5% vs other = 39.4%) and the upwards pathway identified in the nurse manager study is higher (NM = 28% vs other 9.5%) when compared to other studies (Zapf et al., 2011). Additionally, other published works, have identified managers from other industries: business, military, education as perpetrators and targets of WPB (Ortega et al., 2009; Salin, 2001). Likewise, other published works have identified nurse managers as perpetrators (Chipps et al., 2013; Johnson & Rea, 2009), but studies that have exclusively studied nurse managers as targets of WPB, were not identified.

In examining WPB of nurse managers, the literature suggested a need to identify the position of perpetrators and to garner from the perspective of an observer, whether nurse managers were targets of WPB from clinical nurses, nurse manager peers, and executive nurse leaders. As a result, nurse managers in this study were also invited to participate in the observer role and identify sources of WPB based upon their experiences. Based on their observations of WPB, nurse managers (n = 201) who participated in the study were given the opportunity to select all three categories of perpetrators, they are: executive nurse leaders, nurse manager peers, and clinical nurses.

Of those who self-reported being targets of WPB (n = 80), nurse leaders (64.2%, n = 43) were more frequently identified as perpetrating the negative acts than nurse manager peers (7.5%, n = 5) and clinical nurses (28.4%, n = 19). However, 13 participants either missed or chose not to answer this question. Furthermore, the mean rank scores of the summed WPB score were significantly different between the three groups: nurse leaders, nurse manager peers, and clinical nurses (41.22; 29.50; and 18.84) respectively. This is also consistent with the literature,

as leaders (65.4%) were frequently labelled as perpetrators of WPB. Nurse manager peers (7.5%) were less frequently identified when compared to clinical nurses (28.4%) or subordinates; this is not consistent with the literature (Zapf et al., 2011). In addition, when the three groups, nurse leaders, nurse manager peers, and clinical nurses were differentiated, nurse leaders and clinical nurses together demonstrated a stronger effect (r = .53) on nurse managers, than nurse manager peers and clinical nurses. Upon further evaluation, it was noted that observers (n = 201) predominately identified executive nurse leaders as perpetrators (31%, n = 61), nurse managers second (30%, n = 46), and clinical nurses third (23%, n = 63). Other published studies did identify observers of WPB. Specifically, the Chipps et al. (2013) team, reported 59% of nurses in their sample observed or witnessed WPB, but this team did not differentiate between the categories of nurses, such as clinical nurses, nurse managers, or executive nurse leaders. The frequency scores from the nurse manager study demonstrated that nurse leaders were identified by both targets and observers of WPB. However, for the observer group, a statistical difference was not obtained; the target group demonstrated a statistically significant difference. WPB is described as a multifaceted, multidimensional offensive phenomenon that impacts individuals differently (Einarsen et al., 2011). Though this statement is broad, study findings fit with the description of the multi-dimensional phenomenon, as characteristics at the individual, group, and organizational levels are implicated as factors for the promotion of WPB (Heames & Harvey, 2006). For instance, researchers postulate there is evidence at the individual level to support a 'political or self-interest' notion for enhancing career opportunities of the perpetrator (Treadway, Shaughnessy, Breland, Yang, & Reeves, 2013). Then, organizational factors that promote and reward a culture of WPB are also intertwined with the individual factors. Also, the organizational factors combined with the dynamics of the group along with partnerships formed at the

individual and group levels are likely to provide a vehicle for WPB to start and or continue (Hutchinson, Wilkes, Jackson, & Vickers, 2010).

When examining the relationships between the dependent and independent variables, results suggested an inverse relationship between authentic leadership style and WPB. This is consistent with other published work that linked relational building styles with lower levels of workplace bullying (Nielsen, 2013; Spence-Laschinger & Fida, 2013). Conversely, researchers found negative leadership behaviors, such as a non-relational building style demonstrated a strong correlation with WPB (Hauge et al., 2007; Skogstad, Einarsen, Torsheim, Aasland, & Hetland, 2007). Essentially, literature supports the association of positive relational building leadership styles with lower levels of WPB and this correlates with the findings from the nurse manager study.

Likewise, the variable job demand revealed a significant but strong, positive relationship with WPB and job control had a significant, negative relationship. This finding is consistent with the work of Stouten et al. (2010), Baillien, De Cuyper, et al. (2011) and Notelaers et al. (2013). Moreover, additional qualitative studies further extrapolated work demands, (Jenkins et al., 2012) as contributory work environment factors. Though there is a statistically significant relationship between authentic leadership, job demand, and job control, the strength of the relationship for authentic leadership, job control, and workplace bullying is moderate at best. Also, only 19% of WPB was explained by the variation of authentic leadership and only 16% of WPB was explained by the variation of job control. Job demand demonstrated a weak, negative correlation with authentic leadership and only 6% was explained by the variation of job demand.

To discern whether authentic leadership, global social power, job demand, and job control can predict WPB of nurse managers, the independent variables were simultaneously

entered into the regression model. Only authentic leadership, job demand, and job control were identified as predictors, with job demand the strongest of the three. The logistic regression model was able to predict 76% of cases, had a positive predictive value of 71% and a negative predictive value of 79%, but there were six cases that did not fit the model. Though outliers were identified, they were not deleted from the sample because the total predicted values would not have altered the overall results of the model. However, this may have impacted the sensitivity of the model, as logistic regression models have a propensity for sensitivity to outliers (Mertler & Vannatta, 2006). After review of the six cases, it was noted that the answered questions on the NAQ-R fell into a 'grey' area. Some participants were predicted to answer yes, but instead answered no. Nevertheless, the strongest identified predictor was job demand. In previous studies, nurse managers have characterized their role as stressful, emotionally draining, and with reports of drowning in work (Shirey et al., 2010; Udod & Care, 2013). Tuckey et al. (2009), found a positive association with job demand and WPB and a negative association between job control and WPB. Using both a European and a Spanish sample, Baillien, Rodríguez-Muñoz, de Witte, Notelaers, and Moreno-Jiménez (2011), found a strong correlation between increased workload and WPB when job control is low. Essentially, this team concluded, jobs or roles that were labelled highly demanding were linked to increased reports of WPB. Results of the nurse manager study are consistent with the literature.

Study findings did not support the research hypothesis of whether there was a relationship between global social power and WPB directed toward nurse managers by nurse leaders and also by clinical nurses. Global social power demonstrated non-significant findings with WPB, job demand, and job control. Even though the concept of power is embedded into the workplace bullying process, few published studies have examined power as an independent

variable. However, published studies do suggest relational powerlessness (Hodson et al., 2006), a struggle for power (Strandmark & Hallberg, 2007), and a network of partnerships that are connected through power channels (Hutchinson, Vickers, Jackson, & Wilkes, 2010) as contributory work environment factors. On the other hand, in the nurse manager study, a statistically, significant, positive relationship with authentic leadership and global social power was identified. Though, extant research has not specifically explicated the correlation between global social power and authentic leadership; perhaps this positive finding could be explained by the positional authority of the nurse leader. This premise fits with Raven et al. (1998) legitimacy power base. Furthermore, it was postulated, that the lack of support the NM receives from their nurse leader results in diminishing the legitimate base of the nurse manager and increasing their reliance on the clinical nurse to meet organizational goals. Thus, power could be heightened when clinical nurses pull from their informational and expert bases of power. However, this premise does not support the positive correlation with authentic leadership and global social power; specific evidence to support this premise was not identified.

Limitations

This study utilized a non-randomized, convenience sample, but recruited subjects from across the United States via advertisements in the electronic weekly AONE newsletter and the FONE website. Even with the extensive reach of the recruiting process and a snowball sampling technique to recruit nurse managers, the actual sample size was relatively small (n = 214). Likewise, the study utilized an electronic method for data collection. Due to AONE restrictions with supplying email addresses of their members, a mailed strategy, instead of a full email strategy for recruiting participants was used. Additionally, due to various electronic constraints,

some participants reported difficulty with accessing the web address distributed in their letters. Last, Dillman et al. (2014), suggests the use of a 5-pronged sampling technique for online surveys. However, a 2-pronged contact recruitment sampling technique was used due to restrictions from the UCF IRB with using a 5-pronged contract strategy. These restrictions could have limited the recruiting process, thereby contributing to the low sample size.

Though the study recruited nurse managers from across the U.S., due to sample size, study results were not stratified using regions of the U.S., hospital location, types of units, types of hospitals, or bed sizes. Therefore, it is not known if there are differences among these categories with identifying WPB and the severity levels of WPB.

Likewise, a questionnaire that asked participants to self-report data was utilized. This method of data collection garners retrospective data about an incident which may or may not be credible. Subsequently, this could have contributed to common method variance and social desirability bias. Last, the use of a correlational design prohibits causal inferences (Polit & Beck, 2012).

Also, one question from the job demand scale, 'I have unrealistic time pressures' and one from the job control scale, 'I can decide when to take a break' were omitted due to a transcription error. This could have impacted the results.

In the WPB literature, there is much debate about the calculation of the item responses. Some researchers suggest the best method to examine the WPB variable is with the use of a cutoff score. However, the cutoff range that Notelaers and Einarsen (2013) used was determined using a sample from Norway. Participants in the nurse manager study who are classified as occasionally bullied ($\geq .33$ to < 45) or those who were classified as severely bullied (≥ 45), the use of the present cutoff range may not have been sensitive enough to distinguish between the

subtle differences of the ranges. Therefore, it is not known if differences exist with the cutoff scores when used by participants from a non-European country or culture (Nielsen et al., 2011).

Study Conclusions

Through self-reported data, nurse managers were positively identified as targets of WPB. NMs were characterized as sustaining occasional and severe WPB behaviors predominately from their executive nurse leaders, but also from clinical nurses, and nurse manager peers. Results demonstrated significant relationships between authentic leadership, job demand, job control and workplace bullying. Authentic leadership demonstrated a negative or inverse relationship with WPB. As nurse leaders demonstrated characteristics of authentic leadership style, less reports of WPB from nurse managers were noted. The variable job demand exhibited a strong, positive relationship with WPB, suggesting when the workload of the nurse manager is identified as demanding, then WPB is present. Also, job control displayed a negative relationship with WPB, suggesting when nurse managers have less control over their job responsibilities, WPB is reported. Therefore, as demands of the role increase and there is less control over job duties, WPB was identified. Global social power did not demonstrate a relationship with WPB.

Based on the analysis of the data, observers or witnesses of WPB of nurse managers were identified. Respondents corroborated the study findings that nurse leaders, clinical nurses, and nurse manager peers were perpetrators of WPB to nurse managers. Finally, with the use of a logistic regression model, job demand was identified as the most likely contributor of WPB, authentic leadership and job control were also identified as contributory predictors of WPB.

Implications for Nursing Practice, Policy, and Education

Practice

The role of the nurse manager is an important link between the executive administrative and clinical teams. This position is responsible for driving organizational outcomes, ensuring safe patient care, and maintaining team satisfaction (Zwink et al., 2013). In the nurse manager study, executive nursing leaders were the highest rated group (n = 43 or 64%) of professionals perpetrating WPB behaviors to nurse managers. Though this study did not investigate specific aspects of perpetrator bullying, nevertheless, the implications for practice related to perpetrating WPB to nurse managers are striking. First, according to the AONE Nurse Executive Competencies, nurse leaders are to demonstrate core proficiencies that encompasses knowledge of self, positive inter-professional relationships, and the ability to build and utilize expert and effective communication skills resulting in a collaborative environment where safe, effective, and efficient care can be given to patients (American Organization of Nurse Executives [AONE], 2015). Instead, nurse leaders were identified as perpetrating negative behaviors that could harm nurse managers, their organizations, and society at large. Second, professional nurses are held to a Code of Ethics that dictates the creation of a culture of respect, civility, and dignity for all nurses (ANA, 2015). By perpetrating harmful, negative behaviors, nurse leaders are practicing in an unethical manner.

Third, the Institute of Medicine, the Institute of Healthcare Improvement (IHI), and the Magnet Recognition Program® have laid out operational imperatives or frameworks for healthcare organizations. These frameworks identify leadership as the defining link for patient safety, effective and highly functioning teams, the achievement of a psychologically safe culture, and excellence in nursing practice (Institute for Healthcare Improvement [IHI] & Frankel, 2015;

Institute of Medicine [IOM], 2003; Wolf, Triolo, & Ponte, 2008). As described in the complexity leadership theory, all levels of the organization are inter-dependent, entangled, and integrated with each other (Crowell, 2011). Therefore, when nurse leaders perpetrate negative behaviors toward their nurse managers, all levels of the organization are impacted and adherence to the Institutes (IOM & IHI) and Magnet Program® operational imperatives are suspect. Furthermore, though declining financial reimbursements along with fluctuating workforce needs challenge executive nursing leaders, the value of having strong, competent leaders in leadership roles cannot be discounted.

Fourth, consequences of workplace bullying have been linked to effects impacting individuals, groups, organizations (Bartlett & Bartlett, 2011), and society (Vega & Comer, 2005). Though the nurse manager study did not specifically evaluate consequences of WPB directed to nurse managers, 35.7% (n = 80) of respondents did self-identify as recipients of WPB and these nurse managers quantified the severity of the WPB with scores ranging from ≥ 33 to as high as 72. Therefore, since WPB was identified in a population of nurse managers, then the possibility exists that these nurse managers could also encounter deleterious harm identified in the literature. Published research supports an increased likelihood of targets leaving their role and or exiting the organization (Berthelsen et al., 2011; Hogh et al., 2011), higher incidences of work absences due to illnesses (Ortega et al., 2011), and absences from work become more frequent and continuous as the severity of WPB increases (Berthelsen et al., 2011). Physical health issues, burnout, symptoms of post-traumatic stress (Nielsen & Einarsen, 2012), and anxiety and depression (Hauge, Skogstad, & Einarsen, 2010) have also been linked to WPB.

Finally, in the State of Florida, the position of unit/department nurse manager is one of the top five most recruited positions in the acute care setting (Florida Center for Nursing, 2014).

Furthermore, 32% of study respondents indicated they were near the age of retirement and as the retirement of these knowledgeable nurse managers grows closer, the impact to the practice setting could be substantial. Warshawsky, Rayens, Stefaniak, et al. (2013) linked NM turnover to the patient outcomes of increased pressure ulcers and the IOM report identifies the component of leadership as a key ingredient for the delivery of safe patient care (IOM, 2003). Thus, in addition to the nearness of retirement decisions, the impact of NM turnover on patient outcomes, the negative influence of WPB on the practice environment, the prospect of nurse managers exiting the organization or the profession cannot be discounted. Most importantly, the ability of the nurse manager to integrate, initiate, and create a positive work environment while being a recipient of WPB is questionable. Therefore, great leaders at all levels: executive, middle, and clinical must be identified and placed into positions and empowered to create respectful, civil, and collaborative environments where highly effective and functioning teams are the norm.

Policy

The nurse manager study recruited participants from across all regions of the United States. Findings suggest that WPB is not confined to one particular region but is pervasive throughout the country. Moreover, the majority of the time, executive nurse leaders were implicated as perpetrating WPB. At the national level, enacted federal laws that serve as a deterrent or a protectant for individuals that are harmed by WPB do not exist. Furthermore, current state laws or workplace laws do not adequately describe the behaviors, nor is there a law in the United States that specifically addresses the actions or consequences of individuals and or organizations who perpetrator WPB (Yamada, 2011). Also, Joint Commission (JC) has implemented an accreditation standard that requires healthcare organizations to have existing

policies that define disruptive behaviors, education about the behaviors, and procedures for reporting, monitoring, and supporting individuals who are recipients of the behaviors. This JC standard was implemented as a result of the positive correlation between sentinel events and ineffective communication between healthcare professionals (JC, 2008). Even with the JC standard, at the organizational level, few policies exist that allow targets of WPB to be supported. Of the policies that are in existence, the term workplace bullying was not consistently used (Johnson, Boutain, Tsai, & de Castro, 2015), human resource professionals were not listed as the support for the employee, as targets of WPB are directed back to their leader, manager or supervisor for resolution (Salin, 2008). This notation is alarming because results from the nurse manager study identified the executive nurse leader as the predominate perpetrator. Consequently, sending the nurse manager back to their nurse leader to resolve WPB behaviors, could serve as an impetus for the continuation of WPB, but most importantly, this practice could contribute to the 'silence' of not speaking up about the behaviors. Effective policies and procedures that include: a statement from the organization denouncing the negative behaviors, clarification of roles and responsibilities for monitoring, reporting, taking action against perpetrators, and mechanisms for supporting individuals when impacted with the negative behaviors are needed. Furthermore, as antisocial policies and procedures are developed, an inter-professional panel consisting of: clinical nurses, nurse managers, executive nurse leaders, counselors, lawyers, and human resource professionals should be utilized.

Education

The ability to lead is predicated on the capability of the leader to effectively manage or lead themselves and their ability to utilize specific leadership competencies, skills, and attributes

that shapes decisions and drives behaviors (McShane & Von Glinow, 2014). The display of counterproductive behaviors to nurse managers by nurse leaders, suggests deficits with distinguishing and modifying behaviors (Salin, 2003). Furthermore, Lutgen-Sandvik et al. (2007), identified a gap between workers in the U.S. and their knowledge of and ability to recognize the covert and subtle workplace bullying, as these covert and subtle behaviors are not easily identifiable. Consequently, due to the covert and subtle characteristics of the behaviors and the concept confusion noted in the literature, difficulty with identifying WPB behaviors is plausible. To control for this, study respondents were given a specific WPB definition before they answered the items on the questionnaire.

Moreover, in previous years, education surrounding the phenomenon of WPB was not part of the professional development of nurses. Now, with the focused attention on negative, abusive, antisocial behaviors in the workplace, greater emphasis is being placed on developing effective communication skills, conflict management skills, and identifying the antisocial behaviors (Luparell, 2011). However, since the nurse manager study recognized executive nurse leaders as the predominate perpetrator; an assessment to determine the existence of education for antisocial behaviors specifically for executive nurse leaders is warranted. Education can include: types of behaviors with specific examples, effective communication strategies, conflict management approaches, emotional intelligence, and relational building leadership styles.

Further Research

The use of the severity cutoff score was only utilized in one published study that was located in a European country. Further research is needed to determine if there are differences with the cutoff score when used in other non-European cultures. Also, is there justification for

additional differentiation of the cutoff score to allow other respondents with scores that fall on the high side of ≤ 33 to be included as occasionally bullied? Likewise, is there justification for further differentiation of scores that fall between the ranges of 38 and 45? Additional study for differentiating the ≥ 33 to < 45 cutoff score used for estimating the prevalence and severity of WPB is warranted.

A consistent mantra in nursing is: 'nurses eat their young', meaning, nurses are notorious for displaying uncivil behaviors to newly graduated nurses. However, where are those behaviors learned? Is there evidence to support a 'cascading' pathway for WPB that emanates at the executive nurse leader level, then moves onto nurse managers, and subsequently ends with clinical nurses? Evidence does support that clinical nurses are recipients of WPB from their nurse colleagues and also their nurse managers (Vessey et al., 2009). However, further exploration is needed to ascertain if there is a cascading pathway for WPB.

An opportunity for developing and implementing WPB educational programs exists. Content for any educational program at pre-licensure and subsequently throughout the ongoing professional development of nurses should include empirical evidence that describes the nature of the phenomenon, aspects surrounding the definition of WPB, subtle signs of the behaviors, antecedents, and consequences. Likewise, specific tactics to enhance authentic behaviors, communicate effectively with a variety of individuals, and strategies to reduce stress are also warranted. Additionally, educational interventions noted in the literature are few and should be developed using the framework of: primary (prevention), secondary (stop), and tertiary (rehabilitation) tactics and should incorporate strategies that focus on the individual, organization, and society (Vartia & Leka, 2011).

Workplace bullying is described as a pervasive, complex, multidimensional phenomenon that includes individual, group, organizational, and societal dynamics (Einarsen et al., 2011). Throughout the workplace bullying literature, a fair amount of empirical evidence focusing on the individual and organizational aspects of WPB are noted. Though, the nurse manager study concentrated on the organizational factors of WPB, the use of a multi-level design and statistical analyses that extrapolate individual, group, and societal factors are worth exploring. As few studies were discovered that examined WPB individually, from the perspective of the perpetrator, or utilized a group or societal approach. Research at the group and societal levels are needed to understand this association with WPB.

The United States is known as the 'melting pot' of various cultures and ethnic groups. Researchers have proposed that WPB is not specific to one ethnic group or culture (Fox & Stallworth, 2005). Given the diverse cultures of the U.S. population (Perez & Hirschman, 2009) and subsequently the workforce, it is not known if specific cultural differences or interpretations of WPB identified by particular cultural groups can be transferable to other cultures (Escartín, Zapf, Arrieta, & Rodríguez-Carballeira, 2011). Furthermore, it is not known if nurse managers from different cultural or ethnic groups could be recipients of higher rates of WPB, as the demographic data for the nurse manager study did not reveal a high percentage of cultural diversity; further exploration is warranted.

Data from the nurse manager study identified observers of WPB and asked for their reports of who the identified targets were. However, this study did not examine what the observers/witnesses recognized as predictors of the WPB or whether or not the observers intervened in the stopping the negative behaviors. Furthermore, few published studies examined WPB from the standpoint of the observer/witness. Scholars have called for additional

examination of this observer/witness group to determine if there are plausible predictors that are specific to observers (Samnani, 2013). Therefore, examination of these factors could further explain the role that observers/witnesses have with the bullying process.

Global social power did not demonstrate a significant relationship with WPB. Additional work is need to further examine the relationships with WPB and subsequently authentic leadership style.

Summary

For over 30 years, researchers have examined the phenomenon of workplace bullying. Healthcare organizations, known for their stressful, chaotic, and complexed work environments have been implicated as a potential 'breeding' ground for workplace bullying. Consequently, nurses at all levels have reported instances of various antisocial behaviors, to include workplace bullying. Also, published literature details a myriad of deleterious harm that is endured by recipients of workplace bullying. Leaders, through the downward pathway have been branded as commonly perpetrating the negative acts. Nevertheless, published studies that exclusively examined nurse managers as recipients of workplace bullying were not identified.

Using an online survey completed by nurse managers from all five regions of the United States, the presence of workplace bullying perpetrated to nurse managers was established. Ironically, nurse managers acknowledged their executive nurse leaders and clinical nurses who report to them, as the primary perpetrators of the harmful acts. Yet, these nurse manager professionals, the backbone of organizations and leaders of nurses who are the 'engine' that drives the care given to patients, are asked to create and maintain positive work environments even though their own practice environment is unhealthy. Since the greatest strength of any

organization is the nursing workforce, executive nurse leaders must be held accountable for protecting nurses and the nursing profession at large. Therefore, given the correlation made between WPB and unhealthy work environments, the impending challenges with the nurse manager workforce, and the harmful consequences of WPB. Executive nurse leaders, as 'guardians, advocates, and defenders' of nurses, cannot continue to compromise or put at risk the wellbeing of nurse managers, but must demonstrate leadership courage by designing and implementing strategies that will change the trajectory of harm that is perpetrated to nurse managers.

APPENDIX A:
MEMBERSHIP AGREEMENTS

AONE Membership List Rental Agreement

AONE Membership List rental agreement

AGREEMENT by and between the American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association (AHA), an Illinois not-for-profit corporation with principal offices at 155 N Wacker Drive, Suite 400, Chicago, Illinois, and:

Joy Parchment, MSN, RN, NE-BC
Renter

Joy Parchment, MSN, RN, NE-BC
Name of Primary Contact

Mailing Address

City | State/Province | Zip/Postal Code

Telephone | Fax | joy.parchment@knights.ucf.edu
E-Mail Address

1. **Purpose:** The purpose agreed to, as stated below and documented by the attached copy of the proposed mailing, for use of AONE membership files/labels is as follows:
2. **Rental Order:** The Renter wishes to rent the AONE membership list per the following specifications:

   Type of File:
   ☒ Excel file

   List Selection:
   ☒ Full list
   ☐ AONE region(s)
   ☐ State(s)
   ☐ Random sample set (per 1,000 members)
3. **Statement of Ownership Rights:** All materials prepared under this Agreement, including but not limited to, all drafts and final versions of the AONE membership files, shall remain the sole and exclusive property of AONE.
4. **Confidentiality:** All information concerning AONE membership files, including, but not limited to, the proposed, revised and final AONE membership files/labels, is confidential information. The Renter agrees to hold such information in strict confidence.
5. **Request Approvals:** AONE evaluates each request for purchase, approving or rejecting requests within seven (7) business days after receiving a copy of this agreement and a sample of the mailing to be distributed. Any rejection shall specifically state the reason(s). Negotiations for any proposed revisions for the mailing can be made between the parties; however, it is understood that AONE has final authority to approve or reject the rental request.
6. **Approved Use:** AONE membership files are to be used one-time only for the purpose stated in (1) above. They may not be sold, copied, used to compile a database of any kind, or otherwise retained by the renter nor made available to any third party. AONE will not provide refunds for unused portions of rented membership lists. Unused portions of a rented membership list may not be used for another mailing without the advance written consent of AONE.
7. **Price:** AONE shall receive $ 200.00 for the requested membership files (as outlined above) upon execution of this Agreement. All payments shall be made prior to shipment of membership files/labels.

Continued on page 14

AONE Membership List rental agreement continued

Continued from page 13

8. **Indemnification:** It is understood that the Renter is acting as an independent contractor and assumes the entire responsibility for performance under this agreement. AONE, its employees and agents are harmless against all liabilities, claims, causes of action, losses and damages to persons and property, including expenses and attorneys' fees, arising out of or caused by the Renter's performance, excluding any such liability caused by the sole negligence of AONE, its employees and agents.
9. **Duration:** This Agreement will begin when signed by the Renter, and will expire on the date of the proposed mailing: 6-23-15
This Agreement may be cancelled by either party within 14 days' written notice, but only before the mailing list is sent by AONE to the purchaser.
10. **Miscellaneous:**
    a. This Agreement supersedes all prior agreements, oral or written, and constitutes the entire understanding among both parties.
    b. This Agreement shall be governed by the laws of the State of Illinois.
    c. Release of membership files for the purpose of nursing research will be limited to those studies which demonstrate appropriate study methodology. The study results should impact the role of nurses in executive practice who design, facilitate and manage patient care delivery across the health care continuum. Study results will be shared with AONE upon completion of the final report. Any study publications will include the following statement: "Participation of AONE members does not indicate AONE review or endorsement of this study."

IN WITNESS WHEREOF, the parties have executed this Agreement.

American Organization of Nurse Executives:

Signature

Title

Date

User: Jay PARCHMENT

[redacted]

Signature

GRADUATE STUDENT, PhD Candidate

Title

4-23-15

Date

Thank you for advertising with AONE!

AONE Membership List Receipt

From: Forster, Marthe [mailto:mforster@aha.org]
Sent: Thursday, April 30, 2015 12:35 PM
To: Parchment, Joy
Cc: Bolan, Cristen; Meadows, Mary
Subject: AONE Receipt - Joy Parchment ($1,050)

Good afternoon, Joy –

Attached you will find the receipt for your published request and mailing list payment (total $1,050).

Please let me know if you have any questions or concerns.

Sincerely,
Marthe

Marthe Lyngås Forster
Program & Operations Specialist
American Organization of Nurse Executives (AONE)
of the American Hospital Association
155 N. Wacker Drive
Chicago, IL 60606
312-422-2812
mforster@aha.org

Twitter | LinkedIn | Facebook | YouTube

APPENDIX B:
UCF IRB APPROVAL LETTER

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Joy Parchment**

Date: **April 22, 2015**

Dear Researcher:

On 04/22/2015, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Project Title:	Nurse Managers, Work Environment Factors and Counterproductive Behaviors
Investigator:	Joy Parchment,
IRB Number:	SBE-15-11127
Funding Agency:	Southern Nurses Research Society / Council for the Advancement of Nursing Science(SNRS/CAN)
Grant Title:	
Research ID:	NA

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Patria Davis on 04/22/2015 10:42:48 AM EDT

IRB Coordinator

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Joy Parchment, Master of Science in Nursing**

Date: **November 05, 2015**

Dear Researcher:

On 11/05/2015, the IRB approved the following modification to human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Modification Type:	Revised Funding source
Project Title:	Nurse Managers, Work Environment Factors and Counterproductive Behaviors
Investigator:	Joy Parchment, Master of Science in Nursing
IRB Number:	SBE-15-11127
Funding Agency:	UCF College of Nursing Intramural Grant(CON)
Grant Title:	
Research ID:	NA

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Patria Davis on 11/05/2015 12:20:52 PM EST

IRB Coordinator

APPENDIX C:
STUDY CONSENT FORM

Nurse Managers, Work Environment Factors and Counterproductive Behaviors Study

Informed Consent Form

Please Print for Your Records

About the study - The purpose of this research study is to examine work environment factors that are associated with counterproductive workplace behaviors directed to nurse managers. Findings from the study could increase awareness of the behaviors and assist with generating prevention strategies that may decrease these behaviors in the workplace. Your participation is invited and whether you take part in the study is up to you.

Participation in the study - If you choose to participate in this research study, you will asked to access a web based survey. Using a dedicated URL link you will complete an on-line questionnaire that seeks to determine your experience with counterproductive behaviors in the work setting. The questionnaire consists of questions about you, the work environment, and your frequency of exposure to these counterproductive behaviors. Completion of the questionnaire is expected to take approximately 20-30 minutes.

Consent to participate - Your participation in this research study is completely voluntary and there is no obligation for you to consent to participate. Non-participation does not generate a penalty. If you choose to participate, then you can withdraw your participation at any time before submitting your survey. However, returning a completed or partly completed questionnaire will be accepted as consenting to participate in the study.

Risks - This research study asks about experiences with inappropriate workplace behaviors, there is a risk that your participation could produce personal discomfort. If this is the case, then you are advised to seek confidential counseling or advocacy services from trained professionals. These individuals could be found through employee assistance programs.

Confidentiality - This survey is for research purposes only. Your confidential responses will only be reviewed by members of the research team. For statistical purposes, your demographic information will be summarized, categorized into groups but basic identifying information will not be collected. All collected data will be kept confidential and stored in a password protected folder on a password-protected computer kept by the primary investigator.

Concerns or Questions - Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). The University of Central Florida conducts research in accordance with Ethical Conduct in Human Research. If you have any concerns or questions about this research, please contact the principal investigator, Joy Parchment, at joyparchment@knights.ucf.edu
You may also contact the dissertation chair of this graduate student, Dr. Diane Andrews, at diane.andrews@ucf.edu or the manager of the University of Central Florida's Institutional Review Board at, 407-823-3778 if there are any complaints concerning the conduct of this research study. This research

study has been reviewed and approved by the UCF IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901. Last, the research team is very appreciative and grateful for your assistance with this research study.

Q2.2 I have read, understood, and printed a copy of, the above consent form and desire of my own free will to participate in the nurse managers, work environment factors and counterproductive behaviors research study.

- ❍ Yes
- ❍ No

APPENDIX D:
PERMISSION LETTERS

Approval for Negative Acts Questionnaire

Joy Parchment
Thu 9/18/2014 5:40 AM
Permissions for dissertation
To: Ståle Einarsen <Stale.Einarsen@psysp.uib.no>; 1 attachment

NAQ Agreement 2014_09_18_Parchment.pdf504 KB
Good day Dr. Einarsen,
Thank you very much for your reply. I agree to the user terms that are stipulated in the agreement form, have signed it, and attached the form to this email. Right now, I don't have any other questions, but that could change as I get closer to finalizing the pieces for my proposal.
Regards,
Joy
Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida College of Nursing

From: Ståle Einarsen <Stale.Einarsen@psysp.uib.no>
Sent: Tuesday, September 16, 2014 5:56 AM
To: 'joyparchment@knights.ucf.edu'
Subject: FW: Negative Acts Questionnaire

Dear Joy

Thank you for your interest in the Negative Acts Questionnaire. I have attached the English version of the NAQ, a SPSS database, psychometric properties of the questionnaire and the articles suggested on our website. Please use the Einarsen, Hoel and Notelaers article (2009) in Work and Stress as your reference to the scale. I have also attached a book chapter on the measurement of bullying where you also find information on the one item measure.

We will grant you the permission to use the scale on the condition that you accept our terms for users found in the work file attached to this mail. Please fill this in and return. Normally, it is free to use the scale as long as it is non for profit and research only. If not, please be in contact.

One of our term is that you send us your data on the NAQ with some demographical data when the data is collected. These will then be added to our large Global database which now contains some 50.000 respondents from over 40 countries. Please send them as soon as your data is collected. A SPSS database is attached to this mail in the Naqinfo file. If you have any questions, we will of course do our best to answer them.
In case of problems with opening the rar-file? Please have look at this guide: http://www.tech-pro.net/howto-open-rar-file.html
All the best!
Ståle

Conditions for Users of the NAQ

To Whom It May Concern,

If you are interested in using the Negative Acts Questionnaire in your research you are welcome to use this scale in your research as long as you agree with the following terms:

1. That you give us a short description of your research project, and some information about yourself (workplace/institution, education/title).
Please provide the following information;

Dissertation Title/working title:
Workplace Bullying of Nurse Managers

Purpose:
In the WPB literature, nurse managers have been identified as perpetrators of WPB. Yet, no published studies were identified that established this group as targets of WPB. Therefore, the purpose of the study is to examine if nurse managers are indeed targets of WPB. Additional variables will also be explored, they are: authentic leadership style, influence/power, job demand and autonomy

Personal information:
Joy Parchment, MSN, RN, NE-BC
Email: joyparchment@knights.ucf.edu
I am employed as a nurse executive in the role of: Director, Nursing Strategy Implementation and Magnet Program at the second largest healthcare system in Orlando, Florida, United States. I have completed all course work and my candidacy exam for the degree of Doctor of Philosophy in Nursing. Currently and for the next two upcoming semesters, I will be engaged in completing my dissertation. My goal is to graduate, summer of 2015.

University Information:
University of Central Florida
College of Nursing
University Tower - Suite 464
12201 Research Parkway
Orlando, FL. 32823-3265
Phone: 407-823-2744
Fax: 407-823-5675
Email: ucfnurse@ucf.edu

Supervisor information and contact details:
Diane Andrews, PhD, RN (dissertation chair)
Associate Professor
Graduate Leadership and Management Track Coordinator
UCF College of Nursing
University Tower - Suite 464
12201 Research Parkway
Orlando, FL 32823-3265
Phone: 407-823-3084
Email: Diane.Andrews@ucf.edu

2. That you provide us with the NAQ data (only the NAQ data, not any other data you collect) after you have finished your study, including demographic data and response rate. These data must compatible with SPSS.
Please state;
I agree; data analysis will not be completed until the end of May, 2015

---

3. That the use of the NAQ is for research purposes only (non- profit).
Yes it is

---

4. That each permission is for one project only.
Yes, the NAQ will only be used for my dissertation

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5. That you provide us with any translation of the questionnaire you may do, and that such translation must be done in a professional sound manner with back translation.
I agree

Signature,

Joy Parchment

Joy Parchment, MSN, RN, NE-BC
UCF, Doctoral Student

Approval for Upwards Bullying Scale

From: Joy Parchment
Wed 1/22/2014 5:04 AM
To: Sara Branch <s.branch@griffith.edu.au>;

Dr. Branch -
Thank you so very much for the quick reply and the articles. I am blown away by your generosity. There were some articles that I did not have so I am excited to add them to my library.
Have a great day - I will be in touch
JP

Joy Parchment, MSN, RN, NE-BC
Doctoral Student
College of Nursing

From: Sara Branch <s.branch@griffith.edu.au>
Sent: Monday, January 20, 2014 7:42 PM
To: Joy Parchment
Subject: Re: Upward bullying topic

Joy,

It is good to hear that you are researching the topic of upwards bullying and look forward to hearing about your findings.

You can find out more about the scale I used in my thesis. It can be accessed via the Griffith University website (see the link below).

https://www120.secure.griffith.edu.au/rch/items/d681dc3b-64d8-9968-14d2-8089fcd1637d/1/

Essentially what I did was adapt the NAQ-R and added concepts that were raised in the my interview study (see page 186 - 190 for full explanation and appendix for the scale).

I am assuming you have most of the attached papers that are some way related to the concept of upwards bullying but thought I would share them just in case you don't have them.

All the best,

Sara

Sara Branch PhD
Adjunct Research Fellow
Key Centre for Ethics, Law, Justice and Governance
Mt Gravatt Campus - Griffith University
176 Messines Ridge Road
MT GRAVATT QLD 4122

Telephone: +61 (0)7 373 55666
Fax: +61(0)7 373 56812
Pathways Project: www.griffith.edu.au/pathways-to-prevention

"Don't worry about the world coming to an end today. It's already tomorrow in Australia." Charles Schultz

To: Sara Branch s.branch@griffith.edu.au
On Mon, Jan 20, 2014 at 3:00 AM,
From: Joy Parchment <joyparchment@knights.ucf.edu>:

Good day Dr. Branch -
I am presently in the College of Nursing's doctoral program at the University of Central Florida in Orlando, Florida, USA. My area of focus for my dissertation is workplace bullying, specifically upward bullying of nurse managers.
After performing a literature search on the topic, I was not surprised to find that few individuals have studied this aspect of workplace bullying. I have read your studies and am interested in finding out more about the Upward Bullying Scale that was mentioned in the 2006 conference proceedings paper titled "Causes of Upwards Bullying: Manager's Perspectives". This was given at the 20th ANZAM Conference Management: Pragmatism, Philosophy, Priorities.
When I reviewed the literature, I was not able to find detailed references to the data analysis about the scale published in a peer reviewed journal, nor did I find any other reference to the scale from other investigators who have studied the topic.
Here are my questions: Would you be able to assist me with identifying a journal that published the analysis? After my review of the data and if it appropriate for my research question, would it be possible to use the scale for my dissertation? I would greatly appreciate any direction you can provide.
Thank you and I look forward to hearing from you.
Joy

Joy Parchment, MSN, RN, NE-BC
Doctoral Student
College of Nursing

Approval for Authentic Leadership Inventory

From: Joy Parchment" <joyparchment@knights.ucf.edu>
Wed 9/10/2014 7:41 AM
To: Neider, Linda <lneider@bus.miami.edu>;

Thank you very much Dr. Neider - I have a copy of the article and will pull the questions from it. I will keep you posted on the results - my goal is to complete the dissertation by spring of 2015. Again, thank you. Have a super day.
JP
Sent from my iPhone
Joy Parchment

On Sep 10, 2014, at 7:29 AM, "Neider, Linda" <lneider@bus.miami.edu> wrote:
Hi, Joy - I teach in our MBA program designed for Health Sector professionals (mainly physicians, specialists, nurses) and feel your research topic is timely as well as interesting. The questions for ALI are actually presented in the publication itself because we wanted them to be accessible to researchers. If you need a hard copy of the article, I may have reprints around.

Will look forward to finding out what your results indicate.

Best wishes,
Linda

Linda L. Neider, Ph.D.
Professor, Department of Management
University of Miami

Follow me on twitter: neideronthemove
Please excuse typos, grammatical errors, and abbreviations
Sent from iPhone

On Sep 10, 2014, at 6:40 AM, "Joy Parchment" <joyparchment@knights.ucf.edu> wrote:
Good morning Dr. Neider,
I am a PhD student at the University of Central Florida, College of Nursing working toward completion of my dissertation. I am interested in using the Authentic Leadership Inventory in my dissertation; it will examine leadership styles of nurse leaders and workplace bullying. As you mentioned in your 2011 article on the development and testing of the scale, I am looking for an instrument that will always be available because this topic is going to be part of my ongoing program of research.
Thank you for considering this request and I look forward to your reply.
Joy

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida College of Nursing

Approval for Global Social Power Scale

From: Joy Parchment" <joyparchment@knights.ucf.edu>
Thu 9/11/2014 6:36 AM
To:Mitchell.Nesler@esc.edu <Mitchell.Nesler@esc.edu>;

Thank you Dr. Nesler - I intend to study nurse managers and workplace bullying. The literature suggests this group has the highest ability to influence nurses and they are the major perpetrators of workplace bullying. One of my goals is to examine this relationship and hopefully identify that this group are also recipients of workplace bullying.
Thanks again -
JP
Sent from my iPhone

To: Joy Parchment <joyparchment@knights.ucf.edu>
On Sep 11, 2014, at 6:05 AM, "Mitchell.Nesler@esc.edu" <Mitchell.Nesler@esc.edu> wrote:
Good Morning Joy
Yes of course, please feel free to use the scale. As a former associate dean in a nursing program, I'm always happy to help advance nursing research. What is your dissertation about?

Best Regards,
Mitch

Mitchell S. Nesler, Ph.D.
Vice President for Enrollment Management and Decision Support
Empire State College
State University of New York
One Union Ave.
Saratoga Springs, NY 12866
Phone: (518) 587-2100 ext. 2766
Fax: (518) 587-5592
E-mail: Mitchell.Nesler@esc.edu

<Image.1410429888989.gif>

-----Joy Parchment <joyparchment@knights.ucf.edu> wrote: -----
To: "mitchell.nesler@esc.edu" <mitchell.nesler@esc.edu>
From: Joy Parchment <joyparchment@knights.ucf.edu>
Date: 09/11/2014 05:42AM
Subject: Request to use Global Power Scale

Good morning Dr. Nesler -

I am a PhD student at the University of Central Florida, College of Nursing working toward completion of my dissertation. I am interested in using the Global Social Power scale that was discussed in your 1999 article, 'the development and validation of a scale measuring global social power based on French & Raven's power taxonomy" to measure the variable 'power' in my dissertation. I ran across this instrument and believe it will fit nicely with my intended topic. My plan is to examine leadership styles of nurse

leaders and workplace bullying. So, I am requesting permission to use the Global Social Power scale in my dissertation. Thank you for considering this request and I look forward to your reply.

Joy

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida College of Nursing

Approval for Job Demand & Job Control Scale

As noted in Cousins et al. (2004, p. 134), the authors state “the HSE Indicator Tool is freely available to any organization that wishes to use it and is not protected by copyright”.

APPENDIX E:
STUDY QUESTIONNAIRE

Nurse Managers, Work Environment Factors and Counterproductive Behaviors Study Questionnaire

Q3.1 There are specific criteria that each study participant must meet, this section will assist in determining if you meet the criteria for the study. Please answer all questions by checking the appropriate box.

Q3.2 Are you a registered nurse (RN) with an active license?
- ❍ Yes
- ❍ No

Q3.3 Are you currently employed as a nurse manager of an in-patient department or unit in an acute care hospital located in the United States?
- ❍ Yes
- ❍ No

Q3.4 If previously employed as a nurse manager, is it more than 6 months since you have left your role?
- ❍ Yes
- ❍ No

Q3.5 Do you have 24-hour/7 day a week accountability for one or more in-patient acute care departments or units?
- ❍ Yes
- ❍ No

Q3.6 Do you have budgetary responsibilities for one or more in-patient acute care departments or units?
- ❍ Yes
- ❍ No

Q3.7 Are you above the age of 18 years of age?
- ❍ Yes
- ❍ No

Q3.8 In what capacity are you employed? Select only one option.
- ❍ Full-time - yes
- ❍ Variable full-time - yes
- ❍ Part time - yes

Q3.9 Do any of the following descriptions apply to your role? Please check all applicable descriptions.

	Yes	No
Are you an inpatient nurse manager without 24 hour/7 day a week accountability?	❍	❍
Are you a nurse manager of an outpatient and or non-patient care unit/department?	❍	❍
Are you a nurse manager in a non-hospital based unit/department?	❍	❍

Q4.1 About You

This section is about your information as a nurse manager. Please answer all questions by checking the appropriate box that corresponds to the answer that best describes you.

Q4.2 What is your current age?

❍ 20 to 24
❍ 25 to 34
❍ 35 to 44
❍ 45 to 54
❍ 55 to 64
❍ 65 or over

Q4.3 What is your gender?

❍ Male
❍ Female
❍ Declined
❍ Unavailable

Q4.4 What is your Ethnicity?

o Are you Hispanic, Latino, or Spanish origin
o No, not of Hispanic, Latino, or Spanish origin
o Yes, Mexican, Mexican American, Chicano
o Yes, Puerto Rican
o Yes, Cuban
o Yes, another Hispanic, Latino, or Spanish origin
o Unavailable/Unknown
o Declined

Q4.5 What is your race? (One or more categories may be checked)

- o American Indian/Alaska Native
- o Asian
- o Black or African American
- o Native Hawaiian/Other Pacific Islander
- o White
- o Some other race _____
- o Declined
- o Unavailable/Unknown

Q4.6 In which state do you currently reside?

- ❍ Alabama
- ❍ Alaska
- ❍ Arizona
- ❍ Arkansas
- ❍ California
- ❍ Colorado
- ❍ Connecticut
- ❍ Delaware
- ❍ District of Columbia
- ❍ Florida
- ❍ Georgia
- ❍ Hawaii
- ❍ Idaho
- ❍ Illinois
- ❍ Indiana
- ❍ Iowa
- ❍ Kansas
- ❍ Kentucky
- ❍ Louisiana
- ❍ Maine
- ❍ Maryland
- ❍ Massachusetts
- ❍ Michigan
- ❍ Minnesota
- ❍ Mississippi
- ❍ Missouri
- ❍ Montana
- ❍ Nebraska
- ❍ Nevada
- ❍ New Hampshire
- ❍ New Jersey
- ❍ New Mexico
- ❍ New York

- ❍ North Carolina
- ❍ North Dakota
- ❍ Ohio
- ❍ Oklahoma
- ❍ Oregon
- ❍ Pennsylvania
- ❍ Rhode Island
- ❍ South Carolina
- ❍ South Dakota
- ❍ Tennessee
- ❍ Texas
- ❍ Utah
- ❍ Vermont
- ❍ Virginia
- ❍ Washington
- ❍ West Virginia
- ❍ Wisconsin
- ❍ Wyoming
- ❍ I do not live in the continental United States

Q4.7 What is your length of experience? Fill in the blank with the number of years.

A registered nurse (RN) _____

A nurse manager _____

Q4.8 What is your employment status?

- o Full time, >40 hours/week
- o Part time, <40 hours/week
- o Interim
- o Full time Interim
- o Part time Interim

Q4.9 How long have you been employed with your current organization? Fill in the blank with the number of years.

Q4.10 What is the highest level of education you have completed?

- ❍ Diploma
- ❍ Associate of Science (ASN/ADN) in Nursing
- ❍ Bachelor of Science in Nursing
- ❍ Bachelors Degree outside of Nursing
- ❍ Masters Degree in Nursing
- ❍ Masters Degree outside of Nursing
- ❍ Doctoral Degree in Nursing
- ❍ Doctoral Degree outside of Nursing

Q4.11 Do you have a national specialty certification?
- ❍ Yes
- ❍ No

Q4.12 What type of unit or department do you manage?
- ❍ Critical Care
- ❍ Emergency
- ❍ Medical
- ❍ Medical-surgical
- ❍ Obstetrics
- ❍ Oncology
- ❍ Operating Room
- ❍ Pediatrics
- ❍ Post Anesthesia Care Unit
- ❍ Surgical
- ❍ Other _____

Q4.13 How many full time equivalents (FTEs) do you manage? Fill in the blank.

Q4.14 Is your hospital a Magnet®, Non-Magnet® or Pathways to Excellence® designated hospital?

	Yes	No
Magnet®	❍	❍
Non-Magnet®	❍	❍
Pathways to Excellence®	❍	❍

Q4.15 What is the bed size of your hospital?
- ❍ 1-199
- ❍ 200-399
- ❍ 400-599
- ❍ 600-799
- ❍ 800 or more

Q4.16 In what state is your hospital located? Fill in the blank. _____

Q4.17 Is your hospital located in any of the following areas?
- ❍ Rural
- ❍ Suburban
- ❍ Urban

Q5.1 Your Work Environment

Permission to use this scale was obtained from Linda L. Neider, PhD. This section asks for information about your work environment. Specifically, your nurse leader's (director,

administrator, nurse executive) leadership style and influencing behaviors as you perceive it. Rate how frequently each statement fits with your current situation by using the following scale: *disagree strongly, disagree, neither agree or disagree, agree, agree strongly.*

	Disagree Strongly	Disagree	Neither Agree or Disagree	Agree	Agree Strongly
My nurse leader (director, administrator, nurse executive) solicits feedback for improving his/her dealings with others.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) clearly states what he/she means.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) shows consistency between his/her beliefs and actions.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) asks for ideas that challenge his/her core beliefs.	❍	❍	❍	❍	❍
My nurse leader (director, administrator) describes accurately the way that others view his/her abilities.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) admits mistakes when they occur.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) uses his/her core beliefs to make decisions.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) carefully listens to alternative perspectives before reaching a conclusion.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) leader shows that he/she understands	❍	❍	❍	❍	❍

his/her strengths and weaknesses.					
My nurse leader (director, administrator, nurse executive) openly shares information with others.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) resists pressures on him/her to do things contrary to his/her beliefs.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) objectively analyzes relevant data before making a decision.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) is clearly aware of the impact he/she has on others.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) expresses his/her ideas and thoughts clearly to others.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) is guided in his/her actions by internal moral standards.	○	○	○	○	○
My nurse leader (director, administrator, nurse executive) encourages others to voice opposing points of view.	○	○	○	○	○

Q5.2 Permission to use this scale was obtained from Mitchell Nesler, PhD. This section asks for information about your work environment. Specifically, your nurse leader's (director, administrator, nurse executive) leadership style and influencing behaviors as you perceive it. Rate how frequently each statement fits with your current situation by using the following scale: *disagree strongly, disagree, neither agree or disagree, agree, agree strongly.*

	Disagree Strongly	Disagree	Neither Agree or Disagree	Agree	Agree Strongly
My nurse leader (director, administrator, nurse executive) can influence me to work harder at my job.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) can influence the type of projects I become involved in.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) can influence my work-related activities.	❍	❍	❍	❍	❍
My nurse leader (director, administrator, nurse executive) can influence how I evaluate the work of others.	❍	❍	❍	❍	❍
The clinical nurses that report to me can influence me to work harder at my job.	❍	❍	❍	❍	❍
The clinical nurses that report to me can influence the type of projects that I become involved in.	❍	❍	❍	❍	❍
The clinical nurses that report to me can influence my work-related activities.	❍	❍	❍	❍	❍
The clinical nurses that report to me can influence how I evaluate the work of others.	❍	❍	❍	❍	❍

Q5.3 Open access scale as noted by Cousins, et al 2004.Check the appropriate box that best corresponds to your answer by using the following scale: *never, seldom, sometimes, often, always.*

	Never	Seldom	Sometimes	Often	Always
I am pressured to work long hours.	❍	❍	❍	❍	❍
I am clear about what is expected of me.	❍	❍	❍	❍	❍
I have un-achievable deadlines.	❍	❍	❍	❍	❍
I have a say in my own work speed.	❍	❍	❍	❍	❍
I have to work very fast.	❍	❍	❍	❍	❍
I have to work very intensively.	❍	❍	❍	❍	❍
I have to neglect some tasks because I have too much to do.	❍	❍	❍	❍	❍
Different groups at work demand things from me that are hard to combine.	❍	❍	❍	❍	❍
I am unable to take sufficient breaks.	❍	❍	❍	❍	❍
I have a choice in deciding what to do at work.	❍	❍	❍	❍	❍
I have a choice in deciding how I do my work.	❍	❍	❍	❍	❍

Q5.4 Check the appropriate box that best corresponds to your answer by using the following scale: *disagree strongly, disagree, neither agree or disagree, agree, agree strongly.*

	Disagree Strongly	Disagree	Neither Agree or Disagree	Agree	Agree Strongly
I have some say over the way I work.	❍	❍	❍	❍	❍
My working time can be flexible.	❍	❍	❍	❍	❍

Q6.1 Experience with Counterproductive Behaviors

Permission to use this scale was obtained from Stale Einarsen, PhD. The following are often seen as unacceptable, negative, inappropriate behaviors in the workplace. Over the last six months, how often have you been subjected to the following behaviors at your organization? Rate your response using the following scale: *never, now and then, monthly, weekly, daily.*

	Never	Now and Then	Monthly	Weekly	Daily
Someone withholding information which affects your performance.	❍	❍	❍	❍	❍
Being humiliated or ridiculed in connection with your work by your staff or your leader.	❍	❍	❍	❍	❍
Being ordered to do work below your level of competence.	❍	❍	❍	❍	❍
Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks.	❍	❍	❍	❍	❍
Spreading gossip and rumors about you.	❍	❍	❍	❍	❍
Being ignored or excluded.	❍	❍	❍	❍	❍
Having insulting or offensive remarks made about your person, attitudes, or your private life.	❍	❍	❍	❍	❍
Being shouted at or being the target of spontaneous anger or rage.	❍	❍	❍	❍	❍
Using intimidating behaviors such as finger-pointing, invasion of personal space, shoving, blocking or baring your way.	❍	❍	❍	❍	❍
Hints or signals from clinical nurses, other nurse managers or your leader that you should quit your job.	❍	❍	❍	❍	❍
Repeated reminders of your errors or mistakes.	❍	❍	❍	❍	❍
Being ignored or facing a hostile reaction when you approach clinical nurses,	❍	❍	❍	❍	❍

other nurse managers, and your leader.					
Persistent criticism of your errors or mistakes.	○	○	○	○	○
Having your opinions ignored.	○	○	○	○	○
Unreasonable practical jokes directed to you.	○	○	○	○	○
Being given tasks with unreasonable targets or impossible deadlines by your leader.	○	○	○	○	○
Having allegations made against you.	○	○	○	○	○
Excessive monitoring of your work.	○	○	○	○	○
Pressure not to claim something to which by right you are entitled (i.e., sick leave, holiday entitlement, travel expenses).	○	○	○	○	○
Being the subject of excessive teasing and sarcasm.	○	○	○	○	○
Being exposed to an unmanageable workload.	○	○	○	○	○
Threats of violence or physical abuse or actual abuse.	○	○	○	○	○

Q6.2 Permission to use this scale was obtained from Sara Branch, PhD. Over the last ***six*** months, how often have you been subjected to the following behaviors from your clinical nurses at your organization? Rate your response using the following scale: *never, now and then, monthly, weekly, daily.*

	Never	Now and Then	Monthly	Weekly	Daily
A clinical nurse withholding expertise which affects your performance.	❍	❍	❍	❍	❍
Being informed by a clinical nurse just before a deadline of tasks they have not completed.	❍	❍	❍	❍	❍
Being reminded by a clinical nurse of the rules of the workplace in an inappropriate manner.	❍	❍	❍	❍	❍
Being pressured by a clinical nurse not to implement disciplinary action which you believe should be carried out by you.	❍	❍	❍	❍	❍
A clinical nurse becoming a nuisance by annoying you in an inappropriate manner, until you give them what they want.	❍	❍	❍	❍	❍
A clinical nurse obtaining the support of other nurses to back up their own (unreasonable) request.	❍	❍	❍	❍	❍
A clinical nurse filing a grievance or making allegations which are later found to be frivolous.	❍	❍	❍	❍	❍
A clinical nurse threatening to file an unreasonable grievance against you.	❍	❍	❍	❍	❍
A clinical nurse going over your head (to your manager) to intimidate you to change a decision you made or will make.	❍	❍	❍	❍	❍
A clinical nurse using a third party to intimidate you into altering a decision you made or will make.	❍	❍	❍	❍	❍
A clinical nurse not completing work assigned by you, which affects your performance.	❍	❍	❍	❍	❍
A clinical nurse(s) challenging your authority in front of others.	❍	❍	❍	❍	❍

Q6.3 The following questions relate to behaviors or circumstances that could be considered workplace bullying. According to the definition, bullying occurs when an employee systematically and repeatedly over time feel that they have been subjected to negative, unreasonable behavior by one or more employees. This behavior regardless of intent, degrades, offends, intimidates, or humiliates the employee and makes it difficult for the

employee to defend against the behaviors. According to the above definition, have you been subjected to workplace bullying during the last ***six*** months?

- ○ Yes
- ○ No

Q6.4 How often did you experience being bullied either by either clinical nurses, other nurse managers and or your nurse leader within the past six months?

- ○ Now and then
- ○ Daily
- ○ Weekly
- ○ Monthly

Q6.5 How long did the bullying that you experienced from a clinical nurses, other nurse managers and or your nurse leader continue? Rate your answer by identifying the number of weeks or months. _____ Weeks; _____ Months

Q6.6 Is the bullying that you experienced still going on today?

- ○ Yes
- ○ No

Q6.7 Important Reminder

The information shared is for research purposes only. Your responses are confidential and will not assist in your bullying experiences. If you desire to take action or need to seek confidential counseling from trained professionals, please contact a licensed counselor or your Employee Assistance Program.

Q6.8 Think of the circumstances in which you were bullied. From the list below, please identify who bullied you and their gender. Identify if they were: *male, female, or both male and female.*

	Male	Female	Both Male and Female
A clinical nurse who you supervise or manage within your own work team, group, or department.	❍	❍	❍
A group of clinical nurses who you supervise, manage within your own work team, group, or department.	❍	❍	❍
A clinical nurse from another work team, group, or department.	❍	❍	❍
A group of clinical nurses from another work team, group, or department.	❍	❍	❍
A nurse manager from another work team, group, or department.	❍	❍	❍
Your nurse leader (director, administrator) who you directly report to.	❍	❍	❍
Your nurse leader and a nurse manager from another work team, group, or department.	❍	❍	❍

Q6.9 In the last ***six*** months, what impact, if any has the bullying by either a clinical nurse, your nurse leader, or nurse manager colleague, had on your life? Rate your responses using the following scale: *very negative, moderately negative, no effect, moderately positive, very positive*.

	Very Negative	Moderately Negative	No Effect	Moderately Positive	Very Positive
Your physical health and well being.	❍	❍	❍	❍	❍
Your mental health and well-being.	❍	❍	❍	❍	❍
Your confidence and self-esteem.	❍	❍	❍	❍	❍
Your work attendance	❍	❍	❍	❍	❍
Your efficiency at work.	❍	❍	❍	❍	❍
Your willingness to discipline staff.	❍	❍	❍	❍	❍
Your relationships with others at work.	❍	❍	❍	❍	❍
Your career.	❍	❍	❍	❍	❍

Q6.10 Bullying is any inappropriate, unreasonable, negative behavior regardless of intent that degrades, offends, intimidates, or humiliates the employee and makes it difficult for the employee to defend against the behaviors.

	Yes	No
Have you witnessed another nurse manager at your organization being bullied by a clinical nurse within the last six months?	❍	❍
Have you witnessed another nurse manager at your organization being bullied by their nurse leader within the last six months?	❍	❍
Have you witnessed another nurse manager at your organization being bullied by another nurse manager within the last six months?	❍	❍

Q6.11 Did witnessing the behavior affect your work?

❍ Yes

❍ No

Q6.12 If you answered YES, how did the behavior affect your work? Fill in the blank.

_____

Q7.0 Congratulations, you have completed the questionnaire. Thank you for your time!

APPENDIX F:
RECRUITMENT LETTERS

Initial Recruitment Letter to Nurse Managers

May 11, 2015

Name of Nurse Manager Colleague
12345 Anywhere Street
Anywhere, State, ZIP

Dear Nurse Manager Colleague:

I am inviting your participation in the *Nurse Managers, Work Environment Factors and Counterproductive Behaviors Survey*. This online study is part of my final work for fulfillment of a doctoral degree in nursing at the University of Central Florida.

Nurse leaders who are managers and who work in acute care hospitals have been selected to complete a questionnaire about their experiences as a nurse manager. If you are not in the role of a nurse manager, would you kindly *forward* this letter onto your nurse colleagues who fit this role?

A goal of this study is to understand what occurs in the workplace so nursing leaders can develop prevention strategies that may lead to decreasing these counterproductive behaviors in the workplace. I am particularly interested in learning about the experiences of nurse managers with these behaviors and how these behaviors have impacted that role.

The questionnaire, is of a moderate length, and should take approximately 20-30 minutes to complete. To begin the survey, please enter the URL link listed below into your internet browser: NurseManagerStudy

The survey is completely voluntary and your answers absolutely confidential. Should you have any questions or comments about the survey, you can direct them to the principal investigator: Joy Parchment, at joyparchment@knights.ucf.edu.

I appreciate your assistance to understand the experiences of nurse managers with counterproductive behaviors in the workplace.

Warmest Regards,

Joy Parchment

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida
College of Nursing

Invitation Letter to Nurse Leaders

May 11, 2015

Name of Nursing Colleague
12345 Anywhere Street
Anywhere, State, ZIP

Dear Nursing Colleague:

Nurse leaders who are managers and who work in acute care hospitals have been selected to complete a questionnaire about their experiences as a nurse manager. If you are not in the role of a nurse manager, would you kindly *forward* this letter onto your nurse colleagues who manage acute care departments or patient care units?

You are being invited to participate in the *Nurse Managers, Work Environment Factors and Counterproductive Behaviors Survey*. This online study is part of my final work for fulfillment of a doctoral degree in nursing at the University of Central Florida.

A goal of this study is to understand what occurs in the workplace so nursing leaders can develop prevention strategies that may lead to decreasing counterproductive behaviors in the workplace. I am particularly interested in learning about the experiences of nurse managers with these behaviors and how these behaviors have impacted that role.

The questionnaire is of a moderate length and should take approximately 20-30 minutes to complete. To begin the survey, please enter the URL link listed below into your internet browser: NurseManagerStudy

The survey is completely voluntary and your answers absolutely confidential. Should you have any questions or comments about the survey, you can direct them to the principal investigator: Joy Parchment, at joyparchment@knights.ucf.edu.

I appreciate your assistance to understand the experiences of nurse managers with counterproductive behaviors in the workplace.

Warmest Regards,

Joy Parchment

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida
College of Nursing

First Reminder Postcard to Nurse Managers

May 26, 2015
Subject: Express your opinions about the NMCB survey

Dear nursing colleague,
Earlier this week, I sent you a letter asking for your participation in the *Nurse Managers, Work Environment Factors and Counterproductive Behaviors Survey* or your assistance with forwarding this letter onto your nurse colleagues who fit the role of nurse manager.

By providing this link to the survey questionnaire I am hoping that it makes it easy for individuals to respond. To access the survey, just follow this link: NurseManagerStudy

This online survey is important because nurse managers who are pivotal links in acute care settings are frequently asked to meet organizational goals with limited resources. We need to understand how factors in the work environment impact counterproductive behaviors that are directed to nurse managers.

Participation in this study is completely voluntary and answers will be kept confidential. Your consideration of this request is appreciated.

Many Thanks,

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida
College of Nursing

Final Reminder Postcard to Nurse Managers

June 10, 2015
Subject: Last chance to share your experiences for the NMCB study

Dear nursing colleague,
This is a follow up to the mailed postcard that I sent last week asking you to complete the *Nurse Managers, Work Environment Factors and Counterproductive Behaviors Survey* or your assistance with forwarding this letter onto your nurse colleagues who fit the role of nurse manager. This questionnaire is to gain an increased understanding of the work environment of nurse managers and counterproductive behaviors that can impact the role. The survey is ending and this is the last reminder that will be sent about the study. The URL link to the survey is: NurseManagerStudy

Thank you for your help and I wish you continued prosperity in all of your future endeavors.

Sincerely,

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida
College of Nursing

APPENDIX G:
FONE EMAIL REQUEST FOR DISTRIBUTION

FONE Email Request for Distribution

Request for distribution

Joy Parchment

Thu 6/11/2015 5:55 AM

To: Florida Organization of Nurse Executives <info@foneorg.com>;

1 attachment (96 KB)

RECRUITMENT LETTER FONE.pdf;

Good morning Diane,

I am in the process of data collection for my dissertation. Would it be possible for you to distribute this advertisement and recruitment letter to the FONE members? If there is another group that I would need to contact, then please let me know.

Below is the advertisement that is approved by my IRB to use.

Nurse managers, work environment and counterproductive workplace behaviors survey

Acute care nurse managers are being invited to participate in a research study that examines work environment factors associated with counterproductive workplace behaviors directed toward them. Findings from the study could increase awareness of these behaviors and assist nursing leaders with generating prevention strategies that may decrease behaviors in the workplace. This research study is conducted by Joy Parchment, MSN, RN, NE-BC and is her dissertation for fulfillment of a doctoral degree in nursing. If you choose to participate in this research study, you will be asked to access a web based questionnaire using a dedicated URL link. The questionnaire consists of questions about you, the work environment, and your frequency of exposure to these counterproductive behaviors. Completion of the questionnaire is expected to take approximately 20-30 minutes and your responses will be kept confidential. To access the questionnaire, please click here. Questions or comments about the survey, can be directed to the principal investigator, Joy Parchment .

Also, the recruitment letter and the electronic link are also attached, electronic link is: http://bit.ly/1QNOpxl

Thank you for considering this request.

JP

Joy Parchment, MSN, RN, NE-BC
Doctoral Candidate
University of Central Florida College of Nursing

Re: Request for distribution

Florida Organization of Nurse Executives <info@foneorg.com>

Thu 6/11/2015 4:06 PM

To: Joy Parchment <joyparchment@knights.ucf.edu>;

Joy-I will forward your request to the Research Committee who reviews requests of this nature. I will suggest placing a link to the study (if you have one) and sending an email to members to participate. Either Leslie or Jackie will get back to you.

Regards,

Diane

Florida Organization of Nurse Executives
7380 W Sand Lake Drive
Orlando, Florida 32819
Phone: 407-992-2307
Fax: 866-627-0987
http://www.foneorg.com

Approval for FONE member access

Rogers, Leslie D. <Leslie.Rogers@moffitt.org>
Mon 6/15/2015 1:02 PM
Inbox
To: Joy Parchment <joyparchment@knights.ucf.edu>;
Cc:jackie.munro@baycare.org <jackie.munro@baycare.org>; 'DC' <dcbradyasoc@msn.com>;

Hello Joy,
Jackie and I have reviewed your evidence of IRB approval and proposal. We approve access to FONE membership through the FONE website.
We will post your Recruitment Letter on the FONE website with access to the letter in the members only area. We will send out an e-mail to FONE membership notifying them of the opportunity to participate in the study.

First steps - In order to facilitate your request, Diane Brady-Schwartz will work with our FONE webmaster to establish the link to your Recruitment Letter on the FONE members Homepage under the FONE "Featured Opportunities".
Diane will just need to know when you would like to begin recruitment and the data collection period. You may contact Diane in regards to this. She may have further questions regarding any specific needs you have for posting the Recruitment Letter for FONE members. Diane is cc'd on this e-mail.

Best wishes on your study. Please contact either Jackie or myself if we can be of any further assistance.

Leslie Rogers Co-chair FONE Research Committee
Jackie Munro Co-chair FONE Research Committee

Leslie Rogers MBA BSN RN PhD (c)
Director Medical/Surgical and Magnet Program
Moffitt Cancer Center

12902 Magnolia Drive, Tampa, FL 33612 | **tel:** 813-745-2647 | **fax:** 813-745-1802 | **email:** Leslie.Rogers@moffitt.org

APPENDIX H:
NEWSLETTER ADVERTISEMENT

Nurse Managers, Work Environment and Counterproductive Workplace Behaviors Survey - AONE Newsletter & FONE Website Advertisement

Acute care nurse managers are being invited to participate in a research study that examines work environment factors associated with counterproductive workplace behaviors directed toward them. Findings from the study could increase awareness of these behaviors and assist nursing leaders with generating prevention strategies that may decrease behaviors in the workplace. This research study is conducted by Joy Parchment, MSN, RN, NE-BC and is her dissertation for fulfillment of a doctoral degree in nursing.

If you choose to participate in this research study, you will be asked to access a web based questionnaire using a dedicated URL link. The questionnaire consists of questions about you, the work environment, and your frequency of exposure to these counterproductive behaviors. Completion of the questionnaire is expected to take approximately 20-30 minutes and your responses will be kept confidential. To access the questionnaire, please click here. Questions or comments about the survey, can be directed to the principal investigator, Joy Parchment.

APPENDIX I:
NEWSLETTER ADVERTISEMENT AGREEMENTS

The American Organization of Nurse Executives

Membership Access Guidelines, Policy and Agreement

Membership Access for Research

The following guidelines have been established for accessing AONE membership for research participation. Access to membership may be obtained by mailing list rental or request for research participation through an electronic format: AONE eNews; AONE Working for You (AWFY)

Request for Research Participation: Mailing List Rental Policy

See Mailing List Rental Agreement.

Request for Research Participation: Electronic Format

1. All requests for membership access for research participation must be made in writing using the *AONE Membership Access for Research Participation Agreement*; accompanied by the research proposal, evidence of IRB approval and a copy of the survey/questionnaire, must be provided to AONE in advance for its review and approval. AONE evaluates each request within 14 business days after receiving a copy of the *AONE Membership Access for Research Participation Agreement*. Any rejection shall specifically state the reason(s). Negotiations for any proposed revisions for membership access can be made between the parties; however, it is understood that AONE has final authority to approve or reject the request.

2. Each request must be accompanied by the request for research participation language that will be used that will be used to solicit participants.

3. Requests will be accepted only for purposes appropriate to the nurse leader roles and responsibilities, and shall not be in conflict with the AONE mission, goals and activities.

4. Access to AONE membership for research participation is available for the conduct of academic research. Access will be permitted only for those that conform to generally accepted norms and standards for survey research and that impact the role of nurses in executive practice who design, facilitate and manage patient care delivery across the health care continuum. Study publications must include the following statement: "Participation of AONE members does not indicate AONE review or endorsement of this study."

5. The researcher is responsible for providing approved language requesting research participation and an active URL directing participants to the survey and or research home page.

6. Publishing the request for research participation occurs at the first opportunity after the receipt of approved language and payment.

7. Approved requests are published on a first come first served basis. AONE has the right to limit the number of requests at any one time.

8. AONE will not provide refunds for early withdrawal of request for research participation.

Placement
Placement of requests for research participation will appear in a designated section of AONE eNews and AWFY: "Researcher seeking participants". The design and formatting of the research language is the responsibility of the researcher and must meet the parameters of AONE's electronic newsletter platform.

Pricing:
Members:
$250.00 - Includes two published requests in *AONE eNews* and or *AWFY*. $50 for each additional placement referencing the same research proposal.

Non-Members:
$500 - Includes two published requests in *AONE eNews* and or *AWFY*.
$100 for each additional placement referencing the same research proposal.

All payments shall be made prior to publication of research participation request.

Indemnification: It is understood that the Researcher is acting as an independent contractor and assumes the entire responsibility for performance under this agreement. AONE, its employees and agents are harmless against all liabilities, claims, causes of action, losses and damages to persons and property, including expenses and attorneys' fees, arising out of or caused by the researcher's performance, excluding any such liability caused by the sole negligence of AONE, its employees and agents.

Duration: This Agreement will begin on the first publication of the research request and conclude on the last published date. This Agreement may be cancelled by either party in writing within 14 days.

Miscellaneous:
1. This Agreement supersedes all prior agreements, oral or written, and constitutes the entire understanding among both parties.

2. This Agreement shall be governed by the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have executed this AGREEMENT by and between the American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association (AHA), an Illinois not-for-profit corporation with principal offices at 155 North Wacker, Chicago, IL 60606.

American Organization of Nurse Executives:	Researcher: Joy PARCHMENT
Signature	Signature [redacted]
Title	Title GRADUATE Student, PhD CANDIDATE
Date	Date 4-23-15

M.T. Meadows, RN, MS, MBA
312-422-2807 312-278-0475(fax)
mmeadows@aha.org

www.aone.org

The American Organization of Nurse Executives

Membership Access for Research Participation Agreement

Researcher: Joy Parchment, MSN, RN, NE-BC		
Primary contact: Joy Parchment		
Address:		
City:	**State:**	**Zip code:**
Telephone:	**FAX:**	
Email: joy.parchment@knights.ucf.edu		

INCLUDE

☒ **Purpose:** Attach research proposal.

☒ **IRB Approval** Attach evidence of IRB approval.

☒ **Language for publication.** Microsoft word format.

Membership Access Order:	☒ **Member***		☐ **Non-member****
	Number Of Placements	**$ Total**	**Preferred dates**
AONE eNews	2	$250.00	May 1 to June 23, 2015
AWFY	2	$100.00	May 1 to June 23, 2015

*Member:
$250.00 - Includes two published requests in *AONE eNews* and or *AWFY*.
$50 for each additional placement referencing the same research proposal participation.

**Non-Members:
$500 - Includes two published requests in *AONE eNews* and or *AWFY*.
$100 for each additional placement referencing the same research proposal participation.

Payment Method:
☐ **Check: Made payable to: AONE**
☒ **Credit Card**

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