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Nurse Manager Caring and Workplace Bullying in Nursing : the Relationship between Staff Nurses' Perceptions of Nurse Manager Caring Behaviors and Their Perception of Exposure to Workplace Bullying within Multiple Healthcare Settings

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THE RELATIONSHIP BETWEEN STAFF NURSES' PERCEPTIONS OF NURSE

MANAGER CARING BEHAVIORS AND THEIR PERCEPTION OF EXPOSURE

TO WORKPLACE BULLYING WITHIN MULTIPLE HEALTHCARE SETTINGS

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Dedication

This manuscript is dedicated posthumously, to my dear Aunt Vi (Mrs. Rosemary Richards), for her caring for and about me, and for her caring lessons about others. She was a role model for treating others with regard and responded to negativity toward herself and others with the old adages, "Everybody likes what they like" and, "If you can't say anything nice about someone, don't say anything at all." I also want to dedicate this work to my mom and my children, who very graciously tolerated my time away from them and/or their children (my grandchildren) during this journey. Lastly, I dedicate this manuscript to those of us who have observed and/or experienced workplace bullying and recommend that we tirelessly focus on caring, since there is more than enough to go around, it is reciprocal and contagious, and can make this world a better place for all!

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Abstract

This study examined the relationship between staff nurses' perception of nurse manager caring behaviors and their perceived exposure to workplace bullying within multiple healthcare settings. It was based on the theoretical position that caring promotes reciprocal caring and healing for each other and for the larger universe as informed by Watson's theory of human caring (1979, 2006, 2008). Results indicated a statistically significant, negative, linear relationship between the CFS-CM and the NAQ-R ($r = -.534$, $p < .001$), meaning that as staff nurses' perceptions of their nurse manager caring increased, their perception of exposure to negative acts (meeting the definition of workplace bullying) significantly decreased. The sample consisted of primarily older, more experienced, staff nurses who worked 10 years or longer within their work environment. Data analysis also revealed that staff nurses who were females and those who worked in Medical/Surgical settings were significantly more likely to perceive their managers as caring ($p < .05$ respectively) and that a high workload significantly influenced the staff nurses perception of exposure to workplace bullying ($p < .05$). In view of the predicted nursing shortages as baby-boomer nurses retire at the same time the demand for health care is rising (AACN, 2009), these findings highlight the importance of caring leadership for the health and availability of nurses at the bedside, and may lead to shifting work priorities for nurse managers. Study findings may also foster the design and implementation of a caring curriculum and caring competencies applicable for the nurse managers' role either within nursing academic or clinical settings.

Key words: nursing, nurse managers, caring, caritas, workplace bullying

Chapter I
THE PROBLEM

Introduction

Workplace bullying in nursing is commonplace, on the rise, frequently ignored, and detrimental to the health and availability of those who are bullying victims and observers of bullying alike (Berry, Gillespie, Gates, & Schafer, 2012; Cleary, Hunt, & Horsfall, 2010; Hader, 2008; Mikkelsen & Einarsen, 2001; Ortega, Christensen, Hogh, Rugulies, & Borg, 2011; Randle, 2003, 2007; Simons, 2006, 2008; The Joint Commission (TJC), 2008). Workplace bullying is defined as a situation where an individual perceives him-or-herself to be a victim of systematic, negative behavior that is purposefully targeted over a prolonged timeframe with the intent to do harm and where the victim is unable to defend his or herself (Einarsen, Hoel, & Notelaers, 2009; Einarsen, Hoel, Zapf, & Cooper, 2003).

As reported by TJC, more than 50% of nurses are victims of bullying and/or disruptive behaviors and more than 90% stated that they witness the abusive behaviors of others in the worksite. Additionally, an increasing body of evidence suggests that workplace bullying predicts adverse physical and mental health effects in nurses (Hutchinson, Jackson, Wilkes, & Vickers, 2008; Hutchinson, Vickers, Wiles, & Jackson, 2009; Kivimaki, Elovainio, & Vahtera, 2000; Kivimaki, Virtanen, Vartia, Vahtera, & Keltikangas-Jarvinen, 2003; Ortega, Christensen, Hogh, Rugulies, & Borg, 2011; Quine, 1999, 2001; Sa' & Fleming, 2008; Turney, 2003; Woelfle & McCaffrey, 2007). Left unaddressed, continual and long term workplace bullying can lead to posttraumatic stress

syndrome (Tehrani, 2004), suicidal ideation, and suicide (Gilmour & Hamlin, 2003; Normandale & Davies, 2002).

For nurses working in acute inpatient healthcare environments, exposure to workplace bullying can also predict job dissatisfaction and the related intent to leave the organization (Randle, 2003, 2007; Simons, 2008; Simons & Mawn, 2010; Vesey, Demarco, Gaffney, & Budin, 2009). Ultimately, if unabated, exposure to workplace bullying can influence nurses' decisions to leave nursing altogether (Duffield, O'Brien-Pallas, & Aitken, 2004; McKenna, Smith, & Coverdale, 2003). For healthcare organizations, the related effects of workplace bullying, such as job dissatisfaction, unplanned absenteeism, and untoward occupational health outcomes, can lead to the requirement for long term employer attention and costs secondary to reduced productivity (Berry, Gillespie, Gates, & Schafer, 2012; Felblinger, 2009), and employee grievances and/or equal employee opportunity cases from individuals who choose to remain in the work setting (Hall, 2007; Rowe & Sherlock, 2005; Sa' & Fleming, 2008). Most importantly for patients, the negative impact of intimidating and/or disruptive behaviors and bullying can also adversely affect patient safety (Beyea, 2004; Institute for Safe Medication Practices (ISMP), 2003; Institute of Medicine, 2000; Rosenstein & O'Brien, 2005; Rowe & Sherlock, 2005) and lead to sentinel events (TJC, 2008).

Paradoxically, nurse manager oversight for the prevention of bullying behaviors in the workplace is seemingly absent (Lewis, 2004, 2006; Roche, Diers, Duffield, & Catling-Paull, 2010; Rosengren, Athlin, and Segesten, 2007; Woelfle & McCaffrey, 2007). As highlighted within TJC's (2002) public policy initiative, "Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis," 28% of staff nurses

perceive a lack of administrative support and responsiveness by their nursing leaders and managers. The rationale for the lack of oversight has been suggested to be related to multiple factors including the covert and insidious nature of bullying, the normalization of bullying behaviors, and/or the result of a deficit in managerial skills to address this phenomenon (Croft & Cash, 2012; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Lewis, 2004, 2006; Rafnsd'ottir & T'omasson, 2004). Saddled with multiple administrative responsibilities and competing priorities, managers may have little time and/or availability to be on their units (New, 2009; Olender-Russo, 2009a; Olender-Russo, 2009b). Among myriad priorities the nurse manager is expected to address, intentionality and priority to caring activities are frequently omitted (Drach-Zahavy & Dragon, 2002). The lack of response to bullying by nurse managers may actually maintain and perpetuate a bullying culture in nursing and "failure to deal with bullying episodes may amount to a breach of trust and confidence, and a failure of duty to care" (Lewis, 2006, p. 58).

Yet, the perception of supervisory support and related work group cohesion including exposure to workplace bullying is known to be a strong predictor for a nurse's decision to leave or to stay at the bedside (Jackson, Clare, & Mannix, 2002; Johnson, & Rea, 2009; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Longo, 2007, 2009; Simons, 2008; Simons & Mawn, 2010; Yildirim & Yildirim, 2007). Staff nurses often ignore factors such as heavy workload and inadequate staffing if they perceive the work environment and management support as favorable to them (Borda & Norman, 1997; Duffield, O'Brien-Pallas, & Aitken, 2004; Randle, 2003, 2007). Indeed, the nurse manager is considered to be the culture builder at the point of care (Manthey, 2007) and

as such, has a significant role to play in creating caring environments within healthcare

delivery settings (Boykin & Schoenhofer, 2001; Curtin, 2000; Duffy, 1993; Leininger,

1984; Nyberg, 1989, 1990, 1998; Ray, 1997, 2006; Rocker, 2008; Shirey, 2005; Sorbello,

2008; Turkel, 2003; Watson, 2006). By virtue of his or her 24-hour, 7-day week

oversight responsibility, the manager holds authority, and accountability for the nature of

the work environment (Koloroutis, 2007; Nyberg, 1998; Uhrenfeldt & Hall, 2009). His

or her treatment of staff nurses and the perception of his or her caring are critical aspects

for nurses' health, and job satisfaction.

Problem Statement

Workplace bullying is commonplace, on the rise, and detrimental to the health of

nurses, healthcare organizations and the patients served. Supervisory support in this area

is seemingly absent. Yet, the creation of a caring culture within the work environment is

integral to the role of the nurse manager and has been shown to foster caring relationships

between manager and staff, staff-to-staff, and ultimately between nurses and their

patients (Nyberg, 1989, 1998; Watson, 2006). Still unknown however, is whether caring

behaviors by managers can mitigate or abate the RN's actual exposure or perception of

exposure to workplace bullying. Assessing the relationship between the staff nurses'

perception of nurse manager caring behaviors and the staff nurses' perception of

exposure to workplace bullying is critical and timely for understanding the conditions and

needs of the workplace for professional nurses.

Research Question

What is the relationship between the staff nurses' perceptions of the caring behaviors of nurse managers and their perceived exposure to workplace bullying within multiple healthcare settings?

Definitions

Staff Nurses. Staff nurses, by self-report, are registered professional nurses working full or part-time in various staff nurse's roles within multiple healthcare settings.

Nurse Manager. The nurse manager is the person who is perceived by the staff nurse and appointed by the agency to have 24-hour supervisory responsibility, authority, and accountability for all nurses within select healthcare work settings. This position does not refer to individuals who are nurse managers, assistant nurse managers or supervisory off-tour staff.

Nurse Manager Caring Behaviors. Nurse Manager caring behaviors are theoretically defined as ways of being that are reflective of the ten clinical caritas processes (Watson, 2006, 2008). These processes are relational in nature and depict behaviors that honor the wholeness and/or uniqueness of each human being, thus serve as a therapeutic and healing intervention. Nurse manager caring behaviors are operationally defined as the staff nurses' score on the Caring Factor Survey-Caring of Manager survey instrument (Nelson, 2011).

Workplace Bullying. Workplace bullying is defined as a situation where an individual perceives him-or-herself to be a victim of systematic, negative behavior that is purposefully targeted at the victim over a prolonged timeframe with the intent to do harm and where the victim is unable to defend his or herself (Einarsen, Hoel, & Notelaers,

2009; Einarsen, Hoel, Zapf, & Cooper, 2003). Staff nurses' exposure to workplace bullying is operationally defined as their score on the Negative Acts Questionnaire-Revised (NAQ-R) (Einarsen, Hoel, & Notelaers, 2009).

Delimitation

This study was limited to registered professional nurses in a staff nurse role and currently licensed and employed, either full-or part-time, within multiple healthcare settings and who can read and communicate in English.

Basic Assumption

The study proceeded from the basic assumption that the nurse manager has the authority, responsibility, and accountability to oversee all aspects of the staff nurses' patient care delivery processes and related professional activities within multiple healthcare settings.

Theoretical Rationale

The theory of human caring as posited by Watson (1979, 1985, 1988, 1999, 2006, 2008) provided this study's theoretical framework since it is centered around authentic caring connections and relationships that shift professional nursing activities from "rote, atheoretical professional routines of nursing practice to more conscious, intentional caring-theory-guided professional actions" (Watson, 2006, p.49). These actions are experienced with emphasis on three major elements: (a) ten *caritas processes* that describe a nurses'/nurse managers' way of knowing and being; (b) *transpersonal caring/healing relationships* that convey a human-to-human connection beyond the physical realm with potential for spirit-to-spirit connection; and, (c) the *caring moment/caring occasion*, which denotes how the caritas consciousness and ways of being

are experienced and can result in caring and connectivity between both individuals (nurse

manager and staff nurse) and has the potential to go beyond the ego-orientation for

healing and human unity at a deeper level - conveying universal love for humankind

(Watson, 2008, 2009).

The ten clinical *caritas processes* (Appendix A) express the facilitation of caring

through: (a) the practice of loving kindness, decision-making; the instillation of faith and

hope, teaching and learning; (b) spiritual beliefs and practices; a holistic approach; (c) the

development of a helping and trusting relationship; (d) the creation of a healing

environment; (e) the promotion of the expression of feelings; and, (f) miracles

(supportive of a belief in a higher power). Behaviors reflective of the caritas processes

are relational in nature and honor the wholeness and/or uniqueness of each human being

(Watson, 2006, 2008). Behavioral examples include the nurse manager accepting the

staff nurses' expression of both positive and negative feelings (and seeking to understand

alternative perceptions), the promotion of transpersonal teaching-learning (where

learning is appreciative and mutual), creative problem-solving (devoid of negative

criticism), and the managers' provision and articulation of clear expectations regarding

the supportive (mental, physical and/or spiritual) work environment (Watson, 2006,

2008).

Various studies lend support to the idea that caring behaviors by nurse managers

positively influence staff nurses' job satisfaction and turnover (Randle, 2003, 2007;

Simons, 2008; Simons & Mawn, 2010; Vesey, Demarco, Gaffney, & Budin, 2009).

Further, there is evidence that staff nurses' perception of supervisory support is found to

be predictive of how they perceive workplace conditions (Borda & Norman, 1997;

Duffield, O'Brien-Pallas, & Aitken, 2004; Randle, 2003, 2007). Therefore, a study designed to assess the relationship between staff nurses' perception of nurse managers' caring behaviors and their perception of exposure to workplace bullying informed by Watson's theory of human caring (1979, 1985, 1988, 1999, 2006, 2008) is appropriate since staff nurses' perception of being cared for in this way by their nurse managers may also influence their perception of bullying behaviors of others in the workplace.

Hypotheses

Since no existing empirical research has examined the relationship between staff nurses' perceptions of nurse manager caring behaviors and their perceived exposure to workplace bullying in nursing, no hypotheses is offered.

Significance of the Study

Empirical research findings support the positive influence of manager behaviors on staff nurses' job satisfaction and intent to remain at the bedside (Duffield, O'Brien-Pallas, & Aiken, 2004; Kleinman, 2004; Longo, 2009; Longo & Sherman, 2007). Conversely, research findings also suggest that staff nurses' job satisfaction and the related intent to remain at the bedside are negatively influenced by the perception of exposure to workplace bullying (Randle, 2003, 2007; Simons, 2008). Predictors of staff dissatisfaction and turnover are a continued source of concern to nursing. Indeed, a dire situation is looming as the United States braces for an unprecedented shortage of over 500,000 registered nurses (RN's) by the year 2025 in anticipation of the retirement of baby-boomer nurses at the same time as the demand for healthcare is rising (American Association of Colleges of Nursing, (AACN), 2009). Moreover, RNs are increasingly older and their career length-of-stay shorter (AACN). By 2012, one quarter of the RN

population will be 50 years or older (AACN). If not reversed, this trend may perpetuate

cyclical and continuing staffing shortages and threaten the safety of the patient population

served for years to come (Coshow, Davis, & Wolosin, 2009). In light of these alarming

statistics, an empirical study to assess the relationship between staff nurses' perceptions

of caring behaviors of their managers and their perception of exposure to the common

and negative experience of bullying in the workplace may illuminate the kind of nurse

manager behaviors that can foster staff nurses' satisfaction and intention to remain in the

work environment (or delay retirement) and ultimately ameliorate the threat of spiraling

shortages of nurses and the related ability to provide safe and effective patient care.

From a patient's perspective, it is now known that hospitals can be dangerous for

a person's health as an estimated 98,000 to 100,000 patients die annually related to

medical errors while in hospitals (Institute of Medicine, 2000, Healthgrades, Inc., 2010).

Many of these errors stem from a breakdown in communication. For example, results

from The Joint Commission's (TJC) 2008 report of an analysis of 3,548 inpatient sentinel

events (where serious adverse outcomes or death occurred) over a ten-year timeframe

suggests communication breakdown, including disruptive behaviors and workplace

bullying among caregivers, to be a root cause. Collectively, these findings led TJC to

intervene and release a sentinel event alert entitled, "Behaviors that Undermine a Culture

of Safety" (2008). Calling for zero tolerance to intimidating and bullying behaviors, TJC

accreditation requirements now include hospital-wide implementation of a code of

conduct for all employees and an organization-wide approach for the design,

implementation, and monitoring of a program to abate disruptive behavior and bullying

among staff in the workplace. Yet, despite the call by accrediting bodies for an

organizational approach to abate intimidating and bullying behaviors, recent surveys and empirical research suggest that workplace bullying is still prevalent (TJC, 2008; Keeling, Quigley, & Roberts, 2006), on the rise (Lipley, 2006; Royal College of Nursing, 2002) and having strong implications for both staff nurses and nurse leaders alike (Johnson & Rea, 2009; Lewis, 2006; Shirey, 2005).

The assessment of the relationship of staff nurses' perception of nurse manager caring behaviors and workplace bullying in nursing contributes new knowledge to the increasing body of science related to caring, specifically as informed by Watson's theory of human caring (1979, 1985, 1988, 1999, 2006, 2008). The expansion of research initiatives to contribute to the state-of-science related to caring in nursing is paramount. Caring is considered the essence of what nurses do and is unique to the profession of nursing (Boykin & Schoenhofer, 1993; Leininger, 1984; Patista, 1999; Roach, 1984; Skretkowicz, 1993; Watson, 1985, 1999, 2009). Although measuring caring is a relatively new endeavor, a steadily rising increase in the study of caring informed by Watson's theory of human caring in nursing is occurring and attests to the utility of the model (J. Nelson, personal communication, December 8, 2009). Watson (2009) emphasizes that if the concept and study of caring is to be valued by nursing as well as other disciplines, continued rigorous empirical testing for outcomes associated with caring/caring interventions informs and advances the professional discipline of nursing. Moreover, there is an emerging need for nursing to empirically contribute to practices that are unique to the discipline of nursing and advance the knowledge of human caring through the application of the caritas processes within clinical programs and services with the goal of transforming healthcare (Watson, 2009). Additionally, the use of the Caring

Factor Survey – Caring of the Manager (Nelson, 2011) contributes valuable information regarding staff nurses perception of nurse manager caring in accordance with the evolved caritas processes (Watson, 2006, 2008) and adds to the body of science about the use of this tool.

      Empirical studies designed to assess the relationship between nurse manager caring behaviors and the staff RN's exposure to bullying also illuminates the importance of leadership mindfulness and intentional modeling of caring behaviors within clinical environments (Pipe, 2008; Sorbello, 2008; Turkel, 2003; Turkel & Ray, 2004). This can ultimately lead to shifting work priorities to enhance the likelihood that managers will have the time and availability to create a caring and healing environment for patients and for staff alike. Additionally, nurse manager caring for staff may ultimately lead to staff caring for each other and in turn, may facilitate a therapeutic and healing work environment for all. The findings from this study also support the need for the design and implementation of caring curriculum and caring competencies critical for the nurse manager's role both within the nursing administration academic setting (where nursing learning begins) and bridging across to the clinical practice environments (where nursing learning continues).

Chapter II

REVIEW OF LITERATURE

Introduction

This literature review provides a definition of caring, an overview of the theoretical/conceptualizations related to caring, and an overview and critique of the state-of-science of caring in nursing including what is currently known about nurse manager caring. An emphasis is placed on Watson's art and science of human caring and the applicability to this study. Additionally, the definition of bullying, an overview of theoretical/conceptual aspects of workplace bullying in nursing, and an overview and critique of the state-of-science related to bullying is also provided.

Caring and Theoretical Perspectives of Caring in Nursing

Caring is a dynamic concept, one that is often viewed as a basic human trait, a moral imperative, an affect toward self and other, and a therapeutic intervention (Watson, 1979, 1985, 1988, 1999, 2006, 2008). Caring has also been described as a characteristic inherent within an individual depicting a concern for the growth and actualization of another (Mayeroff, 1971) and/or a learned social process between individuals: one that includes intentionality, affective engagement or empathy, and the process of acting on behalf of another (Noddings, 1984). According to Engster (2005), the origin of caring can either be a self-generative or a relational activity that meets the need of oneself and/or another to sustain life and well-being. Additionally, the reciprocal nature of caring between the caretaker and the individual being cared for is suggested to have a contagious effect on those participating in and also observing these caring encounters (Noddings, Watson, 1979, 1985, 1999, 2008, 2009).

Historically, the concepts of *nursing* and *caring* were "often used interchangeably" (Kyle, 1995, p. 506). From the time of Florence Nightingale to the present, caring is increasingly posited as fundamental to what nursing does and central to nursing roles (Boykin & Schoenhofer, 1993; Leininger, 1984; Nightingale, 1860, Nyberg, 1998; Patista, 1999; Roach, 1984; Watson, 1985, 1999, 2009). Boykin and Schoenhofer (1993) emphasize that although caring is not unique to nursing, it is uniquely expressed *in* nursing. Originally, the theoretical concepts and/or models of caring dominating the literature were primarily patient-centered and depicted as characteristic of nursing being a helping discipline or acting on behalf of another (McFarlane, 1976; Orem, 1985; Roach; Watson, 1985; 1988, 1999). These caring actions were primarily described as developed through the acquisition of cognitive and behavioral skills (Gaut, 1983; Swanson, 1999), with inclusion of goal setting (Gaut, 1983), the provision of culturally competent care (Leininger, 1984), and the communication of concern and attention to patient safety (Larsen, 1984). Additionally, Swanson (1999) described the attributes of caring within nursing to also include the nurse having a professional sense of responsibility and personal commitment.

More recently, theoretical concepts related to caring within a nursing administrative context emerged and provided a substantive framework to support the role of nursing leadership within complex healthcare organizations (Nyberg, 1989, 1990; Ray, 1997, 2006; Turkel, 2003; Turkel and Ray, 2004; Watson, 2006, 2008, 2009). "As opposed to nurses living caring in a relationship with a patient, nurse administrators live caring through entering into caring relationships with nurses" (Sorbello, 2008, p.45). Salient theoretical frameworks and/or conceptualizations depicting these caring

relationships within an administrative context include: (a) Nyberg's Model of Caring

Administration (1998) providing role clarity for managers as stewards for the promotion

and integration of caring processes within healthcare systems and at the point of care; (b)

Ray's ethical theory of existential authenticity (1997) illuminating the ethical role of the

nurse administrator as one providing a vision of beneficence; (c) Ray's theory of

bureaucratic caring (2006) providing direction and guidance for nurses in consideration

of how caring exists and is expressed within and throughout hospital organizations; and,

(d) Watson's theory of human caring based on the theoretical position that caring

between manager and staff promotes reciprocal caring and healing for each other within a

greater context of caritas/love for humanity at-large (2006, 2008).

Watson's theory of human caring (2008, 2009) is comprised of three major

elements: (a) ten *caritas processes* (describing a nurses' way of knowing and being); (b)

transpersonal caring/healing relationships (conveying concern for another beyond the

ego and physical realm with potential for spirit-to-spirit connection); and, (c) *the caring*

moment/caring occasion, (denoting how the caritas consciousness and ways of being are

experienced). This theory originated by Watson in accordance with her life's work

developing caring curricula for application within academic and clinical settings (Jean

Watson, personal communication, December 8, 2009). Included are her own beliefs,

values, and life experiences regarding what it means to be human, what it means to care,

what it means to heal, and is posited to result in caring and connectivity between

individuals and having the potential for the promotion of healing at a deeper, more

spiritual level that transcends the human-to-human connection (Watson, 1999, 2008,

2009). The term, caritas (love), is related to the love of humanity and the love of

providing compassionate service to humanity (Watson, 2006, 2008). It is this service to humanity (attributed to the nurse manager's way of being) via application of the caritas processes (Watson) that may mitigate or abate exposure to bullying in the work environment.

      The ten caritas processes were originally described as ten *carative* factors (Watson, 1979). Both describe behaviors that convey caring to another. The word *Caritas* is derived from the Latin word meaning to cherish and connotes feelings of love, appreciation, and generosity of spirit. According to Watson (2008), the transition of the term, carative factors to caritas processes, emerged in order to provide a more meaningful concept and worldview of caring within the discipline of nursing nested within the broader field of Caring Science. A few examples of theoretical transitions include: (a) the caritas process of practicing loving-kindness and equanimity for self and others expanded upon the original carative factor of the formation of a humanistic-altruistic system of values; (b) the caritas process of being authentically present - enabling/sustaining/honoring the deep belief system and the subjective world of self/other expands upon the original carative factor of instilling/enabling faith and hope; and, (c) the caritas process of engaging in genuine teaching-learning experiences within the context of caring relationships that attend to the whole person in consideration of staying within another's frame of reference, expands upon the original carative factor of the promotion of transpersonal teaching and learning. Watson emphasizes that these newly expanded processes of human caring behaviors are both "legitimate and necessary when working with the human experience and the human caring-healing, health, and life phenomena" (2008, p. 4) and balance the medical orientation of curing with the unique disciplinary,

scientific, and professional aspects of caring by nursing (Watson, 1979, 1985, 1999). A complete comparative listing between the original caring factors (Watson, 1979) and the evolved caritas processes is included (Appendix A).

The second element within the theory, transpersonal caring, occurs through the therapeutic use of self, such as by being authentically present and attentive to the relationship, so that true connectivity and related healing between the individual caring and the individual being cared for can occur. This caritas consciousness, can result in the third element of the theory describing a caring moment – a moment in time when the individual caring (in this case, the nurse manager) and the individual being cared for (in this case, the staff nurse) enter into an authentic human-to-human relationship resulting in an internal awakening or self-reflective insight about the situation and/or the dialogue that has occurred (Watson, 2008).

These elements (caritas processes, transpersonal caring, and caring moments) are applicable as an ethical guide to administrative practice. Watson (2006) emphasizes that within complex, economically driven healthcare organizations, the need for a shift to an authentic relationship-centered caring and healing environment is based upon sound ethical principles, noting that caring and economics should not be mutually exclusive. Guided by Watson's caring theory, the nurse leader can promote health and healing within the clinical environment despite the "rapid-fire and often-chaotic challenges currently emerging in healthcare" (p. 118). The promotion of transpersonal caring via teaching-learning processes can provide a supportive, protective, and/or corrective mental, physical, societal, and spiritual inpatient environment for staff (Watson, 2006). This is illustrated by the nurse manager being attentive to relationships with staff nurses,

being calm even in the midst of chaos, listening to learn, rather than speaking, and by being authentically present so that a healing environment that transcends time, space, and physicality can emerge (Watson, 2006).

Effective leadership doesn't happen by accident. Rather, it "is rooted in the inner work of self-reflection and growth" (Pipe, 2008, p. 117). Among the challenges of leading within an increasingly complex and demanding healthcare environment, self-reflection and facilitation of an awareness about what it means to be human - to be the one caring and/or the one being be cared for, is paramount when creating a therapeutic work environment. Moreover, the influence of the nurse leader as a translational force through mindfulness and intentionality can create and/or maintain a culture of caring in the workplace (Watson, 2000, 2006).   It is this generosity of the human spirit that may influence caring from manager to staff and staff to staff and reduce the likelihood that exposure to bullying will occur within the clinical setting.

In summary, relevant theories of caring in nursing all support the increasing recognition of the importance of caring as a core concept grounded in humanism and human science perspectives within nursing and nursing administration. Although minor differences exist among theories relative to origins or specification of behaviors, commonalities about the intentionality of caring and synergism related to the mutual process of caring between the one caring and the individual(s) being cared for are consistently noted (Boykin & Schoenhofer, 1993; Leininger, 1984; Nyberg, 1998; Patista, 1999; Roach, 1984; Swanson, 1999; Watson, 2009). Little research utilizing these theories of caring is available for review. Additionally, only a few related measurement tools are available to test and support these constructs empirically. Watson's theory of

human caring based upon the tenet of mutual caring and love is most applicable to this study designed to consider the relationship between the staff nurses' perception of nurse manager caring behaviors and their exposure to workplace bullying since it: (a) has theory application that promotes and facilitates the art and the science of caring in nursing (McCance, McKenna, & Boore, 1999); (b) has utility in nursing administration since an applicable tool to assess caring (via the caritas processes) within an administrative context is available; and, (c) has the capacity for describing outcomes gained via transpersonal caring and caring moments between the manager and staff nurse (Watson, 2006, 2008, 2009).

Measurement of Caring in Nursing

Debates about the ability to study caring and the appropriateness of study measurement methods and design are ongoing (Beck, 1999; Boykin & Schoenhofer, 2001; Coates, 1997; Duffy, 2002; Swanson, 1999; Watson, 2008, 2009). A few nurse researchers have held the belief that caring could not be measured empirically (Boykin & Schoenhofer, 2001). On one end of the continuum, caring is conceptualized as a basic motive or inward way-of-being. On the other end of the continuum, caring is seen as an outward doing of tangible and objective behaviors – behaviors that could withstand empirical scrutiny (Duffy, Hoskins, & Seifert, 2007; Swanson, 1999; Watson, 2009). In consideration of these complexities, Watson (2009) emphasizes that the utilization of both qualitative and quantitative methods for measurement is advantageous since it enables a greater understanding of the concept of caring and the work of nursing. To that end, salient qualitative and/or quantitative studies have been designed and have addressed: (a) the nature of nurse caring within select patient care models or nursing

populations (Bernick, 2004; Johansson, Holm, Lindquest, & Severinsson, 2006; Nyman & Lutzen, 1999; Turkel, 2003); (b) the perception of nurse caring by patients and by nurses (Coates, 1997; Persky, Nelson, & Bent, 2008); and, (c) the description or comparison of outcomes related to caring processes within a clinical setting (Persky, Nelson, & Bent, 2008; Smith, 2000). All of these studies have supported the nature and importance of caring and have contributed to the body of nursing science on caring.

Over the last two decades, a small but increasing body of knowledge has emerged related to the influence of nurse caring within an administrative context, particularly in consideration of the increasing complexity and economic focus of healthcare agencies (Boykin & Schoenhofer, 2001; Buerhaus, 1986; Nyberg, 1989; Ray, 1989, 1999, 2001, 2004, 2007; Turkel & Ray, 2004). Ray (1997) and Sorbello (2008) emphasize that managers face significant ethical challenges when balancing the provision of a caring environment with economic restraint within acute care inpatient settings. The nurse manager is viewed as being in a key position to meet these challenges and create effective caring environments within healthcare settings (Duffy, 1993; Leininger, 1981; Nyberg, 1989; Turkel, 2003).

Several studies have explored and reported the perceptions of the value of caring attributes and/or caring moments within the work setting. The findings within these studies support the idea that nurse managers' modeling of caring behaviors is a reciprocal process and can serve as a model for how staff can integrate caring within their relationships with each other and within the clinical practice for the patients they serve (Johansson, Holm, Lindquest, & Severinsson, 2006; Turkel, 2003; Uhrenfeldt & Hall, 2009). Rosengren, Athlin, & Segesten (2007) explored and described nurses' perceptions

of nursing leadership (defined as equivalent to the role of the head nurse or nurse

manager) within an ICU setting. Using a phenomenological approach, variations in how

ten informants (including 4 nurses) experienced nursing leadership was explored and

reported. Findings indicated that manager presence and availability was of primary

importance to staff. Sub categories included the importance of the manager providing

support for staff in everyday practice, promoting a positive atmosphere and facilitating

the professional accomplishments of staff.

Similarly, in a larger study designed for tool development, Kramer et al. (2007)

explored and reported what constitutes nurse manager support for staff nurses as

perceived by staff nurses ($n = 2382$), within the context of a productive, healthy work

environment. Among the most supportive roles identified during this process were the

attributes of caring, including the manager being approachable and visible, providing

genuine feedback, and the manager promoting group cohesion and teamwork. The

findings reported within this and previous studies (Johansson, Holm, Lindquest, &

Severinsson, 2006; Rosengren, Athlin, & Segesten, 2006; Turkel, 2003) are consistent

with and illuminate important leadership attributes and are commensurate with behaviors

described as caritas processes within Watson's theory of human caring within an

administrative context (Watson, 2006, 2009). Additionally, study findings exploring

nurse manager caring suggested that there may be a relationship between the nurse

managers' modeling of caring behaviors and the degree of peer caring and/or the delivery

of care nurses provided to patients (Longo, 2009). These findings also support the idea

that behaviors can be learned, accepted, and perpetuated within and throughout the

healthcare setting (Hoel, Giga, & Davidson, 2007; Lewis, 2006).

Strengths and limitations within this body of literature can be noted. There is a lack of consistency in the utilization of terms and operational definitions of caring, leadership, and/or supportive behaviors. Kramer et al. (2007) have shown however, that these terms overlap. For example, nurse manager supportive behaviors identified by over 2000 nurses included the concept of caring as integral to: the manager/supervisor being approachable and having the ability to motivate staff, being present, authentic, giving genuine feedback, having the ability to promote group cohesion and teamwork, and having the ability to resolve conflicts constructively. The selection of participants was purposeful and appropriate to the study designs employed by the researchers. In studies utilizing focus groups, efforts to convey procedural information as to how trust and safety was established were included (Johansson, Holm, Lindquest, & Severinsson, 2006; Kramer, et al., 2007). Descriptive qualitative studies also included detailed data analysis procedures (Johansson, Holm, Lindquest, & Severinsson, 2006; Kramer, et al., 2007; Rosengren, Athlin, & Segesten, 2007; Turkel, 2003). Efforts to establish study trustworthiness or scientific rigor (credibility, dependability and transferability) were also included. In addition to maximizing scientific merit, this information is critical when one considers study replication.

Quantitative studies on nurse manager caring in nursing have primarily examined the relationship between positive nurse manager behaviors on staff nurses' job satisfaction and/or separation from the unit or organization. Kovner, Brewer, Wu, Cheng and Suzuki (2006) found that more than 40% of the variance in satisfaction was attributed to various work attitudes including supervisory support ($b = .081$, $p < .001$) among a large sample of staff nurses ($N = 1,538$). Sellgren, Ekvall, & Tomson (2008) reported that

within a sample of nurse managers ($n = 92$), effective nurse manager leadership behaviors positively influenced staff nurses' ($n = 770$) job satisfaction (all items ranged between $r = .22$ to $.51$, $p \leq .001$) and work climate ($r = .28$ to $.58$, $p < .001$). Similarly, Hall (2007) reported perceived supervisory support among staff nurses ($n = 81$) to be correlated positively with job satisfaction ($r = .48$, $p < .001$) and negatively correlated with work stress ($r = - .39$, $p < .05$), somatic complaints ($r = - .37$, $p < .05$) and days ill ($r = - .25$, $p < .05$). Relationships were also examined relative to tour of duty. Kleinman, (2004) examined the relationship between nurse manager ($n = 10$) leadership behaviors and staff nurse ($n = 79$) retention and found a small association between management by exception (where managers were visible only when needed) and staff nurse retention particularly on the evening and nighttime shifts ($r = .26$, $p = .03$).

A small number of studies examined the influence of the specific attribute of *nurse manager caring* as perceived by staff nurses on staff satisfaction and turnover.   For example, Duffy (1993) reported that nurse managers caring behaviors were significantly correlated with staff nurses' job satisfaction ($r = .36$, p $.007$). Wade et al. (2008) examined the influence of nurse manager leadership and caring behaviors among a convenience sample of staff nurses working within an acute care facility ($n = 731$) and found that nurse managers' leadership attributes significantly predicted 30.6% of job enjoyment ($b = .54$, $p \leq .05$). Similarly, Longo (2009) examined and reported a significant correlation between nurse manager caring and nurses' job satisfaction ($r = 0.622$, $p = < .007$) and intent to stay in the workplace ($r = .336$, $p = < .01$).

In all of these quantitative studies, a lack of consistency in theoretical approaches and related definitions and measurement tools can be noted. Yet, studies utilizing

differences in terms to describe nurse manager caring behaviors (i.e. supportive behaviors, leadership behaviors) are applicable since the definitions utilized for these terms are consistent with the caritas processes as informed by Watson's theory of human caring (1979, 1985, 1988, 1999, 2006, 2008). An additional limitation within most of these studies is the use of convenience samples rather than employing randomized procedures (Hall, 2007; Kleinman, 2004; Longo, 2009; Sellgren, Ekvall, & Tomson, 2008; Wade et al., 2008). However, several of these studies had robust sample sizes to offset this concern (Hall; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Sellgren, Ekvall, & Tomson, 2008; Wade et al., 2008).

The paucity of studies examining caring within a nursing administrative context and workplace bullying in nursing is disappointing since caring is core to the discipline of nursing and critical to nursing administration. Indeed, collaborative efforts to replicate and/or build upon the scholarly work thus far achieved, is timely and critical for our profession and likely to have strong implications for the role and responsibility of nurse managers' within all clinical settings. In consideration of the complexities of the nursing workplace, additional studies to replicate and or advance the science suggesting that staff nurses' perceptions of nurse manager caring and/or support can influence the staff nurses' occupational outcomes are needed. Also needed, are replication studies to consider differences among nurses' perceptions of manager support and staff satisfaction and turnover in accordance with the nurses' tour of duty (Kleinman, 2004). Lastly, further research specific to the concept of caring as informed by Watson's theory of human caring (1979, 1985, 1988, 1999, 2006, 2008) is critically needed to advance the theory and science of human caring and contribute to the body of literature within the discipline

of nursing. The application of these studies to workplace bullying in nursing is noteworthy. Indeed, the findings noted within this growing body of knowledge related to manager caring may have strong implications for nursing since staff nurse satisfaction and retention are likewise influenced by workplace bullying. However, no direct association has been made.

Bullying and Theoretical Perspectives of Bullying in Nursing

According to Smith (2000), the term *bullying* originated in England in the sixteenth century from a Dutch word, *boele* and was synonymous with the term, *lover*. This term subsequently evolved to describe a *fair guy*, and then a *blusterer*, and then evolved to convey recognition for a risk taking activity that resulted in a positive outcome recognized with the phrase, "bully for you" (p. 151). The definition further evolved over time to describe an individual who is habitually cruel to someone weaker or in a more vulnerable situation or as an action verb to depict the process of intimidation, mistreatment, oppression, harassment, victimization, maltreatment, and/or hounding.

Dan Olweus (1978), considered to be the founding father of bullying research, further described the term, bully, to portray an individual with aggressive behavior who intentionally hurts or harms another. Olweus emphasizes that this behavior is repetitive and is comprised of a power imbalance between the bully and victim such that it is difficult for the victim to defend him or herself. For example, in the school setting, Olweus describes these behaviors (both verbal and physical), as perpetrated by students who target weaker or younger school age children who are unable to defend themselves.

Credited with performing the first systematic study of the phenomenon of bullying, Olweus (1978) described his findings within a landmark text entitled,

Aggression in the Schools: Bullies and Whipping Boys.   The results of this groundbreaking research illuminated the characteristics and prevalence of the phenomenon within school settings. Subsequently, following the 1984 suicide deaths of three adolescent boys as a direct result of severe bullying by peers in a middle school in Norway, the work of Olweus and the world-wide prominence of the topic resulted in resources from federal and state agencies to promote research to more clearly identify, describe, and find solutions for this phenomenon.

More recently, the phenomenon of workplace bullying emerged and is defined as a situation where an individual perceives him-or-herself to be a victim of systematic, negative behavior that is purposefully targeted at the victim over a prolonged timeframe with the intent to do harm and where the victim is unable to defend oneself (Einarsen, Hoel, & Notelaers, 2009; Einarsen, Hoel, Zapf, & Cooper, 2003) within the workplace. While some researchers posit that workplace bullying is a phenomenon that primarily occurs horizontally among coworkers (Ferns, 2006; Leiper, 2005; Nueman & Baron, 1997; Randle, 2003), the majority of researchers suggest that a real or perceived imbalance of power between the bully and the victim is a necessary element of bullying behavior in the workplace (Einarsen & Hoel, 2001; Hutchinson, et al., 2006; Lewis, 2006; Matthieson & Einarsen, 2001; Randle 2003; Smith, 2000; Vartia, 2001; Woelfle & McCaffrey, 2007; Zapf & Gross, 2001).

Although the term is frequently used to describe myriad negative behaviors among co-workers, what differentiates workplace bullying from other disruptive behaviors such as simple rudeness and/or incivility in the workplace is that these negative behaviors are intentional, occur over a prolonged period of time and are targeted at

individuals who are unable to defend themselves (Einarsen & Hoel, 2001). Leymann

(1990) proposed that to meet the criteria for bullying, exposure to negative acts had to

occur on a weekly basis over a period of at least six months. Other researchers (Einarsen

& Hoel, 2001; Einarsen, Hoel, Zapf, & Cooper, 2003) suggested bullying to be more

frequent (up to 2 times weekly) and seen along a continuum frequently beginning as a

work-related conflict and then progressing with negative acts frequently surfacing as

subtle and indiscrete, and then escalating to more overt, aggressive acts, thus suggesting a

broader range and degree of victimization. Hutchinson, et al. (2006) emphasized that

although bullying may seem harmless to an untrained eye, these deliberate and prolonged

behaviors can have a cumulative effect and can cause serious harm to the intended

victim. In accordance with this definition and differentiation, bullying has also been

described using terms such as workplace harassment (Lewis, 2004), horizontal violence

(Longo & Sherman, 2007; McKenna, Smith, Poole, & Cloverdale, 2003), and mobbing

(Leymann, 1990; Woelfle & McCaffrey, 2007; Yildirim & Yildirim, 2007).

The use of the term bullying among nurses within the work environment began to

surface in the mid 1990's. Previous negative workplace experiences described by nurses

were frequently associated with the notion of nurses "eating their young" and referred to

the mistreatment of new nurses by older or more experienced nurses that frequently

influenced the victim's intent to stay (Bartholomew, 2006; Longo, 2007; McKenna,

Smith Poole, & Cloverdale, 2003; Rowe & Sherlock, 2005; Simons, 2008; Simons &

Mawn, 2010; Woelfle & McCaffrey, 2007). Simons suggested that these behaviors are a

result of the perceived subordinate role of nursing within the medical model of healthcare

during the nurses' traditional orientation and/or training experiences. Randle (2003)

emphasized that these behaviors can be "commonplace in the transition of becoming a nurse" (p. 395). Hoel, Giga and Davidson (2007) add that these behaviors are negatively reinforced within the clinical setting and if allowed to go unabated, are an "effective source of negative learning and socialization" (Lewis, 2006, p. 276) for new and seasoned nurses alike.

The exposure or the witnessing of bullying behaviors in the workplace is an added burden to the challenges that nurses face on a daily basis. The nature of the work of inpatient nursing is mentally and physically demanding in and of itself (Clancy & Delaney, 2005). Patients are sicker, patient length of stay is shorter, working conditions more complex and unpredictable, technological demands more challenging, and documentation and administrative responsibilities are ever-increasing (Davis, Ward, Woodall, Shultz, & Davis, 2007; Hall, 2007; MacDavitt, Chou, & Stone, 2007). The combination of the prevalence of bullying activities along with the busy healthcare setting, increasingly complex patient situations, and the requirement for interdependent relationships can serve as a breeding ground for uncivil and/or bullying behaviors (Clark, Olender, Cardoni, & Kenski, 2011, Rau-Foster, 2004; Vessey, DeMarco, Gaffney, & Budin, 2009).

Explanatory theoretical/conceptual perspectives have primarily described four origins for workplace bullying: the individual personality or attributes, group or coworker conflict, power struggles and organizational dynamics. For example, Randle (2003) suggested that individual personality traits such as a diminished self-esteem could predict victimization of bullying. Escalating group or coworker conflict is frequently depicted as horizontal violence and has also been suggested as a contributing factor to bullying in the

workplace (Hutchinson, Jackson, Wilkes, & Vickers, 2008; McKenna, Smith, Poole, & Coverdale, 2003; Strandmark & Hallberg, 2007). The abuse of power by the bully and/or an imbalance of power between the bully and victim (Mikkelsen & Einarsen, 2001) are also suggested to be an integral aspect of bullying. These power struggles can occur within the hierarchical nature of nursing and as such are influential for bullying behaviors between staff nurses and their nurse managers and/or nurse managers with their supervisors (Leiper, 2005; Lewis, 2004, 2006; McMillan, 1995). Hutchinson et al. (2006, 2008) posit that the etiology of bullying in nursing is far beyond the influence of self-esteem and horizontal violence, suggesting that nurses are frequently victimized by socio-political oppression within healthcare organizations. The authors suggest that the theoretical underpinnings for bullying within this context are comprised of all three equally important factors related to this phenomenon: the individual (with diminished self-esteem), the purposeful action of individuals or groups (horizontal violence or oppressed group behavior), and organizational perspectives. The observers of bullying may form a "diffuse and invisible force within the social networks within organizations" (Hutchinson, Vickers, Jackson, & Wilkes, 2006, p. 118) such that bullying becomes normalized and/or may also seem invisible in the work setting. Labeled *cooperative bullying*, these predatory alliances within informal organizational networks enable bullies to mask bullying behaviors by co-opting legitimate "organizational routines and processes" (Hutchinson, Vickers, Wilkes, & Jackson, 2009, p. 219).

The culmination of these themes led to the emergence of a mid-range theory for workplace bullying by Hutchinson, Jackson, Wilkes, and Vickers (2008). This theory depicts the nature, extent, and consequences of bullying consisting of: organizational

antecedents (informal organizational alliances, misuse of legitimate authority, processes and procedure, and organizational tolerance and reward), bullying acts (personal attack, attack on reputation and competence, and attack through work tasks) and, consequences (normalization of bullying in work teams, distress and avoidance at work, health effects, and interruption to work and career). This explanatory model offers the first theory of workplace bullying in the nursing workplace.

Measurement of Workplace Bullying

There are primarily three empirical approaches to measuring workplace bullying within the literature (Quine, 2001). The first method is individualistic and qualitative in nature and designed to explore the staff nurses' perceptions and/or experiences of being exposed to bullying behaviors. The second approach is primarily descriptive and usually based upon self-report either by structured interviews or survey methods. These studies typically describe the prevalence of bullying and include demographic or work-related differences. The third approach involves the utilization of underlying theories and/or models in order to support theoretical perspectives that describe the phenomenon more thoroughly. In these studies, relationships and/or interactions between/among individuals and organization dynamics are also considered. A review of studies pertaining to the study of workplace bullying in nursing within these categories will now unfold.

Qualitative research methods in nursing have served to explore the origins of and/or the perception of the experience of being bullied in the nursing workplace. Using grounded theory methods as a framework for collecting and analyzing data collected via unstructured interviews, self-esteem was determined to deteriorate among student nurses during their 3-year academic training by Randle, (2001). Although differences in self-

esteem at the start and completion of their training program were not statistically

supported, workplace bullying emerged as commonplace within their clinical rotations

during this transition. Subsequently, using grounded theory methods in a convenience

sample of student nurses at the start and completion of their nursing training ($n = 56$ and

39 respectively), Randle (2003) explored the major theme of bullying that emerged as

commonplace within the previous study (Randle, 2001).   Findings from this process

supported the idea that "having power over someone or something became integral to

their self-esteem" (p. 396) and concluded that the hierarchical relationship between the

staff nurse and student nurse is such that workplace bullying self-perpetuated as a learned

process within the clinical area.

These findings were also supported by the work of Hoel, Giga and Davidson

(2007). Using qualitative descriptive methods, student nurses' ($N = 48$) perceptions of

exposure to and/or witnessing workplace bullying within clinical settings were explored.

Using content analysis of responses to semi-structured interviews, exposure to workplace

bullying emerged as being widespread, a source of negative socialization, and having

reproductive capacity. Similarly, using a phenomenological approach, perceptions of the

lived experience of two registered nurses being victim to workplace bullying was

explored. Both nurses suggested that being victim to workplace bullying diminished their

self-esteem and elicited self-blame (Corney, 2008). The study findings also supported

the idea that exposure to these negative behaviors is considered to be normal and

frequently unaddressed within the traditional culture of nursing. Lastly, using a

qualitative descriptive design, Simons and Mawn (2010) reported the perception of the

experience of actual exposure to workplace bullying among newly licensed nurses in

Massachusetts ($N = 184$). Following content and comparative analysis of responses to open-ended surveys, four major themes related to the types, causes, and impact of bullying emerged: (a) structural bullying (perceived as unfair and punitive actions by supervisors); (b) nurses eating their young (related to experiencing or witnesses unfair treatment within the formative educational years within the academic setting and /or being new and orienting to the clinical setting); (c) feeling out of the clique related to differences in ethnicity, education and/or experience; and, (d) intent to leave the job (secondary to being targeted by peers almost daily and frustration with the nurse manager being aware and not responding).

Organizational conditions that may influence exposure to bullying within healthcare work settings were also explored. For example, Strandmark and Hallberg (2007) used grounded theory methods to explore the origins of bullying within healthcare organizations. Using semi-structured interviews ($N = 22$, including 6 nurses), categories that emerged formed a conceptual model of "struggling for power – a preliminary stage of bullying" (p. 336). Organizational conditions included within this model were: (a) potential areas for conflicts within organizations (such as when there is the presence of unclear roles and expectations); (b) reduced staffing, weak or poor leadership; (c) the presence of professional and personal value differences (such as affective or cognitive conflicts or humanistic vs. materialistic points of views); (d) individual characteristics such as personal strength or vulnerabilities (including competency, motivation, and self-esteem); and, (e) struggles for power (negative attitudes) within organizations. The latter category, struggling for power within an organizational context, was suggested by investigators to emanate from "poor organizational conditions, weak or indistinct

leadership and the involved parties' personalities and work-related expectations" (p. 338).

These findings also supported the idea that rather than victims being targeted secondary to having diminished self-esteem, victims may be subject to bullying because of their talent and engagement in the work environment. Strandmark and Hallberg (2007) found the following:

> In sharp contrast to bullying among school children, where the
>
> stigma of being physically or socially 'different' often leads to
>
> bullying (Olweus 1992), the adult bullies in our study seem to be
>
> jealous of the higher qualifications and concerns of their victims. (p. 339).

Hutchinson, Vickers, Wilkes, and Jackson (2009) emphasize that tolerance to negative behaviors involves a misuse of public resources or entrusted power and can "serve as a breeding ground for systematic and persistent bullying within healthcare organizations, going far beyond a situation between bully and victim and/or bullying via group acts – and rather, are akin to a type of *organizational corruption*" (p. 336).

Similarly, taking an ethnographic approach, Lewis (2004) identified nurse managers' perceptions of conditions conducive to fostering bullying behaviors within healthcare organizations. Nurse managers ($N = 10$) reacted to a series of unstructured interviews revealing their concerns and identifying key themes that influenced their views on workplace bullying. They included being subjected to: negative managerial actions, being victims of bullying as managers, communication challenges and managerial knowledge and skill deficits in addressing bullying. In a subsequent qualitative study (Lewis, 2006), following the review of 4 bullying vignettes by individuals who had witnessed the bullying of others, ten staff nurses and ten nurse

managers suggested that the delayed recognition and/or lack of addressing and/or containing bullying situations, perpetuated and/or sustained a bullying culture within healthcare environments.

Within this body of qualitative literature of workplace bullying in nursing, strength and limitations can be noted. In general, study methods described did not include a description of how the investigator created trust and safety with study participants, particularly in those studies utilizing focus group methods (Hoel, Giga & Davidson, 2007; Lewis, 2006). This is an important consideration secondary to the potential for emotional responses and the possibility that informants may project distorted perceptions of situations (or cover up behaviors or be reluctant to talk). One study had a small sample size ($N = 2$) thus limited representation of study findings (Corney, 2008). The analysis of the interview data and/or data software methods within select qualitative studies (Hutchinson, Vickers, Wilkes & Jackson, 2009; Simons & Mawn, 2010; Strandmark & Hallberg, 2007) was aptly described. However, a few studies lacked the analysis detail or framework utilized for study replication (Hoel, Giga & Davidson, 2007; Lewis, 2004; Randle, 2001, 2003). In general, efforts to establish study trustworthiness or scientific rigor (credibility, dependability and transferability) were vague or limited (Hoel, Giga & Davidson, 2007; Lewis, 2004, 2006; Randle, 2003, 2007). In addition to maximizing scientific merit, this information is crucial for study replication.

Quantitative methods were also utilized to study workplace bullying in nursing. Indeed, the phenomenon of workplace bullying has achieved significant attention of late, particularly in the media. As reported in *The New York Times*, "Bullying in the workplace is surprisingly common" (Brown, 2010; Parker-Pope, 2008, p. F5). The

application of this adage within inpatient settings is supported by a recent staff survey by

The Joint Commission (2008) suggesting that more than 50% of nurses have been victims

of abusive behaviors at work and more than 90% have witnessed the abusive behavior of

others. The Royal College of Nursing (2005) suggested workplace bullying in nursing is

on the rise. Repeating their "Working Well" survey in a sample of over 5,000 nurses, the

organization found the extent of workplace bullying to have risen from 17% to 28% since

2000.

Several studies examined multiple variables to determine what influences nursing

job dissatisfaction and turnover using multiple regression analysis. Duffield, O'Brien-

Pallas, and Aitken, (2004) explored factors to explain why nurses voluntarily separate

from employment or leave the profession of nursing altogether. Of significance was that

legal and employer issues accounted for 36% ($R^2 = .48$, $p = .0001$) of the variance in

nurses leaving their jobs. While items representing legal and employer issues had factor

loadings ranging from 0.50 to 0.80 overall, workplace bullying produced a robust 0.63

loading related to the decision to leave employment. In a national study of licensed

nurses ($N = 1538$) working in metropolitan areas (where metropolitan areas and nurses

were randomly selected), Kovner, Brewer, Wu, Cheng, & Suzuki (2006) reported that

supervisory support predicted greater than 40% of the variance related to job satisfaction

($R^2 = .54$, $p < .001$).

Several researchers have also studied the influence of workplace bullying on the

health and availability of nurses prospectively. In a large prospective, longitudinal study

designed to examine sickness absence rates following exposure to bullying in a sample

size of 5,655 hospital staff (of which 50% were nurses). Kivimaki, Elovainio, and

Vahtera (2000) reported that sickness absences increased 1.2 to 1.4 times higher in healthcare workers exposed to bullying as compared to those not exposed. In a subsequent longitudinal study of over 10,969 hospital employees (of which 47% nurses were nurses) Kivimaki, Virtanen, Vartia, Vahtera and Keltikangas-Jarvinen (2003) reported that healthcare workers exposed to bullying were 1.6 times more likely to develop cardiovascular disease and 4.2 times more likely to suffer from depression than healthcare workers who were not exposed.

The Negative Acts Questionnaire-Revised (NAQ-R) (Einarsen, Hoel, & Notelaers, 2009) is the most commonly used tool to measure exposure to workplace bullying in nursing. Simons (2008) utilized the NAQ-R (Cronbach's α = .92) in a study designed to examine the prevalence of workplace bullying in a randomized sample of newly licensed staff nurses in Massachusetts. Findings of this study revealed that 31% of these newly licensed nurses perceived being exposed to workplace bullying at least twice weekly and bullying was significantly correlated with the nurses' intention to leave at (r = 0.51, $p <. 001$). Also using the NAQ-R (Cronbach's α = .89), Johnson and Rea (2009) reported that 27.3 % of staff nurses ($N = 767$) in Washington State who perceived they were exposed to bullying within the previous 6 months, were almost two times as likely to leave the organization ($X^2 = 15.2, p < .001$) and three times as likely to have the intent to leave the profession of nursing altogether as compared to those individuals not exposed to workplace bullying ($X^2 = 19.2; p < .001$). Fifty percent of those exposed to bullying perceived being victimized by their managers. Lastly, also using the NAQ-R, Berry, Gillespie, Grant & Schafer (2012) reported that 44.7.3% of novice nurses ($n = 88$) reported exposure to workplace bullying over a 6-month timeframe.

Sa' and Fleming (2008) used the NAQ-R (reliability reported as Cronbach's α = .87), to examine the relationship between workplace bullying and select healthcare indicators among 107 nurses. The investigators found positive correlations between bullying and the symptoms of burnout ($r = .46, p = .01$), emotional exhaustion ($r = .46, p = .01$), somatic symptoms ($r = .20, p = .05$), social dysfunction ($r = .22, p = .05$) and severe depression ($r = .26, p = .01$). Berry, Gillespie, Gates and Schafer (2012) found workplace bullying to negatively influence novice nurses' productivity ($r = - .322, p = .045$). Laschinger, Grau, Finegan and Wilk (2010) utilized the NAQ-R, (Cronbach's α = .92) testing the link between structural empowerment and workplace bullying within a sample of new graduate nurses in hospital settings. Structural empowerment, in accordance to Kantor's Theory (1977), includes supportive structures such as the employee having access to information, support and resources within the work environment. The researchers reported that 33% of the new graduates reported exposure to bullying.   Additionally, the investigators reported a significant negative relationship between structural empowerment and workplace bullying ($\beta = -.37, p = .01$) and suggested that exposure to bullying may be less prominent in environments that provide empowered work structures and processes.

A small number of studies examined workplace bullying in nursing using investigator-developed tools developed in accordance with definitions of bullying in the literature. Quine (2001) examined the prevalence of bullying, and the relationship of bullying with occupational health outcomes ($N = 1100$) where 36% were nurses ($n = 396$). Similar to the NAQ-R, this 10-item tool measured threats to professional status, threats to personal standing, isolation, overwork and destabilization (defined as failure to

give credit when due and/or being removed from responsibility, and/or being repeatedly

reminded of errors, etc.) demonstrated good reliability (Cronbach's α = .71 to .93).

Nurses exposed to each category of bullying reported significantly lower levels of job

satisfaction (*r* = -.20 to -.39, *p < .001*) and significantly higher levels of depression (*r* =

.21 to .33, *p* < .001), anxiety (*r* = .23 to .41) and the propensity to leave the work setting

(*r* = .21 to .26, *p < .001*) as compared to nurse who did not report exposure to bullying.

The results from a two-way analysis of variance suggested that a supportive work

environment acts as a moderator protecting individuals from the harmful effects of

bullying within each category (*p* < .001). Gillen, Sinclair, Kernohan, and Begley (2009)

also designed a questionnaire in order to assess the nature and manifestation of bullying

among a convenience sample of student nurse midwifes sample (*n* = 400) using an

investigator-designed survey (Cronbach's α = .89). Findings suggested that over 33% of

the students perceived being exposed to bullying, and over 50% of those victims believed

the bullying was intentional in nature.

      Yildirim and Yildirim (2007) also used an investigator-designed survey

(Cronbach's α = .93) to assess for the *mobbing* of nurses (*n* = 505) as perceived by peers

and managers working within healthcare settings in Turkey. In this study mobbing was

defined as the systematic and frequent targeting of antagonistic and/or belittling behavior

that over a prolonged period of time similar to the definition of bullying posited by

Einarsen, Hoel, & Notelaers (2009). The researchers reported that a majority of nurses

were exposed to mobbing behaviors (86.5 %) over the last 12 months (*r* = .44 to 65, *p* <

0.001) and found statistically significant differences in exposure to mobbing behaviors

among nurses working in private hospitals as compared to public hospitals (*t* = -2.20, *p* <

0.02). The researchers postulated these findings to be related to increased restructuring activities and decreased job security in public verses private healthcare organizations.

In summary, studies using quantitative methods provide preliminary evidence that suggests workplace bullying is prevalent, on the rise, and frequently ignored in healthcare settings. Differences in theoretical approaches and related definition were noted. Several studies omitted theoretical frameworks (Duffield, O'Brien-Pallas & Aitken, 2004; Yildirim & Yildirim, 2007) to guide their inquiry (Kivimaki, Elovainio &Vahtera, 2000; Kivimaki, Virtanen, Vartia, Vahtera, & Keltikangas-Jarvinen, 2003). Only a few studies (the larger studies) employed randomized procedures to minimize bias (Kovner, Brewer, Wu, Cheng & Suzuki, 2006; Laschinger, 2010; Simons, 2008). In the majority of these studies, the NAQ-R was most frequently employed to measure workplace bullying within nursing (Johnson and Rea, 2009; Laschinger, Grau, Finegan & Wilk, 2010; Sa' & Fleming, 2008; Simons, 2008) and provided criteria as to the frequency and duration of the negative acts consistent with the definition of workplace bullying as posited by Einarsen, Hoel, & Notelaers (2009). As is typically noted with studies utilizing retrospective self-report surveys, test-retest reliability and/or peer verification of findings were not included. In general, the studies utilizing investigator-developed tools (Quine, 1999; 2001, Gillen, Sinclair, Kernohan, & Begley, 2009; Vessey, DeMarco, Gaffney, & Budin, 2009; Yildirim & Yildirim, 2007), lacked ample information related to tool development, particularly related to validity methods. Within most of these studies, there was limited information regarding the influence of societal, cultural and/or organizational conditions despite theoretical influences described by Hutchinson, Jackson, Wilkes, & Vickers (2008), Lewis (2004, 2006) and Strandmark & Hallberg (2007).

The literature lends support to the idea that workplace bullying poses a significant threat to the health and availability of our nursing workforce. Further research is needed to include and/or support specific theoretical explanatory models that inform studies designed to examine and/or describe workplace bullying. In particular, research is needed to explore and/or examine organizational conditions and the role that managers can play to influence or abate these behaviors. Inquiry among those who witness bullying should also be considered.

Chapter III

METHODS AND PROCEDURES

Introduction

This descriptive correlational study was designed in order to evaluate whether a

relationship exists between staff nurses' perception of nurse manager caring behaviors

and their perception of exposure to workplace bullying within multiple healthcare

settings and if so, to describe the strength and direction of the relationship. The study

population and the sample setting, the instruments and measurement methods, the data

collection procedures, the analysis of data, and ethical considerations are also described.

Sample and Setting

A convenience sample of registered nurses in staff nurse roles was recruited from

the Regional Nurse Network (RN-squared, RN^2) affiliated with the University of

California, San Francisco. RN^2 is a grassroots community of over 4,000 registered nurses

working within 177 healthcare settings within the state of California. Access for

membership within this network by RN's is voluntary and in response to solicitation by

hospitals and via advertisements within the San Francisco Bay area. Funding for this

network is provided with a grant provided by the Gordon and Betty Moore Foundation

and is associated with the Center for the Health Professions at the University of

California, San Francisco. The RN^2 network healthcare settings include acute care

hospitals, long term care facilities and home health agencies care. RN^2 is dedicated to the

personal and professional growth of their constituency and provide peer-to-peer learning

and support, workshops, and mentoring opportunities. Recruitment within this sample

was unrestricted across gender, age, and ethnicity, work setting or shift. The only

exclusion criterion was registered nurses presently working in a managerial role.

Study participation was facilitated by way of an introductory message delivered electronically from the RN[2] Program Director to a prospective participant base of over 4000 staff nurses within the network. This message contained a link to a secure website within Survey Monkey. Upon opening the link to Survey Monkey, self-selected participants then read an introductory letter prepared by the researcher. Participants then followed the prompt to access the parts of the survey: the Caring Factor Survey – Caring of the Manager, the Negative Acts Questionnaire – Revised, and the background and demographic work-related questionnaire.

The required sample size for statistical significance was calculated based upon an alpha set at .05, a moderate effect size set at .30 and a power of .80 (Cohen, 1988). Given these parameters, a power analysis revealed that a minimum of 64 participants was required to test the study research question. As stated, the study instruments were disseminated to a potential of over 4000 participants.

Instruments and Measurement Methods

The Caring Factor Survey – Caring of the Manager. The perception of nurse manager caring behaviors by staff nurses was measured utilizing the unpublished Caring Factor Survey-Caring of Manager (CFS-CM) with permission from the author (Appendix D). The CFS-CM (Nelson, 2011) is a newly designed 10-item instrument derived from the Caring Factor Survey (CFS). It is the only tool available to measure staff nurse perceptions of the caring behaviors of the nurse manager in accordance with the evolved theory of the caritas processes (rather than carative factors) integral to Watson's theory of human caring (2008). The ten caritas processes are an evolution of Watson's original work describing caring attributes as carative factors (Watson, 1979) and currently

describe these behaviors as caritas processes (or ways of being) indicative of a deeper

connection of *Universal Love* (in this case, between the nurse manager and staff). If the

10 caritas processes are operational, the recipient of the care (the staff nurse) will feel

caring/caritas in a way that considers body, mind, and spirit and within the application of

compassionate service to others and to humanity at-large (Watson, 2008).

     While the tool has been in an early stage of testing, it is similar in content and

conceptually congruent with the original Caring Factor Survey. Reliability of the original

CFS has been reported as a Cronbach's α = .96 (Nelson, 2011). Criterion validity of the

original CFS was established by measuring the CFS against a well-validated caring tool

considered to be similar to the CFS, namely the Caring Assessment Tool (CAT-II; Duffy,

2002). Pearson correlations between the CAT-II and the CFS were assessed at .80 when

measured at the same time on the same unit (Glasnapp & Poggio, 1985). Reliability was

established with correlations ranging from .80 and above with the exception of one paired

statement related to the promotion of feelings (.74) from patients and support of spiritual

belief and the creation of a healing environment (.77 & .75, respectively) and internal

consistency for item-to-total correlations for all 20 statements ranging from .80 to .93.

Most recently, the CFS was used in a study to assess patients' perception of nurses'

caring behaviors according to Watson's most recent theory of caritas (Persky, Nelson,

Watson, & Bent, 2008). In this study the inter-item reliability of the CFS was

demonstrated (Cronbach's α = .97). Further, nurses' with the highest caring scores (as

perceived by patients) also had high co-worker relationship scores (r, .65, p = .05).

     Comparatively, the statements within the CFS and the CFS-CM are similar. The

CFS is worded in the first person and pertains to the caregiver's or the patient's

perception of the caring behaviors provided. The CFS-CM is similarly worded and

measures the staff nurses perception of the nurse manager's caring behaviors. Each item

corresponds to one of each of the ten caritas processes (Appendix C). For example, the

item, "Every day I am here I see my manager treats employees with loving kindness,"

corresponds to the caritas process of the practice of loving kindness and spiritual regard

(as perceived by the staff nurse). Respondents selected one of seven Likert-style

responses for each item as 1 = s*trongly disagree, 2 = disagree, 3 = slightly disagree, 4 =

neutral, 5 = agree, 6 = slightly agree,* and 7 = *strongly agree.* The CFS-CM also

consisted of an optional open-ended question. This question asks participants to describe

a caring moment between themselves and their manager. This open-ended question

contributed added perspective to the rationale for the answers provided by the

participants and can be categorized and examined for themes using descriptive qualitative

design at a later time.

     The content and face validity of the CFS-CM were established by a team of

experts (headed by Watson) familiar with the administrative application of the caritas

processes. The tool was pilot tested on a sample of staff nurses in the Southeastern

portion of the United States *(N*=10) for the purpose of establishing content validity and

reliability (J. Nelson, personal communication, December 8, 2010). Scores for each of the

10 concepts of caritas ranged from 6.1 to 6.9, on the Likert-type scale (with scores

ranging from 1-7) with the highest scoring concept of caritas for the nurse managers'

decision-making and the lowest ranked concept of caritas was for the nurse managers'

spiritual support. The correlation of each item had a small-moderate (*r* = .20 to .40) to

strong ($r = .80$ or greater) correlation with the total CFS-CM score of all items combined as Cronbach's $\alpha = .81$.

This tool is newly developed and pilot tested. Watson has endorsed this tool to be the optimal choice for measuring staff nurses' perception of nurse manager caring in accordance with the newly evolved caritas processes (J. Watson, personal communication, December 8, 2010). The results of this study will add to the body of science about the use of this tool.

Negative Acts Questionnaire – Revised. Staff nurses' perception of exposure to workplace bullying was measured by scores on the Negative Acts Questionnaire-Revised (NAQ-R, Appendix E). Permission for the use of this tool was granted by the Bergen Bullying Research Group (Appendix F). The NAQ-R is the most widely used tool for measuring exposure to workplace bullying, is a theory-based tool with published psychometric properties (Einarsen, Hoel, & Notelaers, 2009). Studies employing the NAQ-R have included the measurement of bullying both in nursing and non-nursing populations in Sweden and Norway (Einarsen & Raknes, 1997; Mikkelsen & Einarsen, 2001), Great Britain (Hoel, Cooper, & Farragher, 2001; Quine, 1999, 2001), Japan (Abe & Henley, 2010; Takaki, et. al., 2010), Italy (Giorgi, 2008), Portugal (Sa' & Fleming, 2008) and the United States (Laschinger, Grau, Finegan, & Wilk, 2010; Simons, 2008).

The NAQ-R is a 22-item Likert-style tool designed to assess perceptions of exposure to personal and work-related bullying (Einarsen, Hoel, & Notelaers, 2009). All items within the survey are written in behavioral terms with no reference to the term bullying. The conceptual foundation for the design and development of the original tool (the NAQ) was based upon collaborative research efforts by a team of experts exploring

and describing this concept of interest (Einarsen & Skogstad, 1996, Leymann, 1996;

Zapf, 1999). Concerns regarding face validity and the potential for cultural bias were

addressed with the modification of the original tool from the original 29-item Norwegian

version to the English version (the NAQ-R) adapted for use within Anglo-American

cultures (Einarsen & Raknes, 1997; Matthieson & Einarsen, 2001). This was

accomplished using 11 focus groups (61 participants) within the United Kingdom. This

resulted in 22-items with the following Likert-style response choices indicating the

frequency of exposure: 1 = *never,* 2 = *now and then,* 3 = *monthly,* 4 = *weekly* and 5 =

d*aily,* for factors associated with person-related (12 items), work-related (7 items), and

physically intimidating (3 items) bullying. According to Einarsen, Hoel and Notelaers

(2009), exposure to negative acts up to two times weekly for 6 months meets the criterion

for being bullied.

The English version (the NAQ-R) was subsequently tested in a randomized study

of 4996 British employees across 70 organizations. A factor analysis revealed two

factors: *personal bullying*, and *work-related bullying*. The factor, personal bullying*,*

consists of behaviors that include being shouted at, and being subject to gossip, criticism,

teasing and insulting remarks. The second factor, work-related bullying, refers to

behaviors such as unreasonable deadline demands, unmanageable workloads, vital

information being withheld, opinions ignored, and also being pressured not to claim

rights.

Satisfactory reliability and validity have been demonstrated. Studies have shown

that the tool has a high internal consistency (Cronbach's α = .87 to .93) with an overall

Cronbach's α = .92 (Einarsen & Hoel, 2001). Construct validity has also been established

via negative correlations with measures of job satisfaction, ($r = -.24$ to $r = -.52$),

psychological health and well-being ($r = - .31$ to $r = - 0.52$), and psychosomatic

complaints ($r = .32$) (Einarsen & Hoel).

Discriminant validity of the NAQ-R has also been established with reported

negative correlated measures with physical health ($r = -.42$), intention to quit the job ($r = $

.36), and self-assessed job performance ($r = -.24$) (Einarsen & Hoel, 2001). Two recent

studies in the United States also reported statistically significant correlations with

workplace bullying in nursing: negatively (discriminant validity) with structural

empowerment ($\beta = -.37$, $p = .01$, Laschinger, Grau, Finegan, & Wilk, 2010) and

positively (convergent validity) with turnover ($p < .001$, Simons, 2008). In the latter

study, the content structure of one item was minimally altered with permission of the

authors, in consideration of an idiomatic phrase commonly used in the United Kingdom

(S. Simons, personal communication, December 12, 2010). For example, item 6, was

previously worded, "Have you ever been sent to Coventry?" and changed to, "Have you

ever been ignored or excluded?" Permission for this same change in this study has also

been requested and granted (Appendix F).

Varying criteria have been used to determine actual exposure to bullying

behaviors. Leymann (1996) suggested that exposure to bullying at work can be

confirmed if the occurrence of a negative act happens at least once weekly over a six-

month timeframe. Einarsen (2000) defined exposure to negative acts as occurring at least

twice weekly over a prolonged timeframe. Simons (personal communication, September

5, 2011) suggested that the stricter criterion as defined by Einarsen (twice weekly) be

used to avoid an overestimation of exposure to bullying at work. Additionally, her

discussion with Einarsen resulted in the decision for the utilization of weighted scores to further differentiate whether exposure to bullying occurred by using the approximate number of working days in a six-month period for weight as follows: *Never* = 0, *Now and then* = 2, *Monthly* = 6, *Weekly* = 25, and *Daily* = 125. With this method, the summation of scores over a six-month timeframe ranged from 0 – 2750, with higher scores indicating a greater degree of exposure to bullying.

In summary, the NAQ-R is the most commonly utilized tool to measure workplace bullying, has a high internal stability and demonstrates high criterion validity and construct validity (Einarsen, Hoel and Notelaers, 2009). This measurement tool is also relatively brief, has application within multiple healthcare settings, and has been especially adapted to Anglo-American cultures.

Demographic and Work-Related Questionnaire

In addition to the CFS-CM and the NAQ-R, participants completed a set of demographic and work-related questions designed by the researcher in accordance with the literature review, where applicable. Demographic and work-related questions were measured by forced-choice categories include age, gender, race/ethnicity, educational level, number of years as an RN, role in nursing, type of facility or agency, attributes of the facility or agency (including whether Watson's theory of human caring was utilized and also whether the facility was Magnet designated), role of the staff nurse, the number of years working as an RN on current inpatient unit, the average number of hours worked per week, the usually scheduled shift, the average number of patients managed per shift, and the staff nurses' perception of the degree that spirituality and/or religious practices influenced caring behaviors. Also included, was a question about the country where basic

nursing education was received and if so, the length of time he or she has have

subsequently worked as n RN in the United States.

Data Collection Procedures

Following an approval from the Seton Hall University Institutional Review Board

(IRB) the introductory letter and the survey were entered within Survey Monkey.

Prospective participants were introduced to these documents by way of a link to the

secure website via an introductory e-mail message from the RN^2 Program Director. Self-

selected access to the survey was for a period of 60 days with a reminder sent after the

30-day time for an additional 30 days to enhance the response rate and minimize non-

response sample bias.

Analysis of Data

After collection in Survey Monkey format, the data were analyzed using the

Statistical Package for the Social Sciences, version 20.0 for Windows (IBM, 2011).

Descriptive statistics such as percentages, frequencies, means, and standard deviations

were calculated to describe participants' demographic and background data and data

related to the main study variables. Reliability calculations of the study instruments was

conducted. Individual responses to, and correlations between, each of items within both

the CFS-CM and the NAQ-R were also examined for trends within this participant

sample. Additionally, the prevalence of bullying in accordance with the definition of

being exposed to at least two negative acts on weekly basis over the course of 6 months

was ascertained. The Pearson correlation coefficient was used to answer the study

research question as to whether a relationship exists between the staff nurses' perception

of nurse manager caring and their perception of exposure to workplace bullying in

multiple healthcare settings and if so, the strength and direction of the relationship between these two variables. Further, regression analyses were conducted to evaluate the effect of various demographic, educational and work related variables on the mean scores of both the CFS-CM and the NAQ-R.

Ethical Considerations

Prior to conducting this study, approval was obtained from the Seton Hall University IRB. Participation was voluntary and completion of the survey implied consent to participate. RN^2 specified that they would recognize IRB approval from Seton Hall University and requested and were provided copies of all IRB approvals for their records. RN^2 participants received a cover letter (see Appendix B) that introduced the purpose of the study and explained that all surveys were completely voluntary, that all responses would be kept confidential, and that data would be analyzed in an aggregate statistical format only. The letter included the name and contact information of the researcher, should participants have questions or concerns. In return for their participation in the study, respondents will be given access to study results after completion of the study.

Chapter IV

FINDINGS

Introduction

This study investigated whether staff nurses' perception of nurse manager caring behaviors is related to their perception of exposure to workplace bullying within various healthcare settings. Over the electronic data collection period (December 1, 2011 through January 31, 2012), 185 staff nurse participants completed the Caring Factor Survey–Caring of the Manager (CFS-CM, Nelson, 2011; Appendix C), 162 participants completed the Negative Acts Questionnaire – Revised (NAQ-R-R, Einarsen, Hoel, & Notelaers, 2009; Appendix E), 194 participants responded to the background information questionnaire (Appendix G), and156 participants completed all three questionnaires (the CFS-CM, the NAQ-R, and the background information questionnaire).

Data were collected utilizing Survey Monkey® software and analyzed using Statistical Package of Social Science software version 20 (IBM, 2011). The research question was answered based on data from the sample of 156 participants who completed all three questionnaires. This sample size was sufficient to address the research question with power set at .80 and a medium effect size (.30) at the .05 level of significance (Cohen, 1988).

The Sample

Participant data about sample demographics, work environment role and responsibility, and employment patterns are presented in Tables 1 through 4. For the purpose of this study, the demographic and background information is provided for the

156 participants who responded to both the CFS-CM and the NAQ-R. Total group

frequencies of less than 156 within these categories indicate missing (unreported) data.

In general, this participant sample was primarily female (91.7%), between 51 years and

60 years of age (34.6%), and primarily Caucasian (59.6%). Breakdowns of these data are

described in Table 1.

Table 1

Gender, Age, Race/Ethnicity of Participant Sample ($N = 156$)

Demographic	Grouping	Frequency	Percent
Race/Ethnicity	White	93	59.6%
	Asian American	41	26.3%
	Hispanic	4	2.6%
	Black	2	1.3%
	Other	12	7.7%
	Missing	4	2.6%
Gender	Female	143	91.7%
	Male	11	7.1%
	Missing	2	1.3%
Age	20-30 years of age	10	6.4%
	31-40 years of age	21	13.5%
	41-50 years of age	37	23.7%
	51-60 years of age	54	34.6%
	61-70 years of age	30	19.2%
	Missing	4	2.6%

Note. Percent = percentage of 156 participants.

The country where educated, the highest degree attained, certification and the RN

years of experience were also ascertained. Most of the participants within this sample

received their basic nursing education within the United States (71.2%) and had

completed a baccalaureate degree in nursing (52.6%). Of the 43% of participants certified

in a nursing specialty, participants were primarily certified in critical care (14.1%). The

majority of this sample (51.9%) reported working for more than 20 years as a registered

nurse. A breakdown of these data is described within Table 2.

Table 2

Country Where Educated in Nursing, Highest Degree, Certification, and RN Years of
Experience of Participant Sample (*N* = 156)

Demographic	Grouping	Frequency	Percent
Country Educated	USA	111	71.2%
	Outside of USA	31	19.9%
	Missing	14	9%
Highest Degree	Diploma	10	6.4%
	Associate	19	12.2%
	Baccalaureate	82	52.6%
	Masters	40	25.6%
	Post-Master's Certificate	2	1.3%
	Missing	3	1.9%
Certification	CCRN	22	14.1%
	PHN	7	4.5%
	Oncology	5	3.2%
	RNC	6	3.8%
	CNOR	4	2.6%
	CNS	3	1.9%
Years in Nursing	10 years or less	37	23.7%
	11-20 years	29	18.6%
	More than 20 years	81	51.9%
	Missing	9	5.8%

Note. Percent = percentage of 156 participants. Board Certifications: CCRN = Critical Care; PHN = Public
Health Nursing; RNC = Medical Surgical Nursing; CNS = Clinical Nurse Specialist; CNOR = Operative
Nursing. Total participant percentage will not equal 100% since respondent had multiple or no
certifications.

Participants worked within a variety of settings; however an overall majority of

staff nurses worked within acute care settings (79.5%) with less than 500 beds (78.2%)

and were employed within unionized settings (53.8%). A breakdown of this data is

described in Table 3.

Table 3

Organizational Factors of Participant Sample (*N* = 156)

Demographic	Grouping	Frequency	*N*-Percent
Facility size	250 beds or less	63	40.4%
	251-500 beds	59	37.8%
	500 beds	28	17.9%
	Missing	6	3.8%
Facility type	Acute care	124	79.5%
	Government/State	7	4.5%
	HMO/Integrated Care	3	1.9 %
	Home Health Agency	3	1.9%
	Sub-Acute Care	3	1.9%
	Combination of above	10	15.6%
	Missing	6	3.8%
Other Factors	Unionized	84	53.8%
	Non-unionized	14	9.0%
	Magnet facilities	6	3.8%
	Watson's theory	1	0.6%
	Combination of factors	29	29.2%

Note: HMO = Health Maintenance Organization; Watson's theory = those facilities who have employed Watson's theory of human caring; Combination of above = respondents working in facilities with a combination of characteristics that may include union or non-union, Magnet and/or Watson's theory of human caring. Percent = percentage of 156 participants.

Information about the participant's work environment was obtained. Participants primarily worked within medical surgical/telemetry (20.5%) or medical surgical intensive care (17.9%) environments. Of the participant sample 16.7% were occasionally in a charge nurse role. Greater than 44.3% of participants worked on the same unit for 11 years or more. An overall majority (66%) of this participant sample worked the day shift and over 16% reported a patient caseload of 8 or more patients. Within the categories of unit where assigned, role in nursing, and patient workload, missing data rate ranged from 15.4% to 37.8%. A breakdown of these data is described in Table 4.

Table 4

Participant Sample Type of Unit, Staff Nurses' Role, Unit Years, Shift, Patient Workload and Hours Worked Weekly (*N* = 156)

Demographic	Grouping	Frequency	*N*- Percent
Unit	Medical/Surgical/Telemetry	32	20.5%
	Medical/Surgical ICU	28	17.9%
	Ambulatory Care	10	6.4%
	Emergency Room	9	5.8%
	Perioperative	11	7.1%
	Extended Care	7	4.5%
	Missing	59	37.8%
Role	Staff nurses	68	43.6%
	Staff nurse with occasional charge nurse role	26	16.7%
	Charge nurse	11	7.1%
	Clinical Nurse Specialist	8	5.1%
	Per diem nurse	9	5.8%
	Instructor	5	3.2%
	Missing	29	18.6%
Years on Unit	3-5 years	34	21.8%
	11-20 years	36	23.8%
	More than 20 years	33	21.2%
	6-10 years	24	15.4%
	1-2 years	14	9.0%
	Less than 1 year	11	7.1%
	Missing	4	2.6%
Shift	Day	103	66.0%
	Night	29	18.6%
	Evening	21	13.5%
	Missing	3	1.9%
Patient load	4-8 patients	55	35.3%
	1-3 patients	51	32.7%
	More than 8 patients per shift	26	16.7%
	Missing	24	15.4%
Hours worked	More than 40 hours per week	25	16%
	20 - 40 hours per week	120	76.9
	10-20 hours per week	7	4.5%
	Less than 10 hours per week	2	1.3%
	Missing	2	1.3%

Note: ICU = Intensive Care Unit. *Note.* Percent = percentage of 156 participants.

Instrument Reliability

Instrument reliability for the study sample of 156 of participants who responded to both the Caring Factor Survey – Caring of the Manager (CFS-CM, Nelson, 2011, Appendix, C) and the Negative Acts Questionnaire- Revised (NAQ-R, Einarsen, Hoel, & Notelaers, 2009, Appendix E) were examined. Cronbach's alpha for the CFS-CM was 0.97, and for the NAQ-R, 0.92, respectively.

Presentation of Results

The Research Question. The research question asked whether there is a relationship between staff nurses' perception of nurse manager caring, as measured by the total scores on the CFS-CM, and the staff nurses' perceived exposure to bullying in the workplace, as measured by the total scores on the NAQ-R.   Since the variables provided interval level data for the sample of 156 participants who completed both the CFS-CM and the NAQ-R, a Pearson correlational analysis was conducted. The findings revealed a statistically significant, negative correlation between the CFS-CM and the NAQ-R ($r = -.534$, $p < .001$) indicating that as staff nurses' perceptions of nurse manager caring increased, their perception of exposure bullying in the workplace significantly decreased.

Staff Nurses' Perception of Nurse Manager Caring. Staff nurses' perceptions of nurse manager caring behaviors as measured by the CFS-CM were also analyzed. According to Nelson (personal communication, January 15, 2012), the total scores are obtained by adding up the scores for each of the ten questions (Likert-style scores for each item ranged from 1 - 7) (see Appendix C) and then dividing the total score by 10. For this sample, total scores ranged from 1 to 7 with a mean score of 4.37 and a standard

deviation of 1.821, with higher scores indicating staff nurses' perception of nurse managers as more caring.

Upon examining the frequency table, the distribution of the total scores on the CFS-CM was noted to be multimodal, indicating multiple values of high frequency (Polit & Beck, 2004), and positively skewed, indicating that a higher number of staff nurses perceived their managers as caring (responses numbers 5 – 7) than not (responses 1 – 3). The high number of peaks within the range of possible responses suggests that the number of response choices presented to participants for each Likert scale on this tool may have been excessive. These results are presented in Figure 1.
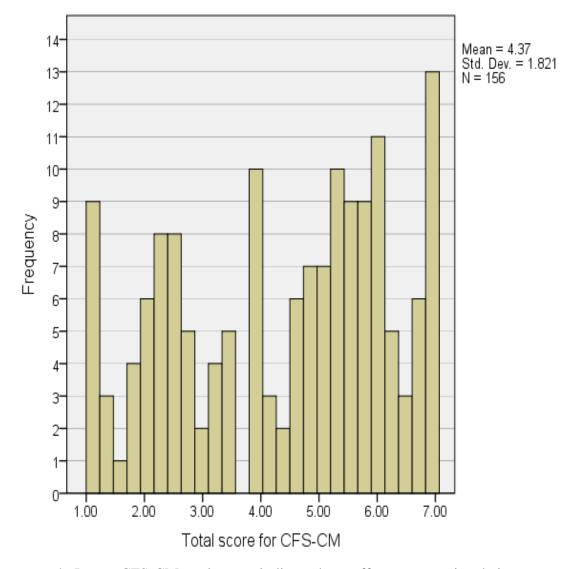
Figure 1. Distribution of Scores for the Caring Factor Survey - Caring of the Manager (Nelson, 2011)

Figure 1. Lower CFS-CM total scores indicate that staff nurses perceive their nurse managers as less caring.

In order to better understand the staff nurses' responses, the response choices

within the 7-point Likert-style scale for each of the ten-items within the CFS-CM Caring

behaviors were categorized into 3 main responses: *disagreed*, for the Likert-style scores

of 1 – 3, *neutral* (meaning, neither agreed or disagreed), for the Likert-style score of 4,

and *agreed* for the Likert-style scores of 5 – 7. The most commonly selected nurse

manager caring behavior that participants disagreed with (Likert-style score 1-3) was the

item, "Creates a healing environment." This indicated that staff nurses frequently

perceived their manager as being inattentive or unable to facilitate a healing environment

at the point of care. The most commonly selected neutral response (Likert-style score 4)

was for the nurse managers' caring behavior of, "The manager of my unit/department

encourages my spiritual beliefs," followed by, "The manager of my unit is accepting and

supportive of my beliefs re: a higher power, which allows for the possibility of me to

grow." These responses may have been an indication of the staff nurses' lack of clarity as

to the role of the nurse manager toward their spiritual beliefs. Further, the notion of a

higher power may be perceived as unrealistic perception among this participant sample.

Lastly, the most commonly selected nurse manager caring behavior that participants

agreed with (Likert scale responses 5-7) was for the item, "When my manager teaches me

something new, s/he teaches me in a way I can understand." The positive perception of

this behavior may indicate the staff nurses' appreciation for their nurse manager's role as

an educator at the point of care. A summary of all responses for each item of the CFS-

CM is shown in Table 5.

Table 5

Nurse Manager Caring Behaviors–Caring of the Manager (*N* = 156)

Behavior Likert Scale Score	Disagree 1-3	Neutral 4	Agree 5-7
Loving kindness	(n=54) 34.62%	(n=17) 10.90%	(n=85) 54.49%
Creative problem solving	(n=56) 35.90%	(n=17) 10.90%	(n=83) 53.21%
Instills hope and respects my belief system	(n=59) 37.83%	(n=10) 6.41%	(n=87) 55.77%
Teaches me in a way I can understand	(n=37) 23.72%	(n=27) 17.31%	(n=92) 58.97%
Encourages my own spiritual beliefs	(n=32) 20.51%	(n=52) 33.33%	(n=72) 46.15%
Responds to me as a whole person	(n=47) 30.13%	(n=23) 14.74%	(n=86) 55.13%
Establishes a trusting and helping relation	(n=54) 34.62%	(n=15) 9.62%	(n=87) 55.77%
Creates a healing environment	(n=63) 40.38%	(n=33) 21.15%	(n=60) 38.46%
Embraces my feelings	(n=57) 36.54%	(n=17) 10.90%	(n=82) 52.56%
Accepting and supportive of my beliefs re: a higher power	(n=41) 26.28%	(n=46) 29.49%	(n=69) 44.23%

Note: The Caring Factor Survey – Caring of the Manager is from Nelson (2011).

Staff Nurses' Perception of Exposure to Negative Acts

Staff nurses' perceptions of exposure to negative acts (such as workplace bullying), as measured by responses to the NAQ-R, were also examined. Total scores and scores on individual items were analyzed. For this sample, the distribution of total scores (*N*= 156) for the NAQ-R were found to be markedly and negatively skewed with a mean score of 161.33 and a standard deviation of 335.72 out of a possible score range of 0-

2750, indicating that the majority of sample participants perceived little to no exposure to

negative acts in the workplace; these data are depicted in Figure 2.

Figure 2. Distribution of Scores for the Negative Acts Questionnaire–Revised (Einarsen,

Hoel, & Notelaers, 2009)

Figure 2. Lower NAQ-R total scores indicate that staff nurses perceived less exposure to
negative acts meeting the definition of workplace bullying.

Individual items within the NAQ-R were also examined. Overall, the most

commonly experienced negative act was *"Unmanageable workload,"* and was indicated

by over 20% of this participant sample. The next most commonly experienced negative

act was, *"Being ignored or excluded,"* indicating that over 17% of participants perceived

being excluded either from the manager, the staff, and/or from unit level activities.

Conversely, the least commonly experienced acts were *"Practical jokes against you"* (*n*

= 4 or 2.6%) followed by *"Threats of violence or physical abuse,"* (*n* = 5 or 3.2%)

indicating that only a small number of staff nurses were exposed to these 2 behaviors.

These data are presented in Table 6.

Table 6

Negative Acts Questionnaire-Revised: Frequency/Percent of Perceived
Behaviors Reaching Bullying (*N* = 156)

Bullying Behaviors	Weekly *n* (%)	Daily *n* (%)	Total *n* (%)
Information withheld	9 (5.8%)	8 (5.1%)	17 (10.9%)
Being humiliated or ridiculed	4 (2.6%)	3 (1.9%)	7 (4.5%)
Ordered to work below competence	9 (5.8%)	15 (9.6%)	24 (15.4%)
Responsibilities removed	14 (9%)	7 (4.5%)	21 (13.5%)
Being gossiped about	8 (5.1%)	8 (5.1%)	16 (10.3%)
Being ignored or excluded	17 (10.9%)	11 (7.1%)	28 (17.9%)
Insulting or offensive remarks	0 (0%)	6 (3.8%)	6 (3.8%)
Being shouted at	5 (3.2%)	2 (1.3%)	7 (4.5%)
Being intimidated	7 (4.5%)	1 (.6%)	8 (5.1%)
Being hinted at to quit	6 (3.8%)	2 (1.3%)	8 (5.1%)
Reminded of your errors or mistakes	5 (3.2%)	3 (1.9%)	8 (5.1%)
Ignored or facing hostility	7 (4.5%)	6 (3.8%)	13 (8.3%)
Persistent criticism of your work	4 (2.6%)	7 (4.5%)	11 (7.1%)
Your opinions ignored	10 (6.4%)	12 (7.7%)	22 (14.1%)
Practical jokes against you	2 (1.3%)	2 (1.3%)	4 (2.6%)
Being given unreasonable tasks or targets	11 (7.1%)	7 (4.5%)	18 (11.5%)
Accusations made against you	4 (2.6%)	5 (3.2%)	9 (5.8%)
Excessive monitoring of your work	9 (5.8%)	13 (8.3%)	22 (14.1%)
Being pressured not to use job benefits	4 (2.6%)	9 (5.8%)	13 (8.3%)
Excessive teasing and sarcasm	3 (1.9%)	1 (.6%)	4 (2.6%)
Unmanageable workload	16 (10.3%)	16 (10.3%)	32 (20.5%)
Threats of violence or physical abuse	3 (1.9%)	2 (1.3%)	5 (3.2%)

Note: Percentages may not add up to 100% because of missing data

Frequency of Staff Nurses' Perception of Exposure to Workplace Bullying

The prevalence of workplace bullying within this study sample was also analyzed by calculating the frequency of staff nurses' exposure to these negative acts. Exposure to workplace bullying is defined as being exposed to up to 2 negative acts daily or weekly, over a 6-month timeframe (Einarsen, Hoel, & Notelaers, 2009). For this sample, 56 participants (35.9%) reported exposure to negative acts up to 2 times weekly over a 6-month timeframe, meeting the definition of exposure to bullying (Einarsen, Hoel and Notelaers, 2009). Sixty-eight (43.6%) participants reported that they perceived no exposure at all. These data are presented in Table 7.

Table 7

Perception of Exposure to Workplace Bullying

Exposed to:	Daily	Weekly	Never Exposed
1 of 22 items	17 (10.9%)	19 (12.9%)	-
2 of 22 items	25 (16.4%)	37 (24.0%)	-
1 or 2 of 22 items	42 (26.3%)	56 (35.9%)	68 (43.6%)

Note: $N = 156$. Weekly data also includes those individuals who perceived exposure to workplace bullying on daily basis if occurring every week over the six-month timeframe. Percentages may not add up to 100% because of missing data.

Correlations between items on the CFS-CM and the items on the NAQ-R.

In order to identify the strength of the relationships between each of the items within the CFS-CM and each of the items within the NAQ-R, a canonical correlation analysis was performed. This analysis allows for the assessment of the relationships between both metric and nonmetric data (nominal or ordinal and interval data, respectively for either the independent or dependent variables) (Hair, Anderson, Tatham, & Black, 1998). This is the first study to analyze the correlations between the items

within these two instruments (the CFS-CM and the NAQ-R), and this statistical

procedure can provide a greater depth of understanding about the overall nature of the

relationships between these study variables. An analysis of these data revealed negative,

statistically significant relationships between the majority of the items within the CFS-

CM and the NAQ-R, indicating that staff nurses' perceptions of nurse manager caring

behaviors and negative acts are inversely related to one another. The correlational data

for all CFS-CM and NAQ-R items are presented in table's 8 and 9.

Table 8

A correlational matrix between individual items of the CFS-CM and the NAQ-R

CFS - CM Item	Withhold information	Humiliated	Worked below ability	Unpleasant tasks	Gossiped About	Excluded	Insulted	Shouted at	Intimidated	Encouraged to quit	Reminded of mistakes
Loving kindness	-.224**	-.218**	-.300***	-.300***	.275***	-.273***	-.207**	-.231**	-.215**	-.251**	-.235**
Creative problem solving	-.259**	-.269***	-.341***	-.326***	-.328***	-.356***	-.238**	-.237**	-.206	-.271**	-.256**
Instills hope	-.258**	-.248**	-.370***	-.365***	-.316***	-.361***	-.233**	-.231**	-.208	-.254**	-.242**
Teaches in a way I understand	-.269***	-.291***	-.323***	-.424***	-.360***	-.294***	-.296***	-.265***	-.234**	-.284***	-.292***
Supports my spiritual beliefs	-.162*	-.241**	-.263**	-.318***	-.296***	-.261**	-.250**	-.271***	-.241**	-.269***	-.230**
Holistic approach	-.263***	-.235**	-.358***	-.358***	-.322***	-.384***	-.228**	-.235**	-.202	-.275***	-.284***
Establishes a helping and trusting relationship	-.239**	-.254**	-.402***	-.347***	-.299***	-.420***	-.232**	-.224**	-.205	-.260**	-.254**
Creates a Healing environment	-.247**	-.254**	-.354***	-.306***	-.260**	-.362***	-.227**	-.209**	-.108*	-.241**	-.227**
Embraces my feelings	-.250**	-.238**	-.336***	-.302***	-.262**	-.433***	-.210**	-.188*	-.162*	-.248**	-.241**
Supports my belief system	-.238**	-.247**	-.250**	-.284***	-.253**	-.409***	-.227**	-.219**	-.175*	-.255**	-.272*

Note. Intercorrelations for staff nurse participants (*n* = 156) for scores on the Caring Factor Survey – Caring of the Manager (Nelson, 2011) and the Negative Acts Questionnaire-Revised (Einarsen, Hoel, & Notelaers, 2009).
* *p* < .05. ** *p* < .01. *** *p* < .001.

Table 9

A correlational matrix between individual items of the CFS-CM and the NAQ-R (continued)

CFS - CM Item	Ignored	Critical	Views ignored	Joked About	Impossible deadlines	Accused	Excessive monitoring	Deny benefits	Teased	Unmanageable workload	Threats of abuse
Loving kindness	-.319***	-.323***	-.395***	-.152*	-.177*	-.276***	-.378***	-.306***	-.229**	-.287***	-.215**
Creative problem solving	-.344**	-.349***	-.369***	-.206**	-.267***	-.306***	-.344***	-.292***	-.232**	-.323***	-.213**
Instills hope	-.337***	-.336***	-.385***	-.208**	-.227**	-.293***	-.323***	-.348***	-.224**	-.321***	-.202**
Teaches in a way I understand	-.386***	-.701***	-.835***	-.231**	-.136	-.294***	-.321***	-.170*	-.269***	-.239**	-.250**
Supports my spiritual beliefs	-.342***	-.304***	-.346***	-.171*	-.199**	-.242**	-.296***	-.221**	-.244**	-.290***	-.159*
Holistic approach	-.324***	-.315***	-.393***	-.159*	-.278***	-.279***	-.374***	-.313***	-.224**	-.329***	-.203**
Establishes a helping and trusting relationship	-.333***	-.295***	-.390***	-.194*	-.301***	-.296***	-.293***	-.384***	-.192*	-.348***	-.182*
Healing environment	-.314***	0.266***	-.407***	-.196*	-.301***	-.284***	-.362***	-.356***	-.164*	-.305***	-.150
Embraces my feelings	-.302***	-.242**	-.366***	-.186*	-.294***	-.280***	-.350***	-.347***	-.178*	-.301***	-.159*
Supports my belief system	-.319***	-.251**	-.385***	-.187*	-.232**	-.281***	-.279***	-.232**	-.184*	-.264**	-.179*

Note. Intercorrelations for staff nurse participants (n = 156) for scores on the Caring Factor Survey – Caring of the Manager (Nelson, 2011) and the Negative Acts Questionnaire-Revised (Einarsen, Hoel, & Notelaers, 2009).
* $p < .05$. ** $p < .01$. *** $p < .001$

Demographic and Work-Related Background Information

Multiple linear regression analyses were conducted to evaluate whether or how well the demographic and work-related variables (as independent variables) predicted the staff nurses' perception of nurse manager caring (the dependent variable) via scores on the Caring Factor Survey – Caring of the Manager (CFS-CM, Nelson 2011). In preparation for linear regression analysis, the variables that were dichotomous were dummy-coded and ordinal variables were put in rank order (Polit & Beck, 2004). For the first model, the independent variables (IVs) of age, race/ethnicity, gender, highest degree in nursing, years of RN-experience, RN-years on unit, type of unit, primary shift, workload, and scheduled hours per week were simultaneously entered in an unordered fashion. Since this model included two items with a high degree of missing data, (workload, $n = 24$ or 15%, and unit where worked, $n = 59$ or 38%), the sample size was reduced to 85. A post hoc G*Power analysis (Faul, Erdfelder, Buchner, & Lang, 2009) was conducted to assess if this sample size was adequate using an alpha of .05, a power of .80, and an effect size of .20 (Cohen, 1988). The power analysis revealed that a sample size of 68 was needed, thus acceptable for all regressions models analyzed (with sample sizes ranging from 79 – 140) within this study. For this model ($n = 85$), the linear regression analysis indicated that gender (specifically females) and type of unit (specifically, those staff nurses working in medicine/surgery/telemetry) accounted for a significant amount of the CFS-CM total score variability, $R^2 = .268$, $F(10, 75) = 2.750$, $p = .01$.

Since healthcare facilities within the state of California are primarily unionized and staffing ratios for nurses are regulated, a second regression analysis was conducted entering the organizational characteristics of union and magnet-designated status and the staff nurses' patient workload as independent variables and the total score on CFS-CM as the dependent variable. Since this model included an item with a moderate degree of missing data (workload, $n = 24$ or 15%), the sample size for this model was reduced to 140. This regression model was not significant, $R^2 = .018$, $F(3, 137) = .831$, $p = .479$, indicating that, for this sample, union and/or magnet-designated status and the staff nurses' workload were unrelated and/or did not predict the staff nurses' perceptions of the caring behaviors of their managers.

The literature lends support to the idea that the staff nurses' relationship with their manager is enhanced if they have increased access to their manager's time and availability (Hall, 2007; Kleinman, 2004), thus a third regression analysis was conducted to analyze correlations between RN-years of experience, RN-years within unit or department, primary shift, and workload as independent variables and the total scores on the CFS-CM as the dependent variable. This model included several items having a small degree of missing data (although 6% or less), thus the sample size was moderately reduced to 134. This regression model was also not significant: $R^2 = .031$, $F(4, 130)$, $= 1.051$, $p = .384$ indicating that for this sample, RN experience, length of time within the unit or department, the primary assigned shift, and workload did not have a significant effect on the staff nurses' perceptions of nurse manager caring. Data analyses for these 3 regression models are presented in Table 10.

Table 10

Multiple Regression Analysis Describing Relationships between Demographic and Work-Related IV's and Nurse Manager Caring Behavior (DV).

Variables	Nurse Manager Caring Behaviors		
	Model 1 β (SE)	Model 2 β (SE)	Model 3 β (SE)
Constant	8.644 (23.365)	46.532 (5.754)	58.324 (8.169)
Age	2.238 (2.420)		
Gender	20.733** (6.618)		
Race/Ethnicity	-.608 (1.613)		
Highest Degree in Nursing	-2.805 (2.341)		
RN Years of Experience	-1.397 (2.679)		-1.855 (1.754)
RN Years on Unit	-3.097 (1.796)		.171 (1.350)
Primary Shift	-1.358 (2.399)		-2.251 (2.049)
Type of Unit	-3.245** (1.005)		
Workload	-2.097 (2.503)	-2.759 (2.136)	
Hours per Week	8.453 (4.987)		
Union Status		997 (3.931)	
Magnet Status		3.269 (4.200)	
R^2	.268	.018	.031
F	2.750**	.831	1.051
n	85	140	134

Note. β = Beta unstandardized coefficients. Standard errors are in parentheses.
*$p <$ .05. **$p <$ .01. ***$p \leq$ .001.

Similarly, three linear regression analyses were conducted to evaluate whether or how well the demographic and work-related factors predicted the staff nurses' perception of exposure to workplace bullying (as measured by the NAQ-R). Since there was a need to assess how different independent measures related to the total score of the CFS-CM, it was also included within each model.

For the first model the independent variables of age, race/ethnicity, gender, highest degree in nursing, workload, scheduled hours, shift, type of unit, RN-years worked, unit-years worked, and the total score on the CFS-CM were entered simultaneously in an unordered fashion. This model included two items with a high degree of missing data (workload, $n = 24$ or 15% and type of unit, $n = 59$ or 38%), thus the sample size was reduced to 79 (exceeding the minimal required sample size of 68 as determined by the post hoc G*Power analysis, Faul, Erdfelder, Buchner, & Lang, 2009). This regression equation was significant, $R^2 = .394$, $F(4, 127) = -9159$, $p \leq .001$, accounting for 39% of the variance in the NAQ-R total scores and lending support to the Pearson product correlation between these two instruments ($r = -.534$, $p < .001$).

Since the state of California is highly unionized and staffing ratios for nurses are regulated; a second regression analysis was conducted to evaluate how well the CFS-CM scores, workload, union and magnet-designated status predicted the total scores on the NAQ-R. Since this model included an item with a moderate degree of missing data (workload, $n = 24$ or 15%), the sample size was reduced to 131. Analysis of this regression model also yielded significant results, $R^2 = .333$, $F(4, 127)$

= 15.867, p ≤ .001, predicting 33.3% of the variance on the NAQ-R score. For this sample population, the independent variable, workload, was significantly correlated with the total score of the NAQ-R ($p < .05$) indicating that the staff nurses' workload significantly influenced the staff nurses' perceptions of exposure to workplace bullying. This model also added further support to the Pearson product correlation suggesting a significant relationship between nurse manager caring and exposure to workplace bullying.

Lastly, since findings within the literature support the idea that the staff nurses' exposure to workplace bullying is typically associated with newly licensed or inexperienced nurses, a third regression analysis was conducted to evaluate whether and/or how well the total scores on the CFS-CM, RN-years of experience, RN-years on the unit, shift, and workload (as independent variables) predicted scores the staff nurses' perception of exposure to workplace bullying as measured by the scores on the NAQ-R. Since this model included two items with a high degree of missing data (the staff nurses role, $n = 24$ or 19%, workload, $n = 24$ or 15%, and the type of unit, $n = 59$ or 38%), the sample size was reduced to 83 (however met the minimal required sample size of 68 as determined by G*Power, Faul, Erdfelder, Buchner, & Lang, 2009). This regression model was significant, $R^2 = .316$, $F(4, 79) = 9.123$, $p = < .001$, predicting 31.6% of the variance in the NAQ-R scores. These findings indicated that, for this sample, the independent variables of the staff nurses' role, type of unit where the staff nurse worked, and the numbers of years working within the unit were unrelated or did not influence their perception of exposure to workplace bullying. All

three analyses however, indicated that the significant correlation between the total

scores on the CFS-CM and the NAQ-R was consistently supported. The results of the

analyses of these 3 regression models are presented in Table 11.

Table 11

Linear Regression Analysis Describing Relationships between Demographic and Work-Related IV's and Exposure to Workplace Bullying (DV).

	Exposure to Workplace Bullying		
Variables	Model 1 β (SE)	Model 2 β (SE)	Model 3 β (SE)
Constant	644.831 (398.004)	429.049 (96.349)	547.858 (138.432)
Age	32.684 (41.477)		
Gender	-130.865 (115.947)		
Race/Ethnicity	-17.983 (27.706)		
Highest Degree in Nursing	34.891 (41.080)		
RN Years of Experience	-74.814 (44.747)		
RN Years on Unit	23.388 (31.249)		12.099 (20.824)
Primary Shift	-52.332 (39.797)		
Type of Unit	1.443 (18.519)		-1.059 (15.872)
Workload	38.836 (43.582)	70.700* (30.382)	
Hours per Week	63.265 (87.689)		
Union2		-45.478 (54.841)	
Staff Nurses' Role			-5.995 (10.519)
Magnet2		48.430 (57.941)	
Nurse Manager Caring Behaviors	-9.159*** (1.987)	-8.586*** (1.193)	-9.701*** (1.745)
F	4.013***	15.867***	9.123***
R²	.394	.333	.316
n	79	131	83

Note. β = Beta. This table reports unstandardized coefficients. Standard errors are in parentheses.
*$p. < .05$. **$p < .01$. *** $p \le .001$.

Summary

Data obtained from the study sample were analyzed to examine the

relationship between the staff nurses' perception of nurse manager caring behaviors

and their perception of exposure to workplace bullying. Also examined, were factors

related to the inquiry that could be inherent in instrument construction and/or

demographic and work-related variables within the study sample. Analysis of the

study data revealed a statistically significant inverse relationship existed between the

total scores on the CFS-CM (staff nurses' perceptions of nurse manager caring

behaviors) and the total scores on the NAQ-R (staff nurses' perceptions of their

exposure to workplace bullying) ($r = -.534, p < .001$).

Relationships between all the items within both the CFS-CM and the NAQ-R

(as ascertained by conducting a correlational analysis), were inversely related and

supported the overall negative correlation between staff nurses' perception of nurse

manager caring and their perception of exposure to workplace bullying. Further, the

findings within the linear regression models (indicating that scores on the CFS-CM

accounted for a significant variance in the NAQ-R) supported and confirmed the

overall relationship between the staff nurses' perception of nurse-manager caring and

their perceived exposure to workplace bullying.

Staff nurses' perceptions toward the specific items among the nurse manager

caring behaviors within the CFS-CM indicated that they most frequently agreed upon

the managers' role as educator, perceived the highest degree of neutrality for the

nurse managers' attention toward their spiritual beliefs, and most commonly

disagreed with the idea that the nurse manager created a healing environment at the

point of care.

Multiple linear regression analyses of the demographic and work-related

variables indicated that gender (specifically females) and the unit where assigned

(particularly the medical/surgical/telemetry work environments) predicted the staff

nurses' perceptions of nurse manager caring ($R^2 = .268$, $F(10, 75) = 2.750$, $p = .01$).

With the exception of gender, the independent variables of age, race/ethnicity, the

highest nursing degree, the RN's years of experience, and/or years on unit, their

primarily assigned shift, and whether the facility was unionized or magnet-

designated, was unrelated to both the staff nurses' perception of nurse manager caring

and their exposure to workplace bullying. Results of these analyses also indicate that

the staff nurses' workload accounted for a significant amount of exposure to

perceived workplace bullying variability among staff nurses ($\beta = 70.700$, $p = .05$).

Chapter V

DISCUSSION OF FINDINGS

Introduction

This study examined whether there was a possible correlation between staff nurses' perception of nurse manager caring behaviors and their perceived exposure to workplace bullying within multiple healthcare settings. To investigate this question, 156 participants completed the Caring Factor Survey – Caring of the Manager (Nelson, 2011), the Negative Acts Questionnaire-Revised (Einarsen, Hoel, & Notelaers, 2009), and a background questionnaire. This is the first study to utilize the as-yet unpublished CFS-CM (Nelson), which measures the staff nurses' perceptions of the caring behaviors of the nurse manager in accordance with the latest evolved theory of the caritas processes integral to Watson's theory of human caring (2005, 2008).

Human caring is a concern for the growth and actualization of another (Mayeroff, 1971); a learned social process, reciprocal in nature, and has a contagious effect on those participating in and/or observing caring encounters (Clerico, Lott, Harley, Walker, Kosak, Michel, & Hulsey, 2012; Noddings, 1984; Watson, 2009). Similarly, negative behavior is a learned social process, also reciprocal and contagious in nature (Hoel, Giga and Davidson, 2007; Leymann, 1990; Randle, 2003, 2007). Informed by Watson's theoretical perspectives, the study's purpose, and design, this chapter provides a discussion of the main and ancillary study findings as

well as concerns related to the study methodology, and the related background

literature.

The Sample

The study sample consisted of participants recruited from the Regional Nurse

Network (RN2) via an online introductory message containing a link to a secure

survey website from the RN^2 Program Director. RN^2 is a grassroots community

organization of professional nurses located in San Francisco, CA and is grant-funded

to provide registered professional nurses with educational workshops for leadership,

career development, and networking opportunities. Participation in RN^2 is voluntary.

Initially, 224 registered nurse members of RN^2 responded to the invitation to

participate in the study. Of the 194 respondents who were in a staff nurse role, 185

completed the Caring Factor Survey – Caring of the Manager (Nelson, 2011), 162

completed the Negative Acts Questionnaire – Revised (Einarsen, Hoel, & Notelaers,

2009), and up to194 participants responded to individual items within the background

questionnaire.

A participant sample of 156 answered all three tools (the CFS-CM, The NAQ-

R and the background questionnaire) and formed the studies' constituency. The

sample size of 156 met the power requirements for study significance, yet the number

of actual participants was low in relation to the total RN^2 membership of over 4000

registered nurses. Survey response rates are primarily related to the participants'

access to and degree of interest in the survey topic (Tuten, Urban, & Bosnjak, 2002).

It is possible that the study set-up, which did not permit potential participants to

access the study site directly, may partially explain the low response rate within the

organizational membership.

Prior attempts to conduct this survey within a large metropolitan tri-state area

were unsuccessful. In each of five attempts, the researcher found that nurse

executives who were approached declined to facilitate a study where staff nurses

assessed the caring behaviors of their nurse managers and their perception of bullying

in the workplace. Two of the five nurse executives expressed concern regarding union

repercussions. Thus, for this study, the decision to access a network of staff nurses

online ($N = 4069$) from 174 healthcare agencies had several advantages. The results

ascertained would be from a broader population base, rather than from one healthcare

facility. Online surveys have distinct advantages: they are anonymous, thus

respondents would be more comfortable being honest, particularly with sensitive

subject matter (Tuten, Urban & Bosnjak, 2002); they are also easy to enter into and/or

edit and allow for the ability to obtain semi-interactive responses; they are also easier

to disseminate with faster delivery speed; and are lower in cost and environmentally

correct (Truell, 1997). A major limitation for using this type of sampling procedure

however, was that participants were self-selected, the sample not randomized, and not

geographically diverse, thus limiting the generalizability of the findings.

The Instruments

Caring Factor Survey-Caring of the Manager. Staff nurses' perceptions of

nurse manager caring within the framework of Watson's latest iteration of her theory

of human caring (2008) were measured utilizing the Caring Factor Survey-Caring of

the Manager (CFS-CM; Nelson, 2011). This is the first empirical study (with

adequate sample size and power) to report findings utilizing the CFS-CM (J. Nelson,

personal communication, December 8, 2010).

For the current study, the CFS-CM demonstrated excellent overall reliability

(Cronbach's alpha, 0.97). However, one item within this 10-item tool seemed to elicit

mixed responses. Over 55% of participants either disagreed or had a neutral response

to the managers' acceptance and support of the participants' beliefs regarding a

higher power, and allowance for the possibility of participants to grow. Although this

item was included within the CFS-CM, the item, when deleted, did not depreciate the

overall reliability of the measure and only increased the reliability index slightly to

Cronbach's alpha, 0.974 (from 0.970).

The frequency distribution of the CFS-CM scores, although positively skewed

and indicating overall positive perceptions of nurse manager caring, was multimodal

at various points within the full width of the Likert-style scales' possible responses.

The number of high frequency responses within the frequency distribution of the total

CFS-CM scores suggested that participants did not need the degree in variance in

item-response choices.

In general, however, the CFS-CM was the appropriate instrument to measure

nurse manager caring behavior for several reasons: (a) it is the only published tool to

date that measures staff nurses' perceptions of nurse manager caring behaviors in

accordance with the most recent, evolved theory of the caritas processes (Watson,

2008, 2009) rather than carative factors, and is designed to expand upon the essential

aspects of caring in nursing to acknowledge the "values, ethics, and skilled practices

of caring, healing, and health" within nursing (Watson, 2008, p. 4); (b) its content

validity has been established and endorsed by content experts including nurse

theorist, Watson (2008); (c) the overall observed reliability for this study was

excellent, as measured by Cronbach's alpha, 0.97; (d) it consists of only 10 items

causing minimal survey burden for participants; and, (e) for this study it was well-

received as evidenced by several study participants who provided positive feedback

regarding the applicability and ease of the tool. All three of the respondents

providing positive feedback toward this tool were developing studies utilizing

Watson's most recent and evolved theory of human caring (2005, 2006, 2008).

The Negative Acts Questionnaire – Revised. Staff nurses perceptions of

exposure to workplace bullying were measured utilizing the NAQ-R (Einarsen, Hoel,

& Notelaers, 2009). This instrument was the optimal tool to measure workplace

bullying in nursing since its content validity has been established and endorsed by

content experts (Einarsen, Hoel, & Notelaers, 2009), it has excellent validity and

reliability (Cronbach's alpha, 0.92), is the most commonly utilized instrument to

measure workplace bullying, and has been used world-wide for both nursing and non-

nursing populations (Einarsen, Hoel, & Notelaers). The limitations for this tool

however, are consistent with the limitations to self-report surveys in general, since

participant responses are subjective, may be influenced by participant bias, and/or

memory inaccuracies (Mitchell & Jolley, 1992; Tuten, 2010), and can be

overestimated, particularly if topic and/or select items within the tool elicit a strong emotional response (Badia & Runyon, 1982; Tehrani, 2004).

The Relationship between Staff Nurses' Perceptions of Nurse Manager Caring Behaviors and their Perception of Exposure to Workplace Bullying

Study results indicated that, for this sample, there was a negative, statistically significant relationship ($r = -.534$, $p < .001$) between participant scores on the CFS-CM and the NAQ-R, revealing that, as the perception of nurse manager caring increased among these staff nurses, their perception of exposure to workplace bullying decreased, and vice-versa. Although a statistically significant relationship was found, it is possible that the correlation might have been stronger if the sample had been younger (over 56% of participants were 50 years or older), less experienced (approximately 52% of participants had 20 or more years of experience in nursing) and with less tenure working on their unit (45% of participants worked 10 years or more on the unit). Typically studies indicating a prevalence of workplace bullying among nurses are among newly licensed, younger nurses, working 2 years or less within their work environment. For example, Simons (2008) reported similar statistical relationships between newly licensed registered nurses' exposure to bullying and their intention to leave the healthcare facility where employed ($r = .051$, $p < .001$). Sa' and Fleming (2008) also reported the symptoms of burnout ($r = .46$, $p = .01$), social dysfunction ($r = .22$, $p = .05$), and severe depression ($r = .26$, $p = .01$) among novice nurses exposed to workplace bullying, and most recently, Berry,

Gillespie, Gates, and Schafer (2012) reported decreased productivity among novice nurses' reporting exposure to bullying in their work setting ($r = -.322$, $p = .045$).

Staff Nurses Perceptions of Nurse Manager Caring Behaviors

For this sample, staff nurses perceived that their managers' were more caring than not, as evidenced by the mean item score of 4.37 on the CFS-CM (out of a possible score from $1 - 7$). Similarly, of the 60 anecdotal remarks within the optional section of the CFS-CM tool that asked participants to describe a caring moment that had occurred between him or her and their nurse manager, 50% ($n = 30$) of the responses were favorable, while 38% ($n = 23$) of responses were not. The positive comments included the staff nurses' perception of the nurse managers' connectedness with the staff: "My manager looks me in the eye, smiles, and says hello to me when she initially sees me;" his or her concern about the illness of the staff nurse and/or his or her family members: "I was diagnosed with breast cancer and she visited me at home, and made sure I had a good dinner," and, "When I was on a medical leave, she kept me posted on the department with get well cards;" the facilitation of time and leave requests, "Understanding my request for time off;" the interest in the staff nurses' career development goals, "She asked me to sit down with her for about 15 minutes to discuss my goals, wants and needs;" and, the recognition and appreciation for the staff nurses' work within the clinical setting, "My manager hugs me when I receive a positive comment regarding the care I have provided," and, "My manager praises us and tells us how proud of her staff she is."

Although the optional open-ended question asked for an example of a caring

moment between the nurse manager and the participant, 23 (38%) of the 60

comments provided were negative. Of that number, 10 participants responded,

"None." Other negative comments included a statement about the nurse managers'

lack of availability and/or interest: "She is never around;" and his or her lack of

acknowledgement, "She has never even said hello to me in all of the years I have

worked on this unit" and "I don't think my manager listens to me, or actually hears

what I am saying." Attesting to the association between nurse manager caring

behaviors and staff dissatisfaction and /or turnover, one participant responded, "There

has been none (caring moments), which is why I am either transferring to another

unit… or to another hospital."

While this is the first study to investigate the relationship between staff

nurses' perceptions of nurse manager caring and their perceptions of exposure to

workplace bullying, the findings ascertained within this study are supported by

several studies reporting that positive relationships between staff nurses and their

manager significantly influences staff nurses' perceptions of a positive work

environment ($r = .336$, $p < .01$, Duffy, 1993), that supervisory support is significantly

correlated to job satisfaction ($r = .48$, $p = < .001$, Hall, 2007), and that nurse manager

caring is significantly correlated with the staff nurses' intent to stay within the

organization ($r = .622$, $p = .007$, Longo, 2009).

Individual item responses within the CFS-CM were also examined. The

degree to which participants agreed, neither agreed or disagreed, or disagreed with

individual items within the CFS-CM showed that for this sample, most commonly, participants agreed that, "When my manager teaches me something new, h/she teaches me in a way that I can understand" ($n = 82$, 58.9%). The affirmation of agreement with the positive caring behavior of the manager as an educator suggests the importance of managerial time and availability toward meeting the needs of the staff nurses at the point of care.

The highest number of neutral responses (response = 4) by staff nurses' was for the CFS-CM items: "The manager of my unit/department is accepting and supportive of my beliefs regarding a higher power, which allows for the possibility of me to 'grow'" ($n = 46$, 29.49%), and the caring behavior, "The manager of my unit/department encourages me to practice my own individual spiritual beliefs as part of my self-caring" ($n = 52$, 33.3%). These results may reflect the staff nurses' differing views as to the applicability of their managers' involvement with their spiritual preferences. Since only one facility was reported as having Watson's theory of human caring as a theoretical base for nursing, it is possible that study participants' may not have perceived that consideration of the spiritual beliefs of nursing staff is applicable and/or relevant to their relationship or interaction with their nurse manager in the workplace. Two anecdotal responses within the optional open-ended question within the CFS-CM tool supported this perspective. One participant stated that he or she "Did not believe in a higher power," the other suggested that the staff nurses' spiritual beliefs or their belief in a higher power is "Not likely to be a real concern of their manager." It is also plausible that since only one facility was reported to be

utilizing Watson's theory of human caring as their theoretical framework, it is likely that nurse managers' within that agency may not have been familiar with the caritas processes and the unique manifestation of the behaviors or practices of caring, healing, and health. Further, the degree of neutrality to this item within this study may also be related to the geographic location of both the pilot (southeast Florida) and the current study (northern California). Respondents from other, geographic locations known for a higher level of religiosity, such as residents of the Midwest and the Deep-South, may have possibly responded differently.

Over 40% ($n = 63$) of staff nurses disagreed that their manager, "Creates a healing environment." This was the only nurse manager caring behavior within the 10-item tool that assessed the staff nurses' perception of the nurse manager's caring about the work environment. One possible explanation for this finding could be related to the staff nurses' perception of the manager's inattention to, and/or lack of availability within, the work environment. Additionally, participants may have had differing views as to the definition of a healing environment. While no empirical work was found to support or refute these finding, studies examining the healthcare work environment at the point of care have not used the term, healing environment. Typically, the terms, work or working environment are used.

This CFS-CM item (pertaining to the manager creating a healing environment) was also found to have a moderate, yet significant inverse correlation within the correlational matrix with the NAQ-R item, "Having your opinions and views ignored" ($r = -407, p < .001$). Within this sample, 103 (66%) staff nurses

worked the day shift. The findings from several studies support the idea that manager

presence and availability influences positive perceptions of their manager,

particularly by staff working the day shift (Hall, 2007; Kleinman, 2004). Rosengren,

Athlin, and Segesten (2007) reported that *distancing* in leadership, as evidenced by

"an empty office, or a worn out ward manager" (p. 525) was a barrier to staff growth

and development. For this sample, the findings among the staff working primarily on

the day shift (69.8%) may indicate that their managers were frequently unavailable

and/or distant, and thus, may explain the significant results between the staff nurses'

perception of nurse manager caring and their perception of exposure to workplace

bullying.

Staff Nurses' Perceptions of Exposure to Workplace Bullying

For this sample, the distribution of the total scores for the NAQ-R as

measured by the mean score of 161.33 and a standard deviation of 335.72 (out of a

possible score range of 0 – 2750) indicated that the majority of staff nurses were not

exposed to bullying in the workplace. Perceived exposure rates to bullying in the

workplace ranged between 26.3% daily exposure to 35.9% weekly exposure (which

may also include individuals reporting daily exposure) over a 6-month timeframe.

These findings were consistent with findings from other studies that examined the

prevalence of workplace bullying within nursing. Within the United States, utilizing

the same tool and operational definition, workplace bullying in nursing ranged from

21.3% for novice nurses (Berry, Gillespie, Gates, & Schafer, 2012), to 27.3% in staff

nurses (Johnson & Rea, 2009), to 31% for newly licensed nurses in Massachusetts

(Simons, 2008) and to 33% (Laschinger, Grau, Finegan & Wilk, 2010). The sample within this study was quite different from previous studies in two major ways: respondents within this study were older; more experienced, and had much more experience working within their work environment.

Cleary, Hunt, and Horsfall (2010) reported that in general, workplace bullying prevalence rates in nursing are both underestimated and unreported. The researchers suggest this is the result of a lack of understanding of the definition of workplace bullying, and the inability to differentiate it from other negative behaviors. For comparison purposes, careful attention to the operational definition is required. Typical jargon by lay people and within the media, utilize the term *bully* to mean, someone who subjects another to one or more negative acts, regardless of whether targeted or intentional, and without reference to the length of exposure time. Yet the hallmark criterion for bullying is that these negative acts are targeted, intentional, and over a prolonged timeframe of 6-months or more (Einarsen, Hoel, & Notelaers, 2009; Einarsen, Hoel, Zapf, & Cooper, 2003). Items within the NAQ-R addressed the entire criterion for bullying, required participants to specify the timeframes of exposure, and did not include the term workplace bullying.

Individual responses to items within the NAQ-R were also analyzed. The negative act most frequently selected ($n = 32$, 20.5%) was for the NAQ-R item, "Unmanageable workload." Similarly, within the regression analysis, workload accounted for a significant variation in the degree of exposure to workplace bullying ($\beta = 70.700$, $p = < .05$). Within the state of California, where staffing ratios are

legally mandated since 2004, staff nurses may be more aware of the significance of

an unmanageable workload. Additionally, staff nurses within unionized settings may

be particularly sensitive to whether managers are demonstrating caring behaviors in

accordance with, or lack thereof, this mandate.

It is unknown whether the perception of an unmanageable workload within

this participant sample is the result of a targeted negative behavior by the nurse

manager or is secondary to a consequence of exposure to bullying in the workplace.

The added stress of being exposed to bullying can result in participants'

dissatisfaction with the work environment and lead to a reduction in productivity

(Berry, Gillespie, Gates, & Schafer, 2012; Johnson & Rea, 2009).

The items within the NAQ-R that the least number of participants selected

was for the perceived exposure to, "Excessive teasing or sarcasm" and, "Practical

jokes," ($n = 4$, 2.6% respectively) and, "Threats of violence or physical abuse," ($n =

5$, 3.2%). These findings lend support to the idea that workplace bullying can be

covert in nature and that overt expressions of bullying, such as exposure to both

practical jokes and physical threats or violence are less likely to occur (Fox &

Stallworth, 2005).

Multiple Regression Analyses

Within linear multiple regression analyses, among all independent variables

only *gender* and the *type of unit* were found to be predictive of perceptions of nurse

manager caring as evidenced by the scores on the CFS-CM. Missing data for the type

of unit where the staff nurses' worked ($n = 59$ or 38%) reduced the sample size for

this regression. Further, the limited number of males within this study ($n = 11$),

although consistent with the ratio of females to males with the national RN

population (USDHHS, 2010), diminishes the value of this finding as well. There is a

paucity of literature supporting or refuting this finding. Only one study reported

males as perceiving the attribute of caring as less important than other tasks within

nursing (Croft & Cash, 2012). Another study found that males are less likely to

identify with or concern themselves with a perceived feminist or *soft side* that the idea

of caring implies (Cleary, Hunt, & Horsfall, 2010).

Within this study sample, regression analysis did not reveal that gender

predicts workplace bullying in nursing. Yet, among nurse managers, research findings

indicate that females are more likely than males to be exposed to bullying (Hoel,

Cooper, & Farragher, 2001; Johnson & Rea, 2009). In contrast however, within

traditional staff nurse or ancillary nursing populations researchers report that males,

are more likely to be exposed to workplace bulling (Dellasega, 2009; Hegney, Eley,

Dep, Buikstra, & Parker, 2006; Hoel, Cooper, & Farragher). This was found to be

particularly significant in males who were nursing assistants (Eriksen & Einarsen,

2004). It is likely that for this model the small number of males within this sample (n

$= 11$, 7.1%) and the missing data for the items pertaining to the unit where worked

(38%) and workload (15%) may also have influenced the lack of significance in the

results for this model.

Regression analysis for this sample also revealed that age, RN years of

experience, and RN years on unit did not predict the staff nurses' perception of nurse

manager caring or their exposure to workplace bullying. These findings are not

surprising since 100 participants (64.1%) were within the category known as "Baby

Boomers" (born 1946-1964). It seems likely that 'older' nurses, particularly those

who are tenured within their organization, may be more satisfied with their jobs and

with their work environment (Ingersoll, Olsan, Drew-Cates, DeVinny, & Davies,

2002; Leiter, Price, & Laschinger, 2010; Wilson, Squires, Widger, Cranley, &

Torangeau, 2008). Conversely, researchers report that younger aged, and/or newly

assigned nurses are frequently alienated rather than cared for, thus nurse

dissatisfaction and related turnover is high (Bowles & Candela, 2005; Kovner,

Brewer, Wu, Cheng, & Suzuki, 2006; McLure, 1972; Simons, 2008).

Similarly within this study sample, the variables of race/ethnicity and the

country where basic nursing education occurred were not predictive of the staff

nurses' perceptions of nurse manager caring behaviors or their exposure to bullying

within the nursing workplace. For this sample, participants were primarily Caucasian

($n = 93$, 59.6%) and received their basic nursing education in the United States ($n =$

111, 71.2%). Forty-six participants were Asian-American (27.2%) and the most

commonly reported country where basic education was received other than the United

States, was the Philippines (n = 15, 9.7%). Although no significant findings indicated

race/ethnicity to influence perceived exposure to workplace bullying, several studies

suggest racial bias to be a form of bullying since racial bias is also targeted,

consistent, and long term (Allan, Cowie, & Smith, 2009; Fox & Stallworth, 2005).

One study conducted within a predominantly non-White setting, found exposure to

workplace bullying among novice nurses to be "primarily driven by the race or

ethnicity of the participants," (Berry, Gillespie, Gates, & Schafer, 2012, p. 84) with

White novice nurses having higher prevalence rates of exposure to workplace

bullying and significantly lower productivity rates than novice non-White nurses ($r =$

-0.38, $p < .001$). Parkins and Feinbein (2006) make the distinction between

discrimination and bullying, cautioning that the personality of the bully influences

whether bullying toward a victim is prejudice-based or non-prejudiced based. The

lack of findings within this category may have been related to the small sample of

such diverse populations.

Study findings also indicated that educational levels and certification did not

predict scores on either the CFS-CM or the NAQ-R. The education level of RN[2]

respondents was quite high. Over 78% of the study sample had university education

(52% with a Baccalaureate, and 25.6% with Master's degrees in nursing). The rate of

university-level education reported within the National Survey of Registered Nurses

(USDHHS, 2010) was only 34%. It is possible that nurses with higher degrees in

nursing have greater employment opportunities, thus are more likely to be in jobs that

they enjoy. This in turn, may indicate job satisfaction, and could explain these

findings. This idea is further supported by the high percentage of staff working 11

years or more (45%) within the same work environment in this study sample.

The length of RN experience was also not predictive of either the CFS-CM or

the NAQ-R scores. The literature indicates that staff nurses working 2 years or less

within their work environment perceive significantly higher levels of exposure to

workplace bullying than did other more seasoned staff nurses (Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Randle, 2003, 2007; Simons, 2008; Simons & Mawn, 2010). For this sample, only 25 participants (16.1%) worked in their work environment for 2-years or less. It is possible that the small sample of nurses working 2 years or less may have influenced these results.

The numbers of hours worked per week or the primarily assigned shift also were not predictive of the total CFS-CM or the NAQ-R scores. These findings are in contrast with studies indicating that the visibility of the nurse manager and day tour of duty significantly influenced the staff nurses' perception of an effective manager and a healthy work environment (Hall, 2007; Kleinman, 2004). Since the majority of this population sample ($n = 120$, 76.9%) worked 20-40 hours (16% worked > 40 hours) on the day shift, access to and visibility of the manager would be more likely and thus, should have positively influenced the staff nurses' perceptions of nurse manager caring and negatively influence their perception of exposure to workplace bullying.

The relationship between the type of unit or practice setting, particularly nurses working within medical/surgical environments, was found to be predictive of the scores on the CFS-CM ($\beta = $ -3.245, $p = < .01$), and not predictive of the NAQ-R scores. For this sample, over 1/5 (20.5%) of study participants worked within medical/surgical environments. It is possible that a reduced workload (over 35% of participants had a range of only 4-8 patients per shift) could explain these results. It is also possible that the small sample of respondents for this item ($n = 97$, 62.2%) could also have explained these results. Typically, workload within medical/surgical

environments within acute care settings (80% of the study sample population) is much higher than reported within this study. Staff nurses' may have perceived their managers to be more caring and exposure to workplace bullying less as a result of a reduced workload (secondary to mandated staffing ratios) within California acute care settings. Kalish & Lee (2011) found that the relationship between nurse staffing (specifically workload) and the staff nurses' perception of teamwork is significantly correlated. Only one study examined workplace bullying within various work settings and reported exposure to workplace bullying to be more prevalent within the medical/surgical environments (Vessey, DeMarco, Gaffney, & Budin, 2009).

For this sample, regression analysis indicated that a high patient workload (greater than 8) predicted perceived workplace bullying ($\beta = 70.700$, $p < .05$). Twenty-six participants (16.7%) reported a workload of 8 or more patients. This finding was further supported by the participants' responses within the NAQ-R, that the most commonly experienced negative act was *Unmanageable workload* ($n = 32$ or 20.5%). In consideration of the current staffing ratio mandates within the state of California, it is unknown how often heavy workload was a reality for this sample population. Medical/surgical units are highly stressful work environments, associated with heavy workload (Croft & Cash, 2012), high turnover and vacancies, and not surprisingly, have been shown to be highly susceptible to workplace bullying as compared to other work environments (Clark, Olender, Cardoni, & Kenski, 2011; Vessey, DeMarco, Gaffney, & Budin, 2009).

Organizational variables, such as whether healthcare facilities were unionized or held Magnet-designation were also found to be unrelated to the CFS-CM and the NAQ-R total scores. Within this sample, 84 participants (53.8%) worked within a unionized healthcare setting. Considering the advocacy role of union personnel, staff nurses may have been particularly sensitive as to whether managers were demonstrating caring behaviors, and/or whether they were exposed to negative acts. Studies do indicate however, that organizational factors, such as organizational volatility (organizational restructuring, downsizing) and the lack of nursing leadership can create a work environment where incivility and/or bullying can flourish (Clark, Olender, Cardoni & Kenski, 2011; Cleary, Hunt, & Horsfall, 2010; Felblinger, 2007, 2009; Lewis, 2007, Strandmark & Hallberg, 2007). One study (Yildirim and Yildirim, 2007) reported statistically significant differences in exposure to mobbing behaviors (similarly defined as workplace bullying) among nurses working in public hospitals as compared to private hospitals ($t = -2.20$, $p < 0.02$) where staff nurses' perceptions of decreased job security were commonly experienced secondary to increased organizational restructuring activities.

The sample size for facilities with Magnet designation was small ($n = 6$, 3.8%) and the significance of the relationship of Magnet designation and nurse manager caring was not supported. Several studies report that nurses were more satisfied, and less likely to be exposed to workplace bullying within Magnet-designated facilities where required shared governance structures were in place (Fornes, Cardoso, Castello & Gill, 2011; Lashinger, Finegan, & Wilk, 2010;

Upenieks, 2003). Only one participant within this study reported utilizing Watson's

theory of human caring, thus no predictions could be determined. Further, no

published studies were found to support or refute this relationship either with nurse

manager caring or with exposure to workplace bullying in nursing.

      For this study, all regression models employing the CFS-CM as an

independent variable were found to predict participants' scores on the NAQ-R ($p <$

.001). These findings support the study findings indicating that a significant inverse

correlation between these two tools, the CFS-CM and the NAQ-R, and that with the

exception of workload, all other independent variables entered are likely unrelated to

the dependent variable, the NAQ-R.

Additional Study Strengths and Limitations

      There are several study limitations that should be considered when

interpreting the data. The participant sample was a non-randomized, self-selected one,

drawn solely from the San Francisco area of California. Generalizability of the

findings to staff nurses within other areas of the country is therefore limited (Badia &

Runyon, 1982).

      The survey method may have limited the participants' responses. The two-

month survey was conducted just before the Christmas holidays through the end of

January of the following year. Typically, organizations refrain from conducting

surveys during this time since staff nurses' are more likely to take vacation time or be

distracted by social events within the organization. Additionally, the survey software

was not amenable to pre-notification and routine reminders. Further, the use of

frequent reminders was not permitted by RN^2 management. This could have affected

participant's access to this study. The use of an electronic pre-notification with the

inclusion of a statement as to why the study is important and frequent reminders is

advocated with electronic surveys (Mehta & Sivadas, 1995). One study reported that

sending out repeated electronic reminder messages increased survey response rates

for electronic surveys by 25% (Sheehan & Hoy, 1997). Still another researcher

reported response rates > 90% when item-specific reminders are sent electronically (J.

Nelson, personal communication, April 8, 2013). For this study only one pre-survey

reminder and only one mid-survey reminder (January 9, 2012) were sent

electronically and none were item-specific and may partially explain the low sample

size among a potential population of over 4000 staff nurses within this study.

The section of the survey that addressed demographic and/or background

information was not pilot-tested. The pilot testing of this tool could have created an

awareness of the need to construct certain questions more carefully and/or add

additional questions that could provide key information for the study. For example,

since nurse manager presence and availability has been associated with staff

satisfaction and retention, a question as to how often the nurse manager meets with

their staff could have either supported or refuted this finding within this sample

population.

Only a small number of the facilities were Magnet-designated ($n = 6$) and only

one of the facilities reported using Watson's theory of human caring to inform their

practice ($n = 1$). It is likely that the participant sample may not have understood

Watson's theory and/or the theoretical application to role of the nurse manager and/or to their relationships with their nursing colleagues.

The missing data for the items, *unit where assigned* and *workload* are definitely a study limitation among this study sample of staff nurses working in the state of California where staffing ratios are mandated. The application of imputation techniques for missing data (Baraldi & Enders, 2010) was not recommended since the lack of response to these items were likely not random (the response rates for all other variables ranged from 97% - 100%). It is quite possible that the low response to these items may have been purposeful since sample participants may have felt uncomfortable identifying their role, their work unit and/or having a high workload since they may have perceived that disclosure of this information could have strong implications for their manager, their facility and/or lead to retaliation.

Summary

This study indicates that within this sample, staff nurses' perceptions of exposure to nurse manager caring is significantly related to their perception of exposure to workplace bullying, and that gender, type of unit, and workload may contribute significantly to these findings. Optional comments provided by the staff nurses provided rich data regarding behavior most indicating of nurse manager caring (or lack thereof). Additionally, the participants' disagreement with the nurse manager caring behavior of creating a healing environment may indicate that the nurse manager is not paying attention to the work environment (and may be a contributing factor to their exposure to workplace bullying). Further, based upon the demographic

characteristics of this sample, the prevalence rate of bullying within this older, more experienced, population of staff nurses, may indicate that the nurse managers' attention to the work environment and to the caring for those who care for others may not be perceived as needed, may not be valued and certainly, not prioritized.

Chapter VI

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This descriptive study was the first research study to examine whether there

was a possible correlation between staff nurses' perceptions of nurse manager caring

behaviors and their perceived exposure to workplace bullying within multiple

healthcare settings. Participants completed the Caring Factor Survey-Caring of the

Manager (CFS-CM) for the measurement of staff nurses perceptions of nurse

manager caring (Nelson, 2011), the Negative Acts Questionnaire-Revised (NAQ-R)

for the measurement of the staff nurses' exposure to workplace bullying (Einarsen,

Hoel, & Notelaers, 2009) and a demographic and background questionnaire. The

study was based upon the theoretical perspective that caring promotes reciprocal

caring and healing for each other and for the larger universe as informed by Watson's

theory of human caring (2005, 2008). According to Watson, human caring is a

learned social process, having a contagious effect on those participating in and/or

observing caring encounters. This chapter acknowledges these philosophical tenets,

and provides a summary of study results, conclusions based upon the study findings,

and recommends related directions for future research. As always, study findings and

conclusions must be considered along with study limitations, particularly resulting

from the non-random, biased sampling. Although the conclusions cannot be

generalized, the findings gleaned from this study contribute new knowledge to the

body of science related to caring and workplace bullying, provide a better

understanding of the newly developed CFS-CM, and offer new insights related to the

role and responsibilities of the nurse manager, specifically toward the staff nurses'

exposure to negative behaviors in the work environment.

Summary/Conclusions

Data analysis for this study sample revealed a statistically significant, negative

relationship ($r = -.534$, $p < .001$) between staff nurses' perception of nurse manager

caring as measured by the CFS-CM (Nelson, 2011) and their perceptions of exposure

to workplace bullying as measured by the NAQ-R (Einarsen, Hoel, & Notelaers,

2009). It can be concluded, that nurse manager caring behaviors play a significant

role in reducing negative behaviors within the work environment. The findings are

noteworthy, particularly since over 50% of the study sample was 50 years or older,

more than half had 20 or more years of experience in nursing, and just under 50% of

the sample had 10 or more years tenure within their particular unit. Sample

populations with these demographic and work-related characteristics are typically

identified as individuals who are most satisfied with their work environment.

Typically, workplace bullying in nursing has been shown to be among younger,

newly licensed, nurses in relatively new work settings (Randle, 2003, 2007; Simons,

2008). These study findings support the philosophical tenets of reciprocal caring

within Watson's theory of human caring (2005, 2008) and have salient clinical

practice, educational, and policy implications for our nursing leaders.

Clinical Practice Implications

The main study finding, that nurse manager caring significantly influences the staff nurses' perception of exposure to workplace bullying, highlights the importance of caring leadership within healthcare environments. Among the nurse managers' myriad responsibilities at the point of care, the caring of staff must be prioritized and intentional. Leadership strategies to ensure that this priority is attainable will need to include both executive and organizational commitment. Nurse executives will need to set the expectation that the nurse manager's role and responsibility prioritize the creation of a healing environment and include the unique aspects of caritas behaviors manifested by being present and available at the point of care. Careful assessment of the relevancy and/or redundancy of meeting agendas and better ways to reduce or consolidate meetings with mechanisms for sharing information, and reporting and/or elevating concerns should be ascertained.

According to Manthey (2007), the manager is the culture builder at the point of care. Study findings, indicating that a majority of staff nurses perceive their nurse managers as inattentive to the creation of a healing environment within this study sample, have important clinical practice considerations for nurse leaders and for healthcare organizations at-large. The creation and sustainment of a caring environment at the point of care will require a change in unit and organizational culture such that an expectation of caring leadership, in this case, pertaining to the nurse manager caring, will need to be embedded within the organizational strategic

plan, the nurse manager's performance goals, position descriptions, and within their competency assessments.

Caring clinical competencies should include caritas processes conveyed via transpersonal caring encounters (meaningful caring conversations resulting in true connectivity) and resulting in caring moments (conveying caritas consciousness and self-reflective insight) between the nurse manager and the staff nurse. For this study, anecdotal comments describing a caring moment between the staff nurse and nurse manager provided concrete examples of effective nurse manager caring behaviors that could be translated within competency assessments. This included the staff nurses' perception of being recognized and/or appreciated by the manager, the nurse managers' attention to their health and well-being, accommodation of their time and leave requests, and the nurse managers' attention to their career development goals.

Responses to the NAQ-R (Einarsen, Hoel, & Notelaers, 2009), indicating that the staff nurses' perception of having a heavy workload significantly influenced their perception of exposure to bullying, also have strong clinical practice implications for nurse managers. Within this study sample, a high percentage of staff reported staffing ratios that exceeded the staffing ratio mandate in California and high workload has been associated with are stressful work environments that can serve as a breeding ground for incivility and bullying behaviors (Clark, Olender, Cardoni, & Kenski, 2011). These study findings indicate the importance of managerial awareness of the assignments and assignment systems utilized by staff to ensure that staff nurses' receive a manageable workload.

According to Longo (2010), the creation of a healing environment requires the nurse managers' attention to, and articulation of, peer-to-peer caring and teamwork among the staff nurses. Nurse manager awareness of whether his or her staff are working as a team and offering assistance to one another can serve as an important criterion for this process (Koloroutis, 2007). Nurse managers can promote peer caring via role modeling caring behavior and leading their staff within shared governance structures. Staff empowerment structures have been shown to be highly effective in developing teams and fostering staff-initiated strategies to assist with workload challenges. These shared governance structures have also been shown to significantly reduce bullying in the nursing workplace (Laschinger, Grau, Finegan, & Wilk, 2010).

Educational Implications

The literature lends support to the idea that a culture of incivility and bullying behaviors "begin within the academy (where nursing learning of nursing begins) and within practice environments (where learning of nursing continues)," (Clark, Olender, Kenski, & Cardoni, 2011, p. 329). Thus, study findings associating the caring behaviors of the manager with the staff nurses perception of exposure to workplace bullying have strong educational implications for deans and directors at every level within nursing academic settings. The art and science of caring will need to be integral to structure, process and outcomes within educational settings in nursing. This includes embedding caring curriculum within the academic strategic plan and at every level in nursing. For graduate nursing administrative students, what it means to be caring within an administrative context and how to develop strategies to foster an

appreciative caring environment that incorporates the caritas processes should be included, either as a required course or embedded within courses such as healthcare ethics or nursing leadership/management.

Study findings associating staff nurses' perceptions of nurse manager caring with their perceptions of exposure to workplace bullying also has educational implications for nurse and nurse educators within healthcare settings. Notably, the caring behavior that most commonly resonated with the staff nurses within this study sample was the role of the nurse manager as an educator. Conversely, the caring behavior most commonly disagreed with was how well the manager created a healing environment at the point of care. Typically, orientation provided for nurse managers covers administrative functions, such as time and leave policies, quality improvement, and personnel management and lacks an orientation to, or the integration of, caring leadership, and the creation of a healthy work environment. Mandatory education, required annually for nurse managers within healthcare settings, should include topics reflecting the organization's strategic goals of caring and utilization of the language of caritas for the employees they serve. Topics such as employee rights and the code of conduct for employees require the inclusion of the definition and differentiation between, incivility and bullying in the workplace and within the annual, organizationally mandated, workplace harassment training in order for nurse managers to identify these negative behaviors in a timely manner.

Sensitivity training for managers may also enhance managerial awareness of the untoward physical, psychological and organizations consequences at the onset of

the victimization and can minimize the proliferation of these behaviors. Indeed, as supported within this study, the staff nurses' perception of exposure to workplace negative acts, such as being gossiped about, being ignored or isolated, and/or being denied opportunities within the workplace, are all behaviors that are experienced and could go unnoticed and, yet, have prolonged implications for the health and availability of staff (Simons, 2008).

Experiential exercises to create and sustain a culture of civility can assist victimized staff nurses (including observers) with communication strategies for the staff nurse and nurse manager (Clark, Olender, Kenski and Cardoni, 2013). Examples include table-top and role-play exercises (Dellasega & Volpe, 2013), both for one-on-one circumstances between peers, and *leading up* strategies (Useem, 1998) between staff nurses' and their managers. This knowledge and skill can be incorporated within administrative caring competencies and assessed regularly, with related educational improvement plans developed, and implemented, if applicable. Consistent with study findings, competencies should include caritas process behaviors such as validated by the staff nurses' responses to the CFS-CM within this study: that the nurse manager responds to the staff nurses' needs and concerns, teaches them in a way they can understand, is creative at problem solving, and is available and open to their concerns, even if concerns differ or are in sharp contrast from the managers.

Executive nurse leaders should consider enrolling nurse managers into a caritas coaching or caring leadership-mentoring program (M. Turkel, personal communication, September 14, 2012). Coaching and/or mentoring activities for the

nurse manager can assist managers with the knowledge and skills to be mindful and

intentional about caring, can promote transpersonal caring encounters and caring

moments between the manager and staff, and ultimately foster a culture of caring in

the work setting.   Additionally, strategies to ensure the sustainability of a caring

mindset and the creation of a caring culture by the nurse managers should include

self-renewal activities such as self-reflection, journaling, and the sharing of caring

stories among the staff (Pipe, 2008; Turkel, 2004).

Policy Implications

A conceptual model of nursing and health policy proposed by Russell and

Fawcett (2005) provides a framework for the policy implications for this study. The

authors suggest that nursing and health policy priorities include addressing the

effectiveness of healthcare delivery systems. For this sample, study findings

indicating that a significant relationship exists between nurse manager caring and

workplace bullying, and that bullying is still prevalent in our nursing workplace (even

within this study population of older, more experienced nurses) suggests the need for

health policy makers to focus on the creation of statutes or guidelines at the very

least, to change managerial priorities within healthcare delivery environments. Efforts

by professional and accrediting bodies suggesting the need for similar role priorities

for the nurse manager have not yet taken hold. For example, in 2005, the American

Association of Critical Care Nurses published 6 standards for establishing and

sustaining healthy work environments. Of these, one standard called for authentic

leadership at the point of care and delineated the requirement for nurse leaders to be

fully committed and engaging others in this initiative. More recently the American Nurses Association (ANA) and the Organization of Nurse Executives (AONE) set forth ANA/AONE Principles (2013) calling for the establishment of collaborative relationships between clinical nurses and the nurse managers.

Despite professional and organizational efforts to set standards and/or create policies to implement processes to monitor and evaluation programs to reduce disruptive behaviors in the workplace, and for this sample population, bullying is still prevalent within the work environment of nursing. Although the prevalence rate within this study seems alarmingly high (26.3% to 35.9%), the rate is consistent within the literature (Johnson & Rea, 2009; Lipley, 2006; Simons, 2008). Hutchinson, Vickers, Wilks, and Jackson (2009) suggest that these rates, although high, are likely to be underestimated and/or under-reported, since bullying is frequently ignored or normalized within the work setting.

Clark, Olender, Kenski, and Cardoni (2013) suggest that the primary reason for the lack of reporting is related to a fear of retaliation rather than a knowledge deficit. This suggests that whistleblower-type policies within the work environment are not effective. A transparent process for identifying uncivil or bullying behaviors in the work setting can enhance organizational awareness of employee complaints and foster organizational trust within healthcare agencies. Departmental or manager-related non-compliance to creating an environment of caring as either a competency-based educational need or conversely, a conduct issue (and addressed accordingly) will support these goals. For some, education can be helpful. For others, a

performance improvement plan is required. For non-compliant staff that have been educated and are aware, progressive discipline and perhaps separation from the facility may be necessary.

An outside review of how well healthcare organizations are managing disruptive behaviors (such as incivility and bullying) is indicated. Organizational review for compliance to required procedures to track and monitor disruptive behavior situations as required by the Joint Commission (TJC, 2008) should be routinely reviewed as part of TJC accreditation reviews that are conducted every 2-3 years. Moreover, attesting to the concept of zero-tolerance, aggregate organizational compliance data and related facility responses should be prominently recorded in national TJC documents and newsletters and widely disseminated among accredited healthcare facilities. Perhaps, similar to the New York Department of Health alphabetized ratings for restaurants, ratings for healthy work environments could be considered.

Recommendations for Future Research

While the study of caring leadership has received much more attention in the last decade, continued utilization of both qualitative and quantitative research methods to build upon what is currently known will enable a greater understanding of the influence and outcomes of caring within the realm of administrative practice in nursing. The findings of the current study indicate that staff nurses' perceptions of nurse manager caring behaviors influence their perception of exposure to workplace bullying. However, because this is the first reported study of the relationship between

these two variables, replication of this research utilizing a randomized study sample

technique within a wider geographic area will increase the confidence in these current

research findings and will enable a greater understanding of the work of nursing.

Specifically, based upon this study, recommended areas of concentration could

include the study of the unique dimensions of caring within an administrative context

(Ray, 1989, 1997, 2006; Turkel, 2007) within nursing.

Empirical studies designed to the relationship between managerial caring and

the staff nurses' access to the manager (either related to the staff nurses' tour of duty,

and/or frequency of meeting times with the manager) on NAQ-R scores and/or known

consequences of workplace bullying (such as unplanned absenteeism, productivity,

turnover and workers compensation), are also indicated to further clarify and support

the need for changing managerial priorities and related responsibilities in the

workplace.

Horzak and Brennan (2012) found the staff nurses' perception of heavy

workload to be a statically significant environmental factor. Study findings also

indicated a significant relationship between the staff nurses' perception of a

manageable workload and their perceived exposure to workplace bullying.

Replication studies are needed.

Further research should also be considered to assess relationships between

nurse manager caring and known consequences of workplace bullying (such as

employee productivity, unplanned absenteeism, turnover rate, a high volume of

employee grievances, and utilization of employee assistance programs), particularly

within organizations that are going through turbulent times such as with facility restructuring and/or hospital mergers and including within faith-based healthcare facilities.

Lastly, little is known about people who bully others. Only one study suggests that nurse managers bully their subordinates as a strategy to push them to get the work done (Strandmark & Hallberg, 2007). Within nursing academic cultures uncivil and/or bullying behaviors among faculty was found to be partially-related to the envy of the excellence of other colleagues (Clark, Olender, Kenski, & Cardoni, 2013). It is unknown whether the prevalence of bullying within this study included staff nurse victimization by the nurse manager. Within the clinical arena, nurses who are bright and talented, rather than inexperienced, are more likely to be a victim of workplace bullying (Lewis, 2009). Further studies are needed.

The Study Instruments

Utilization of the CFS-CM. To date, this is the first empirical study to utilize the unpublished Caring Factor Survey-Caring of Manager (CFS-CM, Nelson, 2011) to measure staff nurse perceptions of the caring behaviors of the nurse manager in accordance with the evolved theory of the caritas processes integral to Watson's theory of human caring (2008). Although the CFS-CM had good reliability and validity for this study sample, it was a newly tested tool having had only a small preliminary pilot study done previously. Further psychometric testing is needed to confirm reliability and validity estimates and confirm underlying factors with the tool

to better measure Watson's theory of human caring as manifested by nurse managers via the caritas processes.

Responses ascertained with the open-ended question, soliciting the staff nurses' recall of a caring moment (or lack thereof) experienced between themselves and their nurse manager, should be empirically studied qualitatively via interview methods and/or focus groups to better understand the staff nurses' perceptions of their experiences relating with the nurse manager at the point of care.

Two limitations were identified related to the CFS-CM items. The marked fluctuations within the CFS-CM total score frequency distribution may indicate that the tool needs to be revised so that item choices within the Likert-style scale are reduced to five or six choices, including the consideration of eliminating the middle response choice altogether (Schuman & Presser, 1996). Additionally, the degree to which participants were neutral or disagreed with the nurse manager caring behavior toward the spiritual beliefs and/or concerns may indicate a knowledge deficit of the uniqueness of the caritas language linked to Watson's theory of human caring (2008). Further review and refinement of these particular caritas items may be indicated.

The background questionnaire provided useful and relevant information about the participant sample, however a few changes are recommended. For example, a question within the background questionnaire asked participants about the degree that staff nurses' perceived that spirituality adds to the perception of caring. Yet, no question within the background questionnaire asked about the spirituality of the participants. Additionally, in addition to including a question about the participants'

primarily assigned shift, the addition of a question about the frequency of one-on-one meetings or staff meetings with the nurse manager would have enabled the ability to assess the participants' perception of accessibility to the nurse manager.

Overall Summary/Conclusions

In summary, study findings for this sample indicate that the staff nurses' perception of nurse manager caring is inversely correlated to their perception of exposure to bullying. Further, workplace bullying prevalence rates within this sample suggest that workplace bullying is not just prevalent in new graduates, or in newly licensed nurses, but as this study indicates, is prevalent among older, more seasoned staff nurses as well. This is the first study to relate nurse manager caring with workplace bullying and study findings contribute to the body of caring science in nursing.

The Principles of Collaborative Relationships (ANA/AONE, 2013) delineate that effective communication and authentic relationships between the nurse manager and the staff they serve are elements of a highly effective practice environment and can go "beyond the surface of shared goals," (p. 2) and provide the synergy needed to achieve deeper, more humanistic relationships at the point of care. Studies that concentrate on caring leadership in nursing can support these principles and provide the evidence to suggest that nurse managers can serve as a translational force to create and/or maintain a culture of caring in the workplace ultimately leading to enhanced care for each other and the patients served (Watson, 2000). A shift in organizational mindset and organizational dialogue around the role of the nurse manager and the

importance of nurse manager caring (specifically toward the staff on the unit) will be

needed.

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Appendix A: **Original Carative Factors and Newly Evolved Caritas Processes**

Carative Factors (1979)	Caritas Processes (2002-2007)
1. Humanistic-altruistic values	1. Practicing loving-kindness and equanimity for self and other
2. Instilling/enabling faith and hope	2. Being authentically present; enabling/sustaining/honoring deep belief system and subjective work of self/other
3. Cultivating sensitivity to oneself and other	3. Cultivating one's own spiritual practices; deepening self-awareness, going beyond "ego-self"
4. Developing a helping-trusting, human caring relationship	4. Developing and sustaining a helping-trusting authentic caring relationship
5. Promoting and accepting expression of positive and negative feelings	5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one being-cared for
6. Systematic use of scientific (creative) problem-solving caring process	6. Creative use of self and all ways of knowing/being/doing as part of the caring process (engaging in artistry of caring-healing practices)
7. Promoting transpersonal teaching-learning	7. Engaging in genuine teaching-learning experiences within context of caring relationship – attend to the whole person and subjective meaning; attempt to stay within the other's frame of reference (evolve toward "coaching" role vs. conventional imparting of information)
8. Providing for a supportive, protective, and/or corrective mental, social, spiritual environment	8. Creating healing environment at all levels (physical, nonphysical, subtle environment of energy and consciousness whereby wholeness, beauty, comfort, dignity, and peace are potentiated (Being/Becoming the environment)
9. Assisting with gratification of human needs	9. Reverentially and respectfully assisting with basic needs; holding an intentional, caring consciousness of touching and working with the embodied spirit of another, honoring unity of Being; allowing for spirit-filled connection
10. Allowing for existential-phenomenological dimensions	10. Opening and tending to spiritual, mysterious, unknown existential dimensions of life-death-suffering; *"allowing for a miracle"*

Appendix B: Participant Recruitment Letter

Dear Fellow Nurse:

I am a doctoral candidate at Seton Hall University in New Jersey and I would like to invite you to participate in a survey I am conducting about your perception of the caring behaviors of your nurse managers (as defined as the individual who has been appointed to have responsibility, authority and accountability for supervising you and who has oversight responsibilities for your work environment) and your perception of exposure to negative acts within your work environment. Your responses will add new and important information to understanding the role of the manager within the work environment.

The survey consists of a ten-item Likert-type scale with one optional open-ended question (Nelson, 2011), a 22 item-Likert-style scale (Einarsen, Hoel, & Notelaers, 2009) and a short questionnaire pertaining to demographic and work-related items. You should be able to complete these surveys in approximately 15 minutes and submit them electronically within Survey Monkey.

The Survey Monkey format is designed to ensure that your data will be confidential and submitted anonymously. Submitted data will not be able to be traced back to participants. To ensure further confidentiality of all responses, the data submitted will be stored only on a memory key and kept in a locked, secure file cabinet in my home office. It will only be available to my research assistant and myself. If you have any questions or concerns, you can contact me at olendely@shu.edu and/or via my cell number, at 201-566-5697.

I hope you decide to participate in this research. If you decide to participate, please click "NEXT" at the bottom of this message. This will provide access to the study materials. Please try to complete the study materials in a one session however, if an interruption is necessary, just, "save and return" and use the same link to access your survey to complete at a later time. Your consent to participate in this study will be implied by your completing and submitting the online survey materials.

Thank you for your time and consideration in helping with this important work! In return for your participation in this study, you will be given access to the study results after completion of the study.

Lynda Olender, MA, APRN, NEA-BC

Appendix C: Survey of Nurse Manager Caring Behaviors (Nelson, 2011)

1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Agree	6 Agree	7 Strongly Agree

The following behaviours are often seen as examples of nurse manager caring behaviors in the workplace. Please circle the number that best corresponds with your experience:

1)	Everyday I am here I see my manager treats employees with loving kindness.	1 2 3 4 5 6 7
2)	My manager is good at creative problem solving to meet my individual needs and requests.	1 2 3 4 5 6 7
3)	The manager of my unit/department helps instills hope and respects my belief system.	1 2 3 4 5 6 7
4)	When my manager teaches me something new, s/he teaches me in a way that I can understand.	1 2 3 4 5 6 7
5)	The manager of my unit/department encourages me to practice my own individual spiritual beliefs as part of my self-caring.	1 2 3 4 5 6 7
6)	The manager of my unit/department responds to me as a whole person, helping to take care of all my needs and concerns.	1 2 3 4 5 6 7
7)	The manager of my unit/department has established a helping and trusting relationship with me during my time here on this unit/department.	1 2 3 4 5 6 7
8)	The manager of my unit/department creates a healing environment in our unit/department that recognizes the connection between body, mind, and spirit.	1 2 3 4 5 6 7

9) I feel like I can talk openly and honestly with the manager of my unit/department about what I am thinking, because the manager of my unit/department embraces my feeling, no matter what my feelings are.

1 2 3 4 5 6 7

10) The manager of my unit/department is accepting and supportive of my beliefs regarding a higher power, which allows for the possibility of me to 'grow.'

1 2 3 4 5 6 7

11) Please describe a caring moment that has occurred between you and your nurse manager (optional):

_____
_____
_____
_____
_____

Appendix D: Permission Correspondence for the CFS-CM

From: John Nelson [mailto:jn@hcenvironment.com]   **Sent:** Tuesday, August 03, 2010 5:23 PM **To:** Olender, Lynda **Subject:** RE: Req_Nelson CFS_Caring of the Manager_8_4_10.docx

Hi Lynda,
I have read the entire document you sent for use of the Caring Factor Survey – Caring of Manager, and I agree that you can use this tool for your dissertation. Please keep me posted on your results and let me know if I can support you in any other way. Congratulations on your continued progress in your studies!

Best to you,

John
President

Healthcare Environment
888 West County Road D., Suite #300
New Brighton, MN 55112 USA
Office Phone: 651-633-4505
Mobile Phone: 651-343-2068
Skype Phone: 651-314-4505
Fax: 651-633-6519
jn@hcenvironment.com
www.hcenvironment.com

Appendix E: Survey of Negative Workplace Behaviors Among Nurses

The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work?

Please circle the number that best corresponds with your experience over the last six months:

1	*2*	*3*	*4*	*5*
Never	*Now and then*	*Monthly*	*Weekly*	*Daily*

1) Someone withholding information which affects your performance   1 2 3 4 5

2) Being humiliated or ridiculed in connection with your work   1 2 3 4 5

3) Being ordered to do work below your level of competence   1 2 3 4 5

4) Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks   1 2 3 4 5

5) Spreading of gossip and rumours about you   1 2 3 4 5

6) Being ignored or excluded   1 2 3 4 5

7) Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life   1 2 3 4 5

8) Being shouted at or being the target of spontaneous anger (or rage)   1 2 3 4 5

9) Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way   1 2 3 4 5

10) Hints or signals from others that you should quit your job   1 2 3 4 5

11) Repeated reminders of your errors or mistakes   1 2 3 4 5

12) Being ignored or facing a hostile reaction when you approach   1 2 3 4 5

13) Persistent criticism of your work and effort	1	2	3	4	5
14) Having your opinions and views ignored	1	2	3	4	5
15) Practical jokes carried out by people you don't get on with	1	2	3	4	5
16) Being given tasks with unreasonable or impossible targets or deadlines	1	2	3	4	5
17) Having accusations made against you	1	2	3	4	5
18) Excessive monitoring of your work	1	2	3	4	5
19) Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)	1	2	3	4	5
20) Being the subject of excessive teasing and sarcasm	1	2	3	4	5
21) Being exposed to an unmanageable workload	1	2	3	4	5
22) Threats of violence or physical abuse or actual abuse	1	2	3	4	5

NAQ – Negative Acts Questionnaire
© Einarsen, Raknes, Matthiesen og Hellesøy, 1994; Hoel, 1999

Appendix F: Permission Correspondence for the NAQ-R (will be scanned into document)

Olender, Lynda

From:	Lynda Olender [lynnyo@aol.com]
Sent:	Tuesday, November 02, 2010 7:02 AM
To:	Olender, Lynda
Subject:	FW: [Fwd: Negative Acts Questionnaire]
Attachments:	Naqinfo.rar

Importance:	Low

-----Original Message-----
From: Ståle Einarsen [mailto:Stale.Einarsen@psysp.uib.no]
Sent: Sunday, October 31, 2010 5:46 AM
To: 'Lynda Olender'
Cc: Ståle Einarsen
Subject: FW: [Fwd: Negative Acts Questionnaire]
Importance: Low

Dear Lynda

Thank your 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 sas your reference to the scale.

We hereby grant you the permission to use the scale as soon as you accept our terms for users found in the work file attachmed to this mail.
Please fill this in and return.

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 150.000 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

Best regards,
Professor Ståle Einarsen
Bergen Bullying Research Group

--
Morten Birkeland Nielsen
PhD

1

Appendix G: Background Information Questionnaire

Please tell me about yourself:
1. **Gender**

☐Male
☐Female

2. **Age (please provide): _____**

3. **Race/Ethnicity:**

☐Hispanic
☐White
☐Black
☐Asian American/Pacific islander
☐Alaska Native/American Indian
☐Other (please add) _____

4. **Your opinion as to the degree that spirituality adds to the perception of caring**

☐Does not add to the perception of caring
☐Slightly adds to the perception of caring
☐Does add to the perception of caring
☐Significantly adds to the perception of caring
☐No opinion

5. **Highest educational level in nursing (please check all that apply):**

☐Diploma in nursing
☐Associate degree in nursing
☐Baccalaureate degree in nursing
☐Masters degree in nursing
☐Post Masters Certificate
☐PhD, DNP or equivalent in nursing
☐Degree in other field (please add) _____

6. **Certifications in Nursing (please add)**
_____
_____

7. **Country where basic nursing education occurred**
_____
_____ **If not in the United States, length of time working in the U.S. :**

☐ Less than 1 year
☐ 1-2 years
☐ 3-5 years
☐ 6-10 years
☐ 11-20 years
☐ Greater than 20 years

8. **Number of years worked on/within current unit/department:**

☐ Less than 1 year
☐ 1-2 years
☐ 3-5 years
☐ 6-10 years
☐ 11-20 years
☐ Greater than 20 years

9. **The number of years worked as an RN:**

☐ 0-2 years
☐ 3-5 years
☐ 6-10 years
☐ 11-20 years
☐ Greater than 20 years

10. **What part of the day does of a majority of your work take place:**
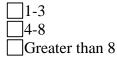
☐ Day
☐ Evening
☐ Night

11. Which role best describes your daily activities:
☐ Staff Nurse
☐ Per Diem/Intermittent Staff Nurse
☐ Travel Nurse
☐ Staff Nurse with occasional Charge Nurse role
☐ Charge Nurse
☐ Assistant Nurse Manager
☐ Nurse Manager
☐ Supervisor
☐ Instructor/faculty
☐ Clinical Nurse Specialist
☐ Office Nurse
☐ Other

12. Type of Unit you currently work on:
☐ Medical/Surgical/Telemetry
☐ Medical and/or Surgical Intensive Care
☐ Emergency Room
☐ Long Term Care
☐ Operating Room
☐ Post Surgical Recovery Room
☐ Ambulatory Care
☐ Home Care
☐ Other

13. Average number of patient/cases under your care per shift:

☐ 1-3
☐ 4-8
☐ Greater than 8

14. Employment Status: Average number of hours usually scheduled per week.

☐ Less than 10

☐ 10-20
☐ 20-40
☐ Greater than 40
☐ Other (I.e., intermittent, salaried)

15. Please indicate the number of operating beds or patients serviced within your facility/agency:

☐ Less than 50
☐ 50-100
☐ 101-250
☐ 251-500
☐ Greater than 500

16. Type of facility you currently work in (check all that apply):

☐ Acute Care (e.g., hospital)

☐ Sub-Acute care (e.g., rehabilitation, long term, nursing home)
☐ Home Health Agency
☐ Religiously Affiliated
☐ Government/State
☐ HMO/Integrated Care Facility
☐ Home Health Agency

17. Other Organizational Factors (check all that apply):

☐ Unionized (please indicate type) _____
☐ Non-Unionized
☐ Has integrated Watson's Theory of Human Caring into practice
☐ Magnet
☐ Other (please add) _____

The survey is now completed! Thank You For Participating!

PLEASE SUBMIT!

Appendix H: Agreement with RN[2] Network

11/10/10

To Whom It May Concern,

I am delighted to be working with RN[2] for the completion of my research interest and therefore agree with the following terms:

1. That I provide you with a short description of my research project, and some information about myself (workplace/institution, education/title) as follows:

Dissertation Title/working title: The Relationship between Staff Nurses' Perceptions of Nurse Manager Caring Behaviors and their Exposure to Workplace Bullying within Select Healthcare Settings.

Purpose: This study will examine a possible correlation between staff nurses' perception of nurse manager caring behaviors (using the Caring Factor Survey – Caring of the Manager) (Nelson, 2011) and their perceived exposure to workplace bullying inpatient healthcare settings (using the Negative Acts Questionnaire-Revised) (Einarsen, Hoel & Notelaers, 2009). See attached abstract for additional details.

Personal information: Name: Lynda Olender, ANP, NEA-BC, RN; Address: 403 Jefferson Ct, Edgewater, NJ 07020; Contact number: (h) 201-313-7273, (c) 201-566-5697. See attached CV for additional details.

University Information: Seton Hall University, 400 South Orange Ave, East Orange, New Jersey 07079; Contact number: 973-761-9607.

Supervisor information and contact details: Dr. Theodore Sirota, Seton Hall University, contact number: 201-767-7330.

2. I agree to provide you with the CFS-CM and NAQ data after I have finished my study, including demographic data and response rate. I only ask if you use the findings and related data that you give me credit for the work. This data will be compatible with SPSS.

Respectfully submitted,

Lynda Olender