ADDRESSING QUALITY OF WORKLIFE: EXAMINING HORIZONTAL WORKPLACE BULLYING BEHAVIORS IN NURSING

by

Sheila Blackstock

RN, College of New Caledonia, 1987
BScN, University of Victoria, 2006

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Abstract

Background: Research suggests that formal and informal institutional workplace structures and processes can create a fertile environment for bullying. Exploration of key organizational antecedents of role ambiguity, role conflict, role overload, and perceptions of nursing supervisor fairness in relation to horizontal workplace bullying among Registered Nurses (RNs) is missing.

Purpose: This study explores relationships between workplace structures, processes, and bullying among RNs, and examines the construct validity of Hutchinson et al.'s (2008) Workplace Bullying Instrument (WBI).

Method: A web-based survey was distributed to 477 (n=94) RNs employed at a British Columbia hospital.

Data Analysis: Correlations assess relationships among variables of workplace structures, processes, horizontal workplace bullying, and intentions to leave.

Results: Workplace bullying among RNs was multidimensional (i.e., comprising individual and organizational factors) and bullying experiences can be situated within workplace structures and processes. The construct validity of WBI was confirmed. Implications for future research and workplace policy are discussed.

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Chapter 1: Introduction

"Nurses eat their young." This informal saying is widely known within the registered nursing profession. Research suggests that bullying among registered nurses (RNs) is a prevalent problem (Freshwater, 2000; Hastie, 2008; Hesketh et al., 2003; Quine, 2001; Randle, 2003; Sheridan-Leos, 2008) nationally and internationally that impairs nurse well-being, workplace morale and patient care. Despite abundant data that workplace bullying has detrimental consequences for health care organizations, employees and RNs, there is a gap in knowledge concerning its causes and organizational factors that may mitigate or exacerbate the problem. Researchers in industrialized nations have utilized occupational frameworks to explore the organizational factors (e.g., policies, structures and processes) that act as antecedents to workplace bullying (Coyne, Seigne, & Randall, 2000; Zapf, 1999). But little attention has been paid to the role of health care organizations' organizational policies, structures and processes that may directly and indirectly exacerbate workplace bullying among RNs.

In recent years there has been growing attention to four central aspects of workplace bullying behaviors. The first aspect is examining the perceptions of acts of workplace bullying from the perspective of the perpetrators and/or victims (Deans, 2004; Felbinger, 2008). Second, researchers have looked at the consequences of workplace bullying acts (Lewis, 2006; Vickers, 2006). Third, researchers have studied the psychosocial factors of the work setting that may play a role in contributing to bullying behaviors (Hutchinson, Wilkes, Vickers, & Jackson, 2008; Salin, 2003). Finally, researchers have examined organizational determinants or features that act as "antecedents." These permit or encourage workplace bullying (Aquino & Lamertz, 2004; Hutchinson et al., 2008), either directly through organizational human resource systems that select, train, reward or punish perpetrators

(Bowling & Beehr, 2006), or indirectly through workplace structures and processes that create role stressors.

This research is about the fourth aspect, organizational antecedents, most particularly workplace structures and processes. Although much is known about workplace bullying among RNs, there are still significant gaps in our understanding of the impacts of organizational antecedents that impact RNs' roles (e.g., workload, job duties, and how RN roles differ from other health care team members' roles). The purpose of the research is to explore key relationships between workplace structures and processes, and nurses' perceptions of "horizontal" workplace bullying behaviors—that is, those that occur between members of an organization with equal power relations or co-workers. (When workers have unequal power relations, the bullying is said to be vertical.)

Past researchers have used the work environment hypothesis, which states that stressful and poorly organized work environments may give rise to conditions resulting in workplace bullying (Agervold & Mikkelsen, 2004; Einarsen, Raknes, & Matthiesen, 1994; Leymann, 1996). According to this situational view, workplace bullying is primarily caused by factors related to deficiencies in work organization and leadership behavior within organizations (Einarsen, 2000; Leymann, 1990; Leymann, 1996). These characteristics of the work environment may influence workplace bullying directly, but they may also contribute to creating a stressful work environment which may, in turn, create a fertile environment for workplace bullying (Bowling & Beehr, 2006). Researchers have looked at the relationship of job stressors such as role stress to workplace bullying behaviors (Bowling & Beehr, 2006; Hoel & Salin, 2003; Lewis, 2006; Spector & O'Connell, 1994). Role stressors occur when there are inconsistencies between the RNs' perception of their role and the health care organization's definition of the RN role as defined by operational requirements and

workplace processes or procedures. RNs' role expectations are defined by the educational processes experienced in formal training, and guided by professional standards prior to employment. Once the RN is on the job, the role definition acquired previously in training must be adjusted to the health care organization's demands. In role-theory terms, Brief, Aldag, Van Sell, and Melone (1979) assert that an RN is socialized to expect that his/her role will include professionally valued tasks (e.g., patient instruction, planning and coordination of patient care). However, the RN's role is influenced by the health care organization through workplace structures and processes (e.g., additional tasks that may not be central to the tasks of professional nursing, and work overload). If the educationally defined role is incongruent with the RN role as defined by the health care organization, then role stress occurs (Brief et al., 1979) and RNs experience role conflict, role ambiguity (Spector & O'Connell, 1994), and role overload (Lewis, 2006). Workplace bullying is more likely to occur when role stressors result from workplace structures and processes (Hoel & Salin, 2003; Lewis, 2006, Spector & O'Connell, 1994).

In addition to workplace structures and processes such as role conflict, role ambiguity and role overload, psychosocial factors, organizational determinants, and other workplace structures and processes such as organizational power differences are related to the occurrence of workplace bullying behaviors among RNs (Salin, 2003). Workplace structures and processes create changes in the work environment that cause role stressors for both the perpetrator and the victim, which can be an antecedent to workplace bullying behaviors (Agervold & Mikkelsen, 2004; Einarsen et al., 1994; Leymann, 1996). It is useful to focus workplace bullying research on environmental factors rather than on individuals' characteristics, as health care organizations can only focus interventions on factors that they can control (Hoel & Cooper, 2001), such as structure, reward systems and job design. Health

care organizations need to be aware of the influence of workplace structures and processes on workplace bullying behaviors among RNs when attempting to react and adapt to organizational reengineering and restructuring motivated by fiscal restraint, changes in health care practices, and changes in staff mix (Human Resources and Skills Development Canada, 1999; McGillis Hall, 2003; Sovie & Jawad, 2001). Organizational changes that result from reengineering may create workplace structures and processes that act as precipitating structures, psychosocial networks or antecedents for workplace bullying among RNs (Notelaers, De Witte, & Einarsen, 2003; Salin, 2003). In fact, research has shown that there are likely pre-existing workplace structures and processes within health care organizations that act as antecedents to the cultivation of workplace bullying behaviors among RNs (Hoel & Salin, 2003).

Definitions

Horizontal workplace bullying. Hutchinson et al. (2008) defined bullying as:

> A range of behaviours that are often hidden and difficult to prove. Perpetrators aim to harm their target through a relentless barrage of behaviours that may escalate over time and include being harassed, tormented, ignored, sabotaged, put down, insulted, ganged-up on, humiliated and daily work life made difficult. (p. 21)

Hutchinson et al.'s (2008) definition was useful in this study for two reasons. First, it was developed specifically for workplace bullying behaviors among RNs. Second, this study used Hutchinson et al.'s (2008) workplace bullying instrument thus it was important for the definitions to be congruent.

Organizational antecedents. Salin (2003) classifies organizational antecedents related to horizontal bullying into three groups: (1) enabling structures or necessary antecedents; (2) motivating structures or incentives; and (3) precipitating processes or

triggering circumstances. Enabling structures or necessary antecedents are described as perceptions of power imbalances, low perceived costs, and dissatisfaction or frustration (Salin, 2003). Motivating structures or incentives result from expected benefit or reward systems and internal competition (Salin, 2003). Precipitating processes or triggering circumstances occur as a result of downsizing and restructuring, organizational changes, and changes in the work group composition (Salin, 2003).

Workplace structures and processes. Workplace structures and processes in institutions are both formal (e.g., human resource systems and organizational reporting structures) and informal workplace structures (e.g., reward systems, social networks, and social climates). They may also involve the potential impacts of whistle-blowing, versus turning a blind eye to workplace bullying in relation to workplace promotion or training. Workplace structures and processes that result from organizational changes at work (e.g., change of a supervisor or manager, job, or organizational change) create role stressors for RNs (e.g., role conflict, role ambiguity, role overload); and perceptions of nursing supervisor fairness act as organizational antecedents, and have been related to workplace bullying behaviors (Hoel & Salin, 2003). This present study focuses on an adaptation of Hutchinson et al.'s 2008 Conceptual Model of Bullying in the Nursing Workplace (see Figure 1), which is made up of three concepts: (1) workplace structures and processes (e.g., features of organizational climate); (2) workplace bullying behaviors; and (3) the consequences of workplace bullying (e.g., negative health effects). The current study focused on two dimensions of Hutchinson et al.'s (2008) Conceptual Model of Bullying in the Workplace: (1) workplace structures and processes; and (2) workplace bullying behaviors.

Figure 1: The Relationship of Structures and Processes to Workplace Bullying

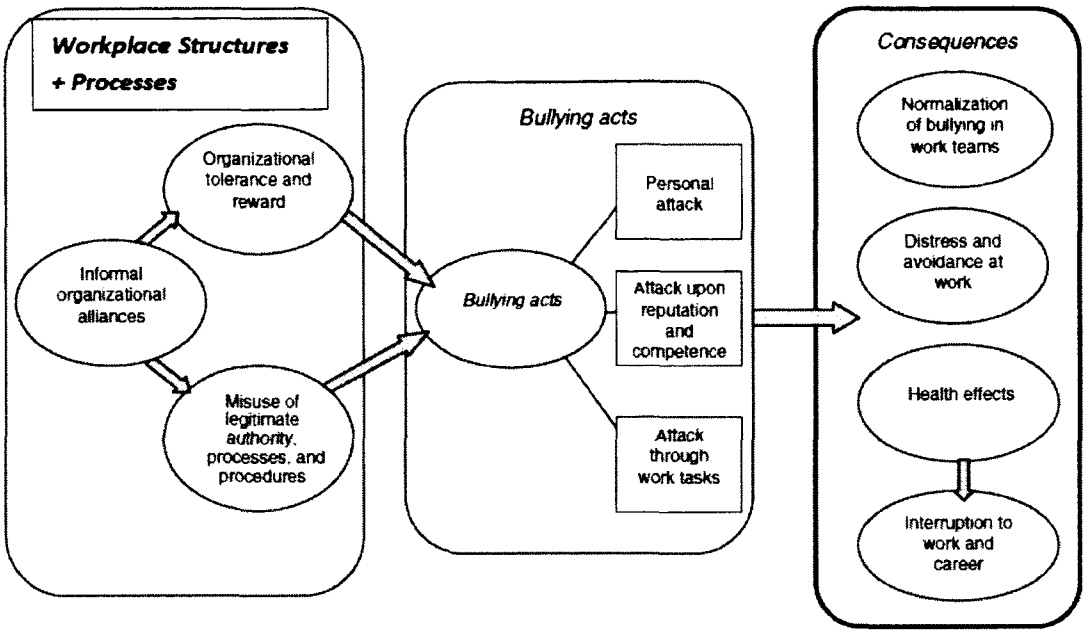

Figure 1. The Quality of Worklife Study focuses on the relationships between workplace structures and processes as antecedents to workplace bullying. Adapted from "A Conceptual Model of Bullying in the Nursing Workplace" by Hutchinson, M., Jackson, D.,Wilkes, L., Vickers, M., 2008, Advances in Nursing Sciences, 31, p.E61. Copyright 2008 by Wolters Kluwer Health, Lippincott Williams & Wilkins.

For the purposes of this study Hutchinson et al.'s (2008) organizational antecedents and the organizational antecedents of role conflict, role ambiguity, role overload, and perceptions of nursing supervisor fairness are referred to as workplace structures and processes for two reasons. First, the workplace structures and processes variables used in this study are supported by past studies. Second, this study focuses on measures of association and is unable to determine causation amongst variables. Hutchinson et al.'s (2008) organizational antecedents are combined with a group of variables (e.g., role conflict, role ambiguity, role overload, perception of supervisor fairness, organizational tolerance, and

reward, informal organizational alliances and misuse of legitimate authority, processes and procedures), which are referred to as workplace structures and processes.

Workplace Policy

The role of workplace policies as an organizational antecedent within health care institutions presents an opportunity to mitigate workplace mistreatment behaviors among hospital administrators (Harlos & Axelrod, 2005; 2008), and is an opportunity to moderate workplace bullying among RNs (Wang, Hayes, & O'Brien-Pallas, 2008). Workplace policies may play a role in the creation of power imbalances when it comes to rank structure, authoritarian leadership styles, and a strong emphasis on conformity of RNs to particular institutional norms of behavior. Health care organizations can demonstrate that employee well-being is valued by integrating employee health and well-being into their vision, as a foundation for policy development (Shamian & El-Jardali, 2007). Occupational Health and Safety Agency for Healthcare (OHSAH), located in British Columbia (BC), is a regional health and safety resource for health care employees and organizations. As a preventative strategy, OHSAH (2008) recommends inclusion of "respect in the workplace" as a policy and procedure resource for workplace violence and harassment in the workplace.

Overview of the Study

As far as can be determined, there is a gap in survey research about the relationship between workplace structures and processes and horizontal workplace bullying behaviors among RNs in acute care settings. If workplace bullying among RNs is not explored in the context of organizational factors or antecedents that may contribute to its existence, then it will continue to be a silent international epidemic (Morris, 2008). Identification of specific organizational antecedents as contributing factors to workplace bullying exposes the problem

but also provides an opportunity for health care organizations to reduce its incidence of workplace bullying. Given the prevalence and the negative impact of workplace bullying among RNs, this study explored perceptions of horizontal bullying behaviors in relation to workplace structures and processes.

This study used the survey instruments developed by Hutchinson et al. (2008) that were used with Australian nurses to explore relationships between workplace bullying on one hand and informal organizational alliances, misuse of legitimate authority, and organizational tolerance and reward (i.e., workplace structures and processes) on the other hand. In the present study these workplace structures and processes were explored in relation to perceptions of horizontal workplace bullying behavior among RNs employed in a British Columbia (BC) hospital.

Previously validated organizational antecedents and correlates were used to build on and extend the organizational antecedents of Hutchinson et al.'s (2008) Conceptual Model of Bullying in the Nursing Workplace. In addition, this study examined the impacts of individual workplace process and procedure variables on bullying behaviors such as role ambiguity, role conflict, role overload (Bowling & Beehr, 2006; Spector & O'Connell, 1994), perception of nursing supervisor fairness (Wang et al., 2008), and the effects of organizational restructuring/reengineering on role ambiguity (Kroposki, Murdaugh, Tarakoli, & Parsons, 1999; McGillis Hall, 2003). As far as can be determined there are not any studies where all of these variables have been considered together in relationship to horizontal bullying among RNs.

Hutchinson et al.'s (2008) Conceptual Model of Bullying in the Nursing Workplace provides preliminary evidence of the relationship between workplace structures and processes and the incidence of workplace bullying behaviors among registered nurses. I

propose that other workplace structures and processes along with Hutchinson et al.'s (2008) antecedents will be demonstrated to be empirically related to workplace incivility and workplace bullying behaviors among RNs.

Prevalence of Workplace Bullying

In Canada, employment statutes and standards increasingly emphasize the need for violence and harassment free workplaces. For example, a Toronto hospital has been at the center of a court case over allegations that it failed to protect a staff nurse who was fatally stabbed by another staff member (Wingrove, 2008). The province of Quebec instituted legislation to deal with workplace harassment in 2004.

In 2005, Quebec received 2,020 complaints of workplace harassment of which 1,025 were validated (National Union of Public and General Employees, 2006). Although it is not possible to disaggregate which, if any, of these complaints were related to workplace bullying among nurses, the number of reports indicates a growing awareness among employees that workplace harassment is unacceptable and employers have a duty to ensure worker safety and well-being. The BC Human Rights Code (1996) states that an employer is required to provide workers with a workplace free of harassment and discrimination, however, it does not address bullying that is not related to protected grounds in the human rights domain such as age, gender or race.

Workplace bullying amongst RNs has been explored by researchers in international settings (Deans, 2004; Merecz et al., 2006; Quine, 2001; Randle, 2003; Roberts, 2000), and in Canada (Freshwater, 2000; Hesketh, et al., 2003; Sheridan-Leos, 2008; Shield & Wilkins, 2006; Trofino, 2003). Previous research has demonstrated that vertical workplace incivility or workplace bullying behaviors is a greater source of workplace bullying behaviors than

horizontal or co-worker sources. Despite high rates of workplace bullying, researchers believe that bullying among RNs is under reported particularly when the perpetrator is a colleague (Hegney, Plank, & Parker, 2003; Hesketh et al., 2003; Hutchinson et al., 2006/2008; Plank & Parker, 2003). Researchers have found that coworkers are the most frequent sources of hostile workplace behaviors (Cortina et al., 2001; Keashly & Jagatic, 2003; Neuman & Baron, 1997).

Horizontal workplace bullying among RNs is present internationally and nationally (Gilmore & Hamlin, 2003). A National Health Service Trust study by Quine (2001) found that almost half of community nurses experienced one or more types of bullying in the previous 12 months. A study in the United States found that verbal abuse among registered nurses is the second most common source of abuse reported by RNs (Felblinger, 2008).

A survey of bullying among RNs in Alberta and British Columbia (Hesketh et al., 2003) found that many RNs experienced emotional abuse and threats of abuse. The importance of good working relationships with nursing coworkers has been linked to retention of RNs in the nursing profession (Hesketh et al., 2003). In practical terms, research on the role and relationship of workplace structures, and processes to perceptions of workplace bullying behaviors among RNs has the potential to inform improvements in health care organizations and the nursing profession.

Purpose of the Study

The purpose of this study was to explore key relationships between organizational work structures, processes, and workplace bullying behaviors among RNs. This study addresses the question: are there relationships between workplace structures and processes, and the perceptions of horizontal workplace bullying behaviors among RNs?

Although this study was limited to one organization at one point in time, the results will provide a basis for other organizations interested in examining the role of workplace structures and processes in relation to workplace bullying behavior among RNs. It will specifically benefit organizations by providing empirical information to begin to address workplace bullying behaviors among RNs; such actions may have secondary benefits of improved workplace morale, quality of worklife, recruitment, and retention. For this reason, the study survey instrument includes an intention to leave measure (Ferris & Rowland, 1987) that will help the target organization gain insight into whether perceptions of horizontal workplace bullying behaviors of RNs are contributing to RNs' decisions to leave their workplace.

There are two contributions that this study makes to nursing research. The study extends Hutchinson et al.'s (2008) study, which employed an Australian sample. As far as can be determined, measures developed by Hutchinson et al. (2008) have not yet been administered to a Canadian sample. Second, previously validated organizational antecedents and correlates were used to build on and extend the organizational antecedents of Hutchinson et al.'s model (2008). This study contributes to existing knowledge by: 1) examining relationships between workplace structures and processes, and horizontal workplace bullying experiences among RNs; and 2) examining the construct validity of measures contained in Hutchinson et al.'s (2008) study.

Chapter 2: Literature Review and Hypotheses

There is robust evidence to show that healthy workplace environments foster both improved organizational performance and workers' health and well-being, which results in improved patient safety and care outcomes (Shamian et al., 2007). Well-being and other new healthy worklife indicators are being developed by the Canadian Council of Health Services Accreditation (CCHSA), which is the governing body for accreditation of hospitals in Canada.

The provision of a safe and healthy workplace can be accomplished through organizational strategic initiatives and policies that promote the health, safety and well-being of nurses (RNAO, 2008). In order to provide a safe and healthy workplace, we need research based information about the relationships among workplace structures and processes as antecedents to workplace bullying. In order to provide grounding for the survey, it is useful to examine the theories and measurements of policies and workplace structures, and their relationships to role stressors (e.g., role conflict, role ambiguity, and role overload), perception of supervisor fairness, and Hutchinson et al.'s (2008) workplace antecedents.

Workplace Policy

Research has drawn into question the continued reliance on workplace bullying strategies that address workplace bullying on an individual level. Even if health care organizations have policies and procedures in place there is robust evidence indicating that social networks of informal organizational alliances, and work group norms, work in opposition to well-meaning policies, and may intercept the integrity of workplace bullying reports (Hesketh et al., 2003; Quine, 2001). Workplace bullying policies can even be considered to be precipitating structures or antecedents, as they may inadvertently provide a

fertile ground for workplace bullying. In their review of workplace prevention programs in the health sector, Wang et al. (2008) argue that the research examining the relationships of workplace structures, and processes to workplace bullying behaviors among RNs presents an opportunity for health care organizations to create or revisit their policies with respect to zero tolerance, respect in the workplace, and whistle blowing. Although there is controversy regarding the use of zero tolerance policies to mitigate external sources of workplace violence in the healthcare sector, Wang et al. (2008) argue that such policies may be effective in moderating horizontal workplace bullying.

Organizations have a legal obligation through the Occupational Health and Safety Regulations (OH&SR, 2003) under the Worker's Compensation Act to deal with worker-to-worker bullying, intimidation or abuse (OH&SR, 2003). Workplace bullying policies (e.g., zero tolerance and respect in the workplace) provide support to facilitate healthier nursing environments, and to change cultures to ones that do not accept workplace bullying. These policies provide guidance to administration, nurse supervisors, and RNs to help them to effectively identify and address workplace bullying behaviors.

In some organizations, there have been reports of difficulty in resolving complaints of workplace bullying. When workplace bullying behaviors are reported through the proper processes, victims are often re-victimized (Vickers, 2006) or labeled as having paranoid tendencies (Leymann, 1990). The perpetrators often continue to influence decision-makers through carefully honed skills of manipulation, deception, and secrecy (Lewis, 2006) that make use of access to decision makers through informal organizational structures. For example, "whistle-blower" policies are being implemented to protect those who report workplace maltreatment in health care organizations (Harlos & Axelrod, 2008). If policies (e.g., respect in the workplace) are not made visible and effective resolutions of disputes

around reports of workplace bullying behaviors (Lewis, 2006) are not achieved then the behaviors can persist although they may remain concealed.

Terms Associated with Workplace Bullying

There is a wealth of research that examines workplace bullying behaviors and consequences, amidst the theoretical domain of *negative interpersonal* workplace behaviors. Terms associated with workplace bullying in the literature include incivility, workplace mistreatment, aggression, mobbing, lateral violence, psychological terror, and psychological harassment (Hutchinson et al., 2008; McCarthy, 1996). The variety of terms, measures, and theoretical definitions used to describe workplace bullying in research studies has impacted the comparability and reliability of research findings (Andersson & Pearson, 1999; Branch, 2008; Cortina et al., 2001; Einarsen, Hoel, Zapf, & Cooper, 2003; Keashley & Jagatic, 2003; Pearson, Andersson, & Porath, 2000).

Incivility is a low intensity deviant behavior which violates workplace norms of respect and has an ambiguous intent to harm (Andersson & Pearson, 1999), and includes discourteous behavior and a lack of respect for others (Pearson, Andersson, & Wegner, 2001). In terms of workplace bullying behaviors among RNs, workplace incivility and workplace bullying behaviors theoretically overlap. The distinction of incivility from other concepts such as aggression is related to the ambiguity of its intent to harm. Perpetrators could plead ignorance or deny any intentions of intent to harm, and thus confuse the resolution of the issue (Andersson & Pearson, 1999). Intent is mentioned by Branch (2008) as being ambiguous in terms of workplace bullying, however, Keashly and Jagatic (2003) suggest that intent is not a defining element of workplace bullying; there is no existing measure of intent in relation to workplace bullying. The attempt to clarify whether the

perpetrator intended to bully a victim is circuitous - the bullying act(s) occur in spite of clarification of intent (Hickling, 2006) thus intent is not an important component. An important take away point from this literature is that focusing on workplace structures and processes can inform healthcare organizations about how to create a workplace culture in which workplace bullying is not tolerated or propagated regardless of perpetrators' intentions.

Mobbing, psychological harassment, and terror refer to interpersonal hostility that is deliberate, repeated, and severe enough to harm the target's personal health or financial status (Namie, 2003). All are forms of workplace mistreatment. Mobbing is typically perpetrated by groups of co-workers. Workplace mistreatment behaviors (Harlos & Axelrod, 2005) are reflected by three dimensions: verbal abuse, work obstruction, and emotional neglect. Verbal abuse is an interpersonal form of mistreatment whereas obstruction and neglect are considered organizational forms (Harlos & Axelrod, 2005).

Workplace aggression or workplace violence is typically perpetrated by individuals rather than groups of co-workers and is defined along three dimensions of physical-verbal, active-passive, and direct-indirect behaviors (Buss, 1961) and in various combinations (e.g., direct, verbal, and active aggression). Workplace aggression can also relate to a failure to respect personal privacy and/or confidentiality. Workplace aggression has the potential to escalate from nonverbal innuendo to physical assault (Farrell, 2001). Severity of workplace aggression is conceptualized by Andersson and Pearson (1999) as a form of workplace violence (high end aggression) or incivility (low end aggression). Workplace violence is any incident, behavior or action that is outside of reasonable conduct in which a person is threatened, harmed, injured, or assaulted in the course of, or as a direct result of, his or her work (United Nations' International Labour Organization, 2003). Workplace bullying

behaviors differ conceptually from mobbing/psychological harassment/terror and aggression as they are more closely associated to workplace violence behaviors (Andersson & Pearson; Branch, 2008; Namie, 2003). Namie (2003) puts into context the degree or scale of severity of workplace bullying on a ten point scale of organizational disruption. Scores for incivility range between one to three, scores for workplace bullying range from four to nine, and ten is reserved for battery and homicide (Namie, 2003). Researchers have used varying terms and measures for workplace bullying that have resulted in a variation of knowledge on workplace bullying behaviors. It is important to use a finite definition and measure of workplace bullying that relates to the theoretical constructs used in this study to contribute substantive knowledge of workplace bullying among RNs.

Workplace Bullying Theories

The workplace bullying theoretical frameworks presented herein represent the predominant theoretical frameworks that contribute to the understanding of the construct of workplace structures and processes, and workplace bullying behaviors among RNs. A critical review of the following theoretical frameworks and measures is provided:

- Incivility and Other Forms of Mistreatment in Organizations (Andersson & Pearson,1999);
- Workplace Incivility (Cortina et al., 2001);
- Model of Workplace Bullying in the Context of Antisocial Behaviors (Branch, 2008);
- Enabling, Motivating and Precipitating Structures and Processes in the Work Environment that Contribute to Bullying (Salin, 2003);
- Harlos and Axelrod's Workplace Mistreatment measures (2005);
- The Model of Bullying in the Nursing Workplace (Hutchinson et al., 2008).

These theoretical constructs have been reviewed to: (a) delineate the construct of horizontal workplace bullying among RNs; (b) provide the theoretical framework to test the construct validity of Hutchinson et al.'s (2008) Workplace Bullying Inventory; and (c) inform the relationship of organizational antecedents to bullying frequencies among RNs.

Incivility and Workplace Bullying: Theoretical Frameworks

The Incivility and Other Forms of Mistreatment in Organizations Model (Andersson & Pearson, 1999) depicts incivil behavior in terms of social interactions. Workplace incivility can spiral in either direction horizontally between equals, or vertically, among hierarchical relationships to more intense workplace behavior such as workplace bullying. Andersson and Pearson (1999) defined incivility as "low-intensity deviant behavior with ambiguous intent to harm" (p. 456), and they positioned it within the core of their theoretical conceptual model overlapping aggression and deviant behaviors. Workplace incivility can escalate to other more deviant behaviors such as aggression, violence, and deviant antisocial behavior that violates norms and antisocial behavior that harms an organization. An incivility spiral depicts the escalation of workplace incivility to more intense behaviors which could spawn secondary spirals within the organization. The incivility behavior can be resolved or it can reach a tipping point in which the behavior could cascade via word of mouth to other co-workers, unless either party refrains from entering into an exchange of coercive actions.

Andersson and Pearson's (1999) model highlights the role of workplace structures and processes such as informality of workplace cultures. Informality may create a culture in which employees are more apt to engage in incivil behaviors. Andersson and Pearson's (1999) hypothesized model acknowledges the role of the organization in relation to incivility,

and other forms of mistreatment; however it does not use workplace structures and processes as a construct.

Branch's (2008) Model of Workplace Bullying behaviors situates workplace bullying as a subset of antisocial and deviant behaviors that encompass incivility and may intensify to aggressive behaviors that could lead to physical violence. Branch (2008) builds on Andersson and Pearson's (1999) Incivility and Other Forms of Mistreatment in Organizations Model and conceptually places workplace bullying between incivility and violence. Branch's (2008) conceptualization links the spiral and escalating intensity of incivility to workplace bullying behaviors. Branch's findings extended from in-depth interviews with 15 managers working in a range of medium to large public and private organizations. Findings indicated that workplace bullying can be differentiated from aggression or violence.

Harlos and Axelrod's (2005) Workplace Mistreatment measures are based on conceptual distinctions and reasoning that were defined by participants in prior research as unjust or abusive (Harlos & Pinder, 1999; Keashly, 1998). Harlos and Axelrod (2005) used factor analyses that demonstrated that mistreatment behaviors are reflected by three dimensions: verbal abuse, work obstruction, and emotional neglect. Workplace mistreatment is theoretically related to workplace bullying behaviors (Andersson & Pearson, 1999).

Salin's (2003) Enabling, Motivating and Precipitating Structures and Processes in the Work Environment that Contribute to Bullying Model identify organizational antecedents' relationship to workplace bullying behaviors. In particular, Salin (2003) describes three groups of workplace structures and processes: (1) non-physical enabling structures and processes such as incentives for bullying colleagues or supervisors; (2) motivating structures and processes; and (3) triggering circumstances such as precipitating processes which all culminate to create an environment in which workplace bullying is apt to occur (Salin, 2003).

Model of Bullying in the Nursing Workplace

Recently, researchers have begun to look at the influence of health care organizations' workplace structures and processes to workplace bullying behaviors among RNs. Hutchinson et al. (2008) developed the Conceptual Model of Bullying in the Nursing Workplace that provides an opportunity for health care institutions to identify workplace structures and processes as correlates to the perceptions of workplace bullying behaviors among RNs. Hutchinson et al. (2008) identified the need to view bullying as a process that occurs as a result of features of the nursing workplace. Hutchinson et al. (2008) developed the model through a staged process. The research underpinning the model highlighted that workplace structures and processes were of crucial importance in the genesis of bullying. The process model's main constructs are organizational antecedents, bullying acts, and consequences (see Figure 1), which explain workplace bullying in nursing. Organizational characteristics (e.g., processes, structures, and routines) and features of the organization (e.g., formal and informal structures), culminate to act as antecedents to workplace bullying behaviors. Hutchinson et al.'s (2008) model situates organizational antecedents as precursors to bullying acts. Organizational antecedents are named as organizational tolerance, informal organizational alliances and reward, and misuse of legitimate authority, processes, and procedures. These workplace structures and processes inform the previously validated workplace structures and processes of role conflict, role ambiguity, role overload, and perceptions of nursing supervisor fairness in relation to horizontal workplace bullying behaviors among RNs (CRNBC, 2008; Einarsen et al., 1994; RNAO, 2008).

Hutchinson et al.'s (2008) measures of bullying include factors of time, duration, and powerlessness and theoretically overlap with incivility (Branch, 2008). Workplace bullying behaviors can include elements that are psychological, verbal, and non-verbal in nature.

Horizontal reflects the power relations of its occurrence. Horizontal workplace bullying occurs amongst organizational members who occupy equal power relations (i.e., co-worker to co-worker), in contrast to members who have unequal power relations. Psychological, non-verbal, and verbal aspects of workplace bullying behaviors are represented by the term workplace bullying behaviors (Branch, 2008).

Hutchinson et al.'s model (2008) was informed by social network theory and oppression theory. Although there are other models of workplace bullying, Hutchinson et al.'s model (2008) is unique in that it is specific to the nursing profession and relates workplace structures and processes to workplace bullying. Hutchinson et al.'s model (2008) is being replicated in part for this study because of its specificity to RNs, organizational antecedents, and workplace bullying behaviors.

The Workplace Incivility Framework (Cortina et al., 2001) has relevance to workplace bullying as workplace incivility theoretically overlaps with workplace bullying behaviors. Cortina et al.'s (2001) Workplace Incivility Scale (WIS) 7-item scale is an empirically validated measure of workplace incivility of received or experienced workplace incivility (Cortina, et al., 2001). As the concepts overlap, the WIS (Cortina et al., 2001) is used in this present study to test the construct validity of Hutchinson et al.'s model (2008) by providing criterion-related validity to Hutchinson et al. (2008) Workplace Bullying Inventory (WBI).

Workplace Structures and Processes

The relationship of workplace structures and processes to horizontal workplace bullying behaviors has been explored in a variety of studies (Griffeth, Hom, & Gaertner, 2000; Hauge, Skogstad, & Einarsen, 2007; Moayed, Daraiseh, Shell, & Salem, 2006; Salin,

2003). One of the key findings is that the personality or characteristics of employees as perpetrators (Gandolfo, 1995; Hutchinson et al., 2008; Seigne, 1998) or victims (Hayle, 2000; Randall, 2003) plays a role in workplace bullying behaviors as do employees' views and experiences of their organization (Bowling & Beehr, 2006).

Workplace structures and processes can take on a dual role in either promoting or mitigating bullying behaviors (Griffeth, Hom & Gaertner, 2000; Salin, 2003). On one hand, role stressors, job stress, work group cohesion, autonomy, and supervisor leadership style can affect the quality of the work environment (Griffeth et al., 2000) and may create a fertile work ground for workplace bullying behaviors. On the other hand, they may mitigate workplace bullying behaviors. Workplace structures and process variables of role overload in relation to time pressures to complete required tasks, uncertainty, organizational changes and organizational problems (Moayed et al., 2006) may also create an environment for workplace bullying behaviors. Researchers have recommended further empirical testing of the role of workplace structures and processes in relation to workplace bullying (e.g., Salin, 2003). For the purpose this study, role ambiguity, role conflict, role overload, and perception of nursing supervisor fairness were chosen as measures of workplace structures and processes for two reasons. First, past research has provided evidence that they are related to workplace bullying and second, no research could be found that combine these factors with other workplace structures and processes that are proposed to be related to horizontal workplace bullying behaviors among RNs (CRNBC, 2008; Einarsen et al., 1994; RNAO, 2008). The workplace structures and processes of workplace bullying behavior explored in this review exclude physical aspects of the workplace environment (e.g., noise or room temperature). These are factors of the worker's physical environment have not been explored in this current research study.

Workplace Structures and Processes Variables

Workplace structures and processes are formal (e.g., human resources systems and organizational reporting structures) and informal (e.g., reward systems and social networks). Workplace structures and processes that result from organizational changes at work have the potential to create role stressors for RNs. Role stressors can be in the form of role conflict, role ambiguity and role overload. In addition, other workplace structures and processes such as perceptions of nursing supervisor fairness, organizational tolerance and reward, informal organizational alliances, and misuse of legitimate authority, processes and procedures, act as organizational antecedents and have been related to workplace bullying behaviors (Hoel & Salin, 2003).

Organizational Tolerance and Reward. Organizational tolerance represents a dysfunctional process that does not effectively deal with workplace bullying behaviors, which may become a normal and expected part of the workplace culture within everyday nursing practice. Perpetrators of workplace bullying behaviors are promoted in spite of their behaviors. Others who remain silent about the workplace bullying behaviors they observe eventually become involved in the process (Branch, 2008; Hutchinson et al., 2008; Salin, 2003). Organizational tolerance and reward refer to 'turning a blind eye' to bullying behaviors in the workplace. Organizational tolerance and reward has potential to create a culture in which those who do not cause trouble or address workplace bullying will be more apt to be promoted or stay under the radar of perpetrators of bullying acts.

Informal Organizational Alliances. Social networks of workers that occur in the nursing workplace, but can also extend to external situations, these networks can create a forum of alliances for positive action—though they can also precipitate mobbing behaviors and predatory alliances that may result in horizontal bullying (Moutappa et al., 2004;

Yildirim, Yildirim, & Timucin, 2007). When such negative behaviors occur, and are complained about, it is difficult for health care organizations to identify the sources and deal with them. As noted previously, many workplace bullying policies and procedures are effective in guiding resolution when only individuals are involved; but they are not as effective at dealing with social networks or informal organizational alliances. Both forms reflect situations in which perpetrators utilize those in positions of higher authority to mitigate or extinguish any bullying reports from co-workers (Hutchinson et al., 2008; Notelaers et al., 2003). In some cases, even formal anti-bullying policies and internal processes are influenced by informal organizational alliances.

Misuse of Legitimate Authority, Processes and Procedures. Misuse of legitimate authority, processes and procedures are processes that keep oppression alive and well. In oppressive workplace environments those in authority can create an environment that produces, through normal work processes, a hyper vigilance on the part of subordinates to impending bullying behaviors. Examples are a supervisor's unfair questioning of sick days, impromptu meetings that serve to shake up the victim's confidence, targeting trivial items and imploding them into major issues, well outside the confines of work performance reviews. In terms of day-to-day nursing practice in which nurses of higher seniority rotate through nurse in charge/charge nurse duties, this could mean that a RN co-worker who is acting as the charge nurse could be in position of higher authority temporarily.

Additional Workplace Structures and Processes Variables

Additional workplace structures and process variables of role conflict, role ambiguity, role overload, and perceptions of nursing supervisor fairness, are reviewed to explain their theoretical relationships as precursors to workplace bullying among RNs. The study uses

these theoretical constructs to test Hutchinson et al. (2008) measures, which are explained later. As noted earlier, workplace structures and processes can encourage bullying either directly through organizational human resource systems that select, train, reward or punish perpetrators (Bowling & Beehr, 2006) or indirectly through workplace structures and processes that create role stressors (e.g., role conflict, role ambiguity, and role overload).

Role conflict. Role conflict is defined as conflict between the needs and expectations of different roles, for example occurring within a role when struggling to meet job tasks within time constraints (Hickling, 2006). Role conflict also occurs between roles, for example when a staff nurse is promoted to a new position and struggles to reconcile previous working relationships with co-workers and communication between co-workers (e.g., mixed, different or opposing messages) on roles assigned or designated amongst team members (Hickling, 2006).

Role theory suggests that when an individual is not aware of what behavior is expected or when expectations are inconsistent [role conflict], or not provided [role ambiguity], those individuals experience stress, reduced job satisfaction, and impaired job performance (Rizzo, House, & Lirtzman, 1970). Researchers extended Rizzo et al.'s (1970) work by defining role stress as anything about a job role that results in adverse consequences for an individual (Beehr, Walsh, & Taber, 1976). Beehr et al. (1976) found that role overload was positively correlated with organizationally valued outcomes as well as with three adverse outcomes: job dissatisfaction, fatigue, and tension. At certain levels, role overload may increase motivation to work if there are intrinsic rewards to be gained from successful completion of work (Beehr et al., 1976). Kelloway and Barling, (1990) combined the three factors of role ambiguity, role conflict, and role overload to provide construct validity to Rizzo et al.'s (1970) role conflict and role ambiguity scales and Beehr et al., (1976) role

overload scales. When the three factors of role ambiguity, role conflict, and role overload were combined in this manner it validated the impact of role stress (Gonzalez-Roma & Lloret, 1998; Kelloway & Barling, 1990). Researchers have questioned the construct validity of Rizzo et al.'s (1970) scales as the wording of items was said to be perfectly confounded with the direction of item wording (McGee, Ferguson, & Seers, 1989) and the two scales of role ambiguity and role conflict possibly reflect a single underlying construct of role stress (Tracey & Johnson, 1981). Kelloway and Barling (1990) added role overload (Beehr et al., 1976) to support the construct validity of Rizzo et al.'s (1970) scales.

Recently, Notelaers et al. (2005) found empirical evidence of the relationship of workplace antecedents to workplace bullying behaviors. They identified that role ambiguity was correlated with role conflict, which in turn correlated with workplace bullying behaviors. Role ambiguity and role conflict have also been identified as risk factors for workplace bullying (Zapf, Knorz, & Kulla, 1996).

Hauge et al. (2007) conducted a large-scale study of the Norwegian workforce (n=2539) which looked at the relationships between job stressors and supervisor's behavior as possible predictors of bullying at work. The study was based on the premise that stressful and poorly organized work environments may be antecedents to workplace bullying behaviors. Hauge et al. (2007) found that role conflict was one of four strongest work setting correlates to workplace bullying behaviors. The others were tyrannical leadership, laissez-faire leadership, and interpersonal conflicts.

Role ambiguity. Over the past two decades, health care organizations have tried to strike a balance between fiscal restraints and health care service delivery through reorganization, re-engineering, and restructuring strategies. Such changes may result in RNs experiencing role overload (Sovie & Jawad, 2001), role stress, role conflict, and role

ambiguity (Kroposki, Murdaugh, Tarakoli, & Parsons, 1999; McGillis Hall, 2003). RNs strive to maintain practice standards in an environment of scarcity in which RN resources are depleted and unregulated workers such as orderlies and porters are brought into the staff mix to take over some aspects of patient care (Sovie, 1985). The changes in staff mix have not decreased RN role ambiguity or role conflict (McGillis Hall, 2003). The fast pace of organizational restructuring has been found to create additional role stress and role ambiguity in registered nursing work environments.

Workplace stress can occur as a result of changes in workplace structures, processes, policies, and staffing compositions. The pace of change obscures the clarity of the RN role, creating role ambiguity. Role ambiguity has been found to be a contributing factor to the occurrence of workplace bullying among RNs (Notelaers et al., 2005; Zapf et al., 1996). Role ambiguity can arise when RNs initiate or are directed to perform a job task or procedure that they believe is within their job scope, however, a nurse in a superior position tells them otherwise or takes over the job task without explanation (Hickling, 2006). Role ambiguity and role conflict have been found to be related to horizontal workplace bullying (Hickling, 2006; Wang et al., 2008).

Role overload. Role overload is having too much work to do in the time available (Beehr et al., 1976). In the current state of nursing shortages and health care cut backs, RNs are faced with having to do more with fewer resources. Increases in nursing workloads due to cutbacks or unsuccessful recruitment of RNs have resulted in increased stressors among nurses and is a major contributory factor to increase bullying activity (Lewis, 2006). According to Felblinger (2008) incivility and mobbing behavior flourish in a workplace environment that propagates and normalizes negative behaviors among nurses. Normalization of negative behaviors among RNs is intensified by organizational changes,

nursing shortages, and increased responsibilities when nursing staff are pressured to take on supervisory roles within unpredictable and chaotic nursing practice environments (Felblinger, 2008).

Perceptions of nursing supervisor fairness. Nursing supervisor responsibilities identified in research literature include daily coordination and organization of patient care, as well as role modeling of professional behavior, and the demonstrated ability to effectively resolve workplace bullying behaviors among RNs (Einarsen et al., 1994; Felblinger, 2008; Spence Laschinger, Finegan, Shamian, & Wilk, 2003). Research has found that supervisor fairness can mitigate and resolve workplace bullying behaviors among RNs (Felblinger, 2008; Spence Laschinger, Finegan et al., 2003). The perceptions of nursing supervisor fairness are important more than ever during a time of nursing shortages. Heightened workplace tensions and other stressors that negatively impact the nursing practice environment occur as a result of nursing shortages, and ultimately influence bullying behaviors among RNs.

The relationship between workplace structures and processes, and workplace bullying behaviors poses a dual relationship– a workplace bully could propagate a toxic work environment, and workplace structures and processes could foster unhealthy work environments that lead to workplace bullying behaviors among RNs. Nursing supervisor fairness can also have a dual impact–in that leaders might identify and deal with workplace bullying or they might propagate the bullying behaviors themselves through being an ineffective supervisor (Wang et al., 2008). Both situations are plausible, and each situation would have to be assessed.

What becomes difficult to tease out are the complexities of determining perceptions of fair treatment in the workplace, which occur as a result of professional everyday

managerial nursing practices or co-worker interactions. Everyday managerial practices such as giving negative feedback on job performance or feedback on unsuccessful attempts at in-house training or education, and being unsuccessful in applications for job transfers or promotions can be interpreted by an employee as unfair actions (Cortina et al., 2008). The personality trait of affective disposition (i.e., choosing to negate legitimate feedback or have pessimistic views), may lead RNs to perceive that they have been mistreated by the organization, which may bias their responses when being asked about the organization in which they practice (Keashly, Trott, & McLean, 1994). A nurse may feel that he/she has been mistreated by the organization if he/she chooses to negate legitimate feedback on their professional practice or have inherently pessimistic views which may bias their responses when being asked about the organization in which they practice. Hence it is important to measure affective disposition (Keashly et al., 1994). In the current study, perceptions of fair interpersonal treatment between a RN supervisor and RN were measured using Donovan et al.'s (1998) Perceptions of Fair Interpersonal Treatment (PFIT) Supervisor scale.

Measuring Horizontal Workplace Bullying Behaviors

Two significant challenges in measuring workplace bullying behaviors are variances in the definitions of workplace bullying, and the frequency of exposure necessary for the behaviors to be called workplace bullying. A third challenge is a victim's ability to easily recall a bullying situation during a particular time frame. The time between the victim's exposure to workplace bullying, and when they declare their exposure may affect their ability to accurately recall the experience. Researchers have addressed these matters to bring consistency to defining workplace bullying, which in the past has been categorized by varying terms and measures (e.g., negative acts). As indicated previously, the most useful

approach for this study is to use Hutchinson et al.'s (2008) workplace bullying definition, and a time frame of 12 months to reflect research supporting respondents' accurate recall of workplace bullying experiences (Blau, 1998), and the salience of one-off experiences (Lee, 2000; Randle, 2003).

The time frame over which respondents are asked to report the frequency of workplace bullying behaviors depends on the theoretical definition of workplace bullying used in a particular research study. The Health and Safety Lab (2006) has suggested that in order to be defined as bullying, the frequency must be more than a one-off, and that bullying behavior be measured on a weekly basis over six months. Other researchers (Notelaeres et al., 2003) suggest that in order to differentiate between the influence of different workplace structures and processes on bullying, reporting two or more negative acts per week has more power. In order to be classified as workplace bullying, behaviors are typically repeated in a regularly (e.g., weekly) occurring matter.

In terms of accuracy of respondent recall, there is evidence that the salience of "one off" experiences supports accurate recall within a 12 month timeframe (Blau, 1998). "One off" situations have been reported as having a significant effect on victims that is equal to or greater than repeated experiences (Lee, 2000; Randle, 2003). Researchers have suggested that recalling bullying experiences from the last five shifts would elicit a more accurate recall of respondent's experiences (Graydon, Kasta, & Khan, 1994) rather than within a 12 month time frame.

The focus of the current study includes both workplace bullying behaviors and workplace structures and processes, measures designed by Hutchinson et al. (2008) to empirically test their theorized relationships between workplace structures and processes, and workplace bullying behaviors. In the current study, workplace bullying frequency is

considered to be the amount of bullying behavior personally experienced by a survey respondent according to Hutchinson et al.'s (2008) definition that is measured over the past 12 months and a frequency of once or greater. As explained previously, the perceptions of horizontal workplace bullying behaviors are measured using Hutchinson et al.'s WBI scale (2008) and are comprised of three factors. The factors include 'attack upon competence and reputation', 'personal attack,' and 'attack through work tasks' (Hutchinson et al., 2008).

Relationships between Workplace Structures and Processes, and Bullying

The studies considered in this research acknowledge that workplace bullying behaviors often become subtle in order to avoid detection, and potential consequences. There is minimal literature on the pre-existing workplace structures and processes in nursing environments that are related to workplace bullying. Although there are other scales available to measure workplace bullying, Hutchinson et al.'s (2008) scales are useful because they provide preliminary evidence of the relationship between workplace structures and processes, and bullying behaviors. Although the role of the structures and processes in relation to bullying among RNs have been examined by Hutchinson et al. (2008) in Australia, there has been limited literature to date in Canada measuring these relationships. Also, Hutchinson et al. (2008) studied the relationship of workplace antecedents (i.e., organizational tolerance and reward, misuse of legitimate processes, and informal organizational alliances) to workplace bullying with the WBI scale but did not use other workplace structures and processes (i.e., role ambiguity, role conflict, role overload, and perception of fair interpersonal treatment). In addition Hutchinson et al. (2005) did not use WIS (Cortina et al., 2001), PFIT co-worker (Donovan et al., 1998), and Workplace Mistreatment scales (Harlos & Axelrod, 2005) to test criterion related validity of the WBI (2008) scale.

The methodology used (i.e., to explore the relationship between organizational workplace structures and processes to horizontal bullying among RNs) is informed by the theoretical constructs demonstrating the relationship of organizational workplace structures and processes to workplace bullying behaviors (Andersson & Pearson, 1999; Branch, 2008; Cortina et al., 2001; Hutchinson et al., 2008; Keashly &MacLean, 1994; Keashly et al., 2003; Salin, 2003), and is used to investigate horizontal workplace bullying behaviors among registered nurses. This research employs descriptive and multivariate statistical tests to explore general associations among variables. The workplace structures and processes explored are not exhaustive, but do include the variables best supported in the literature as having a relationship to horizontal workplace bullying among RNs. Each workplace structure and process likely does not act in isolation in relation to horizontal workplace bullying behaviors among RNs. The workplace structures and processes may occur synergistically or in isolation, reflecting the dynamic process of workplace bullying behaviors.

The theoretical constructs used to inform this study are built on the Model of Bullying in the Nursing Workplace (Hutchinson et al., 2008) in which the relationship of workplace structures and processes are demonstrated to be related to workplace bullying among registered nurses. The variables of: (1) organizational tolerance and reward; (2) informal organizational alliances; and (3) misuse of legitimate authority, processes, and procedures (Hutchinson et al., 2008) are used. Previously validated additional workplace structures and processes, Workplace Incivility (Cortina et al., 2001), Perceptions of Fair Interpersonal Treatment Co-Worker (Donovan et al., 1998) and Workplace Mistreatment (Harlos & Axelrod, 2005) are used in this study to test the construct validity of Hutchinson et al.'s (2008) WBI. The following hypotheses served to explore the empirical relationships between

workplace structures and processes and workplace bullying behaviors among registered nurses.

Hypotheses

This study examined the question: Are there relationships between workplace structures and processes, and the perceptions of horizontal workplace bullying behaviors among RNs? The following hypotheses were proposed, and are outlined in Figure 2.

- Hypothesis 1(H1): There will be a positive relationship between organizational tolerance and reward, and reported workplace bullying behaviors among RNs.
- Hypothesis 2 (H2): There will be a positive relationship between informal organizational alliances, and reported workplace bullying behaviors among RNs.
- Hypothesis 3 (H3): There will be a positive relationship between misuse of legitimate authority, processes and procedures, and reported workplace bullying behaviors among RNs.
- Hypothesis 4 (H4): There will be a positive relationship between role conflict, and reported workplace bullying behaviors among RNs.
- Hypothesis 5 (H5): There will be a positive relationship between role ambiguity, and reported workplace bullying behaviors among RNs.
- Hypothesis 6 (H6): There will be a positive relationship between role overload, and reported workplace bullying behaviors among RNs.
- Hypothesis 7 (H7): There will be a positive relationship between intention to leave, and reported workplace bullying behaviors among RNs.
- Hypothesis 8 (H8): There will be a positive relationship between workplace incivility, and reported workplace bullying behaviors among RNs.
- Hypothesis 9 (H9): There will be a positive relationship between verbal abuse, emotional neglect, and work obstruction, on the one hand, and reported workplace bullying behaviors among RNs on the other.

- Hypothesis 10 (H10): There will be a negative relationship between perceptions of fair interpersonal treatment, and reported workplace bullying behaviors among RNs.
- Hypothesis 11 (H11): There will be a negative relationship between perceived organizational support, and reported workplace bullying behaviors among RNs.

Figure 2: Workplace Structures & Processes, Horizontal Workplace Bullying Behaviors among RNs, and Construct Validity

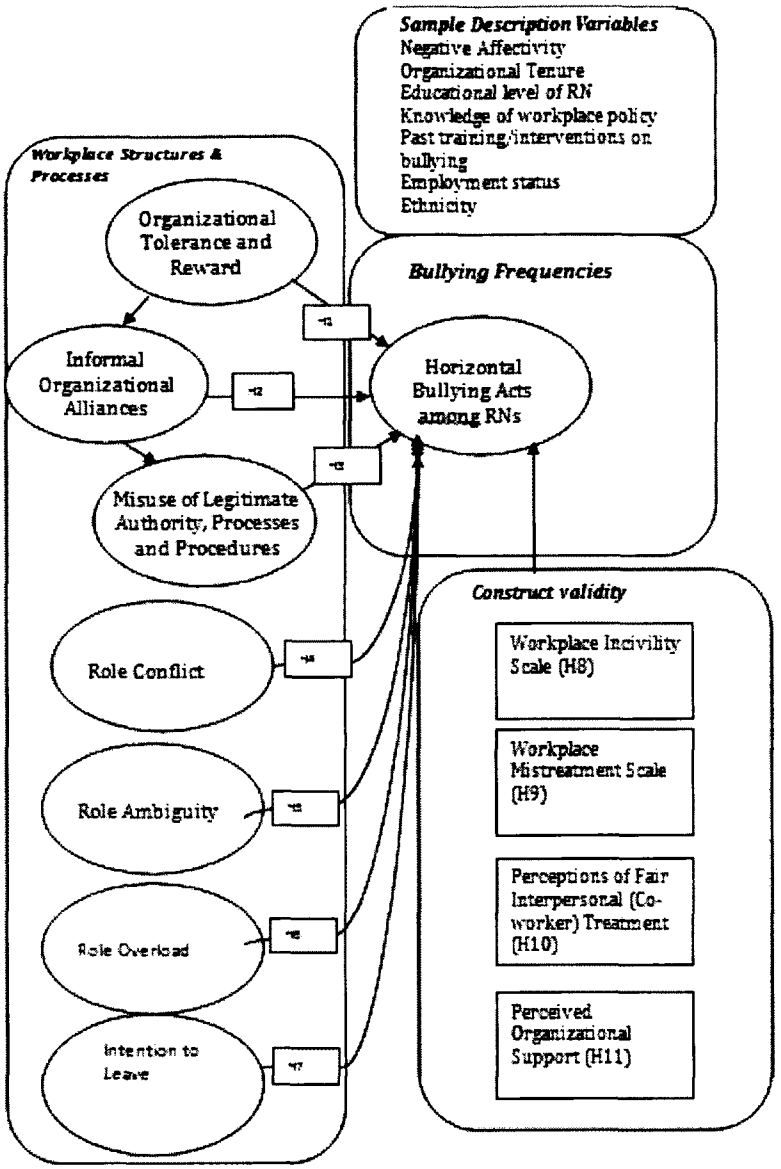

Figure 2. A diagram of health care organizations' workplace structures and processes relationship to horizontal bullying among RNs illustrates the hypotheses (i.e., H1-H11) of this study.

Chapter 3: Methods

Design

This study adapted Hutchinson et al.'s (2008) survey in a non-experimental, correlational research design. All RNs employed by the participating BC hospital at the time of data collection were invited to complete a voluntary, confidential and web-based Quality of Worklife Survey. The survey of a cross-sectional sample of RNs sought to explore the relationships between workplace structures and processes, and experiences of workplace bullying. The respondents were asked to reflect on the past 12 months and report the frequency of their experiences of workplace bullying behaviors among RN co-workers using the following scale: never, once, monthly, weekly or daily. To build on Hutchinson et al.'s (2008) study, additional measures were used to evaluate construct validity, and explore relationships.

This study was conducted with a study population of all RNs employed at the participating hospital. All RNs employed at the time of data collection with active work email addresses were included. The whole population of 477 RNs working at the hospital at the time of data collection (March 2–March 31, 2010) were sent invitations via e-mail to participate in the study. The invitation and all documents were in English which is the operating language of the hospital.

Procedures

Pilot test survey instrument. A pilot study was conducted in December 2009 following receipt of ethical and health authority approvals. Participants in the pilot study were contacted via email with an invitation to participate in the survey. Five people were invited to participate and four accepted. Along with completing measures related to study

variables, pilot study participants were asked to provide feedback on face validity, defined as a judgment concerning "...if a test definitely appears to measure what it purports to measure" (Cohen & Swerdlik, 1988;1999, p. 177). Data gathered (i.e., time taken to complete survey and response consistency) were reviewed as was feedback on the survey itself (i.e., clarity, logical flow, structure and length of the survey). One participant reported feeling discomfort about areas of the measure that were negative. Since this was the only participant reporting such distress, after consultation with the study co-supervisor, no changes were made to the survey.

Recruitment strategy. The survey followed established principles to encourage participation, drawing on Dillman, Smyth, and Christian's (2009) protocol to engage respondents. The key to Dillman et al.'s (2009) engagement strategy is personalization, which is hard to achieve over the internet, however personalization can be enhanced using elements of social exchange theory. Social exchange theory suggests that survey researchers should address three key areas to motivate people to respond: (a) the perceived benefits and costs for responding; (b) the establishment of trust (e.g., confidentiality and anonymity); and (c) the implementation process (Dillman et al., 2009).

The researcher held informal information tables outside the hospital cafeteria on five occasions to personalize the research project for potential respondents (e.g., respondents could meet the researcher and have any questions or concerns addressed). Several RNs indicated that they felt "surveyed out." However, the researcher communicated the perceived benefits of responding by affirming the importance of the respondent's experience and advice, and indicating how the results of the survey would benefit them and other RNs. The web-based survey was convenient to respond to, and had appropriate length to avoid

respondent fatigue. The questionnaire was designed to appeal to a wide variety of people. All respondents were eligible for two draws for a $100 dollar cash reward upon completion of the survey.

To address any perceived costs of responding (e.g., emotional distress or potential backlash from co-workers or the employer for participating in the survey) and to ensure ethical practices were maintained, anonymity, and confidentiality were ensured and maintained. Potential emotional responses in recounting perceptions of workplace bullying behaviors were expected so respondents were provided information on how to contact their Employee Assistance Program (EAP) should they need emotional support.

Participants' trust was enhanced in several ways. Tri-Council ethical research protocols (Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, 2005), as well as Dillman et al.'s (2009) recommendations were followed to enhance trust. Partially identifying information was maintained only for the purposes of data cleaning and later destroyed. Participants were told that results would be provided in aggregate form. Hospital administrative support, consultation with union representatives, and a poster campaign in the hospital conveyed sponsorship by legitimate authority. An email letter of introduction was sent to introduce the researcher to the participants (see Appendix A). As the researcher was known to many nurses in the hospital, the survey list was provided to a research assistant, who sent out the surveys but kept the names confidential.

Web-based Quality of Worklife Survey implementation process. Internet research has been demonstrated to produce results highly similar to conventional research methods (Bordens & Abbott, 2008). The available pool of respondents was reported to have access to work email addresses, and access to internet terminals was available at the internet cafe within the organization and support for nurses was provided with the time to complete the

survey (i.e., given the option of finishing the survey at work or at home). The web-based survey was administered through a secure password-protected internet site. The survey site allowed participants to log on to the survey, which automatically saved their responses. Automatically saving the responses allowed participants the freedom of completing the survey at their convenience with the ability to stop and return later at any time. The 110 question survey took 15 minutes on average to complete.

This study originated as part of a larger study by the researcher's co-supervisor, Dr. K. Harlos. Dr. Harlos had contracted with The Cornell University Survey Research Institute to deliver, monitor, and collect data, then secure and compile the data for computation, along with code book and hard-copy storage. The Cornell University Survey Research Institute was approved by Cornell University Ethical Review Board for its work, and follows human participant regulations.

The web-based survey commenced on March 2, 2010. The Survey Research Institute (SRI) at Cornell built into the survey administration confidentiality provisions. SRI provided the hospital with a data base of unique survey links that were merged with contact information on-site by a research assistant. In addition, a password protected website was created to provide real-time status updates to the survey links database (to facilitate non-respondent reminder emails). The researcher was given aggregate numbers on respondent rates.

Consent. When participants logged on to the secure site, they were asked to read and agree to a consent form prior to being able to proceed to the survey. The consent form provided the participant with information about the study aims, method, potential benefits and harms as well as confidentiality, the voluntary nature of participation, and ability to withdraw at any time (see Appendix B). Once consent was given by a participant they were

taken by the internet site to the survey. Participants had the ability to exit the survey prior to its completion (i.e., if they did not finish the survey as opposed to leaving a few questions blank). If this happened, the survey they were working on was marked as incomplete and was secured and destroyed. Consent forms were automatically collected electronically and stored through a secure data collection method at SRI.

Respondents. In total, 94 people completed the survey out of a possible 477 eligible participants with valid email addresses yielding a response rate of 19.71%. Additionally, nine people started the survey but did not complete it.

Measures

Quality of Worklife Survey instrument. The survey instrument utilized in this study included demographic information and used a combination of scales to form the Quality of Worklife Survey (see Appendix C). Proposed workplace structures and processes of role conflict, role ambiguity, role overload, and perceptions of nursing supervisor fairness were measured using the following empirically validated scales. The scales in the survey instrument were workplace structures and processes, PFIT (Donovan et al., 1998), WIS (Cortina et al., 2001), and WBI (Hutchinson et al., 2008).

Workplace structures and processes variables. These workplace structure and processes variables include four measures: Organizational Predictors of Bullying Scale (Hutchinson et al., 2008); role ambiguity and role conflict were measured using RHL scales (Rizzo et al., 1970); role overload (Beehr et al., 1976); and perceptions of nursing supervisor fairness were measured with PFIT (Donovan et al., 1998).

The Organizational Predictors of Bullying Scale (OPBS). The OPBS subscale entitled Organizational Processes (Hutchinson et al., 2008) comprises 25 items, with a 5-Likert response scale indicating the degree to which the factor is experienced (1 = never; 2 = a few times a year; 3 = monthly; 4 = weekly; and 5 = daily). It also has a Cronbach's $\alpha = .98$. The OPBS scale consists of three factors: misuse of legitimate authority, processes and procedures; informal organizational alliances; and organizational tolerance and reward. It was used by Hutchinson et al. (2008) to measure the antecedents' relationships to workplace bullying among RNs.

Role ambiguity, role conflict and role overload. Role ambiguity and role conflict were measured using RHL scales (Rizzo et al., 1970). Role overload was measured with Beehr et al.'s (1976) scale.

- Role ambiguity (Cronbach's $\alpha = .85$) consists of six items of role clarity and was reverse-scored for analyses (e.g., "I know exactly what is expected of me").
- Role conflict (Cronbach's $\alpha = .83$) consists of seven items (e.g., "I receive incompatible requests from two or more people"). Both use a 7-Likert scale type response (1 = very false; 7 = very true), with high scores reflecting greater conflict and low scores reflecting lesser conflict.
- Role overload (Beehr et al., 1976) consists of three items: two positively worded (e.g., "I have too much work to do, to do everything well") and one negatively worded item (e.g., "The amount of work I am asked to do is fair"),with high scores meaning greater overload and lower scores meaning less overload.

In one study, the internal consistency of the role overload scale has had less than satisfactory results ($\alpha = .49$), however this was attributed to a small non-random sample and the multidimensionality of the scale (Kelloway et al., 1990). Gonzalez et al. (1998) found

that factor loadings were statistically significant and Cronbach alphas from two samples ranged from .72 to .84 for the positive factors, and from .62 to .74 for the negative factors.

Perceptions of Nursing Supervisor Fairness. The PFIT (Donovan et al., 1998) 4-item Supervisor subscale has an alpha coefficient of .90. The scale is designed to measure interpersonal perceptions of fairness which was used to measure the nursing supervisor factor. Sample items include "Supervisors play favorites" and "Supervisors yell at employees." The response options (yes, "?" if you cannot decide, and no) were used. PFIT scale items were scored as follows: positive responses received a +3, negative responses received a +1, and "?" responses received +2 (Donovan et al., 1998).

Intention to leave. Intention to leave the organization was measured with Ferris and Rowland's (1987) single-item scale ranging from 1 ("I intend to stay until I retire") to 4 ("I intend to leave as soon as possible").

Horizontal Workplace Bullying Definition

The Hutchinson et al. (2008) operational definition of bullying frequencies was measured with the Workplace Bullying Instrument (WBI) 12 item, 5-point Likert scale ("1 = never" to "5 = daily"). It has a Cronbach α of .92. The scales consist of three factors: attack on competence and reputation, personal attacks, and attacks through work tasks. As indicated previously, workplace bullying behaviours as defined by Hutchinson et al. (2008) were utilized and reviewed in this study, asking respondents to reflect on their perceptions of workplace bullying behaviours in the past 12 months.

Construct Validity

Criterion-related validity was determined by comparing the results from Hutchinson et al.'s (2008) WBI instrument to that of an established measure (Bordens & Abbott, 2008) of

Cortina et al.'s (2001) Workplace Incivility Scale (WIS). Harlos and Axelrod's (2005) Workplace Mistreatment measures have similar factors that are related to Workplace Incivility Scale (WIS), (Cortina et al., 2001) and were used to test the construct validity of Hutchinson et al.'s (2008) Workplace Bullying Inventory (WBI) measure and the construct validity of Hutchinson et al.'s model (2008). To measure convergent validity of Hutchinson et al.'s (2008) WBI, the WIS (2001) measure was correlated with Donovan et al.'s (1998) Perceptions of Fair Interpersonal Treatment (PFIT) Co-worker scale. Because the latter instrument assesses perceptions of (or climate for) interpersonally fair or civil treatment in the workplace, it should be highly negatively correlated with personal experiences of workplace bullying behaviors among RNs.

Correlations assist in identifying how the value of one variable changes systematically with the value of a second. The correlates used in this study are demonstrated to be theoretically related to workplace structures and processes and workplace bullying behaviours. Theoretical constructs are reviewed to: (a) provide the basis for examining the construct validity and reliability of Hutchinson et al.'s (2008) workplace bullying measures, and (b) provide the theoretical framework to test the construct validity of Hutchinson et al.'s (2008) WBI instrument. Construct validity was determined by comparing the results from Hutchinson's et al. (2008) WBI instrument to the established measure of WIS (Cortina et al.'s, 2001). Cortina et al.'s (2001) Workplace Incivility Scale (WIS) is a 7-item empirically validated measure of received or experienced workplace incivility (Cortina et al., 2001) and was used to provide criterion-related validity to the WBI (Hutchinson et al., 2008).

Workplace Incivility Scale (WIS). The WIS (Cortina et al., 2001) is a valid measure of workplace incivility, which has been demonstrated to theoretically overlap with the construct of workplace bullying behaviors and thus was used to measure the concurrent

validity of Hutchinson et al.'s (2008) WBI inventory. WIS (Cortina et al., 2001) incorporates seven items with their respective factor loadings. The seven incivility factors have an alpha coefficient of .89 and were demonstrated to be highly reliable and cohesive (Cortina et al., 2001). Cortina et al.'s WIS scales (2001) were found to have convergent validity with Donovan et al.'s (1998) PFIT scale. The PFIT (Donovan et al., 1998) measures perceptions of interpersonal fair or civil treatment thus it was demonstrated to be highly negatively correlated (-.59 Pearson correlation) with personal experiences of incivil behaviors (Cortina et al., 2001).

Perceptions of Fair Interpersonal Treatment (PFIT). Research has shown that employees' perceptions of how they are treated in the workplace, their job satisfaction, and their affective disposition are related to a variety of perceptions about an organization. Donovan et al.'s (1998) Perceptions of Fair Interpersonal Treatment (PFIT) scale measures those perceptions of fair and interpersonal treatment as a climate variable in employees' daily work environment, with both co-workers and supervisors. They developed the PFIT scale, which is a 10-item scale with coefficient alpha .92, from an individual level and conceptualized interpersonal treatment as a climate variable in relation to a worker's environment.

Donovan et al. (1998) did confirm that employees' perception of fairness of their work environment is an important variable that is related to other critical job-related variables. However, Donovan et al. (1998) during development of the PFIT measure, found that employees' ". . . affective dispositions did not explain correlations between the PFIT scale and other job-related variables" (p. 690). The PFIT Co-worker Scale (Donovan et al., 1998) was used within this current study to test the criterion-related validity of horizontal workplace bullying behaviors.

The PFIT (Donovan et al., 1998) Co-worker subscale consists of 10 items ($\alpha = .76$). The scale is designed to measure interpersonal perceptions of fairness and was used herein to validate the measure of horizontal workplace bullying behaviors. Sample items include "employees are praised for good work" and "employees' suggestions are ignored." The response options (yes, "?", no) was used and scored. PFIT scale items were scored as follows: positive responses receive a +3, negative responses receive a +1, and "?" responses receive +2 (Donovan et al.).

Harlos and Axelrod Scales (2005). Harlos and Axelrod's (2005) scales of workplace mistreatment include verbal abuse (eight behaviors that intimidate or humiliate people); work obstruction (four behaviors in which organizational resources and personal support are not provided for effective work performance and networking); and emotional neglect (five behaviors that undermine employees through neglecting to provide support or recognition). These measures of workplace mistreatment which have been previously validated (Harlos & Axelrod, 2005) add to the criterion-related validity of Hutchinson's (2008) WBI measures. Workplace bullying is measured at the same time as workplace mistreatment. Harlos and Axelrod's (2005) measures of workplace mistreatment are used as one of the standards against which to evaluate Hutchinson et al.'s (2008) WBI measures for concurrent validity.

Harlos and Axelrod's (2005) scales were used to measure verbal abuse, work obstruction, and emotional neglect. The verbal abuse scale (Cronbach's $\alpha = .89$) consists of eight behaviors that intimidate or humiliate people. Participants were asked to rate the frequency with which they had personally experienced each behavior in the past 12 months, using a 5-point Likert scale (never to daily). The work obstruction scales (Cronbach's $\alpha = .76$) consists of four behaviors designed to measure the lack of organizational resources and personal support for effective work performance and networking. The emotional neglect

scales (Cronbach's α = .81) measure five behaviors that undermine employees through neglecting to provide support or recognition.

Perceived Organizational Support (POS) scale. Researchers have found that perceptions of organizational support have correlated negatively with workplace mistreatment and incivility experiences (Harlos & Axelrod, 2005; Keashly & Jagatic, 2003). Lynch, Eisenberger, and Armeli's (1999) Perceived Organizational Support (POS) scale was used in the current study to test the construct related validity of organizational antecedents to workplace bullying behavior. It has high internal reliability (Cronbach's α =.90). It is expected that perceptions of workplace bullying behavior should correlate negatively with POS (Lynch et al., 1999).

POS (Lynch et al., 1999) is an eight-item, 7-point Likert-type scale that measures organizational antecedents to workplace bullying behavior. It has high internal reliability (Cronbach's α = .90). High scores reflect an employee's perception that they feel their organization is providing them support. If RNs perceive organizational support (Lynch et al., 1999) within the organization, then a negative correlation to workplace bullying behaviors will be observed; divergent correlation will demonstrate construct-related validity.

Summary

The scales in the instrument utilized in this study use a combination of the following aforementioned scales to form the Quality of Worklife Survey in addition to sample description variables:

- The Workplace Incivility Scale (WIS), which has been shown to be theoretically related to bullying behaviors (Cortina et al., 2001).

- Donovan et al.'s (1998) Perceptions of Fair Interpersonal Treatment (PFIT) Co-worker scale, which has been shown to be positively correlated with workplace incivility.
- Harlos and Axelrod's (2005) scales measuring verbal abuse, work obstruction, and emotional neglect.

Workplace incivility theoretically overlaps workplace bullying behaviors therefore Cortina et al.'s (2001) previously validated instrument WIS to measure workplace incivility was utilized. High scores of WIS will reflect a positive correlation to WBI measure. Donovan et al.'s, PFIT (1998) and Harlos et al.'s scales (2005) are used within this study to test the criterion related validity to Hutchinson et al.'s (2008) WBI measure. High scores on PFIT (Donovan et al., 1998) and Harlos and Axelrod scales (2005) reflect a positive correlation to the WBI (Hutchinson et al., 2008) measure. This means that PFIT (Donovan et al., 1998) and Harlos et al.'s scales (2005) are expected to correlate positively with Hutchinson et al.'s (2008) WBI. The additional workplace structures and processes of role conflict and role ambiguity are measured with RHL scales (Rizzo, House, & Lirtzman, 1970), role overload (Beehr et al., 1976) and perception of nursing supervisor fairness (PFIT: Supervisor) measure (Donovan et al., 1998) are measured for their respective relationships to workplace bullying behaviors among RNs.

Sample Description Variables

This study included seven sample description variables: negative affectivity, organizational tenure, educational levels of RNs, knowledge of the organization's Respect in the Workplace Policy, past training/interventions provided by the organization, employment status, and ethnicity. One site was chosen for the study in order to control for variances such as geographic location, size of organization, and the types of services provided to the public.

Negative affectivity. Employees' negative affectivity has previously been found to influence correlations between stressors and work-related variables (Watson, Clark, & Tellegen, 1988). The variable was measured by asking respondents about their dispositional tendencies to experience negative emotions. This tendency has been shown to confound respondent's perceptions of workplace bullying and incivility. The Negative Affect Scale (Watson et al., 1988) measures people's dispositional tendency to experience negative emotions and have a pessimistic outlook, along a five point scale (1 = strongly disagree; 5 = strongly agree) and has a Cronbach alpha of .81. Watson et al.'s (1988) Negative Affect Scale (NAS) is utilized to address previously validated correlations of employees' negative affect or pessimism to perceptions of workplace mistreatment, incivility. This was used within this study to measure employee's negative affect when considering relation of other variables to perceptions of workplace bullying behaviors.

Organizational tenure. Respondents' previous workplace experiences in other organizations may have affected their responses to this survey on workplace bullying. Tenure was assessed by asking respondents to indicate the number of years and months they had been employed by this organization.

Education. Educational levels of RNs have been demonstrated to play a role in the reported experiences of workplace bullying behaviors by respondents. Research has shown that some diploma nurses report more experiences of bullying behaviors (Quine,1999; 2001) and yet other researchers have found that degree nurses may be viewed more negatively by diploma nurses, and therefore are more likely to be bullied (Eaton, Williams, & Green, 2000). A Canadian survey found that for 60.9% of RNs in BC, the highest level of education achieved was a RN diploma followed by 34.1% with a bachelor degree and 5% with a master/doctorate degree (O'Brien-Pallis, et. al., 2005). It was anticipated that there would be

a variance of educational levels within the available sample pool of registered nurses at the hospital. The variance in educational levels of RNs could be related to their workplace experiences surveyed in this study. Respondents were asked their level of education (RN Diploma, Specialty, Bachelor Degree, Master Degree, and Doctoral Degree).

Knowledge of awareness of policy. Support for zero tolerance, respect in the workplace, and whistle blowing policies must be garnered from the top levels of an organization down through to the managerial, supervisory, and nursing leaders working directly with RNs. Policy is the foundation for educational programs and reporting structures in which workplace bullying behaviors are identified, addressed, and reported in a professional manner, in which all parties feel empowered to effectively deal and mitigate any workplace bullying behaviors (CRNBC, 2008; Griffeth et al., 2000; Harlos & Axelrod, 2005). RNs at the hospital are informed and educated on the organizations' Respect in the Workplace Policy at the time of their hiring and reminders of the policy are on wall plaques at the entrances to all wards throughout the hospital. The respondents were asked to reflect on their awareness of the Respect in the Workplace Policy on a five-point scale (1= very slightly, or not at all; 5 = very much).

Past training/intervention. The respondents were asked a dichotomous question (yes/no) about whether they had had any past training or intervention to deal with workplace bullying. This identified the respondents who may have been influenced by previous training or intervention.

Employment status. The employment status of RNs was shown to be correlated to reported perceptions of workplace bullying behaviors. Quine's (1999) study of workplace bullying in a National Health Service Trust sample of community nurses found that 65% (n = 113) of full-time nurses experienced bullying, compared to part-time nurses who reported

35% (n = 61). Respondents were asked "Is your current job temporary or permanent?" and whether their job was "full time, part time or casual."

Ethnicity. Research has previously found correlations between ethnic minority status and frequencies of workplace bullying behaviors . Although this study was not intended to identify discriminatory practices based on race, it was useful to correlate perceptions of workplace bullying behaviors to self-reported ethnicity. Respondents were asked "which ethnic group they associate themselves with mostly" using the Statistics Canada categories of ethnicity.

Basic Demographics

The basic demographics included are not exhaustive however they are relevant to the literature reviewed in the current study.

Gender. Historically, RNs have been predominantly female however recently more male nurses have been attracted to the profession. Research has demonstrated an association between female gender and managing incidents of aggression in a covert fashion, and a reluctance to engage in formal reporting that could contribute to further bullying among registered nurses (Ferns, 2006). Respondents were asked to identify their gender.

Years of nursing experience. Previous research has demonstrated that more experienced nurses have been implicated as perpetrators of bullying toward novice nurses (Bartholomew, 2006; Broome, 2008; Duffy, 1995; Farrell, 2001; Griffin, 2004; Rowe & Sherlock, 2005). As a result, it was important to include years of experience in this study.

Chapter 4: Data Analysis and Results

Overview of Data Analysis

All data from the surveys were entered into SPSS Version 19 (SPSS, 2011). Data were cleaned and screened for violation of assumptions relevant to the planned analyses (e.g., checking for accuracy of data entry, missing values, and normal distribution). In SPSS analysis of data, I used "case wise" deletion, that is, I excluded missing data for each analysis, not across all analyses. Adequacy of expected frequencies, linearity, multicollinearity or redundancy, and homoscedasticity were assessed.

The sample size (n=94) was not large enough to proceed with statistical tests of hypotheses requiring principal factor analyses and regression testing. Typically, principal factor analysis should not be done with less than 100 observations (Bartlett, Kotrlik, & Higgins, 2001). In terms of regression testing, a ratio of respondents to variables is recommended to be 10 to 1(Bartlett et al., 2001). This means for each variable used in this study a minimum of 10 respondents is required for each variable (i.e., 14 variables would require 140 respondents). Hypotheses were restricted to measures of association (e.g., correlation), and therefore correlation coefficients were appropriate to test the hypotheses.

Phase I: Correlational Testing. The purpose of Phase I was to test the hypotheses outlined in Chapter 2 using correlational testing. The study examined relations of Hutchinson et al.'s (2008) workplace structures and processes, role conflict, role ambiguity, role overload, intention to leave, and perception of nursing supervisor fairness with the WBI (Hutchinson et al., 2008) as demonstrated in Table 1. The study used the following sample description variables: negative affectivity, organizational tenure, educational levels of RNs, awareness of the organization's Respect in the Workplace Policy, past training/interventions

provided by the hospital, employment status, and ethnicity (see Table 2). Correlations were used to test each hypothesis.

Table 1: Table of Concepts/Variables

Concepts	Workplace structures and processes	Experience of workplace bullying	Criterion-related validity of workplace bullying
Variables/ Scales	Scales (OPBS): MALPR; IOA; OTR Hutchinson et al., (2008).	Bullying Acts (WBI): PA, ARC, ANT Hutchinson et al. (2008).	WIS (Cortina et al., 2001).
	Role Ambiguity & Role Conflict (Rizzo et al., 1970).		PFIT: Co-worker (Donovan et al., 1998).
	Role Overload (Beehr et al., 1976).		Harlos and Axelrod, (2005) scales.
	PFIT: Supervisor (Donovan et al., 1998).		
	Construct validity: Perceived Organizational Support (Lynch et al., 1999).		

Note: Organizational Predictors of Bullying Scales (OPBS): Misuse of Legitimate of Authority, Processes and Procedures (MALPR); Informal Organizational Alliances (IOA); Perceived Interpersonal Fairness Treatment (PFIT); Workplace Bullying Inventory (WBI); Workplace Incivility Scale (WIS).

Phase II: Construct Validation. The purpose of this phase was to assess in a preliminary manner the construct validity of WBI. Construct validity is defined by Bordens and Abbott (2008) as:

> [v]alidity that applies when a test is designed to measure a construct or variable constructed to describe or explain behavior on the basis of theory. A test has construct validity if the measured values of the construct predict behavior as expected from the theory. (p. G2)

Construct validity is the degree to which the scores obtained from the use of the WBI (Hutchinson et al., 2008) measure workplace bullying behaviors as anticipated from workplace bullying theory. The measures of WIS (Cortina et al.'s, 2001), PFIT (Donovan et al., 1998) and Harlos and Axelrod's (2005) scales were used to test the construct validity of the WBI (Hutchinson et al., 2008) using correlational testing.

Results

Demographics and sample description. A summary of demographic data (e.g., gender, age, and years of nursing experience, etcetera) for the sample are shown in Table 2. The participants (n = 94) were predominantly female 84.5% (n = 87) and 5.8% (n = 7) male. Approximately 61.8% (n = 57) were between the ages of 41-60 years old while 33.7% (n = 36) were between the ages of 26-40 years old (M = 42.31, SD = 10.94). The ethnic background of the participants were predominantly White 89.1% (n = 82) while the remainder did not report their ethnic background.

Table 2: Gender, Age, Years of RN Experience, Employment, & Ethnic Background

Variable	N (%)	Mean	SD
Gender: Male	7 (5.8)	-	-
Female	87 (84.5)	-	-
Age	90	42.41	10.94
Years RN Experience	94	14.20	9.09
Years at hospital	92	11.82	8.63
Ethnic Background:			
White	**82 (89.1)**	-	-

The RNs' number of years of being licensed as an RN in Canada ranged from 1 year or less to 25 years (M = 16.0, SD = 9.09). Approximately 20.4% (n = 21) had 1-3 years of RN licensure in Canada while 28.4% of RNs had been licensed for 25 years in Canada.

The RNs' years employed at the hospital ranged from 1 year or less to 25 years (M = 11.8 years, SD = 8.63). Approximately 38% of RNs (n = 38) had been employed for less than 5 years, and 16% of RNs (n = 16) had been employed for 25 years or more.

The highest educational level completed by RNs was a Bachelor's degree (47% n = 49). Most RNs (59.2%, n = 61) had a diploma in nursing. Participants were asked whether they had taken part in work relationship sessions delivered by the hospital. Approximately 68.9% of RNs had experienced work relationship sessions, 27.2% of RNs reported no experiences with work relationship sessions, and 3.9% of RNs did not remember.

Participants were also asked whether they were aware of the hospital's Respect at Work policy using a 5-point scale (e.g., 1 = very slightly or not at all and 5 = very much aware). Most of the sample (42.7%) was very much aware of the Respect at Work policy, approximately 51.5% of RNs reported 2-4 while 5.8% of RNs were very slightly or not at all aware of the policy.

Horizontal workplace bullying frequencies. Participants were asked about their experiences of workplace bullying (e.g., 1 = never and 5 = daily). Among 90 participants, 30.2% experienced horizontal workplace bullying never to a few times a year; 59.9% experienced horizontal workplace bullying a few times a year to monthly; 8.8% experienced horizontal workplace bullying monthly to weekly; 1.1% experienced horizontal workplace bullying weekly; and none reported daily experiences of horizontal workplace bullying.

Linearity and kurtosis. Data screening revealed moderately strong kurtosis (z = 4.81) of WBI. Tabachnick and Fidell (2007) recommend that the first step in data transformation where the distribution varies moderately from normal distribution is to use square root transformation. A square root transformation was applied to reduce this deviation

in normality prior to analyses. Following the transformation the kurtosis was substantially reduced ($z = 2.92$).

Phase I: Hypothesis testing. Means, standard deviations, and inter correlations of study variables are listed in Table 3. A Pearson product-moment correlation coefficient was computed to assess the relationship between organizational tolerance and reward and horizontal workplace bullying behaviors (H_1). As predicted in Hypothesis 1, organizational tolerance and reward and horizontal workplace bullying were positively correlated, $r = .46$, $n = 84$, $p < .01$. The correlation coefficient was computed to assess the relationship between informal organizational alliances and horizontal workplace bullying behaviors (H_2). As predicted in Hypothesis 2, informal organizational alliances and horizontal workplace bullying were positively correlated, $r = .58$, $n = 84$, $p < .01$. A Pearson product-moment correlation coefficient was computed to assess the relationship between misuse of legitimate authority and horizontal workplace bullying behaviors (H_3). As predicted in Hypothesis 3, misuse of legitimate authority and horizontal workplace bullying were positively correlated, r $= .57$, $n = 87$, $p < .01$.

A Pearson product-moment correlation coefficient was computed to assess the relationship between role conflict and reported horizontal workplace bullying behaviors (H_4). As predicted in Hypothesis 4, role conflict and horizontal workplace bullying were positively correlated, $r = .42$, $n = 87$, $p < .01$. A Pearson product-moment correlation coefficient was computed to assess the relationship between role ambiguity and horizontal workplace bullying behaviors (H_5). As predicted in Hypothesis 5, role ambiguity and horizontal workplace bullying were positively correlated, $r = .42$, $n = 92$, $p < .01$. A Pearson product-moment correlation coefficient was computed to assess the relationship between role overload and horizontal workplace bullying behaviors (H_6). As predicted in Hypothesis 6,

role overload and horizontal workplace bullying were positively correlated, r =.39, n = 93, p < .01. Participants rated role overload as most frequent (M = 3.49, SD = .97) of the three factors.

A Kendall's tau correlation coefficient was computed to assess the relationship between intention to leave and horizontal workplace bullying behaviors (H_7). As predicted in Hypothesis 7, intention to leave and horizontal workplace bullying were positively correlated, t = .23, n = 92, p < .01.

Phase II: Construct Validation. A Pearson product-moment correlation coefficient was computed to assess the relationship between workplace incivility and horizontal workplace bullying behaviors (H_8). As predicted in Hypothesis 8, workplace incivility and horizontal workplace bullying behaviors were positively correlated, r =.65, n = 91, p < .01. A Pearson product-moment correlation coefficient was computed to assess the relationship between verbal abuse, emotional neglect and work obstruction and horizontal workplace bullying behaviors (H_9). As predicted in Hypothesis 9, verbal abuse, emotional neglect, workplace obstruction and horizontal workplace bullying behaviors were positively correlated as follows: verbal abuse, r = .65, n = 89, p < .01; emotional neglect, r = .38, n = 89, p < .01; and work obstruction, r = .65, n = 83, p < .01

A Pearson product-moment coefficient correlation was computed to assess the relationship between perceptions of fair interpersonal treatment co-worker and horizontal workplace bullying (H_{10}). As predicted in Hypothesis 10, perceptions of fair interpersonal treatment and horizontal workplace bullying were negatively correlated, r = -.58, n = 84, p < .01.

A Pearson product-moment coefficient correlation was computed to assess the relationship between perceived organizational support and horizontal workplace bullying

(H_{11}). As predicted in Hypothesis 11, perceived organizational support and horizontal workplace bullying behaviors were negatively correlated, $r = -.53$, $n = 94$, $p < .01$.

Table 3: Means, Standard Deviations, and Intercorrelations of Variables (n=94)

Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. OTR	1.93	**1.15**	—	(.91)												
2. IOA	2.06	**1.23**	.89**	—	(.92)											
3. MALPR	1.78	**.71**	.74**	.78**	—	(.90)										
4. Role Conflict	3.21	**.88**	.41**	.37**	.41**	—	(.83)									
5. Role Ambiguity	2.70	**.74**	.42**	.43**	.48**	.57**	—	(.85)								
6. Role Overload	3.49	**.97**	.21**	.29**	.39**	.56**	.56**	—	(.72)							
7. Intent to leave[a]	1.97	**.94**	.06	.07	.12	.13	.14	.24	—							
8. WIS	1.71	**.82**	.43**	.52**	.40**	.41**	.32**	.38**	.03	—	(.89)					
9. Work obstruction	1.98	**.73**	.45**	.45**	.50**	.58**	.57**	.45	.18*	.41**	—	(.76)				
10. Emotional neglect	3.79	**.84**	.29**	.25**	.33**	.27**	.47**	.30**	.25**	.16	.38**	—				
11. Verbal abuse	1.48	**.51**	.29**	.40**	.38**	.30**	.26**	.30**	.16	.68**	.47	.19	(.81) —	(.89)		
12. PFIT	2.20	**.47**	-.53**	-.58**	-.62**	-.50**	-.58**	-.48**	-.16**	-.38**	-.56**	-.52**	-.37**	—	(.76)	
13. POS	2.90	**.78**	-.35**	-.42**	-.50**	-.41**	-.70**	-.50**	-.32**	-.16	-.54**	-.46**	-.38**	-.68**	—	(.89)
14. WBI[b]	1.14	**.16**	.46**	.58**	.57**	.42**	.42**	.39**	.23**	.65**	.65**	.38**	.65**	.58**	-.53**	(.92)

Note: OTR=Organizational Tolerance and Reward; IOA=Informal Organizational Alliances; MALPR=Misuse of legitimate authority, processes, procedures; WIS=Workplace Incivility Scale; PFIT=Perceptions Fair Interpersonal Treatment (Co-worker);POS=Perceived Organizational Support; WBI=Workplace Bullying Inventory. Pearson's correlations unless otherwise noted a Kendall's Tau correlation. b Square root transform of WBI. Cronbach's alpha internal consistency reliability coefficients for multi-item scales are indicated in parentheses on the diagonal. *p < .05; **p < .01; two-tailed tests of significance.

Ancillary Findings

Workplace structures and processes. In terms of workplace structures and processes, Hutchinson et al.'s (2008) informal organizational alliances factor correlated more strongly with Hutchinson et al.'s (2008)Workplace Bullying Inventory (WBI) followed by Hutchinson et al.'s (2008) misuse of legitimate authority, processes and procedures, and organizational tolerance and reward. Hutchinson et al.'s (2008) informal organizational alliances factor correlated to a greater degree with Cortina et al.'s (2001) Workplace Incivility Scale (WIS) than misuse of legitimate authority, processes and procedures, and organizational tolerance and reward (Hutchinson et al., 2008) which is consistent with theoretical models that highlight the role of informality in creating a culture in which employees are more apt to engage in incivil behaviors (Andersson & Pearson, 1999). The incivility and other forms of mistreatment in organizations model (Andersson & Pearson, 1999) depict incivil behavior within workplace social interactions. An interesting finding from this research was that informal organizational alliances demonstrated a stronger correlation to Hutchinson et al.'s (2008)WBI than to Cortina et al.'s (2001) WIS, which makes sense given the theoretical overlap of workplace structures and processes with incivility, and workplace bullying behaviors (see Figure 3). Also, incivility has the ability to escalate to other more deviant behaviors such as workplace bullying behaviors (see Figure 3). These findings are also consistent with the conceptual model of bullying in the nursing workplace (Hutchinson et al., 2008) identifying bullying as a process that occurs as a result of features of the nursing workplace (e.g., organizational tolerance, informal organizational alliances and reward and misuse of legitimate authority, processes and procedures).

Figure 3: Workplace Structures and Processes, and Deviant Behaviors

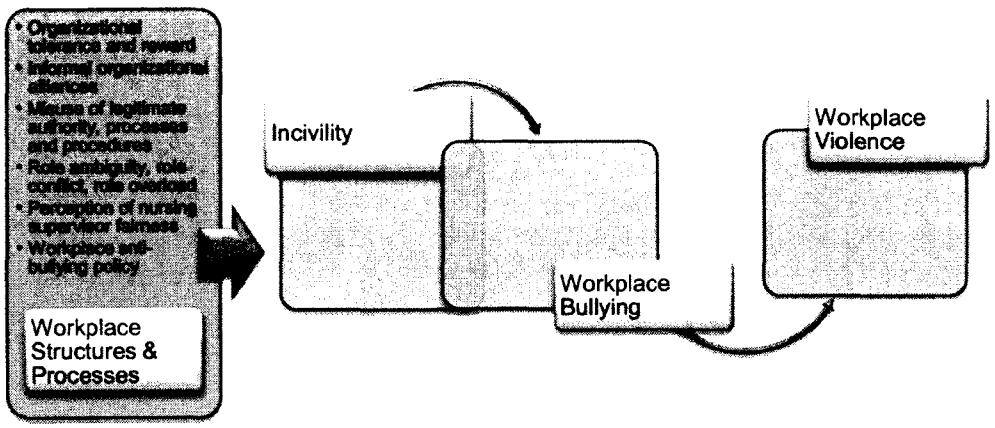

Figure 3: Workplace Structures and Processes are depicted as organizational antecedents to the occurrence of workplace deviant behaviors among RNs. The deviant behaviors begin with incivility and have the potential to spiral to workplace bullying, and workplace violence. Adapted from Andersson & Pearson, 1999, The Academy of Management Review, 24, p. 452-457 and from Hutchinson, M., Jackson, D.,Wilkes, L., Vickers, M., 2008, Advances in Nursing Sciences, 31, p. E61. Copyright 2008 by Wolters Kluwer Health, Lippincott Williams & Wilkins.

Additional workplace structures and processes. Workplace structures and processes of role ambiguity, role conflict (Rizzo et al., 1970) and role overload (Beehr et al., 1976) were strongly correlated with horizontal workplace bullying behaviors among RNs. This finding is consistent with previous research that found empirical evidence of these particular workplace antecedents' relationships to workplace bullying behaviors (Hickling, 2006; Notelaers et al., 2005; Wang et al., 2008; Zapf et al., 1996).

An interesting finding was that role ambiguity (Beehr et al., 1976) was correlated to a greater degree to WBI (Hutchinson et al., 2008) than were role conflict and role overload (Rizzo et al., 1970). In particular 61% (n= 94) of participants indicated "1-3" range (1 = very false; 5 = very true) in response to the statement "Clear planned goals and objectives exist for

my job." As well, 53% (n = 94) of participants indicated "1-3" range (1 = very false; 5 = very true) in response to the statement "I know that I have divided my time properly." As indicated previously, health care organizations' reengineering and organizational restructuring has been found to create additional role overload (Sovie et al., 2001), role stress, and role ambiguity (Kroposki et al., 1999; McGillis Hall, 2003), which can be contributing factors to horizontal workplace bullying (Notelaers et al., 2005; Zapf et al., 1996). A question remains as to why role ambiguity correlated to a greater degree to horizontal workplace bullying than did role conflict and role overload. It is reasonable to assume that RNs who have been recently employed by the hospital may experience more role ambiguity compared to RNs with more tenure at the hospital, however no significant relationships were found between role ambiguity and length of tenure at the hospital. Also, the relationship of role ambiguity to full-time or part-time work status was not significant. A limitation of this study is that the source of the role ambiguity was not investigated, only its relationship to horizontal workplace bullying.

Role overload (Beehr et al., 1976) was correlated to Hutchinson et al.'s (2008) OPBS (subscale of Organizational Processes) misuse of legitimate power and authority (e.g., meetings held without notice), and organizational tolerance and reward (e.g., bullies control allocation of work). Rizzo et al.'s (1970) role conflict (e.g., struggling to meet job demands) was strongly correlated with Harlos and Axelrod's (2005) workplace obstruction (e.g., organizational resources and support are not provided), which was expected given the similarity in factors.

Hypotheses for correlations of perceptions of nursing supervisor fairness relation to experiences of horizontal workplace bullying were not explored in this study for two reasons.

First, the organization's reporting structure places a nursing supervisor in a position of authority to a staff RN. The authority difference means that there is a vertical relationship between a nursing supervisor and a staff RN in contrast to an equal authority relationship between RN co-workers (i.e., horizontal). Horizontal workplace bullying (e.g., co-worker RN to co-worker RN), rather than vertical bullying (supervisor to RN) is the focus of this study. Second, in terms of workplace bullying definitions, there is a difference in definition of horizontal workplace bullying and vertical workplace bullying. It is interesting to report differences in the correlations among factors of the PFIT Supervisor (Donovan et al., 1998) to WBI measure (Hutchinson et al., 2008). For example, the PFIT Supervisor (Donovan et al., 1998) factor, supervisors yell and WBI measure (Hutchinson et al., 2008) correlate, r = .08, and supervisor's play favorites correlate, r = -.06. The findings on these scales mean that these supervisors' behaviors do not correlate with perceived bullying experiences. The correlations are low but they are significant. In contrast, the PFIT co-worker (Donovan et al., 1998) measure and WBI measure (Hutchinson et al., 2008) correlate, r=-.58, n=87. The findings on these scales mean that fair interpersonal treatment correlated negatively with workplace bullying. These findings are not conclusive however, given that the research was specific to horizontal workplace bullying behaviors rather than vertical workplace bullying behaviors.

Ferris and Rowlands' (1987) intention to leave scale correlates with the WBI (Hutchinson et al., 2008), Kendall's Tau $t(90) = .23$, $p < 0.01$. Intentions to leave (Ferris & Rowland, 1987) correlates to a greater degree to Harlos et al.'s (2005) emotional neglect than WBI (Hutchinson et al., 2008), Kendall's Tau t(90) =.25, p<0.01. Emotional neglect was correlated positively with intention to leave, (t (87) =.25), which was validity evidence for

WBI. The findings on these scales mean that there is a stronger impact of emotional neglect on the participant's intention to leave the organization than workplace bullying. An interesting finding was a positive correlation between Ferris and Rowland's (1987) intention to leave and role overload, $t(93) = .24, p < 0.01$, while role ambiguity and role conflict correlations were not conclusive given their respective p values. These findings mean that participants' experiences of emotional neglect and role overload are related to their intention to leave the hospital.

Chapter 5: Discussion

Overview

To date there has not been research among RNs that demonstrates a transposition of workplace structures and processes (e.g., organizational antecedents) onto incivility and workplace bullying behaviors among RNs as depicted in Figure 4. Workplace bullying behaviors are conceptualized in this study of horizontal workplace bullying behaviors among RNs as situated along a continuum that spirals (see Figure 3). As noted previously in the literature review, the continuum spiral begins at one end with workplace structures and processes that may mitigate or propagate workplace bullying behaviors among RNs. The continuum spiral continues to workplace incivility which theoretically overlaps workplace bullying and has the potential to reach workplace violence behaviors. The spirals have the potential to spawn secondary spirals that flow through social networks among organizations and reach a tipping point in which the behaviors can escalate (Andersson & Pearson, 1999).

For the purposes of this study, physical, racial, and sexual aspects of workplace violence were not included in the survey as they are separate forms of negative workplace acts and are covered by different policies; they are separate forms of harassment.

Workplace bullying behaviors can rarely be explained by one factor, nor is workplace bullying a linear process. Rather horizontal workplace bullying is a multi-causal phenomenon (Zapf, 1999) and a dynamic process (Andersson & Pearson, 1999; Branch, 2008), which are influenced by workplace structures and processes. In turn, investigating the relationship of workplace structures and processes' relationship to horizontal workplace bullying behaviors provides construct validity to Hutchinson et al.'s (2008) Model of Bullying in the Nursing Workplace.

Overall, the results of this research reveal four main findings: (a) perceptions of horizontal workplace bullying among RNs are related to workplace structures and processes; (b) workplace incivility, perception of fair intrapersonal co-worker treatment, verbal abuse, emotional neglect, work obstruction, and perceived organizational support, validate reported horizontal workplace bullying experiences and provide construct validity to Hutchinson et al.'s (2008) WBI instrument; (c) role conflict, role ambiguity and role overload are related to reported horizontal workplace bullying; and (d) intention to leave is related to reported experiences of horizontal workplace bullying behaviors. This study's results indicate that all Hypotheses (H_1-H_{11}) are supported.

Construct Validity

The WIS (Cortina et al., 2001), PFIT Co-worker (Donovan et al., 1998), Harlos and Axelrod (2005) scales, and POS (Lynch et al., 1999) scales were used in this study to evaluate the validity of Hutchinson et al.'s (2008) WBI inventory. The WIS's (Cortina et al., 2001) correlation to WBI (Hutchinson et al., 2008) is theoretically supported given that workplace incivility has been demonstrated to theoretically overlap with the construct of WBI (Hutchinson et al., 2008). These findings mean that the construct validity of WBI (Hutchinson et al., 2008) was supported by the previously validated WIS instrument (Cortina et al., 2001).

PFIT (Donovan et al., 1998) was negatively correlated to WBI (Hutchinson et al., 2008) supporting Cortina et al.'s (2001) findings of a negative correlation to WIS. The PFIT scale is designed to measure interpersonal perceptions of fairness which was used to validate horizontal workplace bullying behaviors reported by using Hutchinson et al.'s (2008) WBI. This means as perceptions of fair treatment by co-workers increase, perceptions of horizontal

workplace bullying decrease. These findings are similar to Cortina et al.'s (2001) findings of negative correlation to WIS (Cortina et al., 2001).

The Harlos and Axelrod (2005) scales of verbal abuse scales (i.e., eight behaviors that intimidate or humiliate people) correlate to WBI (Hutchinson et al., 2008). Harlos and Axelrod's (2005) work obstruction (e.g., four behaviors in which organizational resources and personal support are not provided for effective work performance and networking) was correlated to a higher degree to Hutchinson et al.'s (2008) WBI (e.g., attack on competence and reputation, and attack through work tasks) which makes sense given the similarity in factors. Emotional neglect (Harlos &Axelrod, 2005) was correlated to a lesser degree to WBI, (Hutchinson et al., 2008) than verbal abuse which makes sense given that emotional neglect is more passive than verbal abuse which is more active and direct.

POS (Lynch et al., 1999) is an eight item measure of organizational antecedents to workplace bullying behavior as discussed earlier. POS (Lynch et al., 1999) correlated negatively to WBI (Hutchinson et al., 2008) and also correlated negatively to Harlos and Axelrod's (2005) work obstruction. POS (Lynch et al., 1999) correlated to a lesser degree to Harlos and Axelrod's (2005) emotional neglect. It makes sense that POS (Lynch et al., 1999) correlates to a higher degree to measures that have organizational items such as Harlos and Axelrod's (2005) work obstruction. Lynch et al.'s (1999) POS (e.g., "help is available from my organization when I have a problem") addresses similar items related to the organization as Harlos and Axelrod's (2005) work obstruction items (e.g., "failure to get needed resources or support"). Hutchinson et al.'s (2008) WBI items (e.g., attack through work tasks: "I was excluded from receiving information") addresses similar items as Lynch et al.'s, (1999) POS

items (e.g., "my organization shows very little concern for me") and correlates significantly with them.

Chapter 6: Conclusion

The purpose of this study was to answer the question: Are there relationships between workplace structures and processes and the perceptions of horizontal workplace bullying behaviors among RNs? Although there is strong support from previous empirical studies for the role of workplace structures and processes in dealing with experiences of workplace bullying behaviors there are few studies that focus on the role of workplace structures and processes as antecedents or precursors to workplace bullying behaviors among RNs. Overall, the results of this research suggest two things. One is that reported experiences of horizontal workplace bullying behaviors can be situated within workplace structures and processes such as organizational tolerance, informal organizational alliances, misuse of legitimate authority, role conflict, role ambiguity, role overload, perceptions of nursing supervisor fairness and perceived organizational support. The second is that RNs' experience of horizontal workplace bullying behavior is multidimensional, reflecting experiences of attack on competence and reputation, personal attacks, attacks through work tasks, workplace incivility, unfair interpersonal treatment, verbal abuse, work obstruction, and emotional neglect. Hutchinson, Wilkes, Jackson, and Vickers' (2010) recent research also confirmed that bullying behaviors are multidimensional and many are not grounded in conflict but mediated through work routines and tasks. These findings underscore the limitations of remedial approaches that are based on the premise that resolving interpersonal conflict is a useful strategy to respond to bullying among RNs.

Given that Hutchinson et al.'s (2008) WBI scales have a stronger focus on more subtle and less overt aspects (e.g., "attack upon reputation and competence") it is not surprising that organizational processes and procedures (e.g., informal organizational

alliances, misuse of legitimate authority, and organizational tolerance and reward) correlated strongly to experiences of horizontal workplace bullying. In contrast, this study found that attack through work tasks (e.g., role conflict, role ambiguity, and role overload) were not as strongly correlated to Hutchinson et al.'s (2008) WBI scales.

Importantly, the experiences of workplace incivility, work obstruction and verbal abuse were reported to be significantly related to horizontal workplace bullying. The workplace structures and processes explored were not exhaustive, however they included variables well supported in the literature as having a relationship to horizontal workplace bullying among RNs.

Implications for Workplace Policy and Practice

This research helped identify roles and relationships between workplace structures and processes and perceptions of workplace bullying behaviors among RNs to inform health care organizations and the nursing profession. In terms of informing the nursing profession and health care organizations, this research was able to identify key factors (e.g., role ambiguity, role conflict, role overload, and intention to leave) related to horizontal workplace bullying among RNs. Tools and resources that identify and mitigate horizontal workplace bullying could inform health care organizations' policies and practice directives as well as provide a foundation for RNs in their everyday practice. Currently, professional standards for RNs (CRNBC, 2010) and Code of Ethics (CNA, 2010) provide RNs with tools and resources to inform their practice and conduct in health care service delivery, and inter/intra professional relationships. RNs use these tools and resources in their everyday practice in healthcare service delivery.

Missing from these tools are resources specific to horizontal workplace bullying among RNs. This research suggests that education of health care organizations on the impact of organizational restructuring/reengineering on role ambiguity and workplace bullying among RNs is needed. In particular, tools and resources to assist regional health boards, administrators, and nursing managers in identification of potential problems with role ambiguity, role overload, role conflict, and perceptions of nursing supervisor fairness that have been related to workplace bullying behaviors. If CRNBC, CNA, and Health Canada, developed tools and resources to identify and mitigate horizontal workplace bullying that would inform RNs and health care organizations, then workplace processes and procedure variables such as role conflict, role ambiguity, and role overload, perception of nursing supervisor fairness and the effects of organizational restructuring/reengineering on the creation of role stressors such as role ambiguity could be addressed. If health care organizations used these tools and resources to inform their workplace policies and organizational restructuring/reengineering decision making processes, and garnered a process that is inclusive of RNs' expertise at the decision making level to avoid role ambiguity, role overload and role conflict then, there is the potential to provide a foundation for a healthy workplace culture and environment in which factors such as role stressors are mitigated.

There is compelling evidence garnered from hospitals that are given *magnet hospital* designations due to organizational attributes that makes them good places to work and have a demonstrated track record of retaining and attracting RNs even in nursing shortages. These magnet hospitals have identified factors that allow RNs to have control over their nursing practice. These factors influence the health, safety and satisfaction of health care workers and in particular acknowledge the contributions of RN expertise in decision making not only at

the bedside but also at the executive levels. According to Havens and Aiken (1999), magnet hospitals utilize five key factors. First, nursing executives serve on executive decision making teams. Second, magnet hospitals have a flat organizational structure of nursing. Third, magnet hospitals have decision making decentralized to the unit level. Fourth, RNs have autonomy and control over patient care decisions, and finally there is good communication between RNs and physicians within magnet hospitals. If health care organizations used these factors to inform their organizational processes such as mitigating the effects of workplace structures and processes on role stressors of RNs and ultimately workplace bullying among RNs, then perhaps health care organizations would be creating healthier work environments that retain and attract RNs.

RNs also need to be certain that they can report workplace bullying behaviors to the nursing supervisor and feel confident that the matters that they report will be effectively dealt with based on the workplace policies and procedures on workplace bullying as well as the nursing supervisor's professional conduct. Nurse supervisors can be provided with the educational tools to identify, address, and set expectations with RNs in regards to zero tolerance workplace bullying behaviors. They also can encourage dialogue among RNs on workplace bullying behaviors. It is important that nurse supervisors are able to demonstrate fairness to RNs working in the front lines of health care. Nurse supervisors should distribute workloads equally as well as provide nursing workloads within each RN's abilities. If conflicts arise among RNs then a fair nursing supervisor fosters provision of a safe environment. An effective nurse supervisor must be able to role model professional behaviors that reflect their work ethic, professional practice, and personal well-being. It is important

that nurse supervisors provide a safe forum to discuss nursing practice issues and to report, and act on workplace bullying behaviors.

Health care organizations must understand the importance of workplace policies as workplace structures and processes. Understanding workplace policies as a workplace antecedent to workplace bullying among RNs provides an opportunity for health care organizations to mitigate workplace bullying behaviors among RNs and may impact recruitment, and retention of RNs. The BC hospital that participated in this study implemented a Respect in the Workplace Policy for five years before the study began. This policy has value in terms of addressing the precursors to workplace incivility however it does not make direct reference to workplace bullying among RNs and inadvertently, tends to downplay the significance of workplace bullying by categorizing it under an umbrella of disrespect. The BC hospital should revisit existing Respect in the Workplace policies to address informal organizational alliances, misuse of legitimate authority, processes and procedures, and organizational tolerance, and reward. Incorporating new corporate processes (i.e., that place RNs at the decision making level to consider the impacts of restructuring/reengineering on role conflict, role overload, role ambiguity) may assist the hospital in which the study was conducted in addressing these key areas. Also, integration of anti-bullying policies and procedures that address workplace bullying on an individual and multiple participant level is needed to address workplace bullying behaviors that may be deeply imbedded into the negative aspects of informal and formal organizational networks. Although developing anti-bullying policies and procedures in this manner may seem overwhelming, the potential impacts of creating a healthier work environment that mitigates rather than fosters workplace bullying for RNs should not be underestimated. If workplace

structures and processes are addressed then there is the potential to decrease horizontal workplace bullying behaviors among RNs and improve their quality of worklife.

Limitations and Implications for Future Research

This study has four main limitations. First, given the cross sectional survey data, a causal relationship among workplace structures and processes and workplace bullying behaviors among RNs cannot be established. Nonetheless, this study presented an opportunity to make an important contribution to the knowledge base regarding horizontal workplace bullying behaviors among RNs. This information furthers our understanding of variables correlated with workplace bullying behaviors among RNs.

Second, the study was conducted in a single health care organization with RNs working in acute care only. Studies conducted across different departments and positions within the hospital and different hospitals and health care organizations (e.g., urban aboriginal health care, rural aboriginal health care, and other cultural health care organizations) are needed. Of note, other health care professionals and support staff relayed to the researcher that they felt their respective job classifications would benefit from this research and were disappointed that they were not included. They understood why they were not invited to participate in the study after the researcher provided an explanation. Further research that is inclusive of other job classifications and departments may assist the hospital in the identification of additional workplace structures and processes that may be related to reported incidents of horizontal workplace bullying behaviors. Future research needs to be conducted in other hospitals to validate findings.

Third, correlational tests conducted with the sample did result in significant findings however a larger sample would have provided a stronger, sample-based effect size and a

decreased kurtosis level of WBI (e.g., normal distribution). Participation rates may have been related to research fatigue of the RN population. For example, some of the RNs dropping by the researcher's information table at the hospital indicated that they were "surveyed out" from their exposure to previous research, and that previous research results were not shared. I am declaring that this is a limitation in my study so that other researchers would consider doing a qualitative assessment of why some participants chose not to fill out the survey and also that future thought is given to the amount of research to which the hospital's RNs are exposed.

Fourth, as the sample was self-selecting there was some bias, in that those participants who self-selected to participate may have had certain characteristics that are not shared by those who choose not to participate. Survey research allows the study of naturally occurring variables in organizations in which RNs practice and permits potential confounding variables that influence perceptions of workplace bullying behaviors to be controlled. Nevertheless, the web-based design of the survey research has inherent limitations as the sample of the respondents may not be representative of the general population (Bordens & Abbott, 2008). However the Quality of Worklife survey provided preliminary evidence to be garnered for use in acute care institutions in which RNs are employed. The participants excluded from this survey were RNs who quit work at the hospital because of perceptions of workplace bullying behaviors and for other reasons, other health professionals, administrative staff and support staff as well as the RNs who participated in the pilot testing of the study.

Future research into RNs' understanding of their roles and how organizational workplace structures and processes (e.g., orientation of RNs, mentoring, career planning/support, workplace policies, and reorganization/reengineering) impact role conflict,

role overload, and role ambiguity could assist hospitals in identifying key workplace processes and procedures for development. The more that is understood about the role of workplace structures and processes in relation to workplace bullying among RNs, the greater the opportunity will be for health care organizations and RNs to improve RN practice environments. Improved understanding of workplace structures and processes' relationship to workplace bullying among RNs has secondary benefits such as improving workplace culture and has the potential to improve nurse retention.

Despite its limitations, this study has contributed important knowledge about the relationships between workplace structures and processes and the perceptions of workplace bullying behaviors among RNs. Although other job classifications and departments were not included in this study, it brings much needed attention to RNs. As stated previously, research has shown that RNs tend to under report horizontal workplace bullying. This study links horizontal workplace bullying to intention to leave the health care organization where they are employed. Given that a Canadian survey found that 74.6% of RNs in BC ranked having a good relationship with other nurses as the third most important reason for keeping them in the nursing profession (O'Brien-Pallis et al., 2005) this research provided preliminary evidence of the role of workplace structures and processes, and their relationship to horizontal workplace bullying among RNs and ultimately, the quality of worklife for RNs.

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Appendix A

Email Introduction Letter

Information Letter (email announcement)

Email Subject Line: Survey on Quality of Worklife

Dear <Title> <Lastname>,

My name is Sheila Blackstock and I am inviting you to participate in the Quality of Worklife Survey. The purpose of the study for my master's thesis at UNBC, is to learn more about the factors that influence the quality of worklife of RNs at the hospital. I am a Registered Nurse (RN) and a graduate student at the University of Northern British Columbia (UNBC) in the Master of Nursing program.

As you know, quality of worklife is important for individual well-being—nurses and patients—and for organizational functioning. This study will give us a better understanding of factors that affect worklife quality and help identify whether changes in workplace practices and procedures may be needed. Improved quality of worklife should benefit nurse attraction and retention.

The study is conducted as a web survey running today through to ____ . Below is a unique website address which allows you to access the survey at any time. The website describes the study and provides a consent form should you wish to participate. The survey takes about 15 minutes to complete.

RNs who complete the survey will be entered into a lottery to win one of two $100.00 cash prizes. Only RNs employed at the hospital are being asked to participate in this study, so your chances of winning a prize is good.

I know that nursing work is busy and demanding. But do know that the _____and I appreciate your contribution to this research. I am happy to answer any questions before, during or after your participation. You can reach me at _____.

Please click on this link to go to the survey: http://www.xxxxxxxxxxxxx

Sincerely,

Sheila Blackstock, RN, BScN, COHN

Appendix B

Consent for Quality of Worklife Survey

Study Purpose

The purpose of the study is to learn more about the factors that influence the quality of worklife of RNs at the hospital. Your work experience at the hospital means that you can provide relevant and meaningful information about the research topic. It is being conducted Sheila Blackstock who is a graduate student in the School of Nursing at the University of Northern British Columbia (UNBC).

Procedure

This is an on-line survey that will take about 15 minutes to complete. This web link is password protected, so no one else has access to the information that you provide. You do not have to complete the survey in one session; you may exit the website at any time. To return to the survey, simply click on the unique URL link you were assigned. Participants who complete the survey will be entered into a draw to win one of two $100.00 cash prizes. Only RNs employed at the hospital are being asked to participate in this study, so your chances of winning a prize is good.

Risks and Benefits

Some people may experience negative emotions when discussing the quality of work life experiences as a RN employed at the hospital. If you would like to discuss these with someone, please feel free to contact your Employee and Family Assistance Program. The data obtained from this research study may be of benefit to identify factors that will assist with recruitment and retention of RNs at the hospital.

Confidentiality and Anonymity

All data will be retained on a secure password-protected computer in password-protected database for a period of five years. Your information will be stored in a locked filing cabinet and only the researchers will have access to your information at UNBC. After the completion of this project your responses will be destroyed. The data will be destroyed using approved methods of disposal. Your participation is completely voluntary and your responses will remain confidential. All results from the study will be aggregated; no individual information will be reported. If you have questions or need more information about this project, please contact Sheila Blackstock at (250) or @unbc.ca or Dr. Martha MacLeod, co-supervisor at 250-.If you have concerns or complaints about this project, please contact UNBC's Office of Research at (250) or by email: reb@unbc.ca.

Knowledge dissemination

You will be able to read the results of the study by obtaining a copy of the research from the Hospital Website or alternatively once the study has been defended it will be accessible through the UNBC library.

Indication of Consent

My participation in this study is voluntary. I am free to withdraw from the study at any time or to leave unanswered any questions that I prefer not to answer. By completing the survey, it will be assumed that I have agreed to participate. I understand that my participation is confidential. I understand that aggregated data from this study may be published. By clicking on the link below, I consent to participate in this study. Continue To Survey

Appendix C

Sample Questions from Web Based Quality of Worklife Survey

Section A: Work Background

A1. Is your current job...
- o temporary
- o permanent

A2. Is your job...
- o full-time
- o part-time
- o casual

A3. How long have you been employed by the hospital?
- o 1 year or less
- o 2 years
- o 3 years

[CONTINUE TO...]

- o 25 years or more

A4. Have you had any past experience at the hospital with education or information sessions aimed at collaborating work relationships?
- o Yes
- o No
- o ?

A5. How many years of full-time nursing work experience have you had?
- o 1 year or less
- o 2 years
- o 3 years

[CONTINUE TO...]

- o 25 years or more

A6. To what extent are you aware of the 'Respect at Work' policy at the hospital?

1 Very slightly or	2	3	4	5 Very Much

not at all				

A7. What are you plans for staying with the organization?

- o I intend to stay until I retire.
- o I will leave only if an exceptional opportunity comes up.
- o I will leave if something better turns up.
- o I intend to leave as soon as possible.

Section B: Work Attitudes

POS; Negative Affectivity; Role Ambiguity, Role conflict, role overload; PFIT (Supervisor); Work Obstruction, Perceived Organizational Support

The next set of questions asks you about your attitudes and preferences about aspects of your work and life. Please respond to each question, choosing the first response that comes to you, by selecting from 1 to 5 to indicate how much you agree with each statement where **1 = strongly disagree** and **5 = strongly agree**.	1	2	3	4	5
My organization strongly considers my goals and values.					
My organization really cares about my well-being.					
My organization shows very little concern for me.					
My organization would forgive an honest mistake on my part.					
My organization cares about my opinions.					
If given the opportunity, my organization would take advantage of me.					
Help is available from my organization when I have a problem.					
My organization is willing to help me when I need a special favor.					

Negative Affectivity

Next is a list of words that describe different feelings and emotions. Read each word and fill in the oval that indicates the degree to which ***you generally feel this way in your life***; that is, ***how you feel on average*** where **1 = very slightly or not at all and 5 = very much**.	1	2	3	4	5
Afraid:					
Upset:					
Nervous:					
Scared:					
Distress:					

Role Ambiguity, Role Conflict and Role Overload

Considering your current employment, to what degree is this true for you? 1=very false , 5= very true	1	2	3	4	5
Role Ambiguity					
I feel secure about how much authority I have.					
Clear planned goals and objectives exist for my job.					
I know that I have divided my time properly.					
I know what my responsibilities are.					
I know exactly what is expected of me.					
Explanation is clear of what has to be done.					
Role Conflict					
I have to do things that should be done differently.					
I receive an assignment without the manpower to complete it.					

I have to buck a rule or policy to carry out an assignment.					
I work with two or more groups who operate quite differently.					
I receive incompatible requests from two or more people.					
I do things that are apt to be accepted by one person and not accepted by others.					
I receive an assignment without adequate resources and materials to execute it.					
Role Overload					
I have too much work to do, to do everything well.					
The amount of work I am asked to do is fair					
I never seem to have enough time to get everything done.					

Perceptions of Fair Interpersonal Treatment (Supervisor) Scale

What is your organization like most of the time? Circle YES if the item describes your organization, NO if it does not describe your organization, and? I f you cannot decide.			
IN THIS ORGANIZATION . . .			
1. Supervisors yell at employees	Yes	?	No
2. Supervisors play favorites	Yes	?	No
3. Supervisors swear at employees	Yes	?	No
4. Supervisors threaten to fire or lay off employees	Yes	?	No

Harlos and Axelrod Work Obstruction Scales

The next questions ask you about experiences that may occur at work. On a scale where **1 = never, 2=a few times a year; 3=monthly; 4=weekly and 5 = daily**, please indicate how often **in the last 12 months**, you have had the following experiences:	1	2	3	4	5
Work obstruction					
Failure to make personal connections?					
Told your work contributions were not important?					
Failure to get needed resources or support?					
Your requests for information ignored?					

Section C: Workplace Experiences: WBI; PFIT (Co-worker), WIS, Verbal Abuse and Neglect.

Workplace Bullying Inventory (WBI) Scales

The following items are about your experience of workplace bullying. Please read each item and use a cross to indicate whether you experienced it: 1=Never 2=A few times a year 3=Monthly 4=Weekly 5=Daily	1	2	3	4	5
I was blamed.					
My abilities were questioned.					
My work was excessively scrutinized.					
I was excluded from receiving information.					
I was watched and followed.					
I was publicly humiliated.					
I was belittled.					
I was threatened.					
I was ignored.					
I was denied career development opportunities.					
My work was organized to inconvenience me.					
I was given demeaning work below my skill level.					

Perceptions of Fair Interpersonal Treatment Scale

What is your organization like most of the time? Circle YES if the item describes your organization, NO if it does not describe your organization, and ? if you cannot decide.			
IN THIS ORGANIZATION . . .			
Employees are praised for good work	Yes	?	No
Employees are trusted	Yes	?	No
Employees' complaints are dealt with effectively	Yes	?	No
Employees are treated like children	Yes	?	No
Employees are treated with respect	Yes	?	No
Employees' questions and problems are responded to quickly	Yes	?	No
Employees are lied to	Yes	?	No
Employees' suggestions are ignored	Yes	?	No
Employees' hard work is appreciated	Yes	?	No
Employees are treated fairly	Yes	?	No

Workplace Incivility Scale

In the last 12 months while employed at the hospital, have you been in a situation where any of your co-workers: Where 1= never and 5=most of the time	1	2	3	4	5
Put you down or was condescending to you?					
Paid little attention to your statement or showed little interest in your opinion?					
Made demeaning or derogatory remarks about you?					
Addressed you in unprofessional terms, either publicly or privately?					
Ignored or excluded you from professional camaraderie?					
Doubted your judgment on a matter over which you have responsibility?					
Made unwanted attempts to draw you into a discussion of personal matters?					

Harlos and Axelrod Verbal Abuse and Emotional Neglect Scales

The next questions ask you about experiences that may occur at work. On a scale where **1 = never, 2=a few times a year; 3=monthly; 4=weekly and 5 = daily**, please indicate how often **in the last 12 months**, you have had the following experiences:	1	2	3	4	5
Verbal Abuse					
Yelled at?					
Blamed for other's mistake?					
Put down in private?					
Criticized?					
Spoken to in a harsh, cold tone of voice?					
Put down in public?					
Threatened with firing?					
Sworn at?					
Emotional Neglect					
Told you are valuable or appreciated?					
Told my feelings and needs are important?					
Given constructive feedback?					
Praised?					
Publically credited for work or accomplishments?					

Section D: Organizational Processes

Organizational Predictors and Consequences of Bullying Scale

The following items relate to organizational processes and bullying in your workplace. ***Please read each item and use a cross to indicate whether you:*** 1 = strongly disagree 2 = disagree 3 = am not sure 4 = agree 5 = strongly agree	1	2	3	4	5
Meetings called to manage personal injury or illness used to bully					
Records of meetings are falsified					
Threats and intimidation are used					
You are summoned to meetings without notice and intimidated					
You are denied an advocate to support you					
Junior managers are led into taking part in the bullying					
Performance appraisal is used as an opportunity to bully					
Organizational policies and procedures are not followed					
Managers back each other up					
Junior managers turn a blind eye					
The outward appearance of due process is created					
There is a hierarchy of bullies who support each other					

Bullies build alliances to support them					
They have friends in higher places that cover up for them					
They organize work to allow a group to target someone					
They gang up on you					
They build alliances by promoting those who support them					
Senior bullies hide the truth from formal investigations					
Bullies control the allocation of work					
Bullies promote those who stay silent about bullying					
Bullies obstruct change that may reduce their control					
Managers hide bullying under the guise of legitimate change					
Restructure is used to force out those not supportive of bullying					
Regardless of what they do bullies get promoted					
Bullies rigidly control work practices					

Section E: General Information

This last set of questions concerns general questions about you. This information enables us to analyze responses according to various categories of employees. Please remember that your responses are anonymous.

E1. Are you:
- o Male
- o Female

E2. How old were you at your last birthday?
- o 25 years old or younger
- o 26 years old
- o 27 years old

[CONTINUE UNTIL...]
- o 55 years old or older

E3. Are you currently?
- o in a relationship (married, common law, partnered)
- o not in a relationship (single, separated, divorced)

E4. According to Stats Canada, Canadians identify themselves with several ethnic backgrounds. Which group do you **most** identify with?

- o Aboriginal
- o Arab
- o Black
- o Chinese
- o Filipino
- o Japanese
- o Korean
- o Latin American
- o South Asian
- o Southeast Asian
- o West Asian
- o White
- o Other, specify _____

E5. What is the highest education level you have completed?

- o Some university/college/technical degree/certificate/diploma
- o Completed diploma
- o Completed baccalaureate degree
- o Some graduate school
- o Completed graduate degree (master's or doctoral)