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Elizabeth Berry

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Walden University
2015

Abstract

Self Esteem, Locus of Control, and the Relationship

with Registered Nurses' Experience with Workplace Incivility

by

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

March 2015

Abstract

The study's purpose is evaluating the relationship between locus of control and self-esteem in relation to the registered nurse's experience and perception with lateral and vertical incivility. There is a lack of research concerning nurse-to-nurse incivility within the nursing profession. The hypothesis examined whether dynamics of locus of control and self-esteem could provide insight into the personality dynamics influencing incivility in the workplace. This non-experimental quantitative study used 2 self-evaluation tools and 1 demographic survey tool to collect data via Survey Monkey, a commercial data collection company. Participants were 65 randomly selected faculty (n = 36) and graduate students (n = 29) from schools of nursing in Southern California, all active practitioners. Descriptive statistics provided the demographic data and RNs' experience of incivility analysis. Inferential statistics, t-test, and Pearson's correlation analyzed the relationships between study variables. Study results indicated no significant negative relationship between RNs' perceived experience with lateral and vertical incivility, and RNs' level of self-esteem and locus of control. Participants indicated a greater than 80% experience with incivility in the work place either directed at the participant or towards a colleague. The study results will be of interest to health provider managers as a means of insight into the pervasiveness of incivility in the workforce. The study indicated the problem of professional incivility is widely encountered, it rules out the hypotheses that self-esteem and locus of control are related to the problem, and it encourages the need for further study as to the etiology and dynamics of the problem.

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Dedication

I have been told there is a reason a PhD is referred to as the terminal degree. I began this last leg of my academic journey to reach a sense of personal completion and believing this was the terminal degree. What I have discovered is that learning is not terminal and continues in our lives until we take our last breath. Every accomplishment I have had in my life I have shared with the answer to my prayers, the miracle, my daughter Anastasia Noel Berry. I dedicate this dissertation to her for the patience, strength, and never ending faith she has demonstrated and has developed in me through her very existence. God has blessed me and it is to him I give thanks and praise.

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Those who have provided support throughout this process include Dr. Timothy Allison, who encouraged and provided me with the overwhelming understanding of statistics and the statistical nuances found in everything we do. I want to thank every educator that I work with at my place of employment, Jesse McDonald, Barbara Manier, Marva Ricciardi, Gigi Lim, Barbara Miller and Dewee McDermott, for their incredible ability to provide sense out of nonsense, calm out of chaos, and nurturing and caring in the middle of hopelessness. There are no words, only emotion that can best describe my heartfelt thanks.

Table of Contents

Appendix

List of Tables

Chapter 1: Introduction

The Joint Commission published a sentinel event alert on July 9, 2008 regarding "behaviors that undermine a culture of safety." Intimidating and disruptive behaviors in the healthcare environment were noted for their impact on patient safety, health care team dynamics, the ability to synthesize clinical information, and maintenance of an emotionally and mentally healthy work environment (Porto & Lauve, 2006). Lateral and vertical violence (also known as incivility, bullying, horizontal violence, or disruptive behavior) was first investigated among Registered Nurses (RNs) in the early 1980s (Gerardi & Connell, 2007). Hereafter the term "lateral and vertical incivility" will be used to prevent confusion and distinguish between physical violence and psychological abusiveness. Health care providers, patients, and administrations of health care facilities are affected by such behavior through poor patient outcomes, loss of professional respect, poor public relations, malpractice, and negligence.

Incivility in the workplace is not isolated to nursing. The Workplace Bullying Institute (WBI) conducted a 2010 survey of adult Americans regarding workplace bullying. The study revealed that 35% of respondents had experienced workplace bullying. Bullying was found to be four times more prevalent than harassment and that 68% of bullying occurred as same-gender harassment. Respondents showed significant interest supporting legislation for a healthy workplace bill (WBI 2010, Workplace Bullying Survey).

Quine (2001) studied the prevalence of workplace bullying among nurses in the National Health Services trust, England. Quine found that 44% of nurses experienced horizontal incivility in the work place. Furthermore, nurses were found to significantly experience specific bullying behaviors such as isolation, overwork, and destabilization attempts to demoralize and undervalue. Symptoms included malaise, feeling undervalued, feeling depressed, not wanting to go to work, anxiety, not sleeping, and an increase in smoking and alcoholic beverage drinking (Quine, 2001).

Ortega, Høgh, Pejtersen, Feveille, and Olsen (2009) studied the prevalence of workplace bullying and risk groups. This study evaluated bullying in the workplace by job type and industrial groups. The one year prevalence of bullying in the health professions and health care workers was 96%. The study further indicated that there is greater occurrence in bullying between colleagues than from clients/patients.

Problem Statement

Disruptive behavior in the form of lateral and vertical incivility exists among RNs in health care environments without a clear understanding of the relationship between the RNs' perceived experience with lateral and vertical incivility and the correlation with thier self-esteem and locus of control. Literature on this subject ranges from theoretical opinions, impact on job satisfaction and job retention, student nurses perception of lateral and vertical incivility, relationships between individual and organizational factors that may predict incivility in the workplace, and the impact of incivility on an organizations costs seen in absenteeism and productivity (Szutenbach, 2008; Lewis,2009; Federizo, 2009). The literature focuses on the impact of the problem but not on the psychological mechanisms involved in addressing its resolution.

Szutenbach, M. P. (2008) who studied the relationship of peer bullying and its impact on job satisfaction and retention, concluded that there is a need quantitative or mixed methods to identify the cause for such a proliferation in lateral and vertical incivility in the health care environment. Simons (2006) studied the experience of newly licensed nurses in Massachusetts and the influence of bullying in the workplace on their intention to leave the organization they work for. Simons' recommendation for further study included areas that addressed both nurse managers and bedside nurses whether experienced or inexperienced in their roles. Simons further expresses the need to evaluate the experience of lateral and vertical incivility with physicians.

Whitworth (2008) studied the relationship between personality types and preferred styles of handling conflict. Whitworth used the Myers Briggs Type Indicator and the Thomas Kilmann Conflict Mode Instrument, which focuses on methods used to deal with conflict, to examine this relationship. Whitworth's finding indicated no relationship between nurses' personality factors and methods used to deal with conflict.

The literature prompts the following two questions: What specific variables either individually or environmentally, brings about disruptive behavior in the workplace? Why individuals perpetrate and/or perceive behaviors described as lateral or vertical incivility may be impacted by the individuals' self-esteem and locus of control? This study will look at the RNs' perceived experience with lateral and vertical incivility and its relationship to the RNs' locus of control and self-esteem.

Purpose of the Study

Much has been written about the existence of lateral incivility in nursing but there is little research on its underlying cause. The purpose of this study was to examine the link between self-esteem and locus of control, which communication and interpersonal relationship and the association of these dynamics with lateral incivility. Lateral incivility as it is defined is behavioral demonstrations of dysfunctional communication and interpersonal relationship. Self-esteem and locus of control are traits that influence the delivery and reception of communication along with an individual's perception of personal relationship.

Identity theory addresses the concept of self-identity and relationships with the social group. Communication and interpersonal relationship are linked to the two independent variables, self-esteem and locus of control and the influence on the dependent variable lateral/vertical incivility. The healthcare work environment can be identified as a social setting within which registered nurses are a part of the segregated whole. Registered nurses are only one entity that comprises the healthcare community. It is necessary to conceptually understand that the RN's perception of professional identity conflicts with society's perception of nursing. The term "nurse" encompasses many levels of nursing scope of practice. Identity theory pertains to the purpose of this study as the independent variables are integrated into each RN's self-identity.

Research Question and Hypotheses

The study sought to answer the following research question:

In what way do self-esteem and locus of control relate to the nurse's perception of lateral/vertical incivility and if they do relate how do they relate to the nurse's perceptions?

The research question generated the following two hypotheses:

H0$_1$: Registered nurses who experience bullying and incivility in the workplace will not exhibit signs of low self-esteem.

H1$_1$: Registered nurses who experience bullying and incivility in the workplace will exhibit signs of low self-esteem.

H0$_2$: Registered nurses who experience bullying and incivility in the workplace will not exhibit signs of external locus of control.

H1$_2$: Registered nurses who experience bullying and incivility in the workplace will exhibit signs of external locus of control.

Theoretical Basis

The theory of oppressive behavior is common in lateral incivility studies. Oppression theory emphasizes that the incivility is a result of staff nurses feeling oppressed by hospital administrations and managers. Identity theory provides a theoretical basis for the need to understand the RN's understanding of self and their world view.

Identity theory addresses the development of shared relations between one's self and society (Hogg, Terry, & White, 1995). It is necessary to differentiate between identity theory and social identity theory. Social identity theory views society as an undifferentiated whole. Identity theory contends that society is organized but segregated (Hogg, Terry, & White, 1995). In nursing there are RNs, licensed vocational nurses

(LVN), and certified nursing assistants (CNA). Registered nurses who further their education can become advanced practice nurses in areas of education, management, and the practice of medicine as nurse practitioners. This presents a conflicting sense of professional identity, thus social identity theory would view nurses as an undifferentiated whole. Therefore, that population is segregated but organized, just as identity theory asserts. Professional self-perception is influenced by how others perceive one's role, and in nursing this often becomes skewed. Quine (2001) found that nurses who have experienced lateral incivility were found to have a greater incidence of clinical anxiety and depression. The literature review will expand on this aspect as it relates to self-esteem and locus of control.

The Nature of the Study

This quantitative study focused on the independent variables, self-esteem and locus of control, with respect to the perceived experience of lateral and vertical incivility. Each participant completed a validated, self-assessment tool for each of the domains. The assessment tools are discussed in Chapter 3 along with the study process.

Operational Definitions

Lateral and horizontal incivility also known as violence, bullying, or disruptive behavior are defined as any overt or covert behavior verbal, nonverbal, or physical (Porto & Lauve, 2006; Corney, 2008). These behaviors may be perpetrated by one or more individuals with the singling out of an individual or group. The behavior is typically not addressed by management and rarely confronted by the victim.

Vertical incivility is defined as the same behaviors as seen in lateral and horizontal incivility except the direction is from the top (management) to the bottom

(staff). Such behaviors can also be observed from the bottom going to the top such as staff inflicting such behaviors on management.

Locus of Control is a theoretical construct designed to assess a person's perceived control over his or her own behavior. The classification internal locus indicates that the person feels in control of events; external locus indicates that others are perceived to have that control (The American Heritage Dictionary, 2007). According to Mosby's Medical Dictionary (2009) individuals with an internal locus of control believe that they can control events related to their life, whereas those with an external locus of control tend to believe that real power resides in forces outside themselves and determines their life. Locus of Control impacts how we perceive people, our environment, and how we communicate.

Self-esteem is an individual's pride in oneself; self-respect (The American Heritage Dictionary, 2007). Self-esteem can be defined as what one believes to be true about how worthy, lovable, valuable, and capable one is.

Disruptive behavior is defined by The Joint Commission (2008) as any overt or passive behavior that undermines the effectiveness of the health care team and compromises patient safety.

Assumptions, Limitations, Scope, and Delimitations

The assumptions, limitations, scope, and delimitations of a study can determine the study's range of useful data. The assumptions, limitations, scope, and delimitations determine the strength of the data and the application of the study findings.

Assumptions

There are several assumptions in this study. The first is that lateral incivility exists amongst registered nurses in Southern California. Another assumption is that lateral incivility interferes and impacts interpersonal relationships and communication. A significant assumption is that the participants of this study responded to the surveys openly and honestly without self-bias.

Limitations

The limitations in this study are found in the proper use of Survey Monkey, the probable bias in the participants self-reporting, which can lead to the validity of the data. Survey Monkey does not have a method of assigning identifying variables when multiple surveys are entered into the system. The lack of an identifier did not allow for comparative statistical evaluation of a single individuals three surveys. The participants have the academic knowledge to manipulate the responses to the self-esteem and locus of control surveys, which can ultimately skew the data.

Scope and Delimitation

Only licensed RNs, whose names appeared on the California Board of Nursing mail registry and were employed, were invited to participate.

The scope of this study included the state of RNs' locus of control and self-esteem with respect to the perceived experience with lateral/vertical incivility. Other factors were level of education, employment position held, age, sex, years in the profession, ethnic/cultural background, and other demographic factors. The scope also assessed the correlation between locus of control and self-esteem, level of education, employment

position held, age, sex, years in the profession, ethnic/cultural background, and other demographic factors.

Significance of the Study

The implications of this study should not be underestimated. Lewis' (2009) study exposes that incivility in the workplace does impact absenteeism, productivity, and costs which directly effects patient safety and quality of care. Equally important is the effect on the work environment and constant exposure of RNs to a hostile environment. Health organizations may focus on the immediate financial losses through absenteeism and poor productivity but must also recognize the long term effects of a hostile environment on the health of employees, employee retention, and facility reputation.

In hospitals at the patient's bedside RNs are the patient care managers. Registered nurses manage the care of patients in clinic, home health, and public health venues. It is the intention of this study to provide insight into the effect lateral/vertical incivility has on the RNs' perception of self-worth, professional worth, emotional perception and relationship to the environment. Managing the care of a patient requires the ability to synthesize information, communicate effectively within the health care team, and deliver required treatments safely. Threatening, emotionally unhealthy work environments endanger the nurses' ability to accomplish the professional duties safely and with the sense of caring that is so much a part of a nurses' professional identity.

Professional application of the study results will be in the development of professional education focused on the development of conflict management and effective communication within the healthcare team. Education should include understanding of

team development and function in the work environment. Ultimately the goal is to promote healthy work environments resulting in safe and quality patient care.

Summary

Chapter 1 centers on the purpose and underlying principle of this study. Chapter 1 begins with an introduction to the problem of lateral/vertical incivility with a look at the prevalence of the problem. The problem statement is made and followed by the study research hypothesis and purpose. The study purpose and theory is identified and the theoretical framework of identity theory. Operational definitions are defined followed by the assumptions, limitations, scope, and delimitations of the study finishing with the significance of the study.

Chapter 2: Literature Review

The purpose of this study was to examine the link between self-esteem and locus of control, which impacts communication and interpersonal relationship and the association of these dynamics with lateral incivility. The purpose of the literature review was to examine previous studies surrounding bullying in the workplace. The literature review will examine the body of literature surrounding the existence of lateral and vertical incivility toward RNs in health care. This literature review will survey peer reviewed research articles that evaluate the problem of lateral and vertical incivility as it pertains to job satisfaction, retention, employer costs, health of nurses, and the impact to patient care. The review will further address research theories and the relationship to lateral and vertical incivility along with the theory to be used in this study. The study methods used in previous studies will be addressed. Lastly, there will be an examination of literature focused on the two personal traits self-esteem and locus of control and the relationship these traits have with social behavior and interpersonal communication.

The following databases were used to identify literature for this review: CINAHL Plus with full text, Proquest Dissertations and Theses, Health and Medical Complete, Health and Psychosocial Instruments, Medline with Full text, Nursing and Allied Health Sources, Ovid Nursing Journals Full Text, Proquest Central, PsycArticles, PsycExtra, PsycINFO, Psychology A Sage Full Text Collection, and Google Scholar Advanced. Further assistance was obtained through the skills of the librarian at the Riverside County Regional Medical Center medical library using the librarian's national and international database. The following key terms were used in the literature search: Bullying, bullying in nursing, lateral and vertical incivility in nursing, workplace violence, incivility in

nursing, risks to patient safety, Joint commission, and communication issues in healthcare.

Early Literature

In 1976, Krebs published one of the first studies regarding incivility in the healthcare and found incivility 10 times more frequent than workplace violence. Andersson and Pearson (1999) defined workplace incivility as "low-intensity, deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (Andersson & Pearson, 1999 pg.457). In contrast lateral/vertical incivility is defined by the act of bullying which are intended acts or verbal communication that intimidates, degrades, offends, and humiliates or isolates a person creating a danger to the health and safety of the victim (Dowden, 2010).

Quine (1999) did an early study investigating the prevalence of bullying in the work place. The study subjects were nurses from the National Health Services Community Trust, the health care system in the United Kingdom. The study included 1100 employees with 38% reported experiencing bullying over the past year and 42% reported witnessing others being bullied. Although this study looked at all health care occupations nursing ranked highest in experiencing bullying. The study further exposed the high correlation between bullying stress, depression, anxiety, and intent to leave the job (Quine, 1999).

Impact on Retention and Job Satisfaction

In 2001, the International Council of Nurses convened in Copenhagen and identified issues surrounding retention of nurses as the major causes behind the ever

present and growing international nursing shortage (Iliffe, 2001). Early literature has identified lateral and vertical incivility as a probable cause for failing recruitment and retention rates in the nursing profession (Stechschulte, 2008). Stechschulte's (2008) found that the RNs in the study described experiencing behaviors that commonly describe lateral and vertical incivility in their present employment. Although this study was limited by its small sample, nine RNs, two nurses had admitted to leaving several jobs due to lateral and vertical incivility while two other study subjects had already resigned from the health care facility where all the subjects originated from. Stevens (2002) addresses a study done at a large Australian teaching hospital which found that lateral and vertical incivility among nurses was the primary cause for nurses leaving their employment and for some leaving the nursing profession. The prevalence of lateral and vertical incivility globally is significant.

The presence of lateral and vertical incivility among nurses has been identified as a major occupational health problem in Europe, the United Kingdom, Australia, and the United States (Cooper & Swanson, 2002). Cooper and Swanson (2002) determined that lateral and vertical incivility is a significantly under reported and under identified occupational health and safety dilemma. Childers (2004) found that lateral and vertical incivility was so prevalent in hospitals across the United States that 70% leave their place of employment. Furthermore, Childers found that 33% of the nurses were motivated to leave due to resulting health problems. The concern of new nurses introduced into a work environment with lateral and vertical incivility is the possibility they may adopt the negative and disruptive behaviors of other nurses just to be accepted in the work environment (Rocker, 2008).

McKenna, Smith, Poole, and Coverdale (2002) studied RNs in their first year of practice and their experiences with lateral and vertical incivility. To measure the level of distress experienced by the new graduate nurse the Impact of Event Scale was used. The 551 respondents worked in multiple patient care areas. The study looked at the experiences of both overt and covert behaviors defined in lateral and vertical incivility. Results of this study indicated a significant number of new graduate nurses experienced lateral and vertical incivility. The experiences resulted in increased absenteeism and a significant number of study subjects considered leaving the nursing profession. The results from Christmas (2008) support this finding stating that 27.1% of new graduate nurses voluntarily leave their positions in their first year of employment with many of them leaving the nursing profession. There is a cost incurred by the health care facility due to loss of personnel and the cost to replacing the lost employee.

Impact on Costs, Absenteeism, and Productivity

The cost to an organization that ignores lateral/vertical incivility is not only in the loss of job retention and job satisfaction but in increased absenteeism and decreased productivity. Lewis (2011) studied the impact of incivility on the work environment and productivity. Using the Nursing Incivility Scale and the Work Limitation Questionnaire, Lewis (2011, p 41-47) surveyed 659 nurses with these seven objectives:

1. Determine if there is a difference between work environments determined by accrediting bodies as healthy and those work environments considered standard.
2. Determine if there is a difference in the workplace incivility scores between teaching medical centers, community hospitals, and rural hospitals.

3. Determine the relationship between workplace incivility subscales and productivity subscales.
4. Evaluate the impact of workplace incivility on cost and productivity of nursing.
5. Evaluate the relationship between the manager's skill in handling workplace incivility and workplace incivility.
6. Determine the differences in workplace incivility scores based on unit specialty.
7. Determine if there were organizational predictors for workplace incivility.

The results of Lewis's study indicated that there was a significant difference between Magnet status and Pathways to Excellence hospitals as they score lower on the workplace incivility scale as opposed to standard hospitals whose scores were higher. There was no significant difference between academic medical centers, community hospitals, and rural hospitals. The loss of productivity and workplace incivility showed a calculated loss of $11,581 per nurse per year. The surveys indicated negatively regarding the nurse manager's ability to handle incivility between nurses, physicians, and supervisor. Looking at the differences of workplace incivility between unit specialties the study found the intensive care unit and medical surgical units scored lower on the workplace incivility scale compared to the operating room. In comparing scores for the stated objectives in this study the operating room was found to have the highest scores over all other units except in the evaluating of incivility from patients and patient's families of which the operating room scored the lowest of all the units. Finally, Lewis's study found that the organizational factor predicting workplace incivility is directly correlated to the nurses' perception of management's ability to handle incivility. Again, intensive care units, medical surgical units scored higher in this objective showing 4.5

times and 3.29 times, respectively, likely to agree that their managers could handle incivility over the operating room and emergency department nurses.

Hutton and Gates (2008) studied workplace incivility as it relates to productivity but unlike Lewis (2011) they focused on the direction of incivility and its impact on productivity. Incivility can be directed from physicians, other direct care staff, management, patients and families, and general environmental incivility. Hutton and Gates (2008) found that incivility from patients and management impacted productivity significantly more than incivility from physicians and other direct care staff.

Kivimaki, Elovainio, andVahtera (2000) studied workplace bullying and sickness absence in hospital staff. The study evaluated 674 males and 4981 females of which 302 (5%) reported having experienced bullying in the workplace. The study found that victims of bullying had higher body mass and a greater incidence of chronic illness. The conclusion of the study was that workplace bullying has a direct correlation with absenteeism due to illness (Kivimaki, Elovainio, & Vahtera, 2000).

Walsh and Clarke (2003) looked at post-trauma symptoms in health workers following physical and verbal aggression. The study used the Impact of Event Scale Revised (IES-R) and survey questions regarding overall impact, level of expectations, and preparedness. The significant finding in this study was that the experience of verbal aggression had a greater effect on the individual than physical aggression. Furthermore, the responses to the IES-R Intrusion scores were higher regarding involuntary and unwanted recall of the episode (Walsh & Clarke, 2003). This finding is significant as verbal aggression is found extensively in the health care work environment.

Matthiesen and Einarsen (2004) investigated psychiatric distress and symptoms of post-traumatic stress disorder (PTSD) among victims of lateral and vertical incivility specifically bullying at work. The study subjects were from various work environments with 28% being from the health care sector. The IES-R, the Post Traumatic Stress Scale (PTSS-10), and the Hopkins Symptoms Checklist (HSCL-25) were all used to assess the study subjects. The findings in this study showed high levels of distress and symptoms of PTSD in correlating with three out of four victims reporting a higher level on the HSCL-25 indicating a higher than recommended threshold for psychiatric disease (Matthiesen & Einarsen, 2004). The study further indicated the longer time away from the bullying exposure the lower the level of symptomatology.

The qualitative study done by Corney (2008) looked at aggression in the workplace using the Heideggerian hermeneutic phenomenology. Review of the data which was extracted from tape recordings of narrative interactions yielded six themes, stress, guilt, fear, enculturalisation, power/control, and reflection/rationalization. In review of this article the statement that was most disturbing was that in spite of the physical and psychological effects nurses who were victims of aggression remained unaware of how they were being treated until it was pointed out by another (Corney, 2008).

Impact on Patient Care and Safety

Previously referenced in chapter one the Joint Commission (2008) has identified that intimidating and disruptive behaviors contribute to medication errors, poor patient satisfaction surveys, preventable adverse outcomes, increase in the cost of care, and poor job satisfaction and retention. The Joint Commission report further discusses the need for

collaboration and teamwork in the health care work environment to assure safe patient care. Sadly, this destructive behavior wears away at expected professionalism and the hostile work environment is recognized by the patients and their families.

The Association of Peri-Operative Registered Nurses has advocated for patient safety in the perioperative patient care area since 2002 (Kirchner, 2009). Kirchner (2009) asserts that bullying is a significant reason for why a culture of safety is so difficult to maintain. In an article on patient safety in the operating room by Runy (2007) the issue of how operating room staff perceives working relations with peers as an indicator for what type of culture exists within the department. Disruptive behavior and angry outbursts create an environment of intimidation and poor team communication. Runy (2007) cites a study by the American College of Surgeons that examined the impact of communication on patient safety. The review of 460 claims found 19.6% of claims against surgeons were due to failure in communication. Runy (2007) also cites a 2006 survey done by the Very Healthy Americans (VHA) Inc. discovered that 94% of disruptive behavior either directly or indirectly causes adverse events and increases medical errors while negatively impacting the quality of care which can impact patient mortality.

Theory of Lateral and Vertical Incivility (Violence)

Studies done regarding bullying, lateral and vertical incivility, or other disruptive behavior have viewed the study from the theoretical perspective of social constructionism, labor theory (Jamieson, 2004), cognitive learning theory (Szutenbach, 2008), and more commonly from the perspective of oppression theory. Roberts, Demarco, and Griffen (2009) discuss oppressed group behavior as a result of being dominated by those who elevate their own qualities as those that are valued. In turn the

oppressed develop a belief of inadequacy, lack of pride resulting in low self-esteem. The feeling of powerlessness creates fear and anger towards the authority figure and is often projected laterally within one's own group (Roberts, Demarco, & Griffen, 2009). Interestingly, Roberts (1983) states that low self-esteem is often observed in nurses but study measurements to quantify such claims have not been done. Recognizing the destruction of self-esteem through oppression begs questions surrounding personal and group identity. Identity theory will be used as the theoretical construct for this study.

Identity Theory

Identity theory was founded within the discipline of sociology and is described by Hogg, Terry, and White (1995) as a "micro-sociological theory that sets out to explain individuals' role related behaviors" (p. 255). The theory further underscores the multifaceted and dynamic self, negotiating the relationship of one's individual behavior and social construct (Hogg, Terry, and White, 1995). Stryker (1968, 1980) suggests that individuals have role identities that are diverse elements of the self, perceived as independent role positions in society. Understanding that some role identities have a greater significance than others enables us to appreciate the connection between role identities, behavior, and affective outcomes (Hogg, Terry, & White, 1995). Roles that sit higher on the individual's role hierarchy will tend to be more self-defining compared to the roles that are lower on the hierarchy. How an individual perceives themselves within their role and how society perceives the individual within the role may be congruent or not congruent in perception.

Desrochers, Andreassi, and Thompson (2002) discuss role salience, role strain, and psychological distress. The roles discussed were family and work roles. What the

authors discovered in the literature review was that role strain and psychological distress was not associated to the individual's role position on the salience hierarchy. Ashforth, Kriener, and Fugate (2000) investigated the idea of role blurring due to integrating roles resulting in increased anxiety and confusion with respect to salience hierarchy. The ability to function well in one's role is significant as it is reflected in the individual's sense of self-worth and self-esteem (Hogg, Terry, & White, 1995).

Stryker (2007) acknowledges that psychologists who study personality theory admit that identity theory has relevance in the study of personality theory. Stryker further states that personality traits can be integrated changing what distinguishes a particular identity. Erwin and Stryker (2001) further support this in the development of a theory based model indicating the interdependency of identity theory and self-esteem (Stryker, 2007). Stets, Carter, and Fletcher (2008) tested identity theory evaluating identity discrepancies, behaviors, and emotions. The study proved the connection of identity values to behavior, behavior to identity inconsistencies, and identity inconsistencies to emotions. Stets, Carter, and Fletcher (2008) found identity theory to be a strong and sustainable theory stating "People pay attention not only to how others see them, but also to how they see themselves, and both have an effect on the experience of emotion."

The role of the registered nurse takes on many forms. The registered nurse is a caregiver, an educator, leader, manager of care, along with many other intricate duties assigned within the profession. The complexities of health care have placed significant demands on the registered nurse. Despite the demands and responsibility it is not unusual that the nurse does not necessarily have a say in the decisions made that impact patient care and the profession of nursing. The individual's role must provide a sense of

satisfaction, empowerment, and pride if the expected perceived behavior and affect is to be found within the social environment.

Identity theory interprets an individual's ability to establish relationships in society. The relationships established among nurses in the patient care environment have a multitude of functions all of them requiring collaborative and effective communication. Much of the research substantiating identity theory has examined role identity. Stets, Carter, and Fletcher (2008) tested the identity theory as it applies to personal identity as seen in the occurrence and non-occurrence of behavior associated with identity discrepancies both behavioral and perceptual and the relationship of those identity discrepancies as they relate to negative emotions and healthy moral emotions. In testing identity theory Stets, Carter, and Fletcher (2008) found the theory to be strong in connecting identity meanings to behavior, behavior to identity discrepancies, and identity discrepancies to emotions (p.23). Identity theory has not been found to be used in the study of lateral or vertical incivility in nursing but other theories have been ascribed to studies surrounding this topic.

Oppressed group behavior theory has provided some insight to the study of lateral and vertical incivility in nursing (Hutchinson, Vickers, Jackson, & Wilkes, 2006). Continued use of oppressed group behavior theory only provides a partial understanding of this phenomenon. Oppression is known to impact self-esteem and identity negatively and inhibits the development of self and group empowerment (Roberts, 2000). Manojlovich and Spence-Laschinger (2002) studied empowerment and the relationship to selected personality traits and job satisfaction in nurses. They discovered that by changing the hospital environment, that empowerment could be increased improving job

satisfaction, patient satisfaction and in turn improving patient outcomes. Personality traits influence how individuals perceive their world and how they interact with that world. Personality traits also influence how we view ourselves and others and how we communicate within our social circles. Leung and Harris-Bond (2001) discovered that personality and communication style when evaluated by others is able to forecast an individual's amiability and task involvement as opposed to self-ratings (p. 69). How a person identifies self is not necessarily how others identify that person.

Renwick-Monroe (2009) explains that idealized cognitive models, worldview, and an awareness of ontological security are important factors that clarify a person's sense of self (p.429). Renwick-Monroe (2009) discusses how the deliberate use of specific words summons images that impact how a person may be perceived. Identifying an individual as a nurse would typically invoke the image of a caring and compassionate individual where as a bad or incompetent nurse may raise the image of an unsafe or uncaring individual. The behaviors found in lateral and vertical incivility include disparaging, overly critical, and belittling comments made behind the nurse's back or directly to the nurse. The comments are made publically within the work environment and evoke a negative image amongst the health care team. Identity theory recognizes that specific roles sit higher than other roles that an individual may hold most frequently the profession or career choice we make sits very high on the role hierarchy. Demeaning an individual's ability to perform the role or to demean an individual personally takes the sense of self from the role. Identity theory provides a platform on which personality traits, roles, and behaviors can be evaluated independently and correlated.

Self-Esteem

It is necessary to define self-esteem in order to understand the relationship and impact self-esteem has on the other variables examined. Rosenberg (1965), who developed the Rosenberg Self-Esteem Scale, defined self-esteem as a favorable or unfavorable attitude toward the self (p. 15). Another definition that is more explicit is: Self-esteem is the experience that we are appropriate to life and to the requirements of life (Branden, 1992). More specifically self-esteem is:

> (1) Confidence in our ability to think and cope with the basic challenges in life.
>
> (2) Confidence in our right to be happy, the feeling of being worthy, deserving, entitled to assert our needs and wants and to enjoy the fruits of our efforts (Branden, 1992, pg. 8).

The essence of self-esteem is within the self-perception of our worth and competence (O'Neal, Vosvick, Catalano, & Logan, 2010). O'Neal, Vosvick, Catalano, and Logan's (2010) study hypothesized that self-esteem, locus of control, and loneliness would be significant in the perception of the meaning of life. The findings in the study inferred that those who reported internal locus of control and higher levels of self-esteem reported less loneliness and a higher meaning in life. Self-esteem has been connected to socioeconomic status, health and health related behaviors, and self-efficacy (Adler & Stewart, 2004).

Schwalbe, Gecas, and Baxter (1986) study found that collaborative requirements on the job created and increased the importance of self-perceived competence and social opinion as sources of self-esteem. Several types of esteem can be found in the literature they include global self-esteem (overall estimation of one's worth), role-based self-

esteem (worth gained from holding a particular position), task-based self-esteem (one's worth based on self-efficacy), and organization-based self-esteem in which an employee's self-perception is based on how important, meaningful, effectual, and worthwhile they are within the organization (Carson, Carson, Lanford, & Roe, 1997). Mossholder, Bedeian, and Armenakis (1982) studied self-esteem as it related to group process work outcome relationships. The findings indicated that peer group interaction reduced stress and the inclination to leave employment. This response was found to be higher in low self-esteem individuals who tend to be more reliant on their peers for support.

The relationship between self-esteem and workplace deviant behavior was studied by Ferris, Brown, Lian, and Keeping (2009). There has been an assumption in the research community that low self-esteem is a predictor to deviant behavior. The study done by Ferris, et al (2009) evaluates the role of contingencies of self-worth. Ferris, et al (2009) worked from the theoretical premise of consistency theory which states that in order to preserve cognitive uniformity between attitudes and behaviors the individual must maintain behavior that remains consistent with their self-perception. The second theory was behavioral plasticity theory which highlights the impact of high or low self-esteem on negative related variables on assorted outcomes. The study found that the predictions of both theories held true only for individuals with low levels of workplace-contingent self-esteem (Ferris, etal, 2009). Self-esteem influences cognitive, affective, and psychological reactions.

Ford and Collins (2010) study introduced a vague interpersonal rejection to each participant after which salivary cortisol levels were taken and self-reported cognitive and affective responses were evaluated. In comparison with those with high self- esteem those with low self-esteem were found to have higher levels of cortisol, berating themselves being more self-blaming while expressing disapproving comments toward the rejecter. Low self-esteem and cortisol reactivity was found to be reconciled by self-blame while cortisol reactivity was found to mediate the association between low self-esteem and the expression of derogatory feelings and comments toward the rejecter (Ford & Collins, 2010). This study opens the door to concerns for both the physiological health as elevated cortisol levels create chronic illness and the psychological experience of rejection can create a perception of loss of self-worth and control of destiny.

Zitney and Halama (2011) studied evaluated if locus of control, self-esteem, and the interacting of personality traits with either locus of control or self-esteem predict sensitivity to injustice. Seventy-one males and 183 females participated in this study which found personality traits attributed 30% of sensitivity to injustice discrepancy in adding self-esteem and locus of control as predictors increased the variance by 4%. The interaction analysis indicated that internal locus of control shields against unjust events perceived by people with anxious and aggressive characteristics.

Locus of Control

The concept of Internal versus External Control Reinforcement more commonly referred to as locus of control, refers to the premise that a reinforcement or outcome of an individual's behavior is dependent on their own behavior or characteristics (internal locus) as opposed to the belief that the outcome or reinforcement of the individual's

behavior is due to chance, fate, or the powerful control of others (Rotter, 1990). According to Rotter (1990) locus of control has been one of the most studied personality variables in some of the most diverse fields. Numerous studies have been done in the past and continue to be done in various applicable settings.

In 1993, James and Wright study indicated that subjects who perceived external locus of control reported higher levels of stress in contrast to those who reported internal locus of control had significantly lower stress or did not report stress at all. The study did consider stress theorists views that the causes of stress do not solely rest in the traits of the individual or the environment (James & Wright, 1993).

The ability to problem solve is of significant importance in healthcare. Dijkstra, Beersma, and Evers (2011) studied 774 healthcare workers in a cross-sectional study that evaluated internal locus of control as a moderator between conflict at work and psychological strain. The study found that people with internal locus of control used problem solving conflict management more frequently and suffered less psychological strain.

Wang, Bowling, and Eschleman (2010) conducted a study that discovered locus of control was linked to job attitudes, employee well-being, job performance, perceptions of the work environment, interpersonal relationships in the work environment, coping behavior, and intent to leave. General locus of control is most often related to life satisfaction and problem focused coping abilities.

Historically researchers have believed that low self-esteem was influential in aggressive behavior (Wallace & Barry, 2010). Studies regarding self-esteem and aggressive behavior have had inconsistent results and in many cases the existence of an

inflated or fragile self-esteem has been correlated with aggressive behavior. Wallace and Barry (2010) examined the relationship between self-esteem, locus of control, and aggressive behaviors. Their findings indicated that the combination of low self-esteem and an external locus of control were associated with higher aggression including overall aggression, proactive and reactive aggression (Wallace & Barry, 2010). This may indicate that those with a poor perception of self and a feeling of a loss of personal control over events and their environment may be the cause of an aggressive coping response.

This literature search for studies that reflected locus of control and health care workers specifically RNs was not successful in finding very specific studies. Subjects in the majority of locus of control studies were children, adolescent, multiple types of employment, and general populations. It is apparent that this proposed study will provide a body of information that will be foundational with regards to locus of control and the RNs.

Methodology

Throughout the literature search a significant number of articles regarding lateral and vertical incivility demonstrated theoretical analysis of the problem. The studies found regarding lateral and vertical incivility focused specifically on its existence, relationship to stress, and the impact to patient outcomes. It is necessary to evaluate the study methods found in the literature review to better understand the methods process that will be used in this study. The studies reviewed in this literature search proved to be predominantly quantitative survey methods using a number of previously validated tools. One qualitative study found used the Heideggerian hermeneutic phenomenology.

Corney (2008) states “Heidegger’s shift from the problems of epistemology to those of ontology has radically altered debate on the nature of science and knowing, consideration of which can be profitable for nurses endeavoring to understand the human experience” (p. 168). The phenomenology of Heidegger allows for the researcher to be an integral part as a common being having a common background with the study participants. This method allows for very low sample size of one or two participants or large sample size depending on the extent of the information and the significance of the data collected (Corney, 2008).

A significant number of the studies reviewed utilized validated self-reporting surveys and examination of absentee and human resource records. Kivimaki, Elovaini, and Vahtera (2000) studied sickness absence in healthcare workers who reported having been bullied. The quantitative study collected data from employer’s absenteeism registers and a survey that was provided to employees measuring bullying and predictors of health. The Poisson regression analysis was used to correlate the data. Poisson regression is appropriately used for rate data, where the rate is a count of events occur in a particular unit of observation and divided by some measure of the unit’s exposure. In this study the rate data is the absenteeism with the unit of exposure being the incidence of lateral incivility (Kivimaki, Elovaini, & Vahtera 2000). Studies that looked at the existence or type of resulting health issues due to lateral-vertical incivility were also quantitative.

Matthiesen and Einarsen (2004) research psychiatric distress and symptoms of post-traumatic stress disorder in victims of work related bullying. This Norwegian study used three assessment scales, Negative Acts Questionnaire, the Impact of Event Scale, and the Post Traumatic Stress Scale. Using ANOVA, correlation and partial correlation

analysis, and multiple linear regressions the researchers were able to confirm previous studies of this nature along with exposing that a majority of the participants surpassed the endorsed value levels indicating post-traumatic stress disorder (Matthiesen & Einarsen, 2004). The strength of studies such as Matthiesen and Einarsen's is in the validity of the diagnostic survey tools used, and the sample size.

Analysis of data from this proposed study will require analyzing two independent variables as they relate to each other and the dependent variable. This will require the use of regression analysis which focuses on the relationship between the independent variables and the dependent variable. Regression analysis helps in the understanding of the changes in value of the dependent variable as one of the independent variables varied (Triola, 2011). Correlation analysis looks at statistical relationships involving dependence. Linear correlation coefficient r calculates the strength of the linear correlation between the paired quantitative x and y-values in a sample (Triola, 2011 p.497). Multiple variables will require multiple linear regressions for this study.

Summary

The literature review begins with a focus on the early literature surrounding incivility in healthcare. Studies reviewed cover the impact incivility has on employee health, employee retention, job satisfaction, productivity, and institutional costs. The most significant impact to the general public is how incivility in healthcare affects the safety and quality of patient care. Other aspects within this chapter cover theory as it pertains to lateral incivility in healthcare, the personality dimensions to be evaluated in the study, self-esteem, locus of control, and emotional intelligence. Finally, the

methodology section covers methodologies used in prior studies on lateral and vertical incivility in the healthcare setting.

Chapter 3: Methodology

Chapter 3 includes a description of and justification for the research design including how the design stems from the problem statement. The population sample is described along with the sample size and inclusion and exclusion criteria. The choice of instrumentation and their use of specific instruments are presented. Data analysis and the analytic tools used for analysis are described. Finally, the steps necessary to protect study subjects' rights are identified and discussed.

Research Design

This study used a non-experimental, cross sectional, quantitative survey design (Creswell, 2009). The two independent predictor variables self-esteem and locus of control were correlated with the dependent variable the perceived experience with lateral and vertical incivility. The study is non-experimental because no treatment was introduced in this study. Self-esteem and locus of control have been correlated to health and self-efficacy with effective communication and effectiveness in conflict management. Measuring these specific personality traits and correlating the results with the subjects' perceived experience with lateral and vertical incivility experience is logical considering the impact on personal identity and relationship with the environment.

Sample Population, Method, and Frame

The study population used was RNs who have worked as an RN for at least 2 years. To be eligible for the study, they had to be working in some nursing capacity. The population was from Santa Barbara, Ventura, Los Angeles, Orange, San Bernardino, Riverside, San Diego, and Imperial counties in Southern California. California Board of RNs (CBRN) provided the mailing addresses for all licensed nurses in these counties.

Sampling was a single-stage, randomized selection from the BRN list of licensed RNs. Crosby, DiClemente, and Salazar (2006) stated that a sampling frame is a comprehensive list of elements, but in actuality it is rare for a sampling frame to be exhaustive of the population (p. 291). This study focused on RNs who had been out of school at least 2 years and are active working as nurses. This study does not include student nurses, retired nurses, or nurses who were not working. The purpose for this selection is that nurses in their first 2 years of nursing are struggling with the anxiety of adapting to their first work environment and thus see the environment with added instability. Retired nurses or nurses who are not in the present work environment are distant from the memory and experience of lateral and vertical incivility. Identifying these limitations allows the study to be generalized to working nurses with greater than 2 years of experience. Due to a low response rate, it was necessary to change the method of obtaining study subjects. The decision was to approach nursing faculty from surrounding schools of nursing.

The inclusion criteria for the study subjects remained the same but seven nursing school within Southern California were approached and asked to have their faculty participate in the study. Five out of the seven schools participated providing a study response that allowed for reasonable statistical analysis.

Sample Size

A study conducted by Spetz, (2011) for the Board of Registered Nursing states that there are 310, 739 RNs living in California as of March 20, 2011. The number increases and decreases based on migration of nurses to and from the state, graduates who have passed the board for license on any particular day, and fluctuates based on

licenses that become inactive and reactivated. The study sample initially came from the active licensed mailing list provided by the Board of Registered Nursing in the state of California. The addresses with the counties previously identified as Southern California counties were pulled and counted. Allowing for shifts in the population calculations for sample size is based on a population of 311,000. Using a confidence level of 95%, confidence interval of 5%, and a response distribution of 50% the required sample size was to be 384 (Triola, 2011). Anticipating only a 30% response rate it was necessary to mail out 1300 letters with surveys in order to meet the required sample size. This would have required a larger data base to accomplish non-parametric analysis requiring an increase of 2000 letters to be mailed. The response from this group of study subjects failed to yield more than 26 responses resulting in the need to reevaluate.

The low response rate required approaching the Walden Internal Review Board (IRB) with the request to run the study a second time with a collection of study subjects, faculty, from schools of nursing in Southern California. Walden IRB approved the change and the request for participation went to seven schools including the schools IRB and five out of the seven agreed to participate.

Treatment

This quantitative study does not introduce a treatment. The study is focused on the survey method collecting data that will afford information surrounding the dynamics of self-esteem and locus of control as they pertain to the RNs' experience with lateral and vertical incivility.

Instrumentation and Materials

This study used three survey tools. The first tool was the demographics collection tool used to collect data that indicated that the study subject meets the inclusion criteria. The second and third tools used were the measurement tools for self-esteem and locus of control. Each tool was identified along with the process for using the instrument and the expected data to be obtained. Concerns for internal validity and reliability will be addressed.

Description of Instrumentations

The data collection tools are focused on gaining information that surrounds the dependent and independent variables. The dependent variable is the experience with lateral and vertical incivility in the work place. The independent variables are the self-esteem and locus of control. The experience of lateral and vertical incivility was obtained through the demographic survey along with other variables that may reveal relationships that impact the perception of the lateral and vertical incivility in the work place.

The first instrument completed by the study subjects was a demographic survey with questions directed to identify inclusion criteria and exclusion criteria. This step was required as the mailing list from the CBRN does not identify any of the criteria other than active or inactive licensing. The demographic survey was written and designed by this researcher and can be found in the appendix.

The second instrument used was the Rosenberg Self-Esteem Scale a tool for assessing global self-esteem. The tool has been used by researchers in psychology, and social sciences over the years. The reliability and validity of this instrument indicates an internal consistency of 0.77 with a minimum Coefficient of Reproducibility of at least

0.90 (Rosenberg, 1965). The scale is a self-report of 10 questions with answer options of strongly agree, agree, disagree, and strongly disagree.

The third and last research tool used was the Spheres of Control scale designed by Delroy Paulhus. Unlike Rotter whose scale assessed locus of control from a uni-dimensional view Paulhus demonstrated that there is evidence for a multidimensional interpretation (Paulhus, 1983). Paulhus suggested that there are three primary spheres of behavior surrounding an individual's perceived control. The first sphere is personal efficacy focusing on control over personal achievement. The second sphere is interpersonal control with attention to control over other people and groups. The third sphere is sociopolitical control with a concentration on control over social and political events and institutions (Paulhus, 1983). The advantage to the Spheres of Control scale over the Rotter I-E scale is the multidimensionality of the Spheres of Control Scale allows for greater insight to the issue of internal and external control and environment. The scale has been found to have remarkable convergent and discriminant validity with both laboratory and field studies supporting the predictive validity of the Spheres of Control Scale (Paulhus, 1983). The scale has 30 items, 10 items for each scale, personal control, interpersonal control, and socio-political control. Each response uses a seven point scale from agree to disagree. The norms for this instrument have been based on 177 undergraduate students.

The Personal Control scale questions proved to have a standard deviation of 8.3 with an alpha of 0.80. The Interpersonal Control scale questions have a standard deviation of 9.1 and an alpha of 0.83. The third is the Socio-Political scale questions have

a standard deviation of 8.3 and an alpha of 0.75. The Spheres of Control Scale can be found via the internet and grants for public use of the scale for study.

Both the self-esteem scale and the locus of control scale questions are designed to detect consistency across a participant's answers. Locus of control scale questions are designed to identify an individual's spheres of control, personal efficacy, interpersonal control, and sociopolitical control. In comparison the self-esteem scale questions seek a level of the individual's self-worth.

Psychometrics

Understanding the science of psychometrics requires an understanding of psychological testing. Psychological testing is done to test the psychological attributes of individuals (Furr, Bacharach, 2014). Psychometrics is the science behind the testing. What is of significance in psychometrics is the type of information created by the use of the test, the reliability of the data, and matters relating to the validity of the data (Furr, Bacharach, 2014). Two issues surrounding the instruments used in this study are test dimensionality and response bias.

Evaluating test dimensionality requires answering three central questions, how many factors are revealed in the test questions, if the test has more than one factor are they related to one another, and if there are more than one factor then what are those dimensions (Furr,& Bacharach, 2014)? Rosenberg's Self-Esteem Scale is uni-dimensional in that it measures a single dimension global self-esteem. It is expected that with such a test the score would be a single score and related to only one dimension. In contrast Paulhus's Spheres of Control Scale is multidimensional requiring further insights.

Multidimensional tests are tests with higher ordered factors. There are two types of multidimensional tests one with correlated dimensions and one with uncorrelated dimensions. Simply, a multidimensional test with correlated factors means that each factor is related to the other. In contrast a multidimensional test with uncorrelated factors indicates that the dimensions are not related or weakly connected with each other (Furr & Bacharach, 2014). Another aspect of multidimensional tests that needs to be understood is in the scoring of such tests. Multidimensional tests with correlated dimensions begin to score each dimension independently, but ultimately the scores are combined producing a single total score. Multidimensional tests with uncorrelated dimensions score each dimension separately (Furr & Bacharach, 2014). Paulhus's Spheres of Control Scale is a multidimensional test with uncorrelated dimensions. Each sphere, personal control, interpersonal control, and sociopolitical control result is scored independent from the other dimensions. The reliability and validity of both instruments used in this study has been addressed earlier, but another concern in psychological testing is response bias.

Bias

Likert scales may be subject to bias. Social desirability bias occurs when the study subject answers based on making themselves appear more favorable whereas acquiescence bias the study subject answers the statements without regard for the meaning of the statements (Furr & Bacharach, 2014). Study subjects may avoid extreme responses resulting in central tendency bias. Both Rosenberg and Paulhus tests are designed with Likert scales that indicate extreme and moderate responding. The issue surrounding extreme and moderate biases denotes the variances in the inclination to use or avoid extreme responses (Furr & Bacharach, 2014). Furr and Bacharach (2014) discuss

the issue of malingering. Malingering is seen in the study subject's effort to inflate their psychological problems. This type of bias is most likely to occur in criminal competency hearing, workers compensation, personal injury, and disability claims (Furr & Bacharach, 2014). In this study considering the independent variables and the educational level of the population the greatest concern was social desirability and central tendency bias. Professional competence often reflects social desirability and would be of significant importance for study subjects within this study.

Data Collection and Analysis

The data collection process faces numerous challenges just by the nature of how the data is collected and the validity of the data collection instruments. This study used previously validated survey scales but relied on self-reported experiences with lateral and vertical incivility. The subject matter surrounding this study encompasses several psychological factors that may give a study subject pause. It was the hope of this researcher that utilizing a survey method rather than an interview method the study would have been less intimidating in the subjects' ability to answer spontaneously and without bias.

Process

Two thousand study subjects were invited into the study through a letter introducing the researcher, the study, and instructions on how to participate in the study should they choose to participate. The letter of introduction included instructions on how to access the surveys through Survey Monkey and assurance of anonymity. Thirty days from the time the original letters were sent out the number of responses was assessed and a second letter was sent as an invitation reminder. Following this process 139 letters were

returned with wrong address and no forwarding address. Furthermore, after a waiting 60 days post second mailings only 26 subjects responded on Survey Monkey. The response was not adequate for statistical analysis. An application requesting the IRB to consider a change in the procedure in obtaining study subjects was presented. The IRB approved the following subject selection process.

The following schools of nursing were approached for faculty participation, Riverside City College, West Coast University, California Baptist University, Loma Linda University, Western University, Mount San Jacinto College, and California State University San Marcos. Out of the seven schools two declined and five schools participated. The original letter of invitation previously approved by the IRB and used with the initial 2000 mailings was emailed to the deans of the participating nursing schools. The deans forwarded the email invites to all nursing faculty for a total of 431 contacts. This second process yielded a total of 64 responses to the surveys on the Survey Monkey system.

Data

Data was collected from demographic survey and the self-esteem and locus of control scales. The data was evaluated based on the relationships between self-esteem, locus of control, and the individual's experience of lateral and vertical incivility in the work place. Correlation analysis between the study subjects' scores on the two traits and the subjects' self-reported experience with lateral and vertical incivility on the job was evaluated with relationship to the amount of time on the job, type of nursing job, sex, and age. Two of the instruments are designed as Likert scales with measurement of strongly

agree, agree, disagree, and strongly disagree whereas the survey to collect demographic information is designed to obtain categorical data.

Analysis

The study data was analyzed using parametric statistics. Allen and Seaman (2007) indicate that Likert scales can be analyzed as interval data or ordinal data the argument being that parametric tests are more powerful than non-parametric. However, Allen and Seaman point out that without studying the values of the dataset and the objectives of the analysis both can mislead and misrepresent the findings of the survey. The issue of data from the Likert scale being considered interval-level data or be considered ordered-categorical data is a topic open to debate (Statistics Café, 2011). Prior to the study the proposal expected to take a non-parametric course, which would have expected Spearman's rank correlation coefficient to be used for analysis of dependent, independent and variables found within the demographic survey. In review of the surveys information such as sex, years in nursing, and level of education may have an impact on the dependent and independent variables. It was expected that the Mann-Whitney U test would be in place of the *t* test (McDonald, 2009). Mann-Whitney U test is typically used when the data is ordinal, the sample is random, and independence within the samples and mutual independence is assumed (McDonald, 2009). Nonparametric regression was considered to be used but due to the need for a large study response and the low response rate in this study, non-parametric analysis was not considered to be the best course to follow. After significant review of the literature the analysis of data from this study took a parametric course and will be discussed in Chapter 4.

Analysis of the independent variables with the dependent variable is to examine the relationship between the level of self-esteem and locus of control and the experience of lateral and vertical incivility in the work place. Self-esteem and locus of control have been discussed in depth in the literature review indicating the importance of positive self-esteem and an internal locus of control to maintain healthy interpersonal communication skills. Discussion regarding the issue of lateral and vertical incivility in the workplace was discussed in the literature review indicating a breakdown in communication in hostile work environments.

Participants' Rights

The participants in this study were invited to participate in the study but were free to decline. Use of Survey Monkey and numerical coding of the mailers provided anonymity and required the participant to be proactive in determining their participation. The study received approval by the Walden University IRB as complying with the ethical standards for human subjects research. The study was conducted with volunteers recruited outside the investigator's place of work. The investigator does not have any formal relationship with the participating institutions.

Summary

The methods chapter has covered the research design providing an understanding as to the choice of the design, the setting and sample describes the population, eligibility criteria, and sample size. The survey tools are described with explanations regarding the process of use and quantitative data acquired. Data collection along with the method of data analysis is described with explanation as to the necessary changes that were required to complete this study. Chapter Four presents the analysis of the data collected. The

following items are presented in Chapter Four: a descriptive analysis of the overall study, an analysis of the perceptions of experience, descriptive predictor variables, Rosenberg's self-esteem response and finally Paulhus' spheres of control response.

Chapter 4: Results

The purpose of the study was to examine lateral and vertical incivility through the RNs' experience and relate it to self-esteem and locus of control. The following hypotheses guided the study:

H0$_1$: RNs who experience bullying and incivility in the workplace will not exhibit signs of low self-esteem.

H1$_1$: RNs who experience bullying and incivility in the workplace will exhibit signs of low self-esteem.

H0$_2$: RNs who experience bullying and incivility in the workplace will not exhibit signs of external locus of control.

H1$_2$: RNs who experience bullying and incivility in the workplace will exhibit signs of external locus of control.

In chapter 4 study analysis methods are identified and the data is provided as it pertains to the hypotheses and the study questions. Both qualitative and quantitative data is presented. Chapter 4 presents the analysis of the data collected from the research respondents. A review of the study purpose is presented. The tools used for data analysis are presented. Finally, the data analysis is presented according to specific themes: an analysis of the perceptions of experience, descriptive predictor variables, Rosenberg's self-esteem response results, and finally Paulhus' spheres of control response results.

Data Analysis

Data analysis was done using the SPSS, version 20. Due to the low response rate and thus the required changes in sampling, the data analysis process changed to provide adequate and accurate analysis. Descriptive statistics were used in evaluating the demographic information. The parametric *t* test was done to compare the RNs who

experienced lateral and vertical incivility in the workplace to those who did not. The Pearson correlation was used to evaluate the relationship between RNs' level of education and Paulhus' Spheres of Control.

Descriptive Analysis

A total of 65 RNs, 57 females and 8 males, responded to the second attempt to collect data for this study. Among the respondents 32% ranged in age between 45 and 54 years, 29% between 35 and 44 years, 26% between 55 and 64 years, 8% between 25 and 34 years, and 5% between 65 and 74 years of age. Cultural and ethnic group assessment indicated the two largest groups as White at 52% and Filipino at 12%. Black and Asian respondents were both at 8%, Hispanic at 6%, Middle Eastern and other at 5% each, Caribbean Islander and American Indian were 3 and 1 percent respectively. Regarding years of service working as a registered nurse 32% of respondents had worked over 30 years and 15% had worked 6 to 10 years. Those respondents who worked 11 to 14 years, 15 to 20 years, and 21 to 25 years ranked at 12% each. Those who worked 25 to 30 years and 2 to 5 years came in at 9 and 6 percent respectively. Level of education was evaluated with 59% of respondents having Masters in Nursing (MSN), 14% having Bachelors in Nursing (BSN), PhD and Doctorate in Nursing Practice (DNP) was 12 and 11 percent respectively. Five percent of respondents had an Associate Degree in Nursing (ADN). The question regarding type of nursing practice allowed the study subject to provide more than one answer as registered nurses frequently work more than one job functioning in two distinctly different roles. Keeping this in mind, 55% reported working as faculty, 42% working bedside direct patient care, 23% management, 18% advanced practice nursing, and 9% reported working in clinic settings.

Analysis of Particpant Perception of Experience

The percentage of nurses who personally experienced any of the behaviors described as workplace lateral and vertical incivility was found to be 83% with 17% denying having had such

an experience. Those nurses who admitted witnessing workplace lateral and vertical incivility was 86% with 14% denying that they have ever witnessed such behavior in the workplace. The question that assessed who was the perpetrator of the workplace lateral and vertical incivility allowed the respondent to make more than one response. Nurses themselves proved to be the largest group at 77% to perpetrate lateral and vertical incivility in the health care workplace. Sixty three percent of the perpetrators were physicians, 45% management, and 31% was categorized as other. The question that assessed what capacity the nurse worked when the incidence of workplace lateral and vertical incivility was experienced permitted the respondent to answer more than once. Thirty five percent of nurses who experienced lateral and vertical incivility were working as faculty, 20% working as managers, 14% working in a clinical setting, and 12% working as advanced practice nurses. Table summaries of these variables are presented on the following three pages (Tables 1, 2, and 3).

Table 1

Descriptive Statistics of Demographic Variables: Gender, Age, and Ethnicity

Measure (*n*=65)		*f*	%
Gender			
	Female	57	88
	Male	8	12
Age			
	25-34 years	5	8
	35-44 years	19	29
	45-54 years	21	32
	55-64 years	17	26
	65-74 years	3	5
Ethnicity			
	Caucasian	34	52
	Black	5	8
	Asian	5	8
	Hispanic	4	6
	Middle Eastern	3	5
	Other	3	5
	Filipino	8	12
	American Indian	1	1
	Caribbean Islander	2	3

Table 2
Descriptive statistics and demographic variables: Year, Employment status, Education, and Placement

Measure (*n*=65)	*f*	%
Years Registered Nurse		
2-5	4	6
6-10	10	15
11-14	8	12
15-20	8	12
21-25	8	12
26-30	6	9
Over 30	21	32
Presently Employed		
Yes	65	100
No	0	0
Highest Level of Education		
ADN	3	5
BSN	9	14
MSN	38	59
DNP	7	11
PhD	8	12
Type of Nursing Practice		
Bedside/Hospital	27	42
Clinic	6	9
Management	15	2
Faculty	36	55
Advanced Practice	12	18

Table 3

Descriptive Statistics of Demographic Variables: Work Place Incivility

Measure (*n*= 65)	*f*	%
Victim of workplace incivility?		
Yes	54	83
No	11	17
Witnessed workplace incivility?		
Yes	56	86
No	9	14
Perpetrator of lateral and vertical incivility toward you or a nurse colleague		
RN	50	77
Physician	41	63
Management	29	45
Other	20	31
Your work capacity when you experienced lateral and vertical workplace incivility.		
Clinic nursing	9	14
Management	13	20
Faculty	23	35
Advanced Practice	8	12

Descriptive Statistics of Predictor Variable

The predictor variables were combined for this analysis. Personally being bullied and witnessing someone being bullied should both be considered an experience in much the same way sexual harassment is viewed with the witness having experienced the incident and the right to file grievance. Many of the study subjects claimed to personally

experiencing and witnessing lateral and vertical incivility in the workplace. Of the respondents, 58 (89%) admitted to either experience where 7 or (11%) of respondents denied having witnessed or personally experienced such events. A frequency table was developed reflecting the predictor variable results. (See table 4)

Table 4

Descriptive Statistics of Predictor Variable

Measure	*f*	%
Victim and/or witness of workplace incivility?		
Yes	58	89
No	7	11

Inferential Statistics

The study questions examine self-esteem and locus of control in relationship to the RNs' experience of lateral and vertical incivility or not having experienced lateral and vertical incivility. Comparisons are made amongst self-esteem and locus of control with the intent to provide as much clarity as possible. Due to the significantly higher level of education amongst study subjects education was used as a predictor when looking at the individual spheres of control in Paulhus' Spheres of Control survey.

Rosenberg's Self-Esteem

The hypothesis tested for self-esteem was:

$H0_1$: RNs who experience bullying and incivility in the workplace will not exhibit signs of low self – esteem.

$H1_1$: RNs who experience bullying and incivility in the workplace will exhibit signs of low self – esteem.

The hypothesis tested for self-esteem was: $H0_1$: $\mu_{exp} = \mu_{nex;}$ $H1$: $\mu_{exp} < \mu_{nex.}$ The statistical assumptions for the independent-samples *t* test include the following: (a) each data point in the sample is independent, (b) the data in each of the two populations are normally distributed, and (c) the two populations have equal variances. The results of the test were not statistically significant, t (60) = 0.26, $p > .05$. Consequently, the null hypothesis is not rejected; there is no difference in self-esteem scores between the groups. Registered nurses who have experienced lateral and vertical incivility in the work place (M = 17.22, SD = 2.15) reported higher self-esteem than their colleagues (M=17.00, SD = 1.00). The measure of effect size, as indexed by d, was 0.13, indicating a small effect between registered nurses who have experienced lateral and vertical incivility in the work place and their counterparts.

Paulhus' Spheres of Control

The hypothesis tested for spheres of control was:

$H0_2$: RNs who experience bullying and incivility in the workplace will not exhibit signs of external locus of control.

$H1_2$: RNs who experience bullying and incivility in the workplace will Exhibit signs of external locus of control.

The hypothesis tested for personal sphere of control was: $H0_2$: $\mu_{exp} = \mu_{nex;}$ H_1: $\mu_{exp} > \mu_{nex.}$ The statistical assumptions for the independent-samples *t*-test include the following: (a) each data point in the sample is independent, (b) the data in each of the two populations are normally distributed, and (c) the two populations have equal variances. The results of the test were not statistically significant, t (59) = 0.81, $p > 0.05$. Therefore, the null hypothesis is not rejected; there is no difference in the personal sphere of control

between the two groups. Registered Nurses who have experienced lateral and vertical incivility in the work place (M = 58.02, SD = 6.25) reported a higher personal sphere of control than their colleagues (M = 56.00, SD = 5.74). The measure of effect size, as indexed by *d* was 0.34, consequently indicating a small to medium effect between RNs who have experienced lateral and vertical incivility in the workplace and those who have not.

The hypothesis tested for interpersonal sphere of control was: $H0_2$: $\mu_{exp} = \mu_{nex;}$ $H1_2$: $\mu_{exp} > \mu_{nex.}$ The statistical assumptions for the independent-samples *t* test include the following (a) each data point in the sample is independent, (b) the data in each of the two populations are normally distributed, and (c) the two populations have equal variances. The results of the test were not statistically significant, $t\ (59) = -0.15$, $p > 0.05$. The null hypothesis is not rejected; there is no difference between those who have experienced lateral and vertical incivility in the work place and those who have not. Although, RNs in both groups maintain an internal locus of control within the interpersonal sphere those who have experienced lateral and vertical incivility in the workplace (M = 53.59, SD = 9.11) reported lower interpersonal sphere of control than their counterparts (M = 54.14, SD = 6.77). The measure of effect size, as indexed by *d*, was 0.07, thus indicating a small effect between RNs who have experienced lateral and vertical incivility in the workplace and those who have not.

The hypothesis tested for sociopolitical sphere of control was: $H0_2$: $\mu_{exp} = \mu_{nex;}$ $H1_2$: $\mu_{exp} > \mu_{nex.}$ The statistical assumptions for the independent-samples *t*-test include the following: (a) each data point in the sample is independent, (b) the data in each of the two populations are normally distributed, and (c) the two populations have equal

variances. The results of the test were not statistically significant, t (59) = -0.90, $p > 0.05$. Therefore, the null hypothesis is not rejected; there is no difference in one's sociopolitical sphere of control scores between the two groups. Registered nurses who have experienced lateral and vertical incivility in the work place (M = 41.83, SD = 8.69) reported a lower sociopolitical sphere of control than their counterparts (M = 44.86, SD = 4.18). The measure of effect size, as indexed by *d*, was 0.44, indicating a small to medium effect between RNs who have experienced lateral and vertical incivility in the work- place and their colleagues who have not.

Table 5

Results of t-Tests Comparing RNs who have and have not experienced bullying and incivility in the work place.

Variable	*df*	*t*	*d*	*p*
Self-esteem	60	.26	.13	.79
Sphere of control				
personal	59	.81	.34	.42
interpersonal	59	-.15	.07	.88
sociopolitical	59	-.90	.44	.37

The results of the Pearson Correlation test were statistically significant, r (65) = -0.30, $p < 0.05$. There is a negative relationship between one's educational level and their sociopolitical sphere of control. The strength of the relationship was weak, with nine percent of the variance in one's sociopolitical sphere of control explained by their educational level. Therefore, the results found that the higher the level of education the more external one's locus of control is when faced with issues of government, corporations and big business.

Table 6

Pearson Correlation between educational level and Paulhus' Spheres of Control (N= 65)

Variable	education	personal	interpersonal	sociopolitical
	1	2	3	4
education	-	.12	.04	-.30*
personal		-	.60*	.19
interpersonal			-	.12
sociopolitical				-

*$p < 0.05$

Summary

Chapter Four has provided the analysis results of the study data. Despite the difficulty in getting study subjects to respond the final results did provide a picture of the extent of the experience of lateral and vertical incivility, the position of the typical perpetrator, and overall view of the lateral and vertical incivility experience with one's self-esteem and locus of control. The significance of the results will be presented in Chapter Five.

Chapter 5: Discussion, conclusions, and recommendations

Much has been written about bullying in the nursing profession and bullying needs serious discussion within its professional circles. The problem of bullying adds support for the belief that "nurses eat their young." And bullying behavior creates many risks for those who perpetrate and experience such behavior, for example, surrounding patient care, safety, institutional financial loss, and the personal consequences. The purpose of this study was to examine lateral and vertical incivility through the RNs' experience and relate it to self-esteem and locus of control.

Study Findings

The most significant result in this study is that both null hypotheses prevailed: (a) $H0_1$–RNs who experience bullying and incivility in the workplace will not exhibit signs of low self-esteem. And, (b) $H0_2$—RNs who experience bullying and incivility in the workplace will not exhibit signs of external locus of control. The second significant result is that 83% of respondents were a victim of lateral and vertical incivility in the workplace while 86% of respondents witnessed such behavior. For the vast majority of study participants, lateral and vertical incivility is occurring in the health care environment. Previously mentioned in chapter two, Quinne's (1999) study found similar results with 38% having experienced and 42% having witnessed bullying. Krebs (1976) study regarding incivility in the workplace found that incivility to be 10 times more frequent than workplace violence. Knowing that nurses are experiencing the lateral and vertical incivility either directly or indirectly and that the null hypothesis prevails provides insight to the two core personality elements analyzed.

Reflecting back to chapter two studies surrounding self-esteem and locus of control indicated a relationship between low self-esteem and external locus of control being affiliated to an aggressive coping response (Wallace & Barry, 2010). However, Dijkstra, Beersma, and Evers (2011) did find that those in the health care sector with internal locus of control used problem solving and conflict management ultimately reducing work environment strain. The data analysis (tables 4 and 5) for this study indicates that the experience of lateral and vertical incivility minimally if at all impact self-esteem or locus of control. Schwalbe, Gecas, and Baxter (1986) found that cooperative requirements in job creation led to the significance of self-perceived competence and social opinion. Nursing has a clear understanding of the importance of their role in health care this fact may explain the results surrounding self-esteem and locus of control in this study population. Ferris, Brown, Lian, and Keeping (2009) studied the role of contingencies of self-worth. The study was developed out of the general belief that low self-esteem is a predictor to deviant behavior. Their findings was true only for those with low levels of workplace dependent self-esteem. This concept would to interesting to use in evaluating the perpetrators of workplace lateral and vertical incivility.

The Pearson Correlation analysis of level of education and Paulhus' Spheres of Control indicated that the higher the education the less control one believes they have on government or corporate issues. Although this does not have a direct relationship on the study question the results were exposed due to the choice in using Paulhus' Spheres of Control scale.

Changing the method for obtaining study subjects and the data analysis surrounding self-esteem and locus of control begs the question does a higher level education support healthy self-esteem and locus of control? The difficulties in obtaining a statistically significant study subject response rate along with other study challenges provided significant insights and understandings to the development of a research study.

Study Weakness

The two significant difficulties in this study were the inability to get the number of responses originally desired for the study, and discovering that Survey Monkey, which was used for data collecting, did not have a common variable in the collection system. The first problem was resolved by lowering the contact number and approaching populations in academic settings. This solution changed the generality of the population and created a situation in which the data results may appear skewed based on the educational level of the subjects. The second weakness was not anticipating that Survey Monkey did not have a system that provided a common variable when using more than one survey. This made the statistical analysis challenging. This problem could have been avoided by incorporating all three surveys in one entry into the Survey Monkey system. Another solution would have been to provide each subject with an identification number while maintaining anonymity. Despite these issues the study has the ability to be replicated. Obtaining a more general RN population would make this a much stronger study providing a more academically balanced group.

Recommendation for Future Study

Considering that the null hypotheses of this study prevailed, the answer to why lateral and vertical incivility exists in the healthcare work environment remains unclear.

Further study is needed regarding this topic. Studying the use of professional communication, comparison of lateral and vertical incivility between different work environments and industries may provide some insight regarding such behaviors. Another question that arises from this study and a question that cannot be ignored, are these issues social in nature and not simply a workplace phenomenon?

Implications for Social Change

The core of this study deals with social interaction and professional communication, which reflects on the care and safety of patients and the economic impact on the health care industry. There is a moral and ethical obligation to seek social change due to the impact these behaviors have on patients, who are, when under the care of a health care team legally identified as a dependent and vulnerable population. It has been my personal and professional observation that the problem of lateral and vertical incivility reaches all levels of health care that provides direct patient care. Changing the health care work environment culture requires a true understanding of the cause of such behavior. Changing a work environment culture takes time and patience.

Change must take place from within the nurse and throughout the work environment. Hospital administrations need to recognize the difficulties within the work environment and find supportive measures for all health care staff. Hospital administrations have become big on customer service training educating the employee on the mandated Hospital Consumer Assessment of Healthcare Providers and Systems to improve the patient care experience (Centers for Medicare and Medicaid Services, 2013). The patient experience reflects what the patient hears, how the patient is treated, and the environment the patient is treated in. The experience is dependent on the nurses' ability

to communicate therapeutically and to cope with the traumatic full arrest, medication arriving late from pharmacy, the cardiac arrest in pediatrics, or the grieving family. Nurses must be listened to when hospital processes do not work and result in a delay care. Nurses must learn how to strengthen coping abilities and provide supportive behaviors amongst each other. The implications for social change within the health care system and beginning with nurse incivility are significant. As the Affordable Care Act becomes effective there will be more people to provide health care for and a greater need for nurses to be supportive of one another and their patients.

Furthermore, as stated before these behaviors may not need to be viewed as a workplace issue but a social problem that if not addressed will prove to be a human affliction. The evening news is filled with events exposing how people have met with situations that are well within the definitions of bullying, isolation, verbal and physical abuse. Children are resorting to violence as they are unable to cope with the incivility and hostility that they face on what is often a daily basis. Such a human affliction has the potential for becoming contagious.

Summary

This study began with The Joint Commission's 2008 statement reflecting the concerns for the health care environment and patient safety indicating "behaviors that undermine a culture of safety" do exist. Examination of the literature further indicated that workplace bullying and incivility is prevalent and results in consequences for the employee, employer, but most important for the patient. The study was further developed with the purpose of trying to understand why such behavior exists. It was decided the traits of self – esteem and locus of control would be evaluated as they relate to the

registered nurses' experience with workplace incivility. The null hypotheses for this study prevailed indicating that self – esteem and locus of control do not influence the RNs' perception of incivility in the health care workplace, nor does the RNs' perception of incivility in the health care workplace impact self – esteem or locus of control.

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Appendix A: Study Demographics Survey

Elizabeth Berry, MSN, FNP

Ph.D Dissertation

Study Demographics

1. Male ___ or Female ___ Age ____

2. Ethnicity/Culture: ____ Caucasian ____ Middle Eastern
   ____ Black ____ Filipino
   ____ Asian ____ African
   ____ Hispanic ____ American Indian
   ____ East Indian ____ Caribbean Islander

   Any other ethic/cultural decent:_____

3. Number of months/years as a practicing registered nurse ____

4. Are you presently employed Yes or No

5. Present Nursing Degree: ADN ____ BSN ____ MSN ____ DNP ____ Ph.D __

6. Type of Nursing: Bedside ____ Clinic ____ Management ____ Faculty ____
   Advanced practice NP or CNS ____

7. During your time as a practicing registered nurse have you been a victim of bullying, incivility, isolation, or disruptive behaviors in the workplace? Yes or No

8. During your time as a practicing registered nurse have you witnessed a colleague being bullied, isolated by the team, or suffered from incivility or disruptive behaviors? Yes or No

9. Who perpetrated the bullying, incivility, or disruptive behaviors toward you or a nursing colleague? Mark all that apply.
   a. ____ Registered Nurse
   b. ____ Physician
   c. ____ Management
   d. ____ Other Professional title:_____
   e. ____Self

10. In what capacity were you working when you experienced any of the described behaviors in questions 7 and 8? Mark all that apply.
    a. ____ Hospital bedside nursing
    b. ____ Clinic Nursing
    c. ____ Management
    d. ____ Faculty
    e. ____ Advanced Practice

Appendix B: Rosenberg Self-esteem Scale (1965)

Instructions: Below you will find a list of statements that deal with general feelings about yourself. If you strongly agree circle mark SA. If you agree mark A. If you disagree mark D and should you strongly disagree mark SD.

1. On a whole, I am satisfied with myself.	SA	A	D	SD
2. At times, I think I am no good at all.	SA	A	D	SD
3. I feel I have a number of good qualities.	SA	A	D	SD
4. I am able to do most things as well as other people.	SA	A	D	SD
5. I feel I do not have much to be proud of.	SA	A	D	SD
6. I certainly feel useless at times.	SA	A	D	SD
7. I feel I am a person of worth, at least on an equal playing field as others.	SA	A	D	SD
8. I wish I had more respect for myself.	SA	A	D	SD
9. All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10. I take a positive attitude toward myself.	SA	A	D	SD

Appendix C: Spheres of Control Scale: Version 3

Write a number from 1 to 7 to indicate how much you agree with each statement.

```
1        2        3        4        5        6        7
/        /        /        /        /        /        /
Disagree                  Neutral                    Agree
```

____ 1. I can usually achieve what I want if I work hard for it.

____ 2. In my personal relationships, the other person usually has more control than I do.

____ 3. By taking an active part in political and social affairs, we the people can influence world events.

____ 4. Once I make plans, I am almost certain to make them work.

____ 5. I have no trouble making and keeping friends.

____ 6. The average citizen can have an influence on government decisions.

____ 7. I prefer games involving some luck over games requiring pure skill.

____ 8. I'm not good at guiding the course of a conversation with several others.

____ 9. It is difficult for us to have much control over the things politicians do in office.

____ 10. I can learn almost anything if I set my mind to it.

____ 11. I can usually develop a personal relationship with someone I find appealing.

____ 12. Bad economic conditions are caused by world events that are beyond our control.

____ 13. My major accomplishments are entirely due to my hard work and ability.

____ 14. I can usually steer a conversation toward the topics I want to talk about.

____ 15. With enough effort we can wipe out political corruption.

____ 16. I usually do not set goals because I have a hard time following through on them.

____ 17. When I need assistance with something, I often find it difficult to get others to help.

____ 18. One of the major reasons we have wars is because people don't take enough interest in politics.

____ 19. Bad luck has sometimes prevented me from achieving things.

____ 20. If there's someone I want to meet, I can usually arrange it.

____ 21. There is nothing we, as consumers, can do to keep the cost of living from going higher.

____ 22. Almost anything is possible for me if I really want it.

____ 23. I often find it hard to get my point of view across to others.

____ 24. It is impossible to have any real influence over what big businesses do.

____ 25. Most of what happens in my career is beyond my control.

____ 26. In attempting to smooth over a disagreement, I sometimes make it worse.

____ 27. I prefer to concentrate my energy on other things rather than on solving the world's problems.

____ 28. I find it pointless to keep working on something that's too difficult for me.

____ 29. I find it easy to play an important part in most group situations.

____ 30. In the long run, we the voters are responsible for bad government on a national as well as a local level.

Version III was published in a 1990 PID article (Paulhus & Van Selst, 1990)

Paulhus, D.L., & Van Selst, M. (1990). The Spheres of Control scale: Ten years of research. *Personality and Individual Differences, 11*, 1029-1036.

Appendix D: Permission to use Rosenberg's Self-Esteem Scale

May I have permission to use the Rosenberg Self-Esteem Scale in my research?
Dr. Florence Rosenberg, Manny's wife, has given permission to use the Self-Esteem Scale for educational and professional research. There is no charge associated with the use of this scale in your professional research. However, please be sure to give credit to Dr. Rosenberg when you use the scale by citing his work in publications, papers and reports. We would also appreciate receiving copies of any published works resulting from your research at the University of Maryland address listed below.

How do I cite the scale?
You should cite the scale according to the standards of your discipline. The most appropriate citation is:
Rosenberg, Morris. 1989. *Society and the Adolescent Self-Image*. Revised edition. Middletown, CT: Wesleyan University Press.

Are there foreign language versions of the scale available?
The Rosenberg Self-Esteem Scale is perhaps the most widely-used self-esteem measure in social science research. The scale has been translated into many languages; unfortunately, the University of Maryland is not a repository for such scales. Please refer to the scholarly literature in the language which you are using.

Can you tell me what the scale cut-offs are for high and low self-esteem?
There are no discrete cut-off points to delineate high and low self-esteem.
It is recommended that you consult the literature relevant to the population you are interested in studying. By examining this literature you should be able learn more about the norms of a specific population.

The Rosenberg SES may be used without explicit permission.
The author's family, however, would like to be kept informed of its use.
Send information about how you have used the scale, or send published research resulting from its use, to the address below:

The Morris Rosenberg Foundation
c/o Dept. Of Sociology
University of Maryland
2112 Art/Soc Building
College Park, MD 20742-1315

2112 Art-Sociology Building, University of Maryland, College Park, MD 20742 | Ph: 301-405-6392 | Fax: 301-314-6892 | Webmaster

1. **PERMISSION TO USE ROTTER'S LOCUS OF CONTROL SCALE** Dr. **Rotter** will give **permission** providing you agree to the following conditions: 1) collect all copies of the **scale** ...

csuchico-dspace.calstate.edu/xmlui/bitstream/handl

Appendix E: Permission to use Paulhus's Spheres of Control Scale

From: del paulhus <delp1@mail.ubc.ca>
To: Elizabeth Berry <berryea@att.net>
Sent: Fri, July 6, 2012 2:03:30 AM
Subject: Re: Requesting permission to use Spheres of Control in dissertation study

Dear Elizabeth:
You have my permission to use the Spheres of Control inventory for your research.
Sincerely,
Del Paulhus, PhD

On 7/05/12 3:14 PM, Elizabeth Berry wrote:
Hello Dr. Paulhus,
My name is Elizabeth Berry and I am in the dissertation phase of my PhD in Public Health. My study is titled "Evaluation of Self Esteem and Locus of Control and the Relationship to the Registered Nurses' Experience with Lateral/Vertical violence in the Work Place". I have reviewed Rotter's scale and your scale and believe I may get a better insight by using the Spheres of Control. I am in need of a letter of permission and of course any words of wisdom for my study.
I am presently attending Walden University and my dissertation Chair is Dr. Daniel Roysden who I am sending a copy to this email.
Should you wish to discuss my study you may contact me at any time at 951-231-8542. I look forward to hearing from you.
Elizabeth Berry, MSN, FNP

Appendix F: Letter of Invitation to Participate in the Study

Elizabeth A. Berry, MSN, FNP
7450 Northrop Dr. #65
Riverside, CA
Ph. 951-231-8542
Email: berryea@att.net

February 13, 2012

Dear Colleague:

On July 9, 2008 The Joint Commission published a sentinel alert regarding "behaviors that undermine a culture of safety." The issue of bullying among registered nurses has brought about many theories as to why it occurs and studies are few. It is my hope that with your participation the nursing profession can gleam more information in hopes to find a sound method of resolving and preventing this negative behavior.

My name is Elizabeth Berry and I am presently completing my Ph.D. in Public Health. I am presently doing my research on the registered nurse's experience with lateral/vertical violence in the workplace or what is more commonly referred to as bullying in the workplace. The study is looking at the nurse's lateral/vertical violence experience and any correlation to locus of control and self-esteem. The purpose of this research is to explore the relationship between the perceived incivility in the work place and self-esteem and locus of control. This researcher has no potential conflicts of interest surrounding this study.

Inclusion criteria includes:

1. must be presently working
2. must be working for two years or more
3. Living in Santa Barbara, Ventura, Los Angeles, Orange, San Bernardino, Riverside, San Diego, and Imperial counties.

If you do not meet this criteria please abstain from this study.

The study surveys should take no more than 20 to 30 minutes. No personal identifying information will be collected and the results of the survey will be pooled to protect anonymity. There will be no thank you gifts, compensation, or reimbursements for participation in this study. Your willingness to complete the surveys indicate your implied consent to complete the survey study and utilize the survey results in this dissertation study and allow your results to be published.

You may access the survey at: **www.Power2You.com/survey**

Refusing to participate is a personal decision and holds no penalty. Should you have any concerns or you are uncomfortable with the study topic do not feel obligated to complete the surveys.

Sincerely,

Elizabeth Anne Berry, MSN, FNP
13434 Larkhaven Dr. Moreno Valley
cell (951) 231-8542
berryea@att.net

Profile	Registered Nurse for over 30 years. Experience in multiple nursing fields with a solid background in critical care, 7 years in child and adolescent psychiatry including Nursing Management of a locked adolescent unit, and 4 years in medical management with two national health plans. Management positions included oversight of quality of care for medical groups and development of a quality program for the adolescent unit. Experience as a clinical research coordinator for pharmaceutical and biomedical products. As a National Health Service Scholar and Family Nurse Practitioner provided primary health care and reproductive health care to underserved populations including prisoners in the Sutter County Jail and Juveniles in Juvenile Detention. Presently a Nurse Educator for Riverside County Regional Medical Center and adjunct faculty for two nursing schools.	
Education	Ph.D. in Public Health, Walden University M.S.N. Family Nurse Practitioner, University of Phoenix B.S. Nursing, University of Phoenix A.D.N. Registered Nurse, De Anza College	In Progress April 2001 February 1998 June 1976
	Certification and Licensure Registered Nurse: California License Family Nurse Practitioner: California Certification California Furnishing Privileges Public Health Nurse Certification	
Career History	**California Baptist University**, Riverside, CA **Adjunct Faculty** Adjunct faculty for RN to BSN program. Lecturer for Advanced Physical Assessment and Leadership courses.	September 2007- current
	Riverside County Regional Medical Center, Moreno Valley, CA **Nurse Educator** Provide both clinical and didactic education for nurses and other ancillary healthcare professionals. Responsible for relations with nursing programs/schools that utilize facility for clinical education. 2008-2010 Facility Co-Chair on Advisory Board for the Inland Empire computerized Clinical Placement Tool and Consortium. 2010-2011 Treasurer for Inland Empire Consortium. Development and managed the Nurse Residency program and Preceptor Training. Mental Health weekend hospital supervisor.	June 2006 – current

San Bernardino County Department of Public Health, San Bernardino, CA **Family Nurse Practitioner** Provide reproductive health services as defined by the Family Pact funding for both men and women. Services include history and physical with focus well woman exams, sexually transmitted disease screening, birth control and family planning.	March 2005-July 2006
University of Phoenix, San Bernardino, CA (multiple campus sites). **Part time Lecturer for RN to BSN program** Lecturer for Nursing 420, Health Assessment Lecture for Nursing 425, Health and Disease Management	June 2005-2009
California State University, Long Beach, Long Beach, CA **Part time Lecturer, Nursing Department** Clinical nursing instruction for Nursing 331L, Critical Care Nursing and lecture for Nursing 310, Human Life Cycle for Nurses.	August 2003-August 2006
NurseFinders, Sacramento and Redlands, CA **Registered Nurse- Temporary per diem hospital assignments** Temporary hospital assignments focused in critical care units: Intensive Care, Coronary Care, Emergency Department, and Post Anesthesia Care.	March 2002-December 2007
Sutter County Health Department, Yuba City, CA **Family Nurse Practitioner** Responsible for health care of the county jail inmates. Care of inmates included full history and physical, screening for infectious diseases, i.e. TB, sexually transmitted diseases. Provided care in daily sick call clinic Monday through Friday. Determined necessary level of care for inmates and their condition. Provided primary health care to an underserved population. Health care included services in women's health and prenatal care along with pediatrics and geriatrics. Patient population consisted of uninsured, MediCal and Medicare patients. The population was culturally very diverse with East Indian, Hispanic, Mong, and Laotian patients.	August 2001-August 2003

St. Jude Medical Center, Fullerton, CA — August 1999-October 2000
Registered Nurse-Emergency Department
Provided full emergency room nursing duties

Olsten Business Solutions, Loma Linda, CA — 1998
Med-America Clinical Research, Riverside, CA
Clinical Research Coordinator
Oversight of outpatient biotechnology research project for Olsten Business Solutions. Coordinated and determined if patients met inclusive criteria for study. Responsible for oversight of quality controls of the study. Worked with hospital clinic coordinators for study and attended all patient clinics and testing. Prepared all blood samples for shipment to research lab and maintained data base. Maintained and coordinated data. Oversight of inpatient pharmaceutical research project for Med-America Clinical Research. Determined if patient met all inclusive criteria for participation in study. Coordinated with admitting physicians and reviewed hospital stay. Did discharge follow up of study patients. Completed study data for submission to pharmaceutical company.

Riverside General Hospital, Riverside, CA — 1992-1998
Registered Nurse-Emergency Department
Provided full emergency nursing duties including major trauma.

Aetna Health Plans, Loma Linda, CA — 1993-1997
Case Manager
Catastrophic case management including contracting with health care providers, hospitals, and vendors as needed. Oversight of employer groups, medical group, IPAs within the Southern California and Nevada area focus on quality of care and patient management processes.

	Riverside County Department of Mental Health, Riverside, CA **Nurse Manager-Involuntary inpatient adolescent unit** Participated in a team effort in the design and development of the therapeutic program and milieu environment. Developed policies and procedures in compliance with state and local regulatory agencies. Developed Quality performance program to meet JACHO and state requirements. QA program included medication administration adherence, management of assaultive behavior, restraint safety, and treatment activities. Responsible for hiring and all personnel issues within the unit. Passed JACHO inspection with full accreditation first year of opening unit.	1990-1993
	Knollwood Psychiatric and Chemical Dependency Hospital, Riverside, CA **Assistant Head Nurse-Voluntary Adolescent psychiatric and chemical dependency inpatient unit** Oversight and coordination of program activities. Development of the chemical dependency program and community outreach seminars and educational components of the program.	1986-1990
	Multiple positions in Northern and Southern California, all in critical care settings.	1976-1990
Professional Memberships	• Sigma Theta Tau • California Association of Nurse Practitioners • American College of Nurse Practitioners • 2009 – Present National Health Service Corps Ambassador • 2008 – 2010 Facility Co-Chair on Advisory Board for the Inland Empire computerized Clinical Placement Tool and Consortium • 2010-2011 Treasurer for Inland Empire Consortium • Riverside Community College Dept. of Nursing Advisory Board	
Awards	• National Health Service Scholarship • 2007 Caring Spirit Award for education	Awarded, 1999 Awarded, 8/7/07