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An Exploration of Bullied Nurses, Witnesses, and a Hospital's Bottom Lline

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Abstract

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by

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MBA, Franklin University, 2001

BS, National Louis University, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Nurses experiencing bullying or witnessing other nurses bullied may choose to vacate their hospital positions. Nurse attrition negatively impacts a hospital's bottom line, which can lead to insolvency and a lack of access to healthcare by patients. The purpose of this phenomenological study was to understand the choices nurses made regarding their careers after experiencing or witnessing bullying and to calculate a hospital's cost of loss. Freire's oppressed group theory provided the conceptual framework for the study. The basis of the research questions was to understand how the nurse felt when bullied or observing a coworker bullied, the actions taken, and the financial impact to the hospital. The snowball technique secured 11 RN participants for this phenomenological study with data collection consisting of a demographic questionnaire and semistructured interviews. Data analysis followed Maxwell's plan of initial analysis, transcribing and coding, theme identification, a final coding review, and the final abstraction. The findings in this study demonstrated that based on the lived experiences of the participants, demographics did not influence who or how nurses were bullied; and after leaving the employer, bullied nurses and witnesses displayed various emotions that encompassed nonchalance, anger, tears, or relief. Over half said they would have stayed if they had not been bullied or witnessed it. An additional theme demonstrated that the results of bullying significantly affected a hospital's bottom line in revenue and reputation. Eleven suggestions have been recommended for future studies. Academics, hospital administrators, nurses, and the community at large can use the study findings to effect changes in the hospital environment through conversations, grass-roots efforts, and collaboration.

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Dedication

Thank you to the following people for standing with me through this journey my parents, Roger and Rosalie Shriver; my husband Larry Williams; and my best friend Jeannette Travis. You all encouraged me when I did not think I would make it to graduation. You listened to me cry, scream, and rejoice.

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Chapter 1: Introduction to the Study

Introduction

The United States is in the midst of a nursing shortage. Although there have been four nursing shortages since the early 20th century, the current nursing shortage is different. In the United States, 1 in every 3 nurses leaves the nursing profession because he or she was bullied (Weinand, 2010, p. 24). Welding (2011) stated that 75% of nurses left the profession before the end of their first year of working (p. 37). Bullen (2013) noted that bullying was the reason that at least 60% of new graduate nurses left their job by six months (p. 1). The rate that new graduates are leaving the nursing profession is concerning because Baby Boomers have started to retire and there are not enough new nurses to replace them.

In their first jobs, new nurses often feel insecure and realize the practical limitations of the information learned in nursing school. A more experienced nurse may feel overwhelmed by changes in nursing practice, while a midlife career-change nurse may feel ill-equipped to handle a new career. These three types of nurses are targets for the bully because they are unsure, overwhelmed, and disillusioned (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012, p. 1). New hires, both new graduates and experienced nurses, are easy targets for the bully because they have not established rapport with other nurses. Many new nurses lack the confidence to stand up against the bully in fear of being labeled as troublemakers (Castronovo, Pullizzi, & Evans, 2015, p. 209). Bullying in addition to navigating the learning curve as a new hire can be

overwhelming for a nurse. A newly-hired nurse wants to fit in and make it through probation, but when there is a lack of peer support, it is difficult for the nurse to stay long enough to master the culture.

In this study, I explored the lived experiences of bullied nurses and those who witnessed a coworker being bullied to develop an understanding of the impact that bullying has on nurses and on hospital budgets. Castronovo et al. (2015) reported that in studies they reviewed, 53% of nurses felt that bullying was an accepted and common behavior at their place of employment (p. 209). Additionally, 48% stated they had been bullied in the last six months, 35% were being bullied weekly, 28% daily, and 72% of new graduate nurses had been bullied in the prior month (Castronovo et al., 2015, p.209). According to Castronovo et al., 63% of the nursing workforce is bullied every week (35% + 28%). This places a strain on the nurse and on the hospital budget due to direct and indirect losses as a result of bullying.

While there is an abundance of information regarding bullying, such as definitions, detecting and stopping it, and zero tolerance policy writing, there is little research about the feelings of nurses who have been bullied and even less addressing the career decisions that nurses have made in order to protect themselves from further bullying (Vogelpohl, Rice, Edwards, & Bork, 2013, p. 415). When nurses leave the nursing profession, they negatively impact the nursing shortage, patient care, and hospitals' bottom lines.

In the remainder of this chapter, I provided an overview of pertinent research literature related to the problem statement, the purpose of the study, and the research

questions regarding the topic of bullied nurses. Additionally, the nature and significance of the study was addressed. Other areas, such as the conceptual framework, definitions, assumptions, scope and delimitations, and limitations were also addressed.

Background of the Study

Between the years of 2004–2009, I found only two studies that originated from the United States in regards to bullying in the nursing profession (Vogelpohl et al., 2013, p. 415). In my recent review of the U.S. literature, I found seven studies that were published between the years 2010–2013, focusing on various aspects of bullied nurses in the hospital setting. The first was a qualitative hermeneutical phenomenological study by MacKusick and Minick (2010). The researchers interviewed nurses who had already left the profession to understand why they did. Simons and Mawn (2010) focused on new graduate nurses and their intent to leave the profession in a qualitative phenomenological descriptive study, while Cortelyou-Ward, Unruh, and Fottler (2011) explored nurses' intent to leave hospital nursing in a quantitative study. Gaffney et al. (2012) used a constructivist grounded theory to explore how nurses resolved bullying issues in their workplace. Walrafen, Brewer, and Mulvenon (2012) conducted a mixed-method descriptive research survey of nurses bullying in a multi-institutional health care system. Weaver Moore, Leahy, Sublett, and Lanig (2013) conducted a mixed-method study regarding how nurse-to-nurse relationships influenced nurses' intent to leave. Vogelpohl et al. (2013) conducted a quantitative descriptive research study regarding new Registered Nurses (RNs) and their experiences with bullying. Each study was different,

but all contributed to the thick, rich descriptions of the lived experiences of bullied nurses and witnesses of bullying.

Nurses who are bullied and who witness bullying can experience physical and emotional trauma, which can in turn impact the delivery of patient care. This has negative ramifications for the hospital. Physical manifestations can be insomnia, headaches, intestinal problems, hair loss, overeating, and anorexia, while emotional effects are displayed in irritability, anxiety, depression, decreased concentration, and post-traumatic stress disorder (Longo, 2013, p. 951). Castronovo et al. (2015) stated that the psychological manifestations of bullying include psychosomatic illnesses, feelings of isolation and helplessness, anxiety, depression, low self-esteem, increased use of alcohol, tobacco, prescription and illicit drugs, the physical outcomes of eating disorders (weight loss or gain), fatigue, headaches, hypertension, and gastrointestinal disorders (p. 210). Sansone and Sansone (2015) described common illnesses such neck and back pain, joint and muscle pain including fibromyalgia, and cardiovascular disease as manifestations of bullying. Bullied nurses have more than twice the chance of developing cardiovascular disease than other nurses and some may even become so distraught they commit suicide (Sansone & Sansone, 2015, p. 34). Castronovo et al. noted that 29% of bullied nurses had contemplated suicide and 16% had a plan in place (p. 210).

These medical maladies can lead to accidents, workers compensation claims, and prolonged absences. The nurses left in the department must handle the extra patient load, leading to increased stress, call-offs, and bullying (Sansone & Sansone, 2015, p. 34).

Simons and Mawn (2010) found a correlation between bullying and increased absenteeism which had a negative impact on quality of patient care (p. 306).

Vessey, DeMarco, and DiFazio (2011) found that nurses who have experienced bullying or even those who have witnessed it will avoid staff thereby cutting communication and collaboration with others, providing a lower quality of patient care (p. 145). Bullying increases medical errors, poor quality of care, increased morbidity and mortality, hospital-acquired infections, and readmissions (Longo & Hain, 2014, p. 194). Hospital chief financial officers (CFOs) must consider the cost of lawsuits from patients that have suffered from medical errors by nurses. Vogelpohl et al. (2013) postulated that 20% of medical errors are related to distraction by being bullied. Medical errors can increase costs for care related to hospital-acquired infections, increase morbidity/mortality rates, readmissions, and lawsuits filed by injured patients. Each lawsuit can cost over a million dollars (Castronovo et al., 2015, p. 210; Vogelpohl et al., p. 415). Patients who are not satisfied with the care they have received may comment negatively on the hospital surveys and to friends.

Hospitals are negatively impacted through direct and indirect losses. Direct losses include decreased staff and loss of revenue (Bullen, 2013, p. 1). Frequently, physical and emotional distress surface when a nurse is bullied or witnesses another nurse being bullied (Castronovo et al., 2015, p. 210). The stress of being bullied or witnessing it diminishes the nurse's concentration, and accidents occur, to the nurse or the patient in the form of medical errors (Castronovo et al., 2015, p. 210). In a survey of 2000 participants, 7% stated that they had made a medication error as a direct result of being

bullied (Clarke, Kane, Rajacich, & Lafreniere, 2012, p. 270). Physical or emotional illness often results in the nurse being absent from work for an extended period. Hospital administrators can quickly spend over $24 million per year in replacing nurses and in covering absenteeism as well as presenteeism (Vogelpohl et al., 2013, p. 415). Items affecting the hospital's bottom line after a nurse leaves the organization would be the nurse's salary, benefits, and overtime to pay other nurses in the department that pick up the patient load. Additionally, the cost of paying for an agency nurse to come in and cover until a replacement can be found and the cost of recruiting and hiring the replacement nurse. The cost to replace the nurse depends on the length of time it takes to fill the position and for the nurse to be self-sufficient, which varies depending on the department and shift.

Another direct loss that a hospital's administrators must deal with is that of retention and attrition. Rosseter (2014) stated that evidence from a study conducted by KPMG in 2011 revealed that hospitals overall have an attrition rate of 14% (Jan, p.1). Bullen (2013) related that the national nurse turnover rate is 20% (p. 3). Hospitals with a poor nurse retention rate could spend, on average, $3.6 million per year more than what it costs a hospital with a better retention rate (Vogelpohl, et al., 2013, p. 414). Christie and Jones (2014) affirmed that in 2012, it cost $92,000.00 to hire and orient a medical-surgical nurse and $145,000.00 for a specialty nurse (p. 3). Siegel Christian and Ellis (2014) noted that it takes 1.5– 2.5 times the nurse's salary plus benefits in replacement costs for each nurse (p. 203). As demonstrated above, the costs to replace one nurse who leaves can be quite significant.

The precursor to attrition is absenteeism. A part of absenteeism is presenteeism in which the nurse is present and has the outside motions of working but on the inside is far away from the job and disengaged from the situation at hand. Absenteeism is a direct cost, but presenteeism is an example of an indirect cost. Indirect costs are characterized by decreased employee commitment and effort (presenteeism) and wasted time in talking about the problems instead of working (Simons & Mawn, 2010, p. 306). Bullies will spend time setting-up the nurse with such serious and potentially life-threatening actions as hiding lab tests, changing the medication drip rates on IV pumps, and purposefully sabotaging the patient charts. All of this leads to negative work performance, workers compensation claims from accidents, and medical leave for physical or emotional injuries (Gaffney et al., 2012, p. 1-2). These activities cost the hospital money, anger patients/families, and can be a determining factor when nurses decide whether to stay or leave the hospital.

Attrition related to bullying amongst nurses has not been studied well with even less research regarding the impact on nurses who have witnessed bullying. While bullying amongst nurses has been studied extensively throughout the world, there is a paucity of literature in the United States (Simons & Mawn, 2010, p. 306). Castronovo et al. (2015) conducted a search of U.S. newspapers and discovered over 1300 articles about school bullying but only 16 regarding nurse bullying in the workplace (p. 211). As noted earlier, until 2009 there had only been two studies Researchers in the United States are concerned with identifying bullying. Hospital administrators, in particular, will not readily admit that bullying takes place because they are afraid of the ramifications of a

tainted reputation and loss of revenue (Castronovo et al., 2015, p. 210). Nurses may not talk about being bullied willingly and openly because they fear retaliation and ultimately termination (Castronovo et al. 2015, p. 211). These two situations seriously impede any accurate fact-finding of researchers (Gaffney et al., 2012, p. 1). As research concerning bullying intensifies, specific explorations of the effects of bullying on bullied nurses and those that have witnessed it may also increase.

While it is important to identify and clarify the term "bullying," it is also equally important to understand the emotions that nurses are experiencing when they are bullied or have witnessed it. According to Stagg, Sheridan, Jones, and Speroni (2013), nurses that witness bullying are impacted more so than the bullied nurse (p. 333). Older nurses express humiliation and distress when they observe coworkers being bullied (Longo, 2013, p. 952). Those bullied and those who witness it sort through feelings and emotions that directly affect career decisions.

Problem Statement

Nurses are leaving the profession. Welding stated 75% of nurses leave the profession before the end of their first year working (2011, p. 37). One million replacement nurses will be needed by 2016 (Vogelpohl et al., 2013, p. 414). The general problem is that nurses bully nurses at work. NasrEsfahani and Shahbazi (2014) stated that 97% of nurses have admitted to being bullied and 72% have witnessed it (p. 410). The particular problem is that many nurses leave the profession when they have been bullied or witness bullying. The focus of this qualitative transcendental phenomenological study was the bullying experience of licensed RNs in one of the

Midwest United States. The number of research studies increased since 2009, but a gap remains in the literature of understanding the choices of nurses that have been bullied, or have witnessed it amongst peers.

Purpose of the Study

The purpose of this qualitative phenomenological study was to understand the choices that nurses made regarding their careers when they were bullied by fellow nurses or had witnessed it when working in the hospital setting. Additionally, the perceptions of bullied nurses and those that had witnessed the bullying of coworkers were explored. The research paradigm was social constructivism with a feminist lens, building on women's lived experiences as being treated with bias, denigrated, and oppressed. Interviews were be set up with a purposive criterion sample of eight nurses, increasing until saturation was achieved. The expected outcomes of this study were that nurses and non-nurses would have a better comprehension of the choices that nurses make when bullied or when they have witnessed it, that readers of this study will feel compelled to speak up for those nurses that cannot, and that positive social change will be realized through grass-roots efforts and policy.

Research Questions

The research questions are the anchor of a study. The remaining sections are aligned to these questions. When developing the research questions, there were two areas to consider: the important factors in this lived experience and how they affect the person (Simon & Goes, 2013, p. 96). The research questions were the pivot point in understanding the two different types of perceptions and realities of bullied nurses and

observers to bullying. The types of questions asked of bullied nurses and those that had witnessed bullying between coworkers were:

Research Question 1: What are the lived experiences of nurses being bullied by nursing colleagues?

Research Question2: What are the lived experiences of nurses who witness coworkers being bullied by colleagues?

Research Question 3: How does the bullying experience of nurses impact career choices post the bullying experience?

Research Question 4: How does the RN turnover rate impact the bottom line of a hospital, both indirectly and directly in costs?

Conceptual Framework

Phenomenology proved to be a logical choice in understanding the problem of bullying amongst nurses; the why, what, and how, because it allowed the nurse to share the bullying experience in an open state. Each nurse's story related personal perceptions regarding what happened. Maxwell (2008) stated that the stories of those involved equip the reader in the recognition of the phenomenon studied and this is why each nurse's story is vital to this study (p. 223). The reader has no expectations or qualifications as to what will be read. We receive the information and combine it with our lived experiences to create a new reality and our understanding of it (Simon & Goes, 2013, p. 95-96). Each story is different, adding to the thick, rich description and comprehension of what each nurse has experienced. The result leads to a deeper regard for this societal problem,

initiating an understanding as to the reasoning behind the choices that bullied nurses and those that have witnessed bullying make.

In casual conversations with nurses, some do not know that bullying exists and deny ever observing it happening to a coworker, while others are quite prolific with stories of being bullied or of witnessing others bullied. An intriguing caveat from the literature search revealed that there were two types of nurses—those that bully and those that are bullied. Through conversations with nurses, some were not aware that bullying exists. I posit that there are three types of nurses—those that bully, those that are bullied, and those that are unaware. One reason for this "unawareness" is that the nurse graduated from nursing school during the 20th century, before the 1980s. During that time, bullying was not called bullying. It was called "paying your dues" or "rite of passage," etc. Every student nurse and new graduate knew that she was going to have to go through this most distressing time each quarter when assigned to a new unit and when hired for that first job after graduation. It was endured until the next new nurse was hired, and the bullying moved to her.

The paradigm for this study was social constructivism, which began with medieval philosophy and was associated with sociology, education, and anthropology (Simon & Goes, 2013, p. 23). Schwandt (2015) stated that essentially constructivism was related to the mind and knowledge (p. 36). Knowledge was not learned or found, but was constructed (p. 36). The construction was not in isolation but in conjunction with what others had said and understood the experience to be (p. 36). From this conglomeration of information, each person constructed "road maps" to make sense out of what had been

observed or lived (p. 36). It became our reality. With each additional experience, the road map changed (p. 36). Hearing the nurses' stories and ultimately grasping what bullied nurses and those that had witnessed it had endured was the goal of this study. A resolution was made as to how this new knowledge could be incorporated for the overall good.

The theoretical lens was feminism. The goal was to identify, speak out for, and educate others about those that had been ignored and marginalized by Society (Marshall & Rossman, 1999, p. 5). Bullied nurses certainly fit both categories. Fear keeps them from speaking out, and as revealed earlier in conversations with other nurses, some do not even know that bullying exists. When the word feminism is mentioned, it is thought of as female-only, but in this situation, 9.6% of nurses are male (U.S. Dept. of Commerce, 2013, p. 2). Feminism represents people –both male and female.

The combination of phenomenology, constructivism, and feminism work together to open the door to an entirely new way of thinking about bullying; removing the thoughts and constraints of the world and moving them to a new lifeworld of understanding, thinking, and values (Vagle, 2014, p. 116). Phenomenological researchers are concerned with learning about lived experiences as told by the nurses that have been bullied or have witnessed it without any prior biases. The information gleaned from what the nurses divulged is then developed or constructed in a new way (constructivism), acknowledging the phenomena of the meaning of bullying. The patriarchal notion of female oppression developed through the feministic lens is another avenue for interpreting why nurses bully each other. This new knowledge can then be used to create

tools that address social change in areas such as the education of nurses, hospital administrators, academians, policy-makers, and nurses themselves.

Nature of the Study

Phenomenology proved to be the most appropriate methodology for this study. Other methodologies that would have been acceptable but not the best fit for this study would have been a case study, ethnography, or narrative. While each brought its own distinctive perspective to this study, they did not allow for the lifeworld experiences that a phenomenological study does. Schwandt (2015) stated that phenomenology strips away the rules, subjectivism, and morés of world thinking and permits the person to hear what the other person is saying in an objective voice (p.234). There are no preconceived beliefs or judgments before hearing the story, just listening, and then describing what has been learned without bias (p.234). The stories that are told are known as "lifeworld"—the description of life in that person's world from his or her perception to reality, utilizing all of the senses, emotions, and past remembrances to change from "what is" to the "nature of what is" (p. 234). I will focus on the lifeworld of nurses that have been bullied and those that have witnessed it. Through the nurses' stories a new understanding of how bullying affects nurses and their reactions to it can be constructed. Husserl felt that this changing could only be accomplished with epoché or bracketing; identifying our own attitudes, beliefs, and biases to clear our minds for new thinking (Schwandt, 2015, p. 234). Please refer to Chapter 3, "Rationale for Choosing Transcendental Phenomenology; History of Phenomenology" for further explanation of Husserl and bracketing/epoché. Appendix A contains my bracketing for this study.

Data collection came from two sources: a demographic questionnaire sent with the email invitation to participate and a semi-structured interview set up with each participant that met the criteria for the study. The final sample size was determined by those that chose to participate once they had met the initial parameters of either being bullied or having witnessed it among peers while working in the hospital setting.

For a potential participant to be considered for the sample, four criteria must be met:

1. The nurse holds a valid and active RN license
2. The nurse either was or currently is being bullied or has witnessed it happening to a coworker
3. The bullying occurred in a hospital in the United States
4. The nurse had to relate how the bullying occurred and what actions were taken career-wise.

The analysis was conducted by coding, organizing, and actively searching for themes with the overall goal of understanding and knowledge.

Definitions

Bullying: A power struggle between two people (Gaffney et al., 2012, p. 2). Any deliberate, planned, repetitive, and ongoing harassment of one person by another that is meant to show power over that person (Goldsmid & Howie, 2014, p.211). The intent is to cause harm and its outcomes are shame, humiliation, embarrassment, isolation, and loss of dignity both as a nurse and as a person (Goldsmid & Howie, 2014, p.211). This set-up is meant to prove the target as unworthy to practice as a nurse and to ruin the

personal and professional reputation. Therefore, any actions from one nurse to another that hinders that nurse's ability to practice nursing up to expected quality standards is bullying (Granstra, 2015, p.251).

Float or *Floating:* A nursing term that means a nurse has been reassigned from the home department to another nursing department within the hospital for one shift (Simons & Mawn, 2010, p. 308).

Nurses eating their young: a term that nurses use to describe how older experienced nurses harass inexperienced graduates. The more experienced nurses openly bully new nurses to the extent that they are afraid to ask questions or for help out of fear of retaliation and humiliation in front of coworkers. This behavior continues until the new nurse either makes a fatal mistake and is fired, or quits out of despair (Szutenbach, 2013, p.17).

Assumptions

Five assumptions were made regarding this study. As in all studies, it was assumed that the participants were truthful. Second, participants may not have felt comfortable enough to share their lived experiences out of fear of retaliation. The third assumption was that some may not trust the information to be completely anonymized. The fourth assumption was that each nurse that participated had a current RN nursing license and the last assumption was that the nurse had been bullied or had witnessed it while working in the hospital as an RN.

Scope and Delimitations

The purpose of this qualitative phenomenological study was to explore the perceptions of bullied nurses and those that had witnessed bullying of co-workers, with an overall objective to understand the personal experiences of each participant's life and its career impact. The sample population consisted of Registered Nurses who were currently licensed by a Midwestern State of the United States. Areas that were not addressed in this study were bullying in general, policies related to bullying, and the characteristics and behaviors of bullies. In this type of study, transferability may be difficult. For further insight into transferability, refer to Chapter 3, section "Transferability."

Limitations

There were six limitations to this study. Sample size was the first one addressed. The phenomenological researcher's goal was for quality, not quantity. The sample starting goal was eight participants, but the final sample number was determined by saturation. Invitations to complete the criteria test and the demographic questionnaire were sent to Registered Nurses (RNs) that resided within a chosen county of a Midwestern State. The state chosen had over 150,000 RNs licensed to practice. This sample was too large. To reduce the sample size, one county was chosen and then every 10^{th} name selected for the invitation. It was assumed that of those chosen, there would be some that would choose not to participate, may not fit the parameters of the study, or may not check their email and miss the invitation. Additionally, those names that were not

identified to take part in the study may have been suitable participants but were not given the chance.

A second limitation related to the sample was that the nurses come from the same area of the United States. There were over 3.5 million employed nurses in the United States in 2011 (United States Department of Commerce, 2013, p.2). Using one state in the United States prohibited an adequate national representation.

The third limitation regarded the actual interview. Some participants may have hesitated to participate in the interview out of concern that it will not be confidential or somehow become identifiable to bullies. The fear of retaliation can mean the loss of one more story to better perceive this phenomenon. Participants may not have wanted others to know they had been bullied or have witnessed it and some may have painful memories and did not wish to talk about them. There was always the threat of computer hacking, potentiating a lack of trust that the participant's information will remain confidential.

A fourth limitation was time. There may have been RNs that would have participated but felt that they did not have the time due to other commitments (Simons & Goes, 2013, p. 274). The period for answering the email invitation was one week.

Credibility and dependability were the fifth limitations. A general limitation of qualitative studies is that they are difficult to transfer or duplicate because they involve people's emotions and their answers/explanations/stories cannot be check marked in a question box as in a quantitative study (Simon & Goes, 2013, p. 273). Even if the same participants were given the survey at another time, they might not provide the same answers (Simon & Goes, 2013, p. 273). In addition to this, the questions could be posed

to another group, but the answers would not be identical to the results from this study (Simon & Goes, 2013, p. 273). A way to increase validity in this study, however, was through thick, rich description, affording the reader the ability to derive understanding from the presentations (Leedy & Ormond, 2005, p.100). Validity and reliability are elusive terms that can be difficult to prove in qualitative studies. Bracketing or epoché can be used to bolster the rigor of the study.

The sixth limitation concerned the use of bracketing or epoché. It is easy for new researchers to think of bracketing as simply a listing of biases and expectations on a to-do list that is checked off and then forgotten, but that is not what bracketing is about (Dowling & Cooney, 2012, p. 24). Bracketing consists of two phases. The first one entails that the researcher identify all thoughts, preconceived notions about the results of the study, and assumptions. The second phase is a constant review and reflection of these thoughts with the probability that the beginning notes will have emerged as new thoughts by the end of the research (Fischer, 2009, p. 584). The researcher can only bracket what the researcher is aware of (Hamill & Sinclair, 2010, p.19). How the bracketing occurred, what was included in the bracketing, and how it was addressed throughout the study can prove to be a limitation if not carried out correctly (Hamill & Sinclair, 2010p. 19). My personal history of being bullied can be useful, guiding me in the literature search, instrument design, and the data analysis.

The conclusions drawn from this study may only be acceptable for a period of time. As further studies are conducted by other researchers, the conclusions may change at a later date because the limitations will have changed (Simon & Goes, 2013, p. 273).

Even though these limitations were considered hindrances to this study, they could be changed from threats to opportunities by compelling greater scrutiny and awareness in presenting the lived experiences of bullied nurses and those that had witnessed others bullied.

Significance of the Study

Significance to Practice

Once health care administrators, policy makers, and nurses begin to understand the significance of bullying and how it can force nurses to make career choices they never wanted to make, and how much this affects a hospital budget, strategies can be crafted to promote an active voice in the nursing realm. To all bullied nurses and witnesses, the most important personal significant factor in this study was confirmation that bullying does exist and yes, it did happen to them. Bullied nurses no longer have to hide in shame because of it, and they can have their own active voice in regards as to how deleterious bullying is. Although bullying is a very personal encounter with each nurse, it has a ripple effect on family, friends, coworkers, and society.

Significance to Theory

The choice of a phenomenological method presents a deeper, richer understanding of the lived experiences of bullied nurses as well as nurses who have witnesses, augmenting knowledge from prior studies and theories. Freire's oppressed group theory explained one aspect of why nurses are bullied. The desired outcome of this study was to enable a different view of nurse bullying and witnessed bullying from what had been learned in prior studies.

Significance to Social Change

Administrators, leaders of professional organizations, and academics may enable positive social change once they have a clearer understanding of how nurses feel when they have been bullied or have witnessed it and the career actions that nurses felt they needed to take. Hospital management committee members, the Joint Commission's members, American Nurses Association and (ANA) leaders may decide to draft policies that address bullying in more depth, providing a voice for those nurses who are too afraid to speak up for themselves. Another outcome of new policies may be to promote the use of spokespersons and advocates within the hospital system to be available to both employees and patients. Nursing researchers may want to use this information to further their understanding of how bullying impacts the nursing profession, especially in regards to the present nursing shortage.

With education, the shame, from being bullied can be extinguished. Once nurses can admit what has happened to them, they are released from the shame that is holding them down, with a renewed self-esteem, improving their level of nursing care and at-work relationships as well as building up the infrastructure of the hospital. Nurses who have been medically and psychologically damaged from bullying can get the professional help that they likely need with backing from policy makers. Once the nurse has had treatment, he/she may choose to return to the hospital, becoming a voice for those nurses who cannot speak for themselves. Nurses who were considering leaving can now practice nursing with a renewed focus on excellence and improved patient outcomes, which, in turn, will save money for the hospital and build its reputation as well.

Summary and Transition

Bullying is implicated in multiple problems for both hospital administrators and employees. Bullying damages the bottom line of a hospital through bad press, word-of-mouth, and the cost of replacing capable and worthy nurses. The focus of this research was to review and understand what nurses had experienced as bullied targets and as witnesses to such.

In chapter two the history of nursing, which included the topics of nursing caps, uniforms, the 1970s, and what part they played in advancing bullying between nurses was explored. In addition, I explored further Freire's oppressed group theory as well as finishing further explanations of multiple research studies. I addressed how hospitals were affected by bullying, and demonstrated the gap in the literature. The course of data collection and analysis was explained in chapters three and four while recommendations were made in chapter five.

Chapter 2: Literature Review

Introduction

The overarching problem is that nurses bully nurses at work. Researchers noted in the current literature that bullying amongst nurses is more prevalent than previously thought. NasrEsfahani and Shahbazi, (2014), stated that 97% of nurses admitted being bullied, and 72% have witnessed it (p. 410). Nurses and witnesses must make serious career choices after experiencing the effects of bullying. The purpose of this qualitative transcendental phenomenological study was to explore the perceptions of bullied nurses and those who witnessed the bullying of coworkers, understanding the career choices they made to stop the harassment and how nursing turnover impacts a hospital's bottom line.

There were four aligned sections in this chapter. They were nursing history, the nursing shortage, financial, and bullying. In the midst of these sections was the conceptual framework; Freire's oppressed group theory. The conceptual framework explained why nurses bully nurses. The nursing history told the story of how bullying got started and how each section; caps, uniforms, and work assignments influenced and promoted bullying. The nursing shortage in the 21st century, which is quite different from previous shortages, promotes bullying through education and Baby Boomers. Financially, if the hospital administrators and risk managers do not address the issues related to bullying and budget appropriately to cover all of the sequelae in the form of direct and indirect costs, the hospital will become insolvent. Bullying's outcomes such as absenteeism, presenteeism, medical errors, time off from work due to illness or injury,

and shame all directly influence each of the other three sections. They are symbiotically related, feeding off each other.

Figure 1 is a synopsis of this chapter

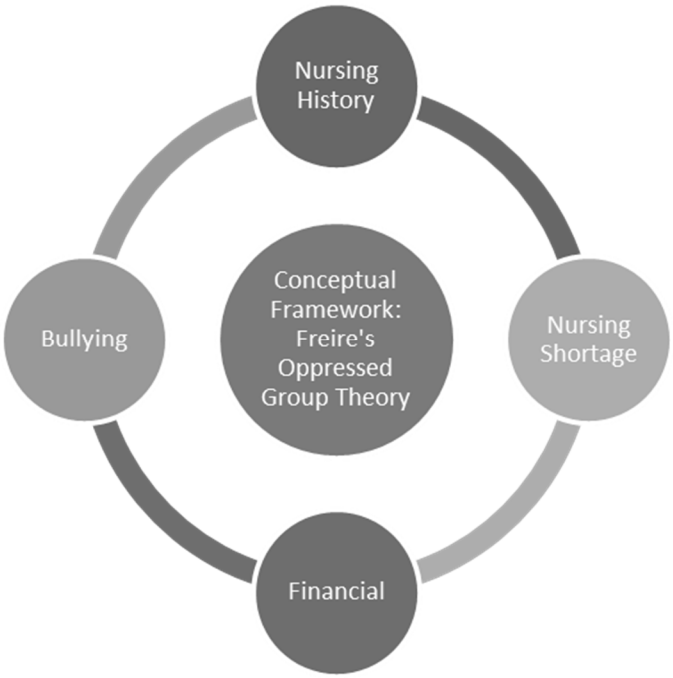

Figure 1. Each heading influences the other headings with the conceptual framework explaining why nurses bully each other.

Literature Search Strategy

When the initial literature review was conducted in 2010, many articles were authored outside of the U.S. This study focused on nurses in the United States. What this search proved, was that there was a paucity of research conducted by United States

academians between the years of 2000–2010. From what I found, researchers from Europe, Australia, and New Zealand had published the majority of articles.

I conducted a second search of the literature in 2015, searching for articles from the years 2011–2015. In order to provide a point of reference, I expanded the literature search to other countries around the world. Again, Europe, Australia, Canada, New Zealand, the Middle East, and the Pacific Rim contributed more research regarding bullying than the United States. The more recent articles from the United States, cited the same early authors such as

- Randle, 2003
- Bowles and Candela, 2005
- Hutchinson, Vickers, Jackson, and Wilkes, 2006
- Longo and Sherman, 2007
- Woelfe and McCaffrey, 2007
- Simons, 2008
- Cleary, Hunt, Walter, and Robertson, 2009
- Johnson and Rea, 2009
- Simons and Mawn, 2010
- MacKusick and Minick, 2010
- Johnston, Phanhtharath, and Jackson, 2010, suggesting saturation.

Refer to Table 1 for the literary search strategy.

Table 1

Literary Search Strategy

Database categories	Databases	Categories Keywords	Peer-reviewed journals	Dissertations	Books
Management & Business	Business Source Complete, Emerald Management, SAGE Premier	Workplace Bullying, Horizontal violence, Lateral violence, Incivility, Conflict Mgmt, Personnel retention, Interprofessional relations, Organizational change, Job satisfaction, Personnel, Management	11 (2010 or before) 12 (2011 or after)	0	0
Multi-Disciplinary	Academic Search, Complete Google & Google Scholar, LGBT Life with full text	See above	7 (2010 or before) 6 (2011 or after)	0	0
Database categories	Databases	Categories Keywords	Peer-reviewed journals	Dissertations	Books
Dissertations & Theses Walden University Dissertations			0	0	1 (2010 or before)
Education	ERIC SAGE Premier Education Research Complete	Baccalaureate Nurses, Associate Degree Nurses, Diploma Nurses, Faculty, History	4 (2010 or before) 12 (2011 or after)	0	1 (2011 or after)
Health Sciences-Nursing	Cinahl Plus with full text, Medline with full text, PubMed, Ovid Nursing Journals with full text Nursing & Allied Health Source Science, Direct Health & Medical Complete	Nursing, Nurses, Nursing Degrees, Baccalaureate Nurses, Associate Degree Nurses, Diploma Nurses, Nurse Attitudes, Nursing Staff, History of bullying/Nursing, Quality of Healthcare Nursing, Bullying & Shame, Nursing Bullying, Shame Nursing & Recruitment	22 (2010 or before) 28 (2011 or after)	0	0

Conceptual Framework

The phenomenon is that nurses bully each other. When a nurses bully nurses, or a nurse observes other nurses being bullied, the nurse is faced with many choices ranging from doing nothing to leaving the nursing profession. What do the nurses feel when they are making these decisions? To help understand these feelings, I chose Freire's oppressed group Theory, which was used in many of the bullying studies found in the literature. Freire's theory explained the feelings of oppressed people, why they bully each other, and the realization that they hold the power to stop it.

Paulo Freire's Oppressed Group Theory

Throughout the literature search, Freire's oppressed group theory was noted to be incorporated in many of the nursing bullying studies. Although Freire's theory regarded people who were politically oppressed, it can still be applied to nursing. It explains how bullied nurses get into this bleak situation, and why/how, they bully each other. Freire went to great lengths to teach the people that they could break free from their bondage. His main worry, however, was that in the process of breaking free, they could become oppressors (Freire, 1970/2005, p. 44). Freire believed that it was considered oppression when one party exploited or restrained another party from achieving self-actualization and often not even considering them as people (Freire, 1970/2005, p. 55). Once the oppression starts, it passes from generation to generation, becoming the norm with both oppressor and oppressed growing insensitive to the fact that it is wrong, which becomes normalcy (Freire, 1970/2005, p. 58). Nurses often do the same things to themselves. Some nurses have been practicing bullying (oppression) for so long that they do not even

realize it. After being in this state for an extended length of time, the oppressed resign themselves to the fact that the situation is hopeless and will never change, so they do not try (Freire, 1970/2005, p. 47). Sadly, this attitude is observed far too often among nurses.

Freire taught the oppressed that the oppressor did not exist without them. The oppressed viewed the oppressor as invincible and invulnerable, so they felt intimidated (Freire, 1970/2005, p. 64). If the oppressed could see that the oppressor was only human, then they could begin to realize that the oppressor could be beaten because the oppressor's power came from them (Freire, 1970/2005, p. 64). The same goes for the bullied nurse or the witness to bullying amongst co-workers. Both the bullied nurse and the witness are wounded, sometimes so profoundly that they can no longer function as nurses. The reality, however, is that freedom threatens the oppressor's future because there will be no one to oppress. It is very challenging for the oppressed to understand this concept because they view the oppressor as all-powerful and the oppressor's goal is to keep them believing it (Freire, 1970/2005, p. 52). Because of this belief, the oppressed strike out at each other with horizontal violence in an unconscious attack at the oppressor (Freire, 1970/2005, p. 62). As bullied children, they learned to protect themselves by striking first. Bullied nurses may not have experienced this type of behavior when they were children and are not prepared for the actions of the bully. The result to the oppressed is that they feel worthless, unfit, and less-than (Freire, 1970/2005, p. 63). Bullied nurses and those who witness it are quite familiar with these feelings.

When comparing the plight of bullied nurses in regards to Freire's oppression theory, it is easy to see how the two groups, dominant and oppressed, fall into place.

Rezaei-Adaryani, Salsali, and Mohammadi stated that it was the cultural belief of the day that women were weaker and less intelligent than men (2012,p. 84). Men considered it their job to protect and lord over the women (Rezaei-Adaryani, Salsali, & Mohammadi, 2012, p. 84). The men also believed a woman's job was to be obedient and non-questioning (Rezaei-Adaryani, Salsali, & Mohammadi, 2012, p. 84). Florence Nightingale promoted the belief to her students that nurses were subservient to doctors and therefore, nothing more than maids to do the doctor's bidding (Rezaei-Adaryani, Salsali, & Mohammadi, 2012, p. 84). Diploma nurses who graduated nursing school before the mid-1970s retained this inferior belief, never knowing that they were bullied. Male doctors dominated female nurses, forcing them to restrain their discontent.

It was not acceptable for nurses to say anything contradictory to doctors. It was customary even as late as the 1970s that nurses would stand up when a doctor entered the nurses station and would offer him their chair, in addition to getting him coffee and whatever else he so desired. Doctors were known to throw charts, scalpels, pens, instruments, and anything else they could get their hands on whenever they were angry (Walrafen et al., 2012, p.10). Nurses were always the target. Whenever a problem occurred, the doctor blamed the nurse. The nurse had no one else to blame—at least in front of the rest of the staff. Behind the scenes, however, the nurse found another nurse to bully. This power structure caused nurses to be very hateful toward each other. The only way that nurses could vent off these uncomfortable feelings was to bully someone else–another nurse with less experience or tenure—a nurse who did not have the same amount of power and could not fight back. The head nurse was responsible for the staff

nurses' actions and did not want to deal with the doctors' temper tantrums, so she would institute the "pecking order." The head nurse would bully the senior staff (or charge nurse), who would bully the rest of the staff RNs. The RNs would bully the LPNs (Licensed Practical Nurses), and the LPNs would bully the nurses' aides. Thus, bullying from the top down was the norm as in the "kick-the-dog" syndrome.

Bullying's primary focus is power, whether real or perceived. A power tactic is for bullies to hide in cliques (Longo & Hain, 2014, p. 195). Bullies formed cliques within each department and each shift, making or breaking a nurse, depending on which side of the clique the nurse resided. If a nurse were not part of the clique and assigned to work with the group, two things could happen during the shift. If the staff liked the nurse it would be a great night—plenty of help, conversation, and acceptance. If not, no one would help, the nurse would be excluded from conversations, and the nurse would be assigned the heaviest workload, and ignored the entire shift. If it were a floating assignment, the nurse could probably endure the treatment for the shift. The nurse managers in some hospital departments would call the nurse the next day for feedback, and this would be the nurse's chance to report the abuse. The head nurse would meet with the staff and reprimand them for their careless actions. The next time the nurse floated back to the unit, the bullies would retaliate, continuing the bullying until the nurse either quit or was fired, depending on how much the bully wanted in revenge.

If the nurse's new permanent assignment was in this department, then a problem ensued. In addition to what the power group had done before, now they added other subtle and not-so-subtle actions to let the nurse know he or she was not wanted, should

leave the unit, and preferably the hospital. Subtle actions would be to say things to the nurse that were hurtful or mean, or to talk to everyone in the group except the nurse. Some would even be as bold as to tell the nurse to leave the hospital because she was inept or stupid and they would say this loudly in front of the rest of the staff and the patients to humiliate her (Barb Ciepley, Personal Communication, June 23, 2009). Patients and their families that heard these accusations would then question the nurse's competence, frequently demanding a different nurse. The result further ingrained the idea of incompetence in the bullied nurse's mind, becoming a self-fulfilling prophecy as the nurse would second-guess, making more mistakes (Gaffney et al., 2012, p. 6). Eventually, the nurse would be fired or quit.

Nursing is clearly a profession where bullying can directly influence patient health, safety, and welfare. Bullying can cause so much distress and distraction that nurses make judgment and medication errors, the quality of the care they give is below par, and job dissatisfaction increases, which leads to a voiced intent to leave (Nikstaitis & Simko, 2014, p. 294). It is very disconcerting to a patient and family to hear nurses bullying each other out in the hallway and even worse if it occurs at the bedside. Patients have checked out Against Medical Advice (AMA) out of fear of what their nurse might do to them.

Two studies, MacKusick and Minick, (2010), and Weaver Moore, Leahy, Sublett, and Lanig (2013) were relevant to mine. MacKusick and Minick wanted to know how nurses felt after they had chosen to leave the nursing profession altogether. Weaver Moore et al. studied how nurses' relationships affected the work environment, and what

unique ways nurses related to each other. The context of my study was to understand the career choices nurses were forced to make when bullied or witnessing it. MacKusick and Minick's provided insight into what the nurses were thinking as they were deciding whether to remain in nursing or not. Weaver Moore et al. introduced topics or themes regarding how nurses evaluated their nursing environment when making decisions on how to better the work environment, which included leaving the profession.

Literature Review Related to Key Variables and/or Concepts

To fully understand how bullying currently affects nurses, there must be an understanding of how it commenced in the United States. Different events in medicine, the nursing profession, and our culture have changed the view of nurses and nursing. Three areas that may have impacted the beginnings of bullying amongst nurses were caps, uniforms, and working assignments.

History of Nursing

Caps: The Root of Bullying in Nursing

Originally, nuns administered the first nursing schools in Paris. The nuns demanded that the nurses wear caps similar to the veils they wore (Stokowski, 2011c, p. 3). The Biblical verse in 1 Corinthians 1:6 stated that women should have their heads covered. A more practical reason was that the full caps completely covered the head protecting both the patient and the nurse from contamination (germs and lice, etc.) as most women during this era had long hair.

What started out as a common sense device turned into the defining icon of the nursing profession. Not just anyone could wear a nursing cap—it had to be earned. As

the years progressed, the cap took on a mystical status and reflected that the wearer belonged to an elite group of educated women, and was to be respected (Stokowski, 2011c, p. 9). Each of these attributes, however, was not to be fully realized until the 1900s.

The first nursing school administrators recognized this as a way to brand their schools and strove to provide uniquely styled caps. Using this marketing and branding skill, the caps that represented particular nursing schools became just as famous and respected as the schools themselves. The Bellevue School of Nursing in New York, established in 1873, was one of the best-known schools as well as the first nursing school in the United States. Bellevue's nursing cap, made of organdy with distinctive pleats and a ruffled edge, was known as a *fluff* or *cupcake*. It was fashioned after the cap at the St. Thomas Training School for Nurses in London, which had been started by Florence Nightingale in 1860 (Stokowski, 2011c, p. 9). It was instantly recognizable. It represented excellence in education and commanded respect.

Soon, caps became the identifying trademark for nurses, and cliques quickly developed, promulgating a social hierarchy. Stokowski (2011c, p. 9) related that a nurse had written to the American Journal of Nursing in 1931 that when she walked into a hospital unfamiliar to her, it was always comforting to see some of the nurses wearing the same nursing cap she wore. Immediately she knew they were friends (p. 19). Even as late as the 1970s, newly hired nurses were scrutinized by the nurses in the department, checking her cap to see from which nursing school she had graduated in order to know whether to be friendly or not.

The fight to get rid of nursing caps started in the late 1970s. Nurses were bitterly divided on this subject. There were pros and cons to wearing the nursing cap. Those against the cap said it was full of fomites and a health hazard as well as uncomfortable and unwieldy—always getting caught in the divider curtain, the croup tents, or the IV lines. Caps also unforgivingly flattened the teased hairstyles of the day. It was difficult to wear the cap in the correct spot without causing headaches by the end of the shift and undue stress to the hair, eventually leading to bald spots. Nurses also contended that wearing a cap did not make a nurse a nurse, which was true, but the symbolism attached to the cap since the 1800s was difficult to break. Caps, white uniforms, white hose, and polished white shoes (Stokowski, 2011b, p. 3) have always identified nurses. The sight of a nurse commanded respect.

Another reason to get rid of the cap was the symbolism of subservience. The 1970s was a turbulent time when women asserted their rights to be women, not servants to men. Women wanted nothing to do with traditions that reminded them of their "maid" past. The cap did that. The cap had to go. Nurses who favored wearing the cap saw it as an assault to all of the hard work that they had put forth to earn the right to wear it. It had always signified confidence, education, and dignity or self-worth. Women who had sacrificed time and dedicated their lives to higher education and nursing could wear a nursing cap.

The nurse's cap was a special object that stood for nursing and nothing else replaced it. The nurse's cap symbolized caring and nurturing (Stokowski, 2011b, p. 4). Patients were the most upset by the demise of the cap. Nurses were easily identified

because they wore a cap and no one else did; patients, especially elderly ones with dimmed vision, used the cap to differentiate between the RN and other personnel.

Uniforms: Bullying by the Employer

Shortly after the feminist movement in the late 1960s and early 1970s, nurses began to fight two traditions: that of wearing a cap and a white uniform. Nurses were being fired for coming to work wearing short-sleeved white polyester dress uniforms. They had always worn long-sleeved or ¾ -sleeved starched white cotton dresses that reflected neatness, cleanliness, and a professional appearance (Rezeai-Adaryani, Salsali, & Mohammadi, 2012, p. 83). Once nurses were able to get their individual hospitals to change from this type of uniform to short-sleeved, non-starched white polyester uniforms, the next step was to get the privilege to wear white pantsuits. Stokowski (2011b) stated that the pantsuits of the 70s did not look anything like today's scrubs. They were fashionable and tailored (p. 2). It was this one change in the style of clothing that demonstrated nurses' intent to demolish an age-old tradition.

By the 1980s, many nurses had abandoned the white uniforms for hospital scrubs. When they stopped wearing caps and white uniforms and began wearing colored scrubs, some patients felt insecure because they could not identify the nurse from the housekeeper (Stokowski, 2011b, p.1). In order to identify the nurse today, many patients must read the nametag to see what it says: RN, Doctor, etc.

Work Assignments: Bullying at its Finest

Another area of prejudicial thinking that fostered bullying was related to which department the nurse worked. There were different degrees of specialties of nurses who

worked in a hospital, and nurses were judged based on where they worked. Nurses were clear about how they treated each other in the various departments. The bigoted ones not only looked down on the rest of the nurses, but they fought viciously among themselves, trying to prove who the best nurse was within their group.

Bullying between nurses was not called that prior to the mid-2000s. Instead, it was called, *paying your dues* or the *rite of passage*—an old, established practice of intimidation and harassment in all types of medical education. The senior nurses took great pleasure in assigning the hardest, dirtiest, and most disgusting jobs, the most complex patients, and the meanest doctors, to the new nurse. It was a way for nurses to pass off the jobs they did not want to do and the patients they did not like to the new nurse. The seasoned nurses were bold about telling the new nurses they were "toughening them up" and "getting them ready" to be nurses. Later in the shift, they would laugh and talk about them when they were within earshot (MacKusick & Minick, 2010, p. 337). Nurses at the time never thought to fight back about it because there was no one to report it to; they just endured it and were glad when it ended, and it was the next "new nurse's turn."

Szutenbach stated that it was the norm to bully all nurses, students and new graduates alike (2013, p. 20). It was just part of being a nurse. The bullying started in nursing school with hazing from the upperclassmen. The instructors and school director determined who stayed and who did not. Once an instructor decided that a new student would not make a good nurse, certain members of the faculty would bully the student unmercifully until the student either quit or failed the course. If the freshmen students

made it through the first year, they could be confident they would graduate from nursing school. The next year was their turn to haze the new freshmen, which smoothed over many of those bad memories from when it happened to them.

By the time the student graduated, two behaviors may have been adopted: bullied or bully. The weaker students would do whatever the bully wanted to mollify future bullying episodes. Eventually, this practice of placating the bully became ingrained in the student, graduating with this personality trait, thus inviting harassment from fellow colleagues when working. The stronger student learned to protect him or herself from bullying by becoming a bully. Even though it was blatantly going on, the student nurse would deny it existed because it was normal now (Szutenbach, 2013, p. 20). This is how nursing school created bullies.

Nursing Shortages

Nursing shortages are not new. They are cyclical (Egenes, 2012, p.18). Each one has occurred for a different reason. Since 1939, there have been three other shortages: 1963, 1980, and the 21st century. The 1939 shortage was a matter of supply and demand because of World War II. The 1963 shortage was actually a continuation of the 1939 shortage, but this time the focus was on salary and education. The shortage of 1980 was related to retention. Researchers were focusing on why some hospital employers could retain nurses while others could not. The 2007 shortage is a continuation of the 1980 shortage although early thoughts were that it was related to the economic collapse of 2007.

The Nursing Shortage of the 21st Century

The present shortage has proven to be quite different from the previous ones. Instead of one or two causative factors, such as war or education, this shortage is a culmination of many causes, including an ever-increasing older population, the Affordable Care Act, retiring health care personnel, nursing faculty who are retiring, and bullying (Budden, Zhong, Moulton, & Cimiotti, 2013, p.5; Egenes, 2012, p. 21). Two areas of concern are education and Baby Boomer nurses, which have repeatedly appeared in the literature review. Both negatively influence the present and future of nursing.

Education

All RNs must be a BSN. While the idea that all RNs possess a BSN degree is realistic, this may not come to pass as soon as nursing leaders would like. A report issued by the Institute of Medicine (IOM) stated that by 2020, 80% of all RNs should hold a BSN degree (Faison, 2012, p. 2). As of 2013, 36% of RNs had a BSN (Budden et al., 2013, p. 8). Younger nurses who graduated after 2000, were more likely to have a BSN (44%) than those who graduated before the year 2000 (33%) (Budden et al., 2013, p. 8). With only a few years left before 2020, the prospects of 80% of RNs possessing a BSN look dim.

Changing the nursing education from a choice of three different ways to become a degreed RN down to one avenue is a solid idea, founded in research; however, the history of how and why there are three ways to get a nursing education must be considered. Diploma schools were the first types of nursing schools, set-up by Florence Nightingale (Stokowski, 2011c, p. 9). When the Second World War started, the U.S. was in dire need

of nurses quickly. In 1943 the federal government created the Cadet Nurse Corps, which provided a free education, uniforms, and a small check in exchange for work as a nurse (Egenes, 2012, p.19). By the end of the war, approximately 160,000 nurses were actively employed in hospitals (Egenes, 2012, p. 19). Diploma schools were the practical answer, as they only required three years of education. BSN schools did not start until the early 1900s and required four-to-five years of training, which was too long. Two-year Associate Degree nurses were not an option until the 1950s—too late for the Second World War.

Each type of training had its purpose. Diploma graduates did everything from bedside nursing to director of nursing. Associate Degree nurses were to be bedside nurses only and not have a hand in leadership, while Baccalaureate degree nurses were expected to take on the leadership roles such as charge nurse, nursing supervisor, or department manager (Amos, 2016, p. 2). Today, the American Association of Colleges of Nursing (AACN) promotes the Bachelor of Science degree in nursing as the entry-level degree and those nurses with an Associate Degree or a Diploma are highly encouraged to complete their BSN degree so they may continue to work (Rosseter, 2015, p. 1). The rationale for this is that baccalaureate nurses can practice in any nursing setting, whereas Associate Degree and Diploma nurses do not have the critical thinking skills or leadership capabilities to function in all areas (Rosseter, 2015, p. 2). Researchers demonstrated that BSN nurses have fewer patient fatalities than Diploma or Associate Degree nurses do. The reality is that any nurse's fatality numbers will increase with each additional patient to care for determined by the complexity of the patient and whether the

work environment is favorable or unfavorable, such as in bullying (Castronovo et al., 2015, p. 210). Nurses agree on these two points: the competency of the nurse is the first factor in favorable patient outcomes. The second point is that it does not matter how competent the nurse is, there is a limit as to how many patients the nurse can handle and when that threshold is crossed, then patient morbidity and mortality rise.

Starting in the late 2000s, an increasing number of hospitals decided to hire exclusively BSN nurses (Buerhaus, Auerbach, & Staiger, 2014, p. 294). Because of this push to have all BSNs on the nursing staff of a hospital, bullying may have increased because AD and Diploma nurses are trying to protect their jobs. Hospitals that either have Magnet certification or have applied for it will only hire BSNs. Magnet certification means that a hospital has applied to the American Nurses Credentialing Center (ANCC) and has earned the certification. Magnet hospitals must have a plan in place to meet the IOM proposition that 80% of all nursing staff will be BSN Degreed by 2020. If the hospital has already met that benchmark, there must be a plan to retain and increase that percentage (American Nurses Credentialing Center, 2015, p.1). From the moment that a hospital applies for Magnet certification, Associate Degree and Diploma nurses are rarely hired (Aiken &Yakusheva, 2014, p. 1). In a city that has more than one hospital system and all are Magnet certified, there are almost no job openings for non-BSN nurses. It also means that surrounding area hospitals favor hiring only BSNs too, keeping up with the neighboring hospitals in perceived quality (a marketing ploy). This policy effectively keeps talented nurses with years of valuable experience from practicing and bars patients from benefitting from their nursing expertise.

Between the years 2002 thru 2012, the number of Associate Degree and Baccalaureate Degree nursing school graduates increased from 77,000 to 184,000, and for the first time in 2011, there were more BSN graduates than ADNs (Buerhaus et al., 2014, p. 293). In 2004, 3.1% were Diploma graduates (Stokowski, 2011a, p. 5). Essentially, the Diploma nurse is a degree of the past. The AD RN degree, however, remains popular. Less than 21% of nurses educated in Associate Degree programs go on to complete a four-year BSN nursing degree program (Stokowski, 2011a, p. 5). Aiken and Yakusheva revealed that in 2014 two-thirds of nurses graduated with an Associate Degree instead of a BSN, which is insufficient to meet the Institute of Medicine's guideline for an 80% BSN workforce by 2020 (2014, p. 3). In my conversations with nurses from various sized hospitals, an increasing number of AD and Diploma nurses are saying they have to decide what they are going to do because Human Resources representatives have approached them about returning to school or else leaving. While hiring only baccalaureate prepared nurses is desirable, there simply were not enough BSNs to fill in the gaps in 2015. Rural areas are impacted more so than urban areas because they simply do not have adequate access to BSN nurses. Accessibility is going to be the largest hurdle for the BSN degree.

Lack of educational opportunities to obtain the BSN. Recruitment efforts had been intense, especially after the economic downturn of 2007, when many people lost their jobs and were looking for new avenues to make money. Many people decided to attend nursing school, and with good reason. Stokowski (2014) related that by the year 2022, forecasters have calculated there will be 3.2 million jobs available for RNs (p. 4).

Even if a person is considering attending nursing school, the goal may not be attainable. To earn a BSN degree, a student must enroll in a 4-year university. Physically, many rural areas are isolated from universities, making the ability to earn a BSN much more difficult. In 2013, 78,089 nursing school applicants were refused a college education in nursing due to inadequate funding to hire faculty and nearby colleges (American Association of Colleges of Nursing, 2014, pp. 1-2). In rural areas, community colleges are more easily accessible; consequently, the AD in nursing is more popular than the BSN.

Even though the number of nursing schools has increased from 1,611 in 2002 to 2,240 in 2012, the growth is not consistent throughout the United States with more schools in the Midwest and West, which puts an added strain to this present nursing shortage (Buerhaus et al., 2014, p. 293). It is not unreasonable to assume that students who attend community colleges do so for decreased cost. If they do not have access to a nursing school close by there are other choices instead of nursing.

Faculty shortage. The good news is that faculty positions are the fastest growing occupation. The need has been projected to be 35%, which equates to 24,000 jobs that will be available by 2022, but the bad news is that there are not enough nurses who have master's or doctorate degrees to fill these roles (Stokowski, 2014, p. 4). According to Budden et al., before 2013, 72% of full-time faculty were 50 years old or older, while only14% were younger than 40 years old (2013, p. 7). Younger nurses are not choosing the faculty route in favor of working as Nurse Practitioners (NPs) because they can make more money and have more career options. The present faculty shortage is only going to

worsen as an increasing number of faculty members retire with fewer new faculty to replace them.

In order to teach, a professor must have a BSN, preferably a master's in nursing, and either actively be enrolled in a doctoral program or possess a doctorate in nursing (DNP—doctor of nursing practice). Thirteen percent of nurses possess a master's or doctoral degree. There are three job opportunities for this group: administration (research as a Ph.D.), Clinical (practicing as an NP—Nurse Practitioner—master's degree), or teaching (both master's and Ph.D. or DNP) (Stokowski, 2011a, p. 6). The present faculty will be retiring soon without adequate replacements. One reason for this shortage is due to money. Nursing instructors make less money than hospital nurses. An overall salary figure of a nurse faculty member would be $47,000.00 to $86,000.00 (Candela, Gutierrez, & Keating, 2013, p. 855). According to the U.S. Department of Labor, the median wage for a nurse in 2012 was $65,470.00, while the median wage of all other occupations was $34,750.00 (2014, Jan, p. 1). In 2014, RNs made, on average, $69,000.00, nurse practitioners made $95,000.00, advanced practice nurses made $109,000.00 while faculty nurses made $70,000.00 (ANA, 2014, p.2). Nurses who are considering returning to school must weigh the factors: School loan repayment, the salary difference between a staff nurse and faculty, and life-work-school balance (Beckman, Cannella, and Wantland, 2013, p. 288). Many nurses cannot justify the sacrifice because they will not see a return on investment (ROI), so they decide to forego teaching. For example, the average cost to attend four years of college to earn a BSN is $36,000.00 to $120,000.00 without room and board (Aiken & Yakusheva, 2014, p. 3). If diploma nurses make, on average,

$65,000.00/year, it would cost $276,000.00 to $360,000.00 in tuition and lost wages to earn a BSN and for an associate degree nurse to earn a BSN would cost $138,000.00 to $180,000.00 (Aiken & Yakusheva, 2014, p. 3). Aiken and Yakusheva noted that a BSN makes about $6400.00 more than either a diploma or associate degree nurse, which means the return on investment would not be realized for at least 20 or 30 years (2014, p. 3). There is very little incentive to return to school to earn a BSN, especially if the nurse is over 40 years old.

Faculty professors are not exempt from bullying either. Peers as well as students bully them. As many as 25% have left teaching positions due to bullying (Mintz-Binder & Calkins, 2012, p. 153). Bullying amongst faculty in the United States is a relatively new research topic (Beckmann et al., 2013, p. 287). According to Beckman et al. a bullied faculty member is twice as likely to leave teaching as a non-bullied faculty member (2013, p. 288). The number one reason given after deciding to leave is the lack of collegiality and the second reason is discriminatory promotion practices (Beckmann et al., 2013, pp. 288-289). Many times, jealousy over promotions or awards leads to bullying between faculty members (Clark, Olender, Kenski, & Cardoni, 2013, p. 212). The professor would like to think that there is a safe haven within the faculty, but bullying exists there too. It is most distressing to have to deal with bullying from co-workers after dealing with bullying from students and upper management on a daily basis.

In addition to faculty bullying each other, students bully them too. Students who bully faculty have the opinion that they can mistreat professors because they are paying

for tuition, and therefore, have a right to say or do whatever they wish (Mintz-Binder & Calkins, 2012, p. 153). Students will overtly bully professors with displays of repeated intentional tardiness, yelling, threats, and even physical harm (Mintz-Binder & Calkins, 2012, p. 153; Luparell, 2011, p. 93). Students are very vocal about what grade they expect to receive and can cause significant irreparable damage to a teacher's reputation if they do not get what they want. In time, the threats and abuse become so disparaging that the teacher leaves (Luparell, 2011, p. 93). The results of repeated bullying cause psychological and physical manifestations, which, in turn, lead to faculty leaving positions either to retire or to work elsewhere in nursing or possibly leaving the profession.

Baby Boomers: Age, Experience, and Bullying

There are three areas to consider when speaking about older nurses: age, years of experience, and bullying.

Age. People who were born between the years of 1946 to 1964 are Baby Boomers. The age of the first Boomers born in1946, would be 70 years old in 2016. Boomers born in 1964 would now be 52 years old. Approximately one million will be eligible to retire before 2020 (Buerhaus et al., 2014, p. 290). Longo stated that anyone who is over 40 years old is considered an older worker in the U.S. (2013, p. 950). Baby Boomers made up the majority of working RNs in 2016. In 2013, 53% of RNs working were 50 years old or older (Budden, et al., 2013, p. 7). In 2016, many choose to continue working because they cannot afford to retire. Many lost most or all of their savings after the 2007 crash in 401k losses or because they had to liquidate 401ks to make house

payments, etc. Because they have not retired as projected, the nursing shortage has remained artificially inflated since 2007. Auerbach, Buerhaus, and Staiger (2014) stated in 2000, forecasters predicted that the number of RNs would be 2.2 million in 2012 and then it would decrease dramatically when the Baby Boomer nurses started retiring after the first ones born in 1946, would turn 65 in 2011. Instead, the RN workforce numbers in 2012 were 2.7 million. There are three reasons for this. First, twice as many students graduated from nursing school. In 2002, there were 74,000 graduates, but in 2012, there were 181,000 (Auerbach et al., 2014, p. 1474). The second factor was the slow recovery from the 2007 economic crash. Baby Boomer RNs who could have retired chose not to; and the third reason is that Baby Boomers, those aged 49-67, currently make up more than 40% of the RN workforce (Auerbach et al., 2014, p. 1475). Nevertheless, the economic sluggishness is not the sole reason Baby Boomers have chosen to remain in the workforce. A trend in the last 40 years is that RNs are intentionally choosing to remain working longer than others work in their age group (Auerbach et al., 2014, p. 1475). Before 2000, less than 50% of RNs were still working at age 62. By 2012, three-fourths of RNs 62 years old were still employed (Auerbach et al., 2014, p. 1476). RNs will change their employment options as they age. At 35 years-old, 85% work in a hospital (Auerbach et al., 2014, p. 1476). By age 50, only half work in a hospital and by age 65, 35% work in a hospital (Auerbach et al., 2014, p. 1476). Older nurses leave the fast-paced demands of the hospital for easier jobs in ambulatory care, home care, telephonic nursing, or teaching, to name a few (Auerbach et al., Aug, p. 1477). This gradual easing out of the hospital does open up positions for younger nurses who have the stamina to

work the 12-hour shifts, do all of the lifting, bending, twisting, tugging, pulling, and reaching that is required of a hospital nurse. Nurses who are in their 40s, 50s, and 60s working a full shift are beginning to feel the effects of all of those years of lifting, twisting, bending, and pulling. Plagued with back, shoulder, and knee problems equates to an increase in workers compensation claims, affecting the hospital's bottom line. Eventually, the Baby Boomers will be forced to retire due to medical ailments, causing another nursing shortage. When Baby Boomers retire, they not only open up a spot for a younger nurse, but they take a tremendous amount of irreplaceable tacit knowledge with them.

Experience. Experienced nurses often are the targets of bullying because of their experience and expertise. Younger nurses, with less experience, are jealous of the confidence and wisdom of the more experienced nurses, resorting to bullying the nurse to prove superior power (Longo, 2013, p. 951). The older nurse who is tired, burned-out, feels devalued, and feels that she or he hit the pinnacle of expertise years earlier may succumb to the bullying. At this point, the intuitive nurse manager will intervene, protect the nurse, and utilize that tacit knowledge in a more intellectual way, supporting and educating the newer nurses instead of working out on the unit (Longo, 2013, p. 953). If the older nurse is unsure of how to operate the new technology in the department, the nurse manager can pair up the older nurse with a younger nurse who is more proficient in the technological machinery, becoming a win-win situation (Longo, 2013, p. 954). If the younger nurse does not respect the older nurse, this situation can become a bullying opportunity on the older nurse due to the insecurity of working with the new technology

(Todaro-Franceschi, 2014, p. 6). If the older nurse is the bully, this is an opportunity to bully the younger nurse, causing the nurse to choose to leave the department. When both the younger inexperienced and the older experienced nurse leaves, each takes valuable knowledge, and tacit knowledge with them.

Bullying. A unique situation that occurs with older nurses who have been practicing for more than 25 years is that they attended nursing school and started working before bullying was called bullying. They endured what was called "rite of passage." In nursing school, the instructors used it as a means of weeding out the students they felt were not good nursing material. This "rite of passage" then continued when the new graduate worked the first job. The older nurses in the department would test the nurse on purpose to see the reaction. If the nurse could endure the testing time and the nurses liked him or her, the nurse would be welcomed into the group. If the new graduate came from a different hospital and the other nurses did not like that hospital, they would evaluate the nurse the first day and make the decision whether to keep or get rid of the nurse. If they decided the nurse would not fit well in the clique, then the nurse would be bullied until she or he made it through the trial period, quit, or was fired. If accepted into the group, eventually the nurse would become immune to these bullying actions; being guilty of doing the same thing to the new nurses who hired on after (Longo, 2013, p. 951). Freire's oppressed theory supports this action.

How Bullying Affects a Hospital's Bottom Line

Direct and Indirect Costs of Retention and Attrition Related to Bullying

Bullying affects a hospital's reputation, it ability to recruit and retain top talent, or how much it erodes into an already strained hospital budget. Papa and Venella (2013) noted that it costs one hundred times more to fix a bullying problem than to take preventive measures (p. 4). Douglas related that in Australia, the cost to employers to handle the ramifications of bullying was between $5 and $30 billion per year (2014, p. 24). In Britain, it costs about $683 million per year (Barber, 2012, p. 300). Hospital executives and risk managers can be lulled into a deceptive degree of calm if there have been relatively few bullying incidents reported and none litigated, causing them to ignore what will probably happen in the next fiscal year (Papa & Venella, 2013, p. 6). It is this inaction that will deeply impact the hospital's financial department due to the lack of allocated funds to absorb the cost of even one litigated case.

Direct costs. Direct costs are items easily identified and quantified in an organization's financial report. Examples include such things as lost wages, workers' compensation claims, medical insurance claims, FMLA, and extended sick leave (short-term disability and long-term disability). Premium wages for temporary replacement nurses, recruitment/retention, and training programs can cost millions in financial loss to a hospital's budget (David & Holladay, 2015, p. 137). Lawsuits, and medical malpractice insurance fees as well as damaged supplies, hospital furniture, beds, computers, wheel chairs, etc. all contribute to direct costs. Papa & Venella posited that in a lawsuit, administrators could expect to pay $3.1 million/person/incident. The yearly cost has been

estimated to be $120 billion (2013, p. 3). In trying to keep up with budgeted expenses, adding these types of numbers to a budget can be disastrous.

Next to lawsuits, the costs to replace nurses who leave are very burdensome. The direct costs include recruitment and training, while time to adapt or learn the new job would be both direct (time paid) and indirect (adapting and learning) (Al-Ahmadi, 2014, p.412). The cost to replace 500 RNs was $7.8 million to $9 million (Wilson, Diedrich, Phelps, & Choi, 2011, p. 454). Christie and Jones stated it costs $92,000.00 to replace a medical-surgical nurse and $145,000.00 for a specialty nurse such as an ICU or ED nurse (2014, p. 3). The cost to replace a nurse who has left due to witnessing another co-worker being bullied can range from $30,000.00 to $100,000.00 (Stagg, Sheridan, Jones, & Speroni, 2013, p. 333). Lee, Bernstein, Lee, and Nokes reported that for each RN hired in Long Island, NY, it costs just under $100,000.00 (2013, p. 263). Depending on what section of the U.S. the hospital is located will determine the cost to replace a nurse. Other factors to consider are the hospital's reputation and if the replacement nurse is a general or specialty nurse.

Indirect costs. Calculating indirect costs related to bullying on paper appears elementary, but the real problem occurs when researchers attempt to quantify the list. Nurses will not talk about their bullying experiences, leaving hospital executives, HR personnel, and risk managers to guess. The result is the same whether the indirect cost is due to bullying or not—it is a loss for the hospital's bottom line.

It would appear the costliest items in a hospital's budget are direct costs, but the indirect costs that hide in the financial ledgers without a specific cost attached, cost much

more. Examples of indirect costs are related to time involved in recruiting, hiring, and training a new employee (Wilson et al., 2011, p. 454), tardiness, absenteeism, presenteeism, diminished productivity, poor morale, decreased quality of patient care, and lack of engagement by staff (Lee et al., 2014, p. 263). Of particular note are absences. Absences and tardiness cost more than $3 billion in the U.S. yearly or the equivalent to 15% of payroll (Liu, Li, Fan, & Nauta, 2015, p. 3). The costs related to absenteeism and presenteeism are increasing job dissatisfaction, increased last minute call-offs, repeated episodes of sickness, decreased quality of work, productivity, and engagement (presenteeism—the employee is physically present at work but not engaged in work), and eventual interpersonal and intrapersonal relationship difficulties (Lee et al., 2013, p. 263). Bullying is a contributive factor to the escalation of indirect costs (Longo & Hain, 2014, p. 195). All of these factors damage a hospital's reputation can have significant financial repercussions.

How Hospital Administrators and Managers Bully Employees

Since bullying is known to exist in the healthcare profession, then it would seem appropriate that it would exist as a tool for managers to use to increase productivity. Do managers, supervisors, and nurses use bullying as a management tool? This question provides some interesting thoughts. Barber (2012) stated that management styles range from laissez-faire to bullying with no clear-cut lines to let managers know they are bullying subordinates instead of encouraging them to be more productive (p. 301). Those very people who use bullying tactics on subordinates to get more work done do not realize or even consider their actions as bullying because they believe they are utilizing a

management tool. The new employee can see the toxic behavior emanating from this culture, accepted as normal (Barber, 2012, p. 301). The last thought is that the managers know they are engaging in (bullying) and do not care about the consequences if their actions yield the desired results, and they do not get caught (Barber, 2012, p. 301). Even if they are, bullies are frequently narcissistic, actually believing their actions have merit.

Managers who have agendas for climbing the corporate ladder will intimidate subordinates for two reasons. One is to show power over the employee and the second one is to be recognized by upper managers so a promotion can ensue. Managers use three tactics: Posting changed work schedules and policies without advising staff of the changes, then writing up offending nurses; pointing out employee errors in nurse staff meetings; and using performance reviews as a veiled threat to coerce employees or terminate them (Longo & Hain, 2014, p. 195). Managers carry out their bullying by hiding behind established department policies.

Another way upper managers can bully the managers below them is through manager meetings. Hospital administrators are in fierce competition for every dollar, demanding the nursing managers in each department attain top ratings on each discharge survey. Those who do not gather top marks face bullying or termination, which is known as vertical violence. It starts with the vice president and moves down to the department manager, who, in turn, bullies the staff nurses. There are cameras throughout the department, as well as tracking devices on each employee's name badge to ensure the nurses are actually working. There are people—nursing supervisors, charge nurses, and peers who are watching each other's moves, which provides the bully an exceptionally

easy access to attack prey. The concept of nursing as a nurturing, healing, and caring type of job has faded, replaced with corporate nursing because administrators are more concerned with the financial bottom line than the medical bottom line.

Another area to consider is the actual physical layout of the hospital. Chipps, Stelmaschuk, Albert, Bernhard, and Holloman (2013) noted the hospital's site and set-up (physically and policies) does influence the extent of bullying (p. 490). The cultures within the hospital change with each shift and department, which is one reason it can be most distressing to the nurse who must switch shifts to cover for another nurse. Those involved in the day-to-day management of a hospital should be concerned about how bullying affects the financial bottom line. It is costly and time-consuming to recruit, hire, and train personnel just to have them go back out the door. Managers, nurse leaders, hospital executives, and policymakers need to make it a priority to make their hospital workplace safe and an inviting place to work. It is prudent for hospital managers to be concerned about how bullying affects their bottom line.

Job Dissatisfaction Related to Bullying With Intent to Leave

The intent to leave is of great concern regarding nurses. Exposure to harmful behaviors and bullying increases the intent to leave, hampers motivation, causing psychological upset and psychosomatic illness (Trépanier, Fernet, & Austin, 2012, p. 387). The manager should not be surprised when the nurse leaves, as 40% of bullied nurses will leave their position or the nursing profession after hinting at being dissatisfied with the job/work environment (Stagg, Sheridan, Jones, & Speroni, 2013, p. 333). HR personnel might wish to consider polling nurses yearly regarding intent to leave. This

information will provide insight on what percentage of nurses to expect to leave the organization, altering the budget accordingly (Wilson et al., 2011, p. 454; Rasool, Arzu, Hasan, Al, Rafi, & Kashif, 2013, p. 175). Although this is a plausible idea, HR personnel, risk managers, and finance officers should not depend on this information to be foolproof as there are nurses who will not be forthcoming in their plans out of fear of retribution.

The problem is that the majority of nurses do not feel safe enough to tell anyone about the bully amidst fears of what the bully might do to them. Ariza-Montes, Muniz, Montero-Simó, and Araque-Padilla reported findings from a study conducted in Britain where 5,200 participants admitted to experiencing bullying (2013, p. 3127). They exhibited signs of worry, being overwhelmed by their workload, and job dissatisfaction (Ariza-Montes et al., 2013, p. 3127). These are preliminary warnings that the victim will seriously consider leaving the organization. Researchers in Norway revealed similar results, and a study from Turkey revealed that 87% of nurses admitted to being bullied (Ariza-Montes et al., 2013, p. 3127). If the nurse feels safe enough to tell HR personnel the real reason for leaving, the truth will be that the nurse is leaving out of fear of retaliation from the bully (Wilson et al., 2011, p. 456). If an organization's leaders want to find out why a nurse has left, they should contact the nurse several weeks later when the nurse feels safe enough to talk about the bully.

This information can serve three purposes. The first purpose is to determine approximately how many nurses have left because of bullying. Then the information can be mined to find out if there is an individual department or shift that has more turnover

than others do in regards to bullying and if a name recurs in the departure notes. The second purpose is to use the information to create educational programs specific to certain types of nurses. Nursing departments are different in the types of stress they encounter and the amount of bullying they experience. The third purpose is to take this information and apply it forward to forecast future departures; combining this information with previous years' trends will assist the financial CFO in determining the next fiscal year's budget.

Nurse Managers and others in leadership roles within the department should be educated about the signs of nurse dissatisfaction. Addressing situations in a confidential manner will make it easier for the nurse to feel safe enough to disclose what has been happening. Nurses often change their opinions about their jobs after experiencing bullying. Instead of working out of a desire to help others, they work out of a sense of pressure because they need the job, increasing the intent to leave the position as soon as another one is secured. The result is that the hospital the nurse left must now find a replacement, which can carry a hefty price tag.

Bullying

In my review of the literature, the statistics appeared to be within an acceptable range. Bullying ranged from 5% to 38% (Walrafen et al., 2012, p. 6). The problem is gross underreporting, and no way to know just how prevalent bullying is. The actual percentage can be assumed to be much higher. Nurses are afraid to talk about their bullying experiences, and may falsely answer or even refuse to answer surveys that are about bullying. Until nurses feel safe enough to speak out, the real number will remain

hidden. There are nurses out there, mostly those who have left the profession, knowing the bullies cannot hurt them anymore, resulting in their willingness to speak openly about their experiences. They will comment on the blogs, sharing their pain, shame. Even if a bullied nurse does not say anything, the bullies read the blogs and the literature, too, and they use it as an excuse to harass their targets for yet another, unfounded reason.

In my impromptu conversations with nurses who work in hospitals—one in a large city, the other in a small town, both reported that bullying is about 95% in each hospital. The large hospital has been Magnet certified for several years, and the small hospital was purchased by a Magnet hospital. All of the AD and Diploma nurses have to decide if they are going to get a BSN degree in order to stay employed or if they are going to leave for another job elsewhere. The problem is that in the small town, there is only one hospital. Twenty miles south, in the next city is a larger hospital, which has also been acquisitioned by a Magnet Certified hospital. In the large city, there are multiple hospitals tied to three different hospital systems, and each one is Magnet, so the nurse who chooses not to pursue the BSN degree is not going to find work in either place. The AD and Diploma nurses have no choices regarding the BSN; they must have the degree to work in any hospital, causing an escalation in bullying. AD and Diploma nurses are trying to save their jobs. They look for the BSN, MSN, or other degreed nurses to bully because as they cannot go against the system, so they attack each other as a way to express frustration.

Age is accepted to be the most influential factor in making this decision. I found through conversations with nurses, that those who are over 45 years of age were hesitant

to return to school, trying to determine if they could realize any ROI and whether they desired to remain in nursing. Those closer to 50 years of age and over displayed the hardest time because they were not ready to retire yet. They could work another 15 years but have no desire to return to school. One nurse who was 64 years old, told me that he felt he was forced to retire although he did not want to, just yet (anonymous nurse, personal communication, August, 2014). Returning to school is a choice for nurses younger than 45 years old in order to keep the present job and secure future employment. Nurse Techs (similar to Nurses' Aides) who decided to go into nursing were choosing the BSN route, instead of the ADN because they already knew no jobs were available for ADN graduates in this town or the next one. The bullying atmosphere in the small hospital has improved because most of the upper management has retired. The large hospital reports the opposite.

The Facts

Bullying is so common that 97% of nurses admitted to verbal abuse, and 72% have witnessed it among co-workers (NasrEsfahani, & Shahbazi, 2014, p. 410). Walrafen et al. (2012) stated between 20% – 53% of nurses had experienced horizontal violence (p. 9). Worldwide, bullying between nurses has been noted to be 90% in many countries (AlBashtawy, 2013, p. 551). Akyl, Tan, Saritas, and Altuntaş stated that France, Britain, and Germany experience the most bullying of any European country. Nurses in these countries admit to being bullied at least once a week and sometimes more (2012, p. 403). Iglesias and Vallejo (2012) noted in their study that 17% of nurses in Spain affirmed bullying and of that, 3% were bullied weekly and 5% were bullied daily

(p. 5). In Europe, the United States, Australia, and New Zealand, the bullying rate is between 10% and 20% in all occupations (Heugten, 2012, p. 291). Healthcare workers in Spain experience four times the amount of bullying than other occupations within the country, but this rate of 11.3% is much less than in the United States where the rate is 38% (Ariza-Montes et al., 2013, p. 3131). Researchers run into the problem of significant differences in reported rates of bullying within a country, such as northern and southern Europe. Northern Europe reported 4-5% bullying while Southern Europe reported 15% (Ariza-Montes et al., 2013, p. 3122). Due to inconsistent statistics, researchers cannot truly determine what the actual bullying rate is. Even within each hospital, there are inconsistencies in bullying rates depending on the department and the shift.

The variance in statistics, however, depends on the researcher's study focus, the method of the study, and the type of instrument used. In the earlier years of 2000 – 2010, researchers could not find enough nurses who would talk about their experiences to create a relevant study. The outstanding reason: nurses did not know that what they had experienced was bullying. Nurses were too ashamed to talk about it, and those who were still working were afraid of losing their jobs due to retaliation by the bullies. Even when nursing sites offered an article about bullying and asked if the nurse perceived him or herself as being bullied, the numbers have not been credible as the exact figures of bullied or bullies cannot be validated.

Absenteeism due to Bullying

Absenteeism can be very costly to an employer's bottom line. Wilson et al. (2011) stated 95% of nurses affirmed absenteeism is an after-effect of bullying, and 20% of those stated they had done so themselves (p. 456). As previously stated, the cost to cover absences/tardiness per year in the United States is about $3 billion dollars (Liu et al., 2015, p. 3). While there are many reasons for absences at work, it would be a valuable study to correlate how many absences are due to bullying. In a United Kingdom study, 30% of nurses on long-term sick leave admitted it was because they were bullied (Iglesias & Vallejo, 2012, p. 3). Nurses eventually must make a choice—quit the job, face the bully and risk losing the job, or avoid the bully by not coming to work. Nurses tend to call off work and avoid the bully rather than face them for another shift (Liu et al., 2015, p. 4). Depending on the nurse's constitution, when the bully cannot be faced anymore, the nurse becomes physically ill to the point that a medical leave may be taken in order to recover. This is an example of an indirect cost for the employer.

Bullying and Resiliency

The literature is replete with studies about bullying—identifying it, writing policies about it, educating employees how to protect themselves from it, but there is relatively little information regarding surviving it. Documentation throughout history reveals that people who have been severely traumatized can recover from the trauma and build resilience to future trauma. Heugten suggested if a program were set up to assist people in overcoming trauma, in this case, bullying at work, many would be able to improve their health and build the resilience (2012, p. 292). It would appear that Heugten

based her thinking on a parallel with the medical stance regarding infection and recovery. For example, once inoculated with the influenza virus, a person will get the flu. After recovery from the flu, there is resistance to future bouts of the same strain due to the resilience of the immune system.

Heugten stated that if people experiencing bullying faced it, they would grow more resilient to its effects. In addition to this, those who experience illness due to bullying can build resilience to it if they seek support and help (2012, p. 292). Heugten further theorized that if the bullying stopped long enough for the victim to regain a sense of balance, then resilience could be built. Once the victim realized what had happened and the power that had been taken away could be retrieved, along with a newfound sense of control. Although the victim will continue to experience bullying, now there is an inner strength to withstand the episodes without succumbing and feeling helpless and vulnerable (Heugten, 2012, p. 294). While this argument appears sound, I have to question how a program like this would get started. Healing cannot begin until the nurse openly admits she experienced bullying. Bullied nurses may not talk about it and many deny it is happening to them. Chipps et al. (2013) discovered that while 6% self-identified as bully targets, according to the NAQ-R results, 33% qualified as targets (p. 486). Even after a nurse admits to being bullied, healing is not immediate and the time to restore balance and courage differs with each nurse. While the nurse is healing, she still must work and will be confronted by bullies again. Facing bullies is a terrifying feeling, and it is easier to avoid them than to face them.

The Aftermath of Bullying: Shame

Two feelings frequently felt by the bullied or the witnesses are guilt and shame. The difference between guilt and shame is that guilt is the feeling of remorse after an omission or incorrect action that hurts another person, while shame is a feeling of being "less than," not worthy, flawed, weak, or dirty, feeling he or she is a mistake (Graff, 2011, p. 134). Shame is so intense the person turns away from the situation, frequently choosing to deny what has happened (Graff, 2011, p. 134). The person may strike out in anger, contempt, a "better-than-you" attitude, or locks everything away behind the doors of depression (Graff, 2011, p. 134). As a result of these repressed feelings, it is quite difficult to even identify shame within oneself.

In order to get over the trauma, the incident(s) that led up to it must be acknowledged and relived. Often this is so painful that the person will relive the incidences going through several episodes to face the shame. Sharing the lived experiences with others may help the person with the healing process. Witnesses to bullying must also admit and relive their shame, which is just as traumatizing as if they had been bullied, and sometimes more so because they must deal with the guilt of turning away from the bullied nurse and not helping.

In guilt, the person looks for and asks for forgiveness, openly confessing his or her wrong to the party involved, while shame causes the person to repress what happened and the feelings associated with it (Graff, 2011, p. 134). When a nurse experiences shame, it is easier to self-silence and deny anything is going on than to stand up to the bully and risk losing the much-needed job. Self-silencing, withdrawal, and isolation are

protective mechanisms that the bullied victim uses to stave off further bullying episodes. All that this accomplishes is to protect the bully from being discovered (Etienne, 2014, p. 7, Gaffney et al., 2012, p. 2, and Szutenbach, 2013, p. 20). These actions cement the nurse's feelings of powerlessness.

Once bullied, the person's self-esteem is traumatized to the point of being afraid to leave the job at the hospital; the nurse does not feel worthy or good enough to practice nursing (Gaffney et al., 2012, p. 5). Nurses feel like it was their fault and a direct reflection on them (Douglas, 2014, p. 21). If they do lose their job due to bullying, then they have a difficult time finding another job due to insecurity and self-doubt. Eventually the bullied nurse is so wounded, she hopes the nursing leaders will see her plight and address the problem for her as she does not have the strength to defend herself any longer (Longo, 2013, p. 952). Rarely does this happen even if the nurse leaves various verbal, written, and body language clues or even goes so far as to tell co-workers to remember the incidents that have happened. People will not recognize them as such until after the fact when they look back. The nurse will do everything but actually come out and say she needs help. The nurse needs to realize that until others are aware of the involvement with bullying, it does not exist except in the nurse's mind.

Witnesses to Bullying

The majority of the focus is on the bullied nurse, therefore, the witness' involvement has not been acknowledged very often. In Wilson et al.'s study, 85% of nurses confirmed they had witnessed bullying in the last six months (2011, p. 455). The percentage of witnesses to bullying is as variable as the percentage of bullied victims.

Walrafen et al. (2012) noted that it was 29% - 77% (p. 9). Stagg et al. (2013), noted 50% of the nurses they interviewed had witnessed bullying (p. 337). Vessey et al. observed that 76% of nurses reported having witnessed colleagues being bullied on a weekly basis, while 88% admitted to being part of that weekly group (2011, p. 142). Christie and Jones (2014) stated that 93% of nurses witness bullying (p. 213). As demonstrated in the above figures, there is no exact number of known witnesses to bullying, just as there is no precise number of nurses bullied. This statistic indicates that there are more wounded nurses working than there are healthy ones. Most nurses fall into one of three categories: bully, bullied, or witness.

In addition to witnessing the actual bullying, the witness must now deal with feelings of guilt, remorse, and shame. At the time of the observation, the nurse is torn inside about whether to step in and do something or not, risking job loss if she or he does act as opposed to keeping quiet and looking the other way. Stagg et al. (2013) remarked that 83% of nurses revealed they did nothing when they witnessed bullying because they were afraid the bully would come after them in retaliation for interfering and they needed their jobs (Freire, 1970/2005, p. 47; Gaffney et al., 2012, p. 4, and Stagg et al., 2013, p. 336). This is especially difficult if the witness is a new employee and trying to fit in. Witnesses are deeply disturbed and traumatized from what they have viewed and the choices they are forced to make (Vessey et al., 2011, p. 143). If the witness's personal values are to help someone being attacked in this manner and chooses not to help, then there is guilt and shame. Several thoughts run through a witness's mind. First, he or she cannot believe what is being seen and heard. Witnesses stand by and watch as the

victims get set-up by the bullies. Examples are changed assignments, unshared information, unmanageable patient assignments, and cruel jokes, openly laughing at errors, and gossiping about the victim's ineptness as a nurse (Gaffney et al., 2012, p. 5). Once the shock of what has just been witnessed passes, the witness begins to watch the other nurses to see if they are bullied, and if anyone steps in to help them. The nurse begins to wonder if, and when, it will be his or her turn and if will anyone will help.

The witness must interact with the bullied nurse each time they work together. The witness becomes so guilty that he either denies or represses the guilt for choosing not to help. Consequently, this becomes his state of normalcy. The witness may become physically ill, developing physical diseases such as hypertension, cardiac disorders, posttraumatic stress disorder, or even consider suicide (Nikstaitis & Simko, 2014, p. 295). The witness is too ashamed to face the bullied nurse or the bully. In order to assuage the pain, the nurse will resort to tardiness, absenteeism, and presenteeism. The final action is intent to leave the shift, the department, the hospital, or the nursing profession to be shame-free (Rasool et al., 2013, p. 177). Many believe the guilt and shame will remain until dealt with properly.

Another problem with bullying is that of isolation. After the bully has humiliated the victim publicly, any witnesses and friends turn away from the victim because they do not want to be associated with such an incompetent person and they do not want to be bullied next by showing any concern for the victim. Inside they feel guilty for abandoning their friend and co-worker. They fear job loss if they speak up as they have witnessed this before and never saw any punishment given to the bully or changes in the

department. Witnesses will provide support to the victim when it is clear the victim is leaving. It is now safe to talk to the victim and advise that the bully has done this to countless previous workers (Heugten, 2012, p. 297). The victim will be able to acknowledge that what has been experienced has been indeed happening and will feel relief while the witness will feel less remorse for not helping earlier. In future conversations, the witness may be able to explain why he did not step in and help.

Research studies aligned with the conceptual framework

MacKusick and Minick's Study

Two studies stood out as similar to this proposed study, which seeks to understand the career choices that nurses make when they have been bullied or when they have observed other nurses being bullied. MacKusick and Minick (2010) conducted a qualitative study targeted specifically to nurses who had left nursing. They noted that one-third to one-half of new graduate nurses had either changed positions or left the nursing profession completely by the time they had been in practice three years (p. 335). MacKusick and Minick's study was seminal because the United States was lagging in research compared to Europe, Australia, and New Zealand. The nursing academicians in the United States were just beginning to recognize that bullying might exist amongst nurses but didn't recognize it as a causative factor in why nurses were leaving.

MacKusick and Minick had to know why nurses were leaving. MacKusick and Minick's study consisted of interpretive hermeneutic phenomenology for their method, obtaining information from semi-structured interviews with nurses that had left the profession altogether (2010, p. 336). The authors used the snowball technique to obtain

their purposive sample. They contacted RNs who worked in the southeastern part of the United States, asking them for names of nurses who they were acquainted with that had left the profession (p. 336). The nurse had to have left nursing for six months and had to have been a nurse for more than one year to qualify for the study. The authors felt that during the first year, nurses leave in higher numbers due to the shock of what the job of nursing actually entails as opposed to what they thought it meant (p. 336). Ten former nurses met the requirements and agreed to participate in the study.

After obtaining the usual demographic information, including age, sex, highest college degree, etc., each participant was asked to relate the personal experience that caused them to decide to leave clinical nursing. The results from the demographical questions were that 70% were 40-49 years old, 80% were female, 70% were Caucasian, and 50% had left from the Medical-Surgical Department. Comparing the AD and BSN, they were even at 50% each. In regards as to whether this was the participant's first job or not, was 50% each. Thirty percent had a bachelor's degree in another field, and seventy percent were presently employed in fields other than nursing (MacKusick & Minick, 2010, p. 337). The demographic findings were typical of the RN population at that time.

In the initial analysis, nurses expressed guilt at having left the profession. They missed the interactions with families and the satisfaction they enjoyed at knowing they had helped to make another individual better (MacKusick & Minick, 2010, p. 337). When the nurses related why they were frustrated with their careers, many stated that they were upset because patient and family wishes were many times ignored (MacKusick

& Minick, 2010, p. 337). MacKusick and Minick deduced three themes from their interviews: that the workplace was not friendly and cold, there was much emotional upset in regards to the quality of patient care they were giving, and exhaustion from physical and emotional fatigue (2010, p. 337). The fatigue and exhaustion were outcomes of the first two themes.

According to the participants, working in a cold, non-friendly environment was the biggest concern. Behaviors they associated with this type of environment were being ignored, not helped when they needed it, being advised to toughen up so they could improve as nurses, belittling comments, public confrontations, and sexual harassment including gender abuse (MacKusick & Minick, 2010, p. 337). When nurses advised their managers/directors that doctors were throwing items at them, they were told it was their fault (MacKusick & Minick, 2010, p. 338). The practice of nurses failing to support each other was normal. Those that left did so because they were so emotionally scarred they could not continue in the situation (MacKusick & Minick, 2010, p. 338). There is a unique need when practicing nursing in a hospital and that need is companionship. Patients are too complicated for a nurse to manage single-handedly. Nurses need both physical and emotional support, confident there is another nurse willing to help. Bullied nurses are isolated nurses and have no one to call.

A second theme was emotional distress related to patient care. Nurses were subjected to observing physicians providing inappropriate, disrespectful, and unduly aggressive care towards patients (MacKusick & Minick, 2010, p. 338). There was no dignity afforded the patients as they were treated as “another practice session” for the

doctors to hone surgery or "code" skills (MacKusick & Minick, 2010, p. 338). The participants felt that there was a great lack of support from managers and peers when these ethical situations were discussed as they were ignored or ridiculed (MacKusick & Minick, 2010, p. 338). As a result, the nurses felt they had no other choice but to leave, not wanting to continue in a profession that had lost sight of what nursing started out to be—a caring, nurturing, and comforting profession. (MacKusick & Minick, 2010, p. 338). The choice to leave presented both relief and fear. Relief came because the situation causing the discomfort was over. The bully and bullying were gone. The fear of not being able to find a job set in. Throughout the bullying the nurse felt "less than" and unworthy to practice nursing. If the nurse could gather herself and build her resilience, she could turn this fear into drive and rediscover her worth and dignity. The third theme was fatigue and exhaustion. An additional stressor to fatigue and exhaustion was the fear of the phone call requesting the nurse to come in on her day off and work. Rest and relaxation on the day off became more difficult due to waiting for the inevitable phone call. If the nurse said "no," then the bullying would increase at the next shift. If the nurse said "yes," then it was a very strenuous shift because others had called off, leaving the department short-staffed and the nurses burdened with even more work, shorter tempers, and increased bullying (MacKusick & Minick, 2010, p. 339). It was on those hard days that the nurses, so exhausted, would make mistakes and would ruminate over the situation, anticipating the phone call they would get from their manager (MacKusick & Minick, 2010, p. 339). While waiting for the call, the nurse would try to figure out what to do if fired or have the nursing license revoked. When the nurse did

return to work for the next shift, focusing on the work was difficult due to the exhaustion from anxiety and anticipation.

The outcome of this study was that the nurses left because they felt they had no other choice. The administrators were not listening, the victims were being ignored, with no one to turn to for support, and they knew that if they did not leave, something drastic would happen (MacKusick & Minick, 2010, p. 339). This choice was most disconcerting, because it meant the nurse would have to leave the profession she loved so much (p. 339). Limitations to the study were that the authors could not guarantee replication of the study, as there were only 10 participants (MacKusick & Minick, 2010, p. 339). Another question that the researchers had was, "Why do some nurses accept abuse as acceptable in the workplace?" (MacKusick & Minick, 2010, p. 339). The answer to this question may come from the popular theories used in nursing today, such as Foucault's power theory or Freire's oppressed group theory. This issue would be a valuable study. One of the answers may be that nurses who have encountered bullying for years do not even recognize it as such anymore.

Weaver Moore, Leahy, Sublett, and Lanig's Study

A second study by Weaver Moore et al. conducted in 2013, posed a similar research question. They wanted to understand how nurse relationships affected the work environment. Previous studies had demonstrated that when nurses included collaboration and solid communication, positive relationships formed, which improved working conditions by lessening bullying (Weaver Moore et al., 2013 p. 172). As noted in MacKusick and Minick's study, nurses must have the belief that there are other nurses

willing to help them. The authors wanted to know what specific ways nurses related to each other to ensure that these environments existed.

As Weaver Moore et al. (2013) conducted their literature review, looking for unhealthy work settings that focused on bad behavior accepted as normal, they expressed frustration that there was very little to be found (p. 172). According to Weaver Moore et al., studies had not been conducted investigating what nurses thought about positive and negative relationships and how they affected the work environment (p.174). One reason conjectured by the authors was that poor nurse relationships were ignored and therefore not reported to administrators (Weaver Moore et al., 2013, p. 172). Weaver Moore et al. noted that if the managers invest time in building up their departments, making all employees feel needed, wanted, and valued, then bullying will decrease (2013, p. 173). Good nurse-to-nurse relationships are conducive to healthy work environments.

The authors utilized a mixed-method study, recruiting participants from five Sigma Theta Tau chapters located in Southwestern Ohio. Eighty-two responded to their electronic questionnaire. It was divided into two sections: demographics and the qualitative questions. The results from their demographics were that the mean age was 45 years old, 89% were female, 54% worked the day shift, and 21% worked in the ICU (Weaver Moore et al., 2013, p. 174). The instrument used for this study was a questionnaire written and piloted by the authors.

The findings covered the following categories: consideration to leave, the environment, the nurse manager's role, new graduates, and what was missing. In the first category, consideration to leave, the question was posed: Had the nurse ever considered

leaving the nursing profession due to poor nurse-to-nurse relationships? Seventy-nine percent said no, and twenty-one percent said yes. A second question was presented: Had the nurse ever considered leaving the nursing department she was working in due to poor nurse-to-nurse relationships. Thirty-three percent said no, but forty-one percent said they had left or had considered it (Weaver Moore et al., 2013, p. 175). Three themes emerged from these answers, which included lack of support from managers, cliques, and frequent clashes between employees on the unit. Lack of managerial support covered areas such as older nurses bullying new graduate nurses and indifference to reported or observed poor nurse behavior. Cliques reminded the nurses of high school, evidenced by nurses "eating their young" and displaying an elitist attitude. Daily work conflicts between nurses were common, causing much despair (Weaver Moore, et al., 2013, p.175). Nurses were quite vocal in compelling other nurses to leave the department and/or nursing completely because they were not "good enough" or competent enough to be a nurse working with them.

The second finding was environmental characteristics. The point of this question was to discover what characteristics were needed to provide a positive work environment. Four themes were identified: supportive behaviors between nurses, being tolerant and accepting each person for who they were (51%); positive leadership as leaders set the tone for the department (39%); teamwork (24%); and communication, which embraced being non-judgmental (21%) (Weaver Moore et al., 2013, p. 175). Overall, nurses wanted to be treated as equals and respected for their diversity and what unique talents they brought with them. They wanted leaders who listened to them and interacted with

them. The nurses wanted to be able to communicate openly, honestly, and to resolve differences within the department so they could work as a cohesive team.

The third finding was the nurse manager's role. In this question, nurses were asked to describe how the nurse manager promoted positive relationships. The responses were that 44% felt the managers did not do enough to promote any type of relationships between the staff nurses, while 20% felt the nurse managers were promoting negative relationships via coercion and rewards. On the positive side, 56% believed the managers were fostering positive relationships (Weaver Moore et al., 2013, p. 175). Three themes emerged; managers encouraged nurses, managers confronted conflicts, and managers promoted a positive environment (Weaver Moore et al., 2013, p. 176). Each of these themes described what nurses wanted and expected from their managers: They wanted someone to listen to them and respect their observations; they wanted their manager to protect them; and they wanted their manager to demonstrate she cared about and valued them as individuals with important skills and talents to offer the department.

A fourth finding concerned new graduates and their place in the department. Ninety-one percent of experienced nurses related that new graduates needed to exhibit positive personal characteristics, be open to learning, and have effective mentors or preceptors (Weaver Moore et al., 2013, p. 176). New graduates needed to be humble enough to listen and display a willingness to learn from the experienced nurses even if the older nurse did not have a BSN. Seasoned nurses wanted to share their tacit knowledge with new graduates so they would not have to struggle and make the same mistakes they had made years earlier.

Nurses were asked one last question: What is missing that would support improved nurse-to-nurse relationships? Twelve percent did not think there was anything more that could be done to rectify the situation. Six percent were not sure what could be done. Eighty-two percent believed that there were things that could be initiated to make relationships better (Weaver Moore et al., 2013, p.176). Three themes emerged; stronger leadership, utilizing common courtesy between nurses, and improving communication (Weaver Moore et al., 2013, p.176). These themes were a conglomeration and confirmation of the previous areas. Nurses felt that in order to build positive relationships within the department, there had to be respect, camaraderie, humbleness, tolerance, passion, and communication.

The findings from this study demonstrated that nurses are leaving the profession due to poor nurse relationships, i.e.: bullying. All nurses within a department need to realize that each has a responsibility to improve and maintain solid relationships. Managers set the tone for the department, which can be conducive to building positive relationships or contribute to bullying. Nurses need to be open to learning, communicating honestly, and be committed to working together as a team.

The authors knew the chapter leaders of the sorority who then gave permission for the authors to contact all of the sorority members via e-mail. The limitation to this was that the sample was confined to one group (a sorority) of people and may not have provided a complete picture of how other nurses in other places would answer the questions posed in the questionnaire. There were 82 participants from five chapters of the Sigma Theta Tau sorority. The anonymized questionnaire was posted for two weeks.

The limitation to the final number of participants is the question of how many were initially invited to participate. The article did not elaborate on that. The length of time the questionnaire was available may be a limitation if the participants were not aware of when the questionnaire was first available and how much personal time the participants had to complete the questionnaire. Each researcher analyzed all of the responses and then a consensus was formed regarding the overarching themes to the questions. It was impossible for the researchers to verify or clarify participants' answers. They would have to rely on their own interpretations of what had been said. At this point, personal bias could be introduced.

Gap in the Literature

Bullying occurs worldwide as demonstrated in the literature review. The percentages are approximately the same regardless of the country, and all researchers complain of the same problem—they cannot pinpoint exactly how many nurses experience bullying or have witnessed it, nor can they determine the actual cost to hospitals because of it. There remains a gap in the literature regarding the lived experiences and perceptions of bullied nurses and witnesses. After 2009, the number of research studies conducted in the United States steadily increased, but the majority of the research continues to come from Europe, Britain, and Australia (Vogelpohl et al., 2013, p. 415). The outcome of this lag in research is a paucity of information regarding the prevalence of bullying in the United States (Chipps et al., 2013, p. 480). Additional research is needed to understand why nurses choose to leave bedside nursing or even the nursing profession due to experiencing bullying or witnessing it amongst colleagues

(MacKusick & Minick, 2010, p. 336). Addressing the issue of the career choices nurses make due to bullying will provide further information and understanding of this phenomenon, thus filling the gap in the literature and provide the necessary impetus for social change.

Summary

Research studies have demonstrated that nurses are being bullied or witnessing bullying in the United States and abroad, but the exact number is unknown. We do not know how bullying affects the choices that nurses make career-wise after they have been bullied or have witnessed it. This study looks at nurses still in the profession reflecting on what they did in the past, if bullied or as a witness, and where they are now. Nurses have the freedom to change jobs frequently, but no one ever asks if it was due to bullying or another reason such as re-location, etc.

Bullying and witnessing it result in significant trauma, directly impacting the hospital's bottom line in lost wages, insurance payments, entitlement payments, workers compensation, recruiting/hiring of replacement nurses, lawsuits, etc. What we do not know is how much bullying occurs in any hospital because that type of information could ruin a hospital's reputation, causing financial ruin if made public.

While this literature search contributed background information regarding bullying, what it is, how it operates in the workplace, and statistics, it remains a mystery as to what happens to those bullied. We do know that bullying is like a rock thrown into a pool. It is not just about the bully and the bullied, it extends to coworkers, other departments, the hospital by way of reputation, direct and indirect costs, patients,

families, visitors, and the community as well. Bullying influences the attrition rate, which, in turn, negatively impacts the present nursing shortage.

Decisions related to the reactions of bullied nurses and witnesses were examined. In chapter three, there was a discussion about the research methodology. Using transcendental phenomenology, I presented how bullying affected those who had been subjected to it and the career choices resulting from it. Parts of the discussion included the research design; delineating the population and sample, collection, and the plan for data analysis. In chapter four an analysis of the findings from chapter three, and a comparison of findings from other studies was presented. Chapter 5 was a summarization of recommendations for further studies.

Chapter 3: Research Method

Introduction

The purpose of this qualitative transcendental phenomenological study was to explore the perceptions of bullied nurses and those who had witnessed the bullying of coworkers, understanding the actions they took career-wise to stop the harassment, and how the hospital's bottom line was impacted by bullying. The goal of phenomenological research is to pursue a deep understanding of the meaning of a phenomenon that a person has experienced (Converse, 2012, p. 31). The benefit of phenomenological research is that it is multi-faceted—each person's story is unique, and when combined with others' stories, the researcher can present a true rich, thick description of the phenomenon. The focus of this chapter was the research study: the set-up, design, the researcher's role, methodology, trustworthiness, and ethical concerns.

When a nurse is bullied, it not only affects the nurse, it compromises the delivery of care to all of the patients assigned to that nurse as well as the hospital's budget. It is not a question of "if," but "when" patients will experience the effects of bullying. All of this can be a direct outcome of nurses fighting each other verbally, and or physically at the nurses' station, in the hall, or in the patient's room. Actions such as distraction, medication errors, inaccurate and incomplete assessments, incorrect charting, or overall poor nursing care points to the decline in the quality of care given by the nurse. Initially, the patient is the one harmed, but the hospital's financial health is also impacted. The purpose of this research study was to develop a greater understanding of the phenomenon of nurses bullying nurses through a qualitative transcendental phenomenological study

utilizing semi-structured interviews with both closed- and open-ended questions, a worldview paradigm of social constructivism, and the theoretical lens of feminism.

Research Design and Rationale

The Problem Statement and Research Questions

The problem statement, which was first introduced in Chapter 1, stated that nurses bully nurses at work. Four research questions were proposed:

Research Question 1: What are the lived experiences of nurses being bullied by nursing colleagues?

Research Question2: What are the lived experiences of nurses who witness coworkers being bullied by their colleagues?

Research Question 3: How does the bullying experience of nurses impact career choices post the bullying experience?

Research Question 4: How does the RN turnover rate impact the bottom line of a hospital, both directly and indirectly in costs?

Central Concepts of the Study

There were three central concepts of this study. They were to understand how the nurse felt when bullied by a co-worker/peer; or how the nurse felt when observing a co-worker/peer being bullied; the actions taken to address it; and the financial impact to the hospital. This "coming to know" or enlightenment of these feelings was ascertained through a transcendental phenomenological study. The framework for the study was twofold. First, there was an online demographic questionnaire that accompanied the initial email invitation to participate in the study. Completion of the questionnaire

denoted acceptance of the terms of the study and a wish to participate. The second part of the framework was the Skype interview where the actual mixes of closed- and open-ended questions were asked and follow-up dialogue ensued.

The Research Tradition: Qualitative Transcendental Phenomenological Studies

The unique characteristics of qualitative methodologies are credibility, dependability, transferability, and confirmability while quantitative research is focused on validity and reliability. Qualitative research is directed towards understanding or interpreting the stories of the participants instead of a straightforward statistical account of the research problem (Houghton, Shaw, & Murphy, 2013, p. 12). While quantitative studies are attempting to prove a hypothesis, qualitative studies are attempting to understand personal perceptions and lived experiences of the participants.

Vaismoradi, Turunen, and Bondas (2013) posited that the challenge is to present the stories as close to the natural form, yet maintain a scholarly voice in the offering (p. 398). There are many derivatives of qualitative methodologies such as grounded theory, phenomenology, case study, ethnography, narrative, etc. with each one contributing its own unique characteristics such as epistemology, artistic taste, morals, and strategy for study. All of these traits overlap one another in each of the methodologies allowing the researcher to group characteristics into "families" demonstrating the similarities displayed amongst them are more valuable than the differences (Vaismoradi, Turunen, & Bondas, 2013, p. 398). For the researcher, this means there is flexibility in choosing between the different "family members" offerings or characteristics (2013, p. 398). The researcher will pull similarities from both phenomenology and ethnography to create the

finished transcendental phenomenological narrative. Both phenomenology and ethnography involve the researcher working with groups of people. Researchers may work through gatekeepers, believing that they will build trust within the groups before the researcher embarks on the study. Researchers find representatives within their groups to participate, sharing their stories, which reflect the overarching lived experiences of the group as a whole.

Rationale for Choosing Transcendental Phenomenology

History of Phenomenology. Reiners (2012) stated that phenomenology had its origins in 19th-century philosophy. Popular at that time was the positivist paradigm. Followers of this paradigm believed that reality could be studied because it was tangible; therefore, objectivity quantified knowledge, which was completely separate from human interaction. This was the basic tenet for quantitative research. The antithesis of the positivist paradigm was the naturalistic paradigm. The belief here was that reality was fluid and anchored in personal realities. Phenomenology aligned with this. This type of research afforded an awareness of phenomena not possible in a quantitative study (2012, p. 1). While many theorists have imparted their ideas on what phenomenology is, how it is used, and why; two men, Husserl, the father of phenomenology and his student Heidegger, influenced it the most.

Husserl. According to Converse, Husserl (1859-1938) adopted Brentano's theory of intentionality. Brentano believed all thoughts and perceptions have meaning within the mind. Husserl expanded on Brentano's theory of intentionality by taking it out of psychology and placing it in phenomenology (2012, p. 29). Husserl purported that

consciousness was a link between the short-term past as well as the future, open to whatever it "saw," linking this information with past knowledge, memories, and beliefs (Henriques, 2014, p. 453). Husserl theorized that intentionality was a composite of what was previously known and was a purposeful awareness of an event (Henriques, 2014, p. 456). Converse stated that Husserl wanted to know "What do we know?" and his goal was to understand the essence of lived experiences through philosophical reduction. Philosophical reduction was similar to intentionality except this new concept of philosophical reduction encompassed the use of bracketing or epoché (2012, p. 29). He contended that through bracketing or epoché, each person's preconceptions resided in the conscious realm (intentionality) and could be recognized and set aside so the subject to be studied could be understood in its pure essence. Husserl proposed that a researcher had to distance himself from the study, and for this reason, it was crucial to identify the biases and bracket them out. The outcome of the suspension was that the researcher would not influence the participants, thus allowing the stories to remain pure. The reason bracketing is so important is that its use implies all judgments have been removed with the focus on the description of the phenomenon instead of an interpretation (Dowling & Cooley, 2012, p. 23). Husserl named this new phenomenology descriptive (transcendental) phenomenology (Converse, 2012, p. 29). Descriptive (transcendental) phenomenology was an acceptable choice for this study because the goal was to provide a description of what the participant had said.

Heidegger. Heidegger took the opposite stance regarding phenomenological study. Heidegger (1889-1976) was a student of Husserl's (Converse, 2012, p. 29).

Instead of agreeing with Husserl regarding epoché, Heidegger contended that no one could bracket out all presuppositions and believed that biases should be part of the research as long as the researcher was aware of what they were (Converse, 2012, p. 29). Heidegger was interested in interpreting the world, not just describing it as Husserl did. Heidegger desired to know the deeper meaning of people's everyday experiences. He maintained that the researcher's perceptions of the phenomena being studied were significant factors and added to the richness and understanding of the study. Heidegger conjectured that the way we interpret our world is how we understand our world (Reiners, 2012, p. 2). Heidegger believed that what occurred in the world was indispensable to understanding "being" and could not be separated from the researcher (Converse, 2012, p. 29). Heidegger's question was "What is being?" To him, bracketing/epoché was not a priority because the philosophy of hermeneutics assumed that there was prior understanding and it was to be incorporated into the interpretation of the research question being studied (Reiners, 2012, p. 2). He wanted to find the hidden meanings in these descriptions and called it interpretive phenomenology (Reiners, 2012, p. 2). Heidegger's purpose for interpretive phenomenology was to interpret or explain the perceptions of the participants (Reiners, 2012, p. 2). Heidegger believed that by retaining biases during research and analysis, added to the credibility of the study (Reiners, 2012, p. 3). Identifying the biases that we can and focusing on learning about the phenomenon that we are also studying appears credible on paper, but, again, the biases that we are not aware of or do not want to be aware of may be the ones that will influence our thinking the most.

Alignment of Research Design, Problem, and Purpose

Husserl and Heidegger influenced how we conduct research. Two points to remember when choosing whether to use Husserl's transcendental descriptive phenomenology is that this type is used to describe the phenomenon while Heidegger's interpretive phenomenology is used to interpret the meanings of the phenomenon (Reiners, 2012, p. 2). Even though each school of thought differs, they both agree on the same thing—ensuring that the lived experience of each person in the study is described and understood.

I chose to use Husserl's transcendental phenomenology. The goal was to identify each bias while researching this subject. The positive aspect of using epoché is that it makes the researcher sit and seriously think about prejudices and preconceived notions. An additional caveat for the researcher is to use biases to ask questions arising from his or her own bullying experiences. By asking the questions that others have not, adds a new dimension to the available knowledge and reinforces credibility.

The Role of the Researcher

Role of Researcher Defined

As a researcher, I will gather, analyze, and surmise the nurses' reactions to living through bullying; demonstrating how it affected them and what they did to regain a sense of order in their lives. I am the data collection instrument (Salmons, 2012, p.1). I am responsible for setting the tone for this research. From the interactions with my dissertation committee and to the participants interviewed in the study, the amount of cooperation that I received was related as to how trustworthy I was. Because I am an

RN, and I have been bullied and witnessed it throughout my nursing career, I am considered an emic researcher, specifically an indigenous-insider. I am also regarded as an etic researcher because of the bracketing/epoché used throughout the study.

Emic (insider) and Etic (outsider) Researchers. Salmons stated there were two types of researchers—etic and emic (2012). Etic researchers are outsiders, without any previously lived experience regarding the study. Emic researchers, on the other hand, do have previously lived experience with the proposed problem and are considered insiders. In actuality, there is no completely etic or emic researcher, but a blending of both in a study, especially when Husserl's descriptive phenomenology is used. Bracketing/epoché automatically places the emic (insider) into the etic (outsider) position (Salmons, 2012, p. 18). To fulfill the goals of this study, I used my skills as both an emic indigenous-insider and etic.

Emic Researcher. This insider status gives the researcher an edge when recruiting the sample. It also promotes initial trust between the researcher and participants, encouraging a deeper exchange of information. Insider status can also act as a segway to online and face-to-face groups to locate suitable sampling frames (Salmons, 2012, p. 17). In this study, I used my indigenous-insider status to build initial trust with the participants.

There are six different types of insiders. Table 2 denotes the different types of emic researchers and their actions.

Table 2

Types of Emic (insider) researchers

Type	Actions
Total Insider	Has intimate knowledge of how the group operates but not everything
Partial Insider	Knows some of the things that the group does but is not close to the group
Indigenous-Insider	Is completely aware of everything that the group stands for and believes in
Indigenous-outsider	Not accepted by the group—treated as an outsider and is unfamiliar with beliefs, stories, and knowledge about the group's operations
External-insider	Previous indigenous-insider but has relinquished all ties with the group.
External-outsider	Is not accepted in this group but has been accepted in other groups….has a basic knowledge of what this group stands for. Is considered an interested by-stander

Note. (Greene, 2014, pp. 2-3)

There are advantages and disadvantages to holding insider status. The advantages are:

- The proponent of acting as an insider is that the participants may increase their trust in the researcher because both have similar experiences, sharing richer, deeper information than if corresponding with an outsider without understanding of their plight (Salmons, 2012, p. 16).
- Having experienced the same phenomenon, the researcher is already familiar with the nursing environment to be studied and has an edge when developing questions

and asking follow-up questions during an interview, knowing when to probe deeper and how to frame the questions (Greene, 2014, p. 3).

- During the interview, the researcher can assay the body language and prosody of speech, which will give added clues of questions to ask as well as to determine if the interview should be stopped because the participant is becoming too uncomfortable to continue.
- The researcher will be less likely to stereotype or judge nurses when they reveal personal thoughts and actions during the interview (Greene, 2014, p. 3).
- The insider researcher is familiar with the "nursing lingo" and can communicate in ways an outsider cannot (Greene, 2014, p. 3).
- Because of a shared bond, nursing and being bullied as a nurse, the insider has easier access to participants when approaching groups.

The disadvantages are:

- An insider must be careful not to inject bias into the study analysis or the actual interviews via body language or voice (Salmons, 2012, p. 16).
- The participants may back off from completing the study if the researcher's demeanor is too strong (Salmons, 2012, p. 16).
- If the participant relates stories similar to the researcher's, this can trigger suppressed biases, which are then released into the interview, negatively affecting data analysis, transferability, and dependability (Greene, 2014, p.4).
- The researcher may "go native" during the data collection process (Greene, 2014, p. 5).

- The group members may perceive the researcher as being too close to the situation, not wanting to share information.
- They perceive the researcher as distant and not trustworthy (Greene, 2014, p.6).
- There could be a power struggle as the researcher interviews peers (degrees, hospital employment, and length of time practicing as an RN) (Greene, 2014, p. 6).

Etic researchers. There is a place for etic researchers in every study. To maintain objectivity and clarity during data analysis, the researcher can use bracketing (Salmons, 2012, p. 18). Generally, etic researchers are thought of as uninvolved, uncaring, and "outside looking in" (Salmons, 2012, p. 16), but this impartial attitude can be used in a positive way through the use of bracketing/epoché. The use of bracketing/epoché can balance out the emic researcher element of over-engagement in the data collection process.

Personal and professional relationships. I am a college professor and do not work in the hospital setting. I had no personal knowledge or acquaintance with any of the potential participants in the study. My original sample collection stemmed from a list of RNs that I had obtained from the State Board of Nursing. When no one responded to the email invitation, I had to change my sampling tactic and moved to the snowball technique. I was able to secure 11 participants and knew three of them, but only casually. One was a previous neighbor that I had not seen in over six months. One was an RN I had worked with in 2005, and the third nurse I knew from her rounding in the nursing

department where I worked. Another person had referred both nurses that I knew through work when I asked for names of people that might be interested in participating.

Ethical Issues

Management of bias. My issues of personal bias were that I had been bullied most of my life, commencing in fifth grade and continuing throughout my adult working career as an RN. Bullying was unknown in nursing until the mid-2000s, although it existed in a covert way for centuries. At the start of the dissertation process in 2010, I was not even aware coworkers had bullied me. Once I learned this was what had happened, I began bracketing while researching and writing. At first it was impossible to speak civilly about it, but as time has passed, I was able to listen to others discuss their lived experiences without becoming upset. Bracketing and memos can be reviewed in Appendix A. By the conclusion of this study there should be a noted change in feelings, attitudes, and thinking.

Method

Participation Selection Logic

The population. The population is nurses. There are over 2.68 million nurses in the United States (United States Department of Labor, 2016, p.1). The á priori sample size for this study was eight nurses and finished with 11. Drivers that determined the actual sample size were how much the participants knew about the topic, how many nurses were willing to talk about their experiences, the intricacy and comprehensiveness of this problem, and my skill as an interviewer and analyzer (Morse, 2015, p. 1214). This

was a minute number compared to the actual number of RNs, but their stories revealed the feelings of what it was like to be bullied or worse yet, to witness it.

The sampling strategy. There are two options for securing a sample: nomination and an existing sample frame. Nomination depends on a credible person to confirm the identity of each participant, while the use of an existing sample is verified by association within a specific group or the use of a list such as a student class roster (Salmons, 2012, p. 14). I did use an existing sample frame from a State Board of Nursing for the study, but had to switch to snowball sampling when no one responded to the email invitations I sent.

Purposive criterion sample selection. The purposive/purposeful criterion sample was drawn from a State Nursing Board list of licensed Registered Nurses (RNs) in a Mid-Western State of the United States. Within this state, there were more than 150,000 nurses who worked in the hospital setting. This was too large for a sample. To correct this, emails were sent to every 10th nurse residing or working in one county. The goal was eight participants or until saturation was reached. As stated earlier, no one responded to the email invitations within a four-day timeframe, so I dropped that approach and started the snowball technique. With this technique, I was able to secure 11 participants.

Purposive or purposeful sampling was used because it selected particular people, places, or things to represent the whole (Salmons, 2012, p. 14). Additionally, this study adopted criterion sampling because it involved a pre-determined set of criteria unique to this study, which was crucial when conducting semi-structured interviews (Salmons,

2012, p. 14). The criteria list for the sample also provided an extra avenue of verifiability and endorsed further triangulation of the study (Salmons, 2012, p. 14). While purposeful sampling gathers distinct types for the sample, criterion excludes every kind except what is needed for the sample. These final participants provided the study with an information-rich sample.

Criterion for inclusion into the study. The four inclusionary elements were: (a) The nurse is a Registered Nurse (RN), (b) The nurse must describe the bullying or witnessed experience, (c) A career choice was made after the bullying or witnessed bullying occurred, and (d) All events had to have transpired in a hospital in the United States. I assumed there would be resistance to discussing what happened because it meant the nurse must re-live the feelings of pain and shame so closely associated with the experience(s) of bullying. To my surprise, each nurse was eager to talk about his or her experience. This was why it was important to let the participants know that I understood their feelings; I had experienced the same ones. By sharing stories, some healing began. Measures were taken to provide for follow-up counseling if the participant felt the need to do so.

Sample size and saturation. The State Nursing Board was chosen, as it would provide a much wider number of nurses who had experienced bullying or observation of such. The important part of qualitative research was not the number of participants, but the quality of the information and whether this information answered the research questions adequately (Lee, 2014, p. 95). The sample was set up to enlarge or decrease as needed; trying to pre-determine sample size is a fruitless endeavor (Morse, 2015, p.1214).

During the data analysis, I discovered that the sample size provided adequate representation. If saturation had not been achieved, then analysis would have been difficult because findings would have been limited, themes hard to identify, and nothing worthwhile to write about (Morse, 2015, p. 1214). Essentially, the number of interviews that were needed could only be approximated before the actual study ensued and were determined when saturation had been attained during the interview process (Henriques, 2014, p. 462). If saturation had not been achieved, then additional nurses would have been contacted to participate. Qualitative studies focus on quality, not quantity, so a few participants offering thick, rich descriptions of their lived experiences would meet saturation as well as provide a better quality study than a larger group of participants sharing superficial thoughts.

Participant protection. The participants may experience mental and physical issues after talking about their lived experiences. Some of the interview questions were pointed, forcing a recall of past painful experiences. Many times, shameful acts are buried deep in our subconscious because they are so painful. When the nurses related their stories, this tapped into buried memories and might have caused psychological or physical discomfort, requiring professional healthcare services. Information where they could go for free mental health services was provided in the initial email that invited them to participate in the study.

Instrumentation

There were four data collection instruments:

1. The demographic questionnaire. This was included in the initial e-mail and served as implied consent when completed and returned. This was researcher created and consisted of 47 structured closed-ended questions that can be reviewed in Appendix D It was similar to other demographic questionnaires with the usually expected questions such as gender, ethnicity, age, etc. It then moved away from the current queries by inquiring about such topics as graduation year from nursing school, what choice was made to stop the bullying/witnessing, when the bullying started, etc. The demographic questions provided an initial sketch of the participant. The interview questions were customized from the answers given in the demographics. These questions provided a more concise and clearer interview while alleviating additional questions that may have bored or annoyed the participant.
2. The interview questions. These were also researcher created and consisted of 149 closed- and open-ended questions in a pool, further dividing them into subcategories. Certain questions were related to specific categories, others could be added as needed, and still others were stock questions— asked to every participant. The master list of questions can be viewed in Appendix E.

Both the demographic and interview questions took their lead from the headings in Chapter 2 and the four research questions, which were:

1. What are the lived experiences of nurses being bullied by nursing colleagues

2. What are the lived experiences of nurses who witness coworkers being bullied by their colleagues?
3. How does the bullying experience of nurses' impact career choices past the bullying experience?
4. How does the RN turnover rate impact the bottom line of a hospital, both indirectly and directly in costs?

The master list of both demographic and interview questions specific to each research question can be found in Appendix E and a comparison between demographic and interview questions can be viewed in Table 3.

Table 3

Comparison and Alignment of Demographic and Interview Questions, Chapter Two, and Research Questions 1-4

Demographic Questions		Interview Questions	
Category	Sub-categories	Category	Sub-categories
Category 1: Demographics	Degree Type of nurse Graduation Years working Nursing department Employment Shift Gender Ethnicity Age	Category 1: Transition Questions	Ice-Breakers Probing
Category 2: Bullying RQs 1 & 2	Start of Bullying* Absenteeism* Shame * Bullying and Coworkers*	Category 2: Bullying RQs1 & 2	Bullied Nurse* Witness* Both*

Table continues

Category 3: Choices RQ3	Choice*	Category 3: Choices RQ3	Choice*
Category 4: Bottom Line RQ4	Direct Costs* Indirect Costs* Hospital Administrators*	Category 4: Bottom Line RQ4	Direct Costs* Indirect Costs* Hospital Administrators*

Note. * = headings from Chapter 2. For ease of coding and analysis, both the demographic questionnaire and Skype interview questions contain the same categories and are aligned with the research questions and chapter two.

3. Skype. This was the portal for the video face-to-face interviews over the Internet. It has the capability of video, audio, and chat. Both the audio and chat can be recorded.
4. Call Graph. This is an audio recording program I used to ensure everything had been recorded in entirety.

Researcher-Developed Instrument

Rationale for developing the instrument. While conducting the literature search, I discovered the majority of researchers used the Negative Acts Questionnaire-Revised (NAQ-R) as the instrument of choice for their studies. This instrument, however, was not appropriate for this study. The NAQ-R has three sections: personal bullying, work-related bullying, and physical intimidation. These three categories were not related to the scope of this study, and there were no open-ended questions.

For this study, I developed an instrument suitable for semistructured interviews because I could not find one that met this study's needs. The questions were a mix between structured and semi-structured. Structured questions required only a limited answer such as yes/no or a number and were considered closed-ended questions. These were the demographic questions that revealed the background of the participant and were

used to give a frame of reference to work from when customizing the questions for each interview. There were also closed-ended questions in the interview questions, as they were used as a bridge to the open-ended questions. MacKusick and Minick (2010), Simons and Mawn (2010), Walrafen et al. (2012), and Weaver Moore et al. (2013) published their demographics in their articles. While none of the studies contained exactly the same demographic questions, there were enough similarities to compare and contrast some of their findings with mine in chapter four.

Procedures for Pilot/Field Studies

I utilized a field test instead of a pilot study. Field tests are used to demonstrate content validity in qualitative studies. For the field test, I invited one nurse to participate in reviewing the cover letter, instructions, criteria test, and the demographic questionnaire. The nurse was not connected to the sample. Next, the nurse evaluated the interview questions. The field test can reveal wording that is incorrect or written in a difficult-to-understand format for the demographics. For the Skype field test, I measured for video quality, ease of use, and recording quality. I also used the field test as practice using the Skype application to ensure I could proceed with the interviews smoothly and without injecting bias.

Procedures for Recruitment, Participation, and Data Collection

Recruitment. I sent the email invitation to half of the nurses in the sample pool. There was no response after four days. I switched to snowball and secured 11 participants. I sent them the email invitation. After reading the invitation, each nurse opened the attachments, completed the criteria list and the demographic questionnaire,

and sent an email back to me. After confirming eligibility to participate in the study, I contacted each potential participant to set up a time for our Skype interview. Only one nurse was interested in conducting a Skype interview. The remainder was either face-to-face, over the phone, or online.

Participation. The original sample was drawn from the list of Registered Nurses who resided in one county within a Midwestern state. I sent an email to the nurses with the initial invitation and further instructions sent as attachments regarding the criteria factors, the demographic questionnaire, Skype interview, and return instructions. The invitation was available for one week. If the nurse qualified to participate, the completed criteria and demographic questionnaire attachments could be sent directly to me at a secure email address. When I switched to the snowball technique, after contacting each potential participant by phone, I sent the invitational email with attachments.

When the participant returned the email with the demographic questions, I checked for successful criteria inclusion and entered his or her name and a corresponding 3-digit number into Excel spreadsheet number one. The answers to the demographic questionnaire were also be entered in the pre-assigned á priori categories. From here, I customized the interview questions in regards to the demographic answers. This was in addition to the stock questions asked of every participant. The ease of using Excel to rank and rate the different categories made this part of the analysis less complicated. I compared the information with that of four separate studies and presented the results in chapter four.

Contingency plan if sample size is insufficient. There was a problem with securing enough participants, and I had several other options available. I met with a group of nurses at The Faith Community Nursing (FCN) Consortium. One nurse participated from that group. Two additional options were the Public Health Department, and two local universities that have nursing programs. I did not use them. Other choices were the local chapter of the American Nurses Association (ANA), and the Walden University participant pool. I did not use the local chapter of the ANA, but did inquire about Walden's participant pool. I did not need to use it. A source I had not thought of was snowballing, using friends and relatives. This is where I found the remaining 10 participants.

Prior to data collection. Before executing the data collection, I needed Walden's IRB approval. In preparation for this study, I had satisfactorily completed the National Institutes of Health (NIH) training on Human Research Protections, April 24, 2014. My IRB approval number is 05-12-16-0096207. It expires May 11, 2017.

It is important to partner with a gatekeeper to act as a segue to the sample by introducing the researcher and briefly explaining the project, promoting credibility of the study as well as encouraging trust, thereby increasing the participation rate (Salmons, 2012, p. 17). In this case, however, there was no gatekeeper with whom to partner, so I expected some of the nurses would delete the email, assuming it was spam or a virus (Salmons, 2012, p. 17). By using words in the subject line unique to nursing, I thought this would increase the chances that wary nurses would open the email and read it instead of thinking it was phishing, malware, or spam. It did not.

There were several areas to consider when preparing the demographic questionnaire and interview questions:

- The types of questions
- How to present the questions including the wording and the prosody
- The time limit to answer each question and for the entire interview process
- A backup plan if the technology fails or too many participants decide to stop the interview process, leaving me with fewer participants than what is needed to meet saturation
- The number of questions

If there are not enough thought-provoking questions, then the participant does not provide enough thick, rich description in relating the lived experience. If the participant is asked too many questions or it takes longer for the interview than anticipated, then the participant becomes annoyed and bored, with a propensity to withdraw early from the study.

The next step in preparing for the sample was to assemble the Excel spreadsheets. The first page was concerned with the demographic questionnaire. The coding categories were the demographic questions. The second page of the Excel spreadsheet was associated with the interview. The á priori categories were placed into this sheet. Á priori categories were those categories I thought would be represented in the interviews from my experience as an emic indigenous-insider.

Before moving on, consideration was given as to whether a neutral aspect in body language and voice could be presented due to my prior experiences with being bullied

and witnessing it. An option was to have someone else administer the interview questions, but the major drawback to using another person was that the person would not recognize when the participant had said something important, nor would they know what questions to ask in this situation. This would result in having to re-meet with the participants to clarify their explanations, which wasted their time and mine. A negative aspect of having to re-interview was that I might not be able to set up an appointment time with the participant, causing the participant to decide to withdraw from the study because the additional probing questions cause too much physical and psychological discomfort.

Initial email. The initial email invitation contained the introductory letter, which included instructions regarding how to complete the criteria test, the demographic questionnaire, and how to send it back to me. This can be found in Appendix B. The four inclusionary criteria and the online demographic questions were included as attachments.

Data collection. The instruments consisted of two sections: structured closed-ended demographic questions and structured and semi-structured open-ended interview questions. The study was split into two parts. The first half consisted of the initial email that included the demographic questionnaire. After the RNs passed the criteria requirements to participate, they completed the demographic questionnaire and returned all three sections to me. This served two purposes: to identify who wished to take part in the study through implied consent and a way to contact the participant to set up the interview. The remaining questions were asked during the interview. Both the

demographic questionnaire and the interview initially presented with identifying factors including names, phone numbers, and email addresses. The identifying factors were deleted from the study once the analysis was complete. After collection of the initial demographic questionnaire, the participant's name was replaced with a random 3-digit ID number and assigned in the first Excel spreadsheet. Next, the demographic questionnaire data were loaded into the appropriate categories in the first Excel spreadsheet.

Once the information had been categorized from the demographic questionnaire, I then began to assemble a composite "portrait" of the participant, such as year of graduation from nursing school, degrees, age, etc., which served to customize the interview questions that were unique to each participant's "portrait." In addition to the base or stock questions asked of every participant, I also accessed a pool of questions in order to tease out more information, enriching the thick rich description collection. This is called intentional analysis (Henriques, 2014, p. 466). With these exclusively prepared interview questions, I embarked on the interview process. The four research questions were addressed during the interviews.

In the beginning of data collection, it is up to the researcher to help the participants' voice their experiences. It is not the researcher's job to inject opinions, experiences, or validations to the participant, as this is where epoché comes in, identifying and suspending all thoughts about the phenomenon before commencing with the data collection (Henriques, 2014, p. 457). One way to help participants talk about their lived experiences is to ask them to explain what happened, how it was interpreted, and the actions taken. The orchestration of the demographic questionnaire and the

interview fulfilled that need. To encourage deeper thought, as each interview developed, I asked specific questions related to what had been said.

During the interview, the participant may dredge up buried experiences or perceptions about the incident being described. For some, this was a needed and welcomed release. For others, this was quite disturbing and it was up to the researcher to determine whether the participant was uncomfortable and needed to end the interview or if the interviewer could proceed. A tactic to use at the beginning of each interview was to explain directly what the interview was going to entail and that bringing up buried memories may cause problems (Henriques, 2014, p. 461). Allowing the participant, the choice to stop or continue with the interview decreased further physical and psychological discomfort. A reference to free mental health services was given. By being transparent, as well as reinforcing that the utmost care would be given to maintaining confidentiality throughout the study, the participants were more at ease and willing to share more details of the events in question (Henriques, 2014, p. 461). The more the participant trusted me, the better quality of interview responses garnered.

The data were organized and analyzed with the use of Excel spreadsheets, Call Graph, MS Word, Express Scribe, and NVivo. After the data collection and during the analysis, the possibility existed that the participant may need to be contacted to clarify issues, words, or phrases. The goal, however, was to understand clearly what the participant had shared without having to re-live the episodes again (Henriques, 2014, p. 457). The interviews were projected to be completed at one per day. This would allow

for listening, transcribing, and coding each participant's responses before moving on to the next one.

All data collection devices have advantages and disadvantages. The following table (4) demonstrates the points:

Table 4

The Advantages and Disadvantages of Software used for Data Collection

Software	Advantages	Disadvantages
Demographic Questionnaire	being in email format, the answers can be easily transcribed to an Excel spreadsheet	An additional step in the data collection process
	closed-ended questions with a majority of checkboxes facilitate easier organization of data and theme-finding	Can give the participant a sense of uneasiness about maintaining confidentiality if using e-mail
	written checkbox answers to questions do not allow for errors in interpreting or reading	Closed-ended questions do not allow for explanation
	the few written answers are asked in a way to elicit a short answer	
Skype	Provides face-to-face interview without being face-to-face	It may not work properly, forcing the use of a phone interview
	The sample location is away from the researcher, making actual face-to-face interviews impossible	It may break down periodically during the interview, thus compromising the interview and forcing a change to a phone interview
	Skype provides the capability to see body language and prosody, allowing for an additional sense (sight) to be used, facilitating interpretation better	The recording function may not work properly
		The video function may not work properly
		The participant may not trust Skype to maintain confidentiality in either the video or audio recording
Call Graph	Facilitates recording of the interview so it can be sent to Express Scribe for transcription	It is a software program and may not work properly

Data Analysis Plan

Conceptual plan. There are two big hurdles for the novice researcher, executing the data collection/analysis appropriately and then presenting the final analysis findings in as pure an essence as possible, yet with a scholarly voice. The neophyte researcher must take the time to plan carefully how the data collection and analysis will be carried out (Maxwell, 2013, p. 105). Making the right choice for the conceptual plan, the backbone of the analysis, involves choosing the most appropriate theorist's plan that aligns with the study. For this study, I considered several different plans, including those of Colazzi, who required member checking, Giorgi's who negated member checking, and Van Kaam, who required that expert judges be used to confirm the credibility of the analysis (Reiners, 2012, p. 2). While all of these are pertinent alternatives, I did not choose them; instead, I decided to use Maxwell. Maxwell's plan fits most closely with this study.

Maxwell's plan involved five steps. The first step began with the initial analysis (Henriques, 2014, p. 466) and was called the eidetic process (Henriques, 2014, p. 465). Henriques declared that the eidetic process/analysis began with the finely detailed vivid descriptions expressed by each participant during the interview and continued throughout the analysis with researcher-involved epoché (Henriques, 2014, p. 465).

Maxwell recommended that the researcher sit down and write notes about the interview in order to recall details and important nuances based upon the participant's rendition of what transpired as soon as it was completed before listening to the recordings (Henriques, 2014, p. 465). Before the interviews, the second Excel spreadsheet was set

up and contained the á priori categories that were aligned with the interview questions serving as the beginning benchmark for the analysis. After the initial note taking, I listened to each recording from Call Graph, comparing it to my notes, examining for what was there and what was not there, making corrections and additions as needed. Writing in the methodological journal also provided an audit trail of this process. Each participant delivered a different amount of information during the interview. It was important to keep a keen eye and ear to what was said and not said. No discrepant cases were identified in this study.

Mulvihill et.al. (2015) stated that abecedarian researchers needed to learn to "look" beyond what they "see." The act of "seeing" consisted of just gathering information—what was seen; neither identifying nor understanding it, but the act of "looking" was purposeful. During the interview I made a conscious choice to attempt to understand and interpret what was seen as well as what was not seen, searching for what was not being said, reading between the lines, and what was missing from the body language or prosody of the participant (Cook, 2011, p. 1333 and Mulvihill et al., 2015, p. 1494). From these observations, additional probing questions were asked in order to reap a richer, thicker description of each participant's lived experience. Each interview experience added further enrichment to the researcher's ability to "see," ask, and learn (Henriques, 2014, p. 465). An iterative process builds over time and with experience.

From here, the researcher moves on to the second step. This is where I transcribed the interview word-for-word, into MS Word while also utilizing Express Scribe software, which converted the transcription to an MP3 program. No questions

arose during this time that could not be adequately answered; therefore, the participants did not have to be re-interviewed to clarify issues (Henriques, 2014, p. 465). Interviewing is a learning process and I expected to have to return to the participants to clarify what was said because I had failed to think of the right questions to ask during the initial interview. Fortunately, this was not an issue.

Member checking or transcript reviews were important tools that could be utilized at this time. In the initial email, each participant was given the option to review his or her interview transcripts. The goal was for participants to review their interview transcripts, affording them the opportunity to suggest changes to what they said (Morse, 2015, p. 1216). The difference between a transcript review and member checking is that a transcript review is a verbatim transcript provided to the participant to examine for correctness of what was said, while member checking is a summary of the interview, which can be expanded to include conversations between the researcher and participant during the interview process (Morse, 2015, p. 1218). It involves the researcher asking the participant to agree with, disagree with, or enlarge upon a recurrent statement from other participants in the study. This type of member checking is looking for confirmation of persistent and regular patterns throughout the collection/analysis process; strengthening dependability (reliability) (Morse, 2015, p. 1218). The transcript review is better suited for the descriptive study while member checking favors the interpretive study, although they are interchangeable and the choice is up to the researcher. If the researcher does not have a clear understanding, then the analysis will be precarious with loss of credibility, dependability, transferability, and confirmability (Morse, 2015, p. 1218). The findings

would be useless. I chose to utilize the transcript review because this study was descriptive, not interpretive.

Step 3 began with identification of the unique essence of each interview. Maxwell (2013) suggested the use of subcategories or connectors to help with this task (p.105, 107). While organizational categories fracture the stories into pieces so they can be re-assembled later for comparison and boost theoretical thinking, connectors do not focus on similarities, but on relationships that marry ideas into a whole context (Maxwell, 2013, p. 113). An example of connectors would be functional and theoretical categories. Functional categories are used to describe what the participants have said and do not interject additional thoughts or theories. Functional categories are useful tools for trends, themes, patterns, section headings, and word-mapping (Maxwell, 2013, p. 107). The researcher returns to listen to the audio, reading the transcriptions, probing for new themes, sub-themes, redundant themes, and re-evaluation (Cook, 2011, p. 1333). The data can be sorted into functional categories and the á priori categories can be reviewed for worthiness, with new codes added that further describe the data and obsolete codes deleted, or information combined with other codes (Maxwell, 2013, p. 107). This is the time-consuming part of the analysis task, determining where to place data generally, and then specifically into micro-themes; sorting, organizing, coding, and re-coding or condensing. During this process, little nuggets of knowledge can be unearthed to gain a richer, deeper understanding of the story, grasping the overall picture so relationships or themes can be deduced (Maxwell, 2013, p. 106). The expectation is that the information

gleaned from this section, combined with the organizational categories will contribute significantly to the rich, thick description and understanding of this phenomenon.

Coding is meant to be helpful to the researcher so that similar information is coupled with comparable information, facilitating ease of analysis (Maxwell, 2013, p. 107). The downfall with coding is that if it is too restrictive with too many categories and sub-categories, the ability to unearth new ideas will be hindered, possibly causing the researcher's bias to surface (Barbour, 2008, p 196). Coding must be fluid and capable of being deleted, and new codes added as needed (Barbour, 2008, p 196). This cannot be accomplished if the coding is too formal and restricted. Barbour further stated that throughout the analysis process, the researcher must ask the following questions:

- How useful are the codes? Are they too restrictive, not informative, break up the information so much that it cannot be used later, or not relevant to the data
- Can some codes be broken down further into functional and theoretical categories and then sub-categories
- What sort of language is being used? Is there bias, prejudicial statements, or innuendoes?
- What explanations do the participants provide (p. 204)

It was much simpler to determine which categories to keep, which ones to delete, and which ones to modify once these questions were answered. The identifying factors were removed once the analysis was complete.

Next was the fourth step. The initial coding, categorizing, and subcategorizing have been completed and now is the time to "look" at what has been collected. The

fourth step took all of the participants' essences and synthesized them into themes, patterns, and trends (Henriques, 2014, p. 466). A review of the codes, journals, memos, and notes assisted in developing the overarching theme for the study as well as applying what I had learned from this journey in relationship to what the participants had said. Did the journals relate something opposed to what the study revealed? If so, why? Was it due to missed information or aberrancy requiring further investigation? Had bias come through and tainted the study. Was epoché appropriately utilized? Were previously unrecognized biases identified from the journal writing? If so, how were they handled? Was the study findings generalized into an overall theme retaining the essence of each participant? The final task was to describe the essence of the phenomenon and then send to NVivo, searching for values and a final sweep for any missed information.

The last step was concerned with distilling all of the information together into the final presentation. It was a blending of all of the stories into the final abstraction (Henriques, 2014, p. 466). All of the reviews and analysis from NVivo demonstrated saturation of the research problem, the research questions had been addressed, and no new information had been discovered in the last review of the codes and analysis. It was time to write a textural description of "what" happened and "how." The composite essence was written in a scholarly voice within the narrative format, employing tables and figures to assist in explaining the findings of this study. This was where I described the journey from collecting data to the finished project, sharing follow-up procedures after the initial interviews such as repeat interviews for clarification or debriefing when participants exited, transcript review reports, and what I did with discrepant cases or

sensitive information. In this final presentation, I demonstrated how this study was credible and dependable through triangulation, and how transferability and confirmability were established.

Software and Tools used during Data Analysis Process

An explanation of each tool and type of software used in this study can be viewed in Appendix K. Tools used included notes/memos, journals, and an audit trail. Software used for this study included Skype, Call Graph, Express Scribe, MS Word, Excel spreadsheets, and NVivo.

Issues of Trustworthiness

When discussing the issue of trustworthiness, it is imperative to demonstrate that all measures were taken to provide accurate information. The reader must come away from the study confident that the statistics and knowledge provided are up-to-date, correctly cited, and provide clear and undisputable details. Examples of questions that build trust in the reader's mind are:

- Is the goal of the study clear?
- Why would anyone want to read this study—what is the significance of it?
- Does it present itself in such a way as to invoke a desire to learn more about the subject?
- Is the information on the data collection reflected accurately in the final narrative of this study?
- Will the information gleaned from this study fill a gap in the literature?
- Did I learn anything from this? If so, what did I learn?

- Could I use this information in my life or that of others?

Lincoln and Guba posited that four categories established trustworthiness in a research study. They were credibility, transferability, dependability, and confirmability (as cited in Schwandt, 2015, p.309). Lincoln and Guba felt these terms better identified and explained qualitative studies than terms such as internal and external validity, reliability, and objectivity, which were quantitative study terms. Early on, qualitative researchers were forced to adapt quantitative terms to fit qualitative studies, which did not work well. These terms did not allow the use of qualitative tactics to prove them. Real-life studies involve people's feelings, their stories, lived experiences, thoughts, and actions related to such. These things cannot be measured in the conventional quantitative way within the laboratory atmosphere (Lincoln & Guba, 1986, p.15). The difference between the quantitative and qualitative study is that the quantitative study is sterile and black-and-white, while the qualitative study is fluid without any absolutes. The quantitative study looks at statistics only; there are no feelings allowed~~, while the.~~ The qualitative study is based on feelings.

Credibility

Credibility is related to internal validity in quantitative research. Credibility is proof that the information received from the participants and then torn down, analyzed, and rebuilt remains true to what was initially said (Schwandt, 2015, p. 309). For a study to be credible, it must be able to stand on its own as a result of the accuracy and solidness of its findings (Morse, 2015, p. 1213). Accuracy and solidness are proven when the readers can identify with the essence described, as it resembles their own experience

(Morse, 2015, p. 1213). When the description of the lived experiences matches the nature of the phenomenon, the study has earned credibility.

Lincoln and Guba (1986) devised six categories related to credibility. They were prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, and member checks. Each category ensured that the information proposed by the researcher was as credible in a qualitative study as that of a quantitative study. The goal of prolonged engagement and persistent observation was to identify, over time, discrepancies in the initial findings (p. 19). Another measure to add is triangulation.

Triangulation involves gathering information from various sources. The researcher should be confident that the data collected and ending conclusions are credible and dependable if all of the sources revealed the same or similar information (Houghton, Shaw, & Murphy, 2013, p. 13). Triangulation is comparable to the three-legged stool. If there are only two legs, the stool is not very trustworthy for sitting. By adding the third leg, however, now the stool is strong, dependable, and trustworthy.

Peer debriefing, another tactic combined with triangulation, uses outside parties with no affiliation or desire to know about the study, to ask questions, keeping the researcher accountable. Two other activities, negative case analysis and member checks also bolster credibility (Lincoln & Guba, 1986, p. 19). Lincoln and Guba did not suggest transcript review as another option related to member checks. Because my study was descriptive and not interpretive, I used transcript reviews instead of member checking, in addition to methodological and environmental triangulation to prove credibility in this study.

Guion, Diehl, and McDonald presented five types of triangulation. They were data, investigator, theory, methodological, and environmental (2011, pp. 1-2). I chose to use methodological triangulation for my study.

Data triangulation involves the collection of data from different sources such as stakeholders and participants in the study (Guion et al, 2011, pp. 1-2). Data compared and contrasted with the results, either strengthens or weakens the credibility of the study (Guion et al, 2011, pp. 1-2).

Investigator triangulation involves using more than one investigator in the analysis process (Guion et al, 2011, pp. 1-2). Each investigator uses the same study techniques as the original study (phenomenology, ethnography, etc.) and then all of the findings are compared (Guion et al, 2011, pp. 1-2). If agreement is reached between the investigators regarding the findings, then the case has earned credibility (Guion et al, 2011, pp. 1-2).

Theory triangulation utilizes professionals from different disciplines to interpret the data (Guion et al, 2011, pp. 1-2) pointing out strengths and weaknesses to the study (Guion et al, 2011, pp. 1-2). The more professionals agree with the researcher's findings, the more solid the credibility of the case (Guion et al, 2011, pp. 1-2).

Methodological triangulation is quite complicated because more than one methodology is used for the study (Guion et al, 2011, pp. 1-2). If comparison of these diverse findings (surveys, interviews, etc.) demonstrates congruent results, then credibility is proven (Guion et al, 2011, pp. 1-2). In this study, I collaborated between two types of instruments—a demographic questionnaire and an interview, each working

symbiotically to provide a complete data set. I also compared my findings with those of five previous studies that were presented in chapter one.

The last type is environmental triangulation, which involves using different locales, times, etc. for the same study (Guion et al, 2011, pp. 1-2). If the findings are consistent, then the study is credible (Guion et al, 2011, pp. 1-2).

Dependability

The counterpart of dependability is reliability in the quantitative world. Schwandt noted that dependability focused on the researcher (Schwandt, 2015, p. 309). It is the researcher's responsibility to ensure that the study is carried out in a logical way, and the data are provided in an ethical manner (Schwandt, 2015, p. 309). Dependability is closely related to credibility and can be proven via triangulation, data division, and re-running the analysis to check for replication, or with the services of an external auditor (Morse, 2015, p. 1213). Keeping and referring to the information in reflexive and methodological journals is very helpful in supplying information for an external audit (Lincoln & Guba, 1986, p. 19). An audit trail is a safety net for the researcher. The auditor's job is much like that of the IRB, ensuring quality, dependability, and trustworthiness of the study.

Transferability

Transferability in a qualitative study mirrors external validity in a quantitative study. Through transferability, the reader should be able to take the information from the researcher's work and transfer those concepts to other studies with similar data (Schwandt, 2015, p. 309). Each nurse has a story to tell. The nurse's bullying experience

was uncomfortable and frightening. Comparing and applying these findings to others' stories, using thick, rich description allows the reader to understand the plight of the bullied nurse as well as the nurse who has witnessed bullying (Lincoln & Guba, 1986, p. 19). The final result is that the details of the nurses' stories of bullying or witnessing it and the career-altering decisions they made in order to stop it, compared with the information gathered from the literature review, adds depth, richness, and credibility to this study. Due to the nature of qualitative studies, the stories will vary between participants. If the same participants were asked to relate their stories at another time, they would not necessarily be duplicated, therefore it cannot be expected that transferability can be completely accurate when comparing studies or replicating the same study (Houghton et al., 2013, p. 16). Transferability in this sense cannot be compared to that of quantitative studies. When dealing with human feelings, the researcher must focus on the essence, not the exact wording in order to prove transferability.

Confirmability

Confirmability, or objectivity in the qualitative study, is proof to the reader that the researcher has produced reliable and trustworthy information (Lincoln & Guba, 1986, p. 19). It is objective, or non-biased, relating the facts appropriately and purely, proving them by other means. Lincoln and Guba suggested the use of an auditor to substantiate dependability and confirmability for any study. Dependability proves the process of the study while confirmability proves the product or the data that were discovered (Lincoln & Guba, 1986, p. 19). The use of an auditor should be thought of as protection instead of

a hindrance to any researcher. The audit will bring out inconsistencies, malalignment, and other problems that can damage the worth and integrity of the study as well as confirming the strong points and trustworthiness of the study.

Table 5 displays how qualitative terms are related to quantitative terms and what characteristics qualitative criteria have.

Table 5

Comparison of Qualitative Criteria & Qualities Related to Quantitative Criteria

Qualitative Criteria	Characteristics	Related to Quantitative Criteria
Credibility	Believability	Internal Validity
Dependability	Stability	Reliability
Transferability	Meanings Preserved	External Validity
Confirmability	Accuracy	Objectivity

Note. (Houghton et al., 2013, p. 13; Lincoln & Guba, 1986, p. 19)

Ethical Procedures

Sensitive information and maintaining confidentiality. If, during the interview, the participant reveals sensitive information such as names of organizations or people, I will have to include this in the raw data, but it must be protected. Fortunately, none of the participants revealed any sensitive information. There are several ways to make sure confidentiality is maintained. I set up a separate email address for the interviews to increase trust and provided information as to how I would maintain confidentiality (Cook, 2011, p. 1332). I deleted all identifiers during the coding process, making sure that no one else heard the recordings while I transcribed them, and locked all computers, flash drives, verbal recordings, and transcriptions in safe places. I was the

only researcher involved with the data analysis except for the NVivo consultant, but the information sent to the consultant had all identifiers eliminated.

The data were collected and loaded into an Excel spreadsheet residing on a password-protected computer. A flash drive was used for additional security as well as for backup. All paper, the computer, and flash drive are locked in my private office. No one else has access to the data. Once the dissertation was completed, the paper was shredded; the computer's information loaded into a flash drive for storage for at least the next five years and after the flash drive was formatted, all information related to this study was deleted from the computer. At the end of the five years, the flash drive will be wiped clean of all information and destroyed. Before writing up the final abstraction or analysis, I provided for confidentiality assuring the participants what had been said was not be identifiable to them.

Mental health assistance. Due to the nature of the interview, answering the questions required the participants to re-live the bullying experience(s), or the witnessing of such, possibly causing physical or psychological distress. Instructions on how to access free mental health services, such as counseling if the participant so desired, was provided in the initial email. I clarified before the interview began if the participant felt the interview too distressing, it could be stopped at any time. Additionally, if I determined the interview was too stressful I could stop it. I advised each participant there would be no negative consequences for stopping the interview process or withdrawing from the study.

Vulnerable populations' ethical concerns for this study. Vulnerable groups I had to consider for this study were minors, institutionalized people, mentally incapacitated and emotionally disturbed individuals, pregnant females, subordinates, students, or clients, those whose first language was not English, people in crisis, those who were economically disadvantaged, and elderly citizens. Minors, those in prison or treatment facilities, subordinates, students, clients, and those who did not have a good command of the English language were automatically excluded from the study because they did not qualify for an RN license. The remainder of the vulnerable populations: those in nursing homes, assisted living, crisis (natural disasters or acute illness), the economically disadvantaged, mentally and emotionally disabled, pregnant women, and the elderly (those over 65 years old), could qualify to participate in this study if they met the inclusionary criteria. Since I did not screen for age, economic condition, living situations, pregnancy, or mental health, I did not know if any of the participants were dealing with one or more of these issues.

Conflict of interest. There was no conflict of interest as I was not affiliated with any of the nurses in the original sample. I work as an online college professor and do not teach nursing classes. I teach healthcare business classes. The sample consisted of Registered Nurses (RNs) who maintain an active nursing license and are presently working or were working in a hospital setting.

Summary

It was important for me to have a clear understanding of how what I wrote can affect others' reflections. As other people such as bullied nurses, bullies, hospital

administrators, academics, researchers, and the reader not intimately acquainted with nursing read this study, what will they see? Will they view this as a biased study to prove that bullying does exist? Will those nurses who have been bullied be further marginalized by what was written in this study? Will bullies use the findings from this study as an excuse to bully further? Will the readers be confident after reading this study that a faithful effort had been put forth to bring honest and authentic information? Will the information from this study be used constructively and progressively to encourage policymakers in recognizing and assisting this marginalized group of nurses thus effecting social change? The goal of this study was to produce an accurate and ethical study and all questions were addressed.

My findings from the literature searches demonstrated that there is a deficiency in knowing how this culture group—bullied nurses and witnesses, survive because they are not in the mainstream of society. One of the unfortunate side effects of bullying is intimidation. Nurses who have been bullied, or have witnessed it, are afraid to speak freely about their experiences. They are afraid out of shame and fear because their identity might be discovered. Even today, in 2016, many nurses claim ignorance of this culture group. Too often, this marginalized segment is not allowed to voice opinions or feelings. Consequently, they live in isolation. After the reader has been educated regarding what the bullied nurse and witness must go through to protect him or herself from further physical, emotional, mental, and spiritual attack, the reader may choose to take a definite stand and speak out for those that cannot.

The findings from this study were presented in chapter four. I am anticipating new information to share that has never been discovered in other research. In chapter five, I summarized and presented recommendations for further avenues of study. Some of the recommendations were for economic change regarding attrition, retention practices, a different outlook on bullying, and increased social awareness; all actions that promote social change.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to understand the choices nurses made regarding their careers when fellow nurses bullied them or had witnessed it when working in the hospital setting. I devised four research questions for this study. The first three questions inquire about nurses and their experiences with being bullied, witnessing coworkers being bullied, and the career choices they made. The fourth question delved into the financial ramifications to a hospital when nurses leave.

Research Question 1: What are the lived experiences of nurses being bullied by nursing colleagues?

Research Question2: What are the lived experiences of nurses who witness co-workers being bullied by colleagues?

Research Question 3: How does the bullying experience of nurses impact career choices post the bullying experience?

Research Question 4: How does the RN turnover rate impact the bottom line of a hospital, both indirectly and directly in costs?

The remainder of the chapter describes the field test, the research setup, the demographics for each of the participants and the study, how the data collection and analysis, the results of the study, and trustworthiness.

Field Test

I conducted three different field tests before embarking on the research. The first test, conducted on February 28, 2016, focused on the demographic questionnaire. The tester, another RN, who was not involved in the actual study, reviewed the questionnaire. I had four requirements for the tester. The first requirement was to time the test. There were 47 closed-ended questions, which took about 5 minutes to complete. The next requirement was to rate the difficulty of the questions. The tester felt the questions were of average difficulty and not too personal or probing for an initial questionnaire. The third requirement was to note if any of the questions made the tester uncomfortable and the last requirement was for the tester to determine if the questions eased the participant into wanting to continue with the phone interview. The tester felt the questions were non-threatening and did encourage further participation in the study.

On March 6, 2016, I conducted another field test, this time involving the interview questions. I conducted this test via phone with an RN not affiliated with the actual study. The tester had previously completed the demographic questionnaire and returned it to me. I then assembled a custom interview based on the answers given in the demographic questionnaire using my pool of 149 interview questions. The call lasted about 20 minutes. The tester felt the questions were of average difficulty and did not cause undue stress. The tester thought my demeanor was collegial and friendly, which promoted a desire to continue with the interview process through completion.

A third field test, undertaken on March 30, 2016, involved the initial email including the introductory letter, instructions, and the demographic questionnaire.

Reading the entire email and answering the questions took about 10 minutes. The tester felt there should be a "no" option for question #3, which asked about further degrees. This choice was added to the question. The tester also felt that questions #33-37 were repetitive although there were obvious necessary differences. These questions involved the number of nurses on leave within the department for various issues such as medical leave, maternity, FMLA, and Workers' Compensation. The tester additionally felt that answering questions about co-workers calling off or coming in late was difficult to answer as that number changed daily. On a positive note, the tester felt the test was gender inclusive and non-biased.

When I conducted the interviews in the actual research, all of the participants felt at ease in answering the questions, and freely shared their stories. I had allotted 30 to 45 minutes for each interview, but the participants would share so many stories and go into so much detail that the interviews, on average, lasted about an hour, a few were closer to two hours. They did not seem to mind the extra time—sitting comfortably in their chairs, laughing and talking as if time was not significant because they were intent on sharing their stories.

Research Setting

Originally, I had planned to conduct Skype interviews. In reality, out of the 11 participants, I only conducted one Skype interview. Six interviews were face-to-face, three were by phone, and one was online. Four of the face-to-face interviews were conducted at each participant's home. The remaining two interviews involved two people who worked at the same place. Each interview was separate and private. One

was in a conference room, and the other was in the manager's office. The three phone interviews were conducted for various reasons. Two lived too far away to interview in person, and the third phone interview was a matter of convenience because the nurse worked nights and had just finished a shift. The online interview was conducted because the nurse was working until leaving on vacation and there was no time to schedule a face-to-face or phone appointment before the close of my research.

All of the interviews, except for the online interview, were relaxed, with both the participant and myself sitting comfortably in the living room or outside on the porch. I used my smartphone to record all of the interviews except for the Skype interview and the online interview. When I arrived at my office, I would turn on my computer, open up Call Graph, and record the smartphone recording onto it. When it was completed, Call Graph would make both a .wav and a .mp3 copy. I could choose which one I wanted downloaded to Express Scribe.

There were no budgetary constraints to this study that would impact the end results of the analysis. Each participant was advised in the initial email that by completing the demographic questionnaire and returning it plus the criteria test along with the initial email implied consent had been given to continue with the study.

Demographics

The population for this study was licensed Registered Nurses (RNs) in a Midwestern state. My goal was eight to ten participants. Initially, I called the State Board of Nursing and requested a list of Registered Nurses who had active licenses in the state. The list is a matter of public record. The list of RNs within this state was far too

many. I decided to pick one county of the state to sample. Because there were so many active RNs the chosen county, greater than 15,000, I decided to choose every tenth name on the list. The initial contact sample consisted of 1,527 names and included 157 male RNs. I split the list into two parts. The first half of 740 names was sent out on a Friday. After four days, no one had responded to the email invitation. I decided to try the snowball technique. I called friends that attended a church that had several nurse members. From that group, I received seven names, of which five agreed to participate. Then I contacted two of my colleagues in the Faith Community Nursing group that I attend. One met the requirements to participate. I called two other friends, and they provided me names for one that belonged to a large church in a city about 45 minutes away and the other, an RN that worked at one of the local hospitals. I contacted another friend, and he provided me with five names, but no one wanted to participate. I called an old neighbor. Both he and his wife were RNs. He participated and found two nurses at the facility he manages who were eager to participate. His wife did not take part although her husband stated she had been bullied. I had 11 participants for the study. In chapter 3, I had indicated that I did not know any of the participants, which was before I had to switch to using snowball to find participants. Of the 11 participants, I knew three. I only knew the name of one nurse because the nurse rounded in the hospital department I worked. The second nurse I did work with in the same hospital department and the last nurse had been my next door neighbor, which I knew casually and had not seen in six months.

I wanted to compile as diverse a sample as possible in order to obtain the richest results. Table 6 presents the demographic information according to degree, gender, ethnicity, year of graduation from nursing school, age group, and years working. As expected, the majority of the nurses were female and White because most nurses are female (90%) (US Dept of Commerce, 2013) and White (U.S. Dept. HHS, 2013).

Table 6

Demographic Table of Participants

Participant	Current Degree	Gender	Ethnicity	Graduation Year	Age	Years Working
P01	BSN, MSA	F	White	1960-1969	70-79	50-54
P02	AD	F	White	2000-2015	50-59	10-14
P03	BSN	F	White	1990-1999	30-39	15-20
P04	AD	F	White	1980-1989	60-69	25-29
P05	BSN	F	White	2000-2015	30-39	10-14
P06	BSN	M	Black	2000-2015	30-39	1-4
P07	Diploma	F	Black	1980-1989	50-59	30-34
P08	AD	F	White	1980-1989	60-69	30-34
P09	AD	F	Black	1990-1999	50-59	21-24
P10	AD	F	Asian	1990-1999	30-39	1-4
P11	AD	F	White	1980-1989	60-69	35-39

Table 7 is a comparison of my study with seminal studies that were discussed in chapters one and two. The six studies; two from 2010, one from 2012, two from 2013,

and this study in 2016 provide a means to compare age, gender, ethnicity, and education statistics. As noted by bold type, the age range is 30 to 55, gender is females 80% to 93%, ethnicity is White 64% to 96%, and education is AD 43% to 55% and BSN 27% to 63%.

Table 7

Comparison of my 2016 study with studies from 2010, 2012, and 2013

Study	Age	Gender	Ethnicity	Education
My study, 2016	**30-39 = 36%** 50-59 = 27% 60-69 = 27% 70-79 = 9%	**F = 10 = 91%** M = 1 = 9%	**White = 64%** Black = 27% Asian = 9%	Diploma = 9% **AD = 55%** BSN = 36%
Simons & Mawn 2010	22-61; mean = **35.8 years**	**F = 92%** M = 8%		**AD = 43%** BSN = 37% Diploma RN, Bachelor's or Masters in other area = 63%
MacKusick & Minick 2010	22-29 = 10% 30-39 = 10% **40-49 = 70%** 50-59 = 10%	**F= 8 = 80%** M = 2 = 20%	**White = 70%** Black = 20%	**AD = 50%** **BSN = 50%**
Walrafen, Brewer, & Mulvenon 2012	Up to 25 = 7% 26-35 = 17% 36-45 = 19% **46-55 = 39%** 56-65 = 18% >65 = 1%	**F = 93%** M = 7%	**White = 96%** Black = 3% Asian = 1%	Diploma = 9% AD = 19% **BSN = 63%**
Vogelpohl, Rice, Edwards, & Bork 2013			**White = 92.6%** Black = 5.2%	
Weaver Moore, Leahy, Sublett, & Lanig 2013	22-62; mean = **45 years**	**F = 88.5%** M = 11.5%		

The demographic questionnaire covered the following categories:

- Degree
    - AD = 6
    - Diploma = 1
    - BSN = 4
- Gender
    - Female = 10
    - Male = 1
- Ethnicity
    - Asian = 1
    - Black = 3
    - White = 7
- Graduation Date
    - 1960-1969 = 1
    - 1980-1989 = 4
    - 1990-1999 = 3
    - 2000-2015 = 3
- Age
    - 30-39 = 4
    - 50-59 = 3
    - 60-69 = 3
    - 70-79 = 1

- Years Worked as an RN
    - 1-4 yr = 2
    - 10-14 yr = 2
    - 15-29 yr = 3
    - 30-34 yr = 2
    - 35+ = 1

Data Collection

IRB approved my application on Thursday, May 13, 2016. By May 25, 11 nurses had agreed to participate, which provided enough rich information to achieve saturation. As I received names from friends, I contacted each person and personally invited them to participate in my study. I explained briefly-what the study was about and asked if they had been bullied or had witnessed it and whether or not he or she would like to participate. I sent each participant the invitational email explaining the study in detail as had been approved by the IRB, the criteria test, and the demographic questionnaire.

One of the participants did not think she had been bullied. After asking some questions and providing examples of nursing school bullying and bullying at work, she equated her treatment to bullying. When she realized she had been bullied, her comment was: "I can't believe that I was bullied!....So that's what happened to me…..I never knew that that was what happened to me" (P09, personal communication, May 25, 2016). She participated in the study.

The data collection lasted 25 days. I had two data collection instruments: the initial email invitation with the demographic questionnaire and the follow-up interview

questions. The demographic questionnaire was a 47-item closed-ended questionnaire that took the participant about five minutes to complete. The answers consisted of marking a listed answer, a simple yes/no, or number answer. After I received the demographic questionnaire, I entered it into an Excel spreadsheet and then created a customized interview questionnaire from it. The customized questionnaire master sheet contained 149 questions dispersed throughout different categories including demographics and the research questions. The interview questions were written in the "if-then" mode and followed a tree of deeper probing questions. For example:

1: What was your initial nursing degree? (this was from the demographic questionnaire) If the participant checked Diploma or Associates Degree, then I would move on to question #2.

2: Have you ever been turned down for a job or not even apply because you did not have a BSN?

A. If "Yes", then:

a. if you were turned down, what did you do?

b. if you did not apply, why not?

B. If "No" then I proceeded on to the next question in the list. Choices "a" and "b" were open-ended questions that forced an explanation and further questions as I deemed appropriate. In some of the questions, the drilling down questions filled several more levels than this example.

As a nouveau interviewer, I was prepared to make follow-up calls. The entire interview questions were answered to my complete understanding and further follow-up

clarification was not needed. I credit this because of my emic indigenous-insider background as an RN and previous experience with bullies, in addition to participants willing to share their experiences.

I worked from home using my PC or laptop. I set up one appointment daily and spent the entire day interviewing, transcribing, coding, and analyzing the information while it was fresh on my mind. Each phone and face-to-face interview were recorded with my smartphone and a software program called Call Graph in addition to handwritten notes. Each interview was given a unique identifying number, labeled, and saved to Express Scribe for later transcription. When ready for transcription, I would play the recording while I typed it word-for-word into the designated area of Express Scribe. After that, I took the transcription and compared it with the notes I took during the interview, making changes/additions/explanations as needed. Two participants requested their transcript for review and comments.

There was one change to the data collection from the original plan. My proposed plan to obtain participants from a State Board RN licensure list failed. I sent out emails and did not receive any returns. I surmised that people were afraid to open emails from sites or names they did not recognize. No one replied even though I labeled the email, "Have you witnessed or experienced bullying as a nurse?" I had to change my plan and started snowball sampling. This technique provided enough participants for this study.

One unusual circumstance prompted a change regarding how the sample was collected. I conducted an online interview instead of a Skype, phone, or face-to-face interview.

Data Analysis

I followed Maxwell's plan for data analysis, which was explained in chapter three. Maxwell (2013) discussed the use of multiple methods in data collection. The purpose of using a variety of methods was to enhance the collection and analysis experience for the researcher (Maxwell, 2013, p. 102). Maxwell stated that observation complements interviewing as both are needed in order to understand completely what the participant has said (Maxwell, 2013, p. 102). Through observation, the researcher can describe how the participant acted while answering the interview questions. Observing the body language, facial expressions, and prosody all add dimension and clarity to the interview. The interview is the repository of words and thoughts. Combining the two adds 3-D to the picture being painted with words, instead of a flat 2-D when using writing alone. I noticed a very distinct difference between the one online interview and the other face-to-face or phone interviews in this study. The online interview provided the answers to the questions but denied access to ask further questions or to observe the participant's body language or hear how the answers were said. The face-to-face and phone interviews were much more in-depth and richer.

After the initial phone call I had with the participant, I started writing notes, planting ideas for probable categories to use in the data analysis (Maxwell, 2013, p. 105). I noted whether the participant's tone of voice and inflections revealed anger, sadness, remorse, or acceptance. Then, at the face-to-face interview, I observed the surroundings and the participant's behavior, actions, and dress. During the interview, I not only listened to the answers, but I paid attention to how each participant responded to those

questions. Was there hesitation before the answer? Was there unresolved anger, resentment, or remorse in the tone? Was there an acceptance of what had happened and the incident(s) filed away as a lesson learned? Maxwell posited that the interviewer must be analyzing the data while collecting the data (Maxwell, 2013, p. 104). At the computer, listening to the conversation again while transcribing, I would remember how things were said, facial expressions, and body language. By the time I had the transcription completed, I knew the participant and the feelings regarding his or her experience.

Maxwell then posited that the researcher had three choices to assist with the analysis: memos, categorizing strategies (thematic analysis/coding), and connecting strategies (narrative analysis) (2013, p. 105). Memos are important to use during data analysis to identify thoughts as well as encourage further introspection (Maxwell, 2013, p. 105). For memos, I utilized three different types of journals: personal, reflective, and methodological, drawing off my notes to add another dimension to my understanding of the participants' stories. Next, I incorporated categories. Because I am both an emic and etic researcher, specifically an indigenous-insider, I already had listed á priori categories in my Excel spreadsheet used for part of the analysis aligned with the interview questions serving as the beginning benchmark for the analysis.

I utilized connectors later on in the analysis when looking for relationships. Categories and connectors are thought to be similar, but in reality, are not. Categories are similarities and differences of data to be compared/contrasted, while connectors are the points that make it clear to the reader how ideas are connected to one another (Maxwell, 2013, p. 106). Both strategies work together but are not part of each other.

The process of coding is meant to be helpful to the researcher, coupling similar information, facilitating ease of analysis (Maxwell, 2013, p. 107). Coding must be fluid with the capability of deletion, and new codes added as needed, using it to answer the research question(s), and promote transferability throughout the study (Maxwell, 2013, p. 105).

Next, I reviewed all of the information; the codes, journals, memos, and notes to devise a general theme, applying what I had learned from this journey in relationship to what the participants had said. The final task was to describe the essence of the phenomenon and then send to NVivo, searching for any missed information. The use of a tool such as NVivo is an adjunct to what I, the researcher have discovered. NVivo provides another look at the data. During review of NVivo's findings, I found additional information to assist in my understanding of what choices nurses made when bullied.

The last step involved the final composition of the research findings. It was time to write a textural description of "what" happened and "how" to assist in describing the findings of this study. Since this is a transcendental study, the goal was not to interpret but to describe, relate, and state what the participants said.

During each interview, I noted the flavor and uniqueness of each person's story. I came away knowing each participant on a personal level in my mind. Each participant presented a different facet of the effects of bullying. One was sarcastic and hateful of her experience. Another was tearful and afraid, requiring much reassurance to speak of what had happened—it was safe here. One was happy to talk about her experiences, and another was rather nonchalant. As I transcribed each interview, I remembered how the

participants responded to my questions, the laughter, the sadness, the remorse, the anger, the courage, and the shame.

As I assembled the demographic questionnaire and the interview questions, I made sure they aligned with different categories presented throughout the paper. Each category contained a corresponding rationale. There were ten demographic categories, which included:

- Education
- Graduation
- Years Working
- Type of Nurse
- Nursing Department
- Employment
- Shift
- Gender
- Ethnicity
- Age

The interview questions arose from the demographic questions contained eight categories:

- Bullying, related to RQ1 what are the lived experiences of nurses being bullied by nursing colleagues?
- Absenteeism, related to RQ 1 & 2

- Shame, related to RQ2 what are the lived experiences of nurses who witness co-workers being bullied by colleagues?
- Bullying and Co-workers, related to RQ2
- Choices, related to RQ 3 how do the bullying experience of nurses impact career choices post the bullying experience?
- Bottom line: Direct Costs, Indirect Costs, and Hospital Administrators, related to RQ 4 how does the RN turnover rate impact the bottom line of the hospital, both indirectly and directly in costs?

The complete list of demographic and interview questions can be viewed in Appendix E.

There were no discrepant cases in this study. Each participant's story was unique and within the bounds of expected outcome. While each participant told a story, the overarching themes of all of the stories remained the same. The differences were in the depth of the wounds, the amount of resilience, the time since the episode(s), and the attitude of each participant.

Evidence of Trustworthiness

To prove trustworthiness of this study, I employed the use of five different techniques. I utilized two types of instruments—a demographic questionnaire and an interview questionnaire. I also compared this study with five other studies previously conducted between the years of 2010 to 2013. Transcript reviews were offered to each participant. I also kept notes in three different types of journals. One was personal and dealt with my feelings throughout the project. Another was reflective, covering my feelings about the project and its progression, while the last journal was methodological,

and addressed my thoughts regarding the actual workings of the study. Each journal provided a different concept of the study. The results from NVivo 11 also added to the dependability of the study.

Credibility

To prove credibility I used two different instruments, the demographic questionnaire, and the live interview. Credibility is proof the information received from the participants and then torn down, analyzed, and rebuilt remains true to what was initially said (Schwandt, 2015, p. 309). I also compared some of the findings from this study with five other studies. Both tactics are known as methodological triangulation. Last, I offered transcript review. Two of the eleven participants wanted to view theirs and were satisfied with the results.

Transferability

The details of the nurses' stories of bullying or witnessing it and the career-altering decisions they made in order to stop it, compared with the information gathered from the literature review, added depth, richness, and credibility to this study. Through transferability, the reader should be able to take the information from the researcher's work and transfer those concepts to other studies with similar data (Schwandt, 2015, p. 309). The comparison between this study and the five previous studies reinforced transferability. Each nurse's story presented similar feelings, conditions, and actions from the past as compared to the present, proving that my findings aligned with previous findings from other studies.

Dependability

Dependability is my chance to demonstrate accountability and responsibility in my research study. Schwandt noted that dependability is focused on the researcher (2015, p. 309). Dependability is closely related to credibility and can be proven via triangulation (Morse, 2015, p. 1213), which I used by comparing other studies with mine. Keeping and referring to the information in reflective and methodological journals can be very helpful (Lincoln & Guba, 1986, p. 19). To increase dependability, I kept three journals, used two types of instruments, and offered transcript review.

Confirmability

Confirmability is proof that what has been written in this study is correct and robust. The use of reliable and scholarly sources produces reliable and trustworthy information, thus confirming that the information I discovered was accurate and appropriately aligned with seminal works (Lincoln & Guba, 1986, p. 19). Comparing my results with those of the five studies, the use of the three journals and the NVivo results provided confirmability in this study.

Results of the Study

This study consisted of two parts. One part was about nurses who had experienced bullying or witnessed it and the choices they made career-wise to stop it. The other part was the financial sequelae resulting from the choices nurses make after they have experienced or witnessed bullying. To find the answers to the four research questions posited in this study, I used a demographic questionnaire to provide a preliminary portrait of each participant in 10 general demographic categories and then I

asked general lead-in closed-ended questions to develop a baseline of the nurse's experience with bullying. From there I constructed a custom interview questionnaire from the answers in the demographic questionnaire utilizing a pool of 149 interview questions. I identified four categories for this study. Demographics with ten subcategories; bullying that addressed RQ 1and 2 with three subcategories; bullying and coworkers related to RQ2; choices related to RQ3; and the fourth category was the bottom line related to RQ4 with three subcategories. A complete table can be viewed in Appendix J.

Category 1: Demographics

Education. Rationale: *By determining the nursing degree that the participant holds, I will know how to adjust questions further in the interview. EX: I would not ask an AD nurse questions that only a BSN nurse could answer.*

This study consisted of nurses with three different nursing degrees: Diploma, AD (Associate's Degree), or BSN (Baccalaureate Degree). One of the first questions I asked the participants was the initial nursing degree, the current degree, and any other degrees. Table 8 compares the initial nursing degree of each participant with the current nursing degree.

Table 8

Initial Nursing Degree vs. Current Nursing Degree

Initial Degree		Current Degree	
Diploma	2 (18%)	Diploma	1 (9%)
AD	8 (73%)	AD	6 (55%)
BSN	1 (9%)	BSN	4 (36%)

One Diploma nurse earned a BSN while two Associate Degreed nurses further their education by earning BSNs. Although the BSN increased by three, the Associate Degree remained the popular choice by 19%. One nurse had a Master's Degree in Health Care Management, and another one had a second Associates Degree in Science. According to Budden et al., 36% of RNs had a BSN (2013, p. 8). The BSN participants in this study were equivocal to the statistic stated by Budden et al.

Graduation. Rationale: *This is a crucial question because there was a great change that occurred in nursing during the 1970s. Nurses who graduated before 1980 (Baby Boomers and Vets/Traditionals), had a much different nursing school experience than those who graduated after 1980 (Gen X and Millennials). The Pill and Women's Lib, both established in the 1960s and 1970s, forever changed how women lived in the early 1970s. There were massive technological changes in the medical field such as the discovery of the CT (1971) and MRI (1971) machines, as well as blood glucose testing (1970). Most infectious diseases were eradicated via vaccines: measles (1964), mumps(1967), rubella (1970), pneumonia (1977), meningitis (1978) and smallpox was declared officially dead in 1980. Dialysis, hip replacements, and transplants—all initially discovered in earlier years and used at large teaching hospitals, were now available to more people due to technology, which changed the course of medicine. Nurses were no longer "handmaidens" to the doctors, but were colleagues, working in conjunction with them instead.*

The year of graduation, as well as the age of the nurse at graduation, plays an extensive role in what the nurse has experienced throughout his or her nursing career.

Before 1975, nursing was more of a low-tech holistic nature. I was a nursing student from 1973 to 1976. I remember carrying a recipe in my pocket to make IV solutions in glass bottles and living through the cap and uniform wars. In this study, one nurse graduated nursing school between 1960-1969. She remembered those same things and more. She agreed that nursing was different when we wore white uniforms, hose, shoes, and caps. The difference in our nursing experiences, however, was that she worked in a major teaching hospital that developed the first ICU and carried out the first organ transplants. I worked in a medium-sized hospital in the Midwest that was not as advanced. Table 9 lists the graduation dates for the 11 participants in this study. They cover a period of over 50 years.

Table 9

Graduation Dates of Participants in this Study

Graduation Date	*Number of Graduates*
1960-1969	*1*
1970-1979	*0*
1980-1989	*4*
1990-1999	*3*
2000-2015	*3*

By the time the next four participants graduated from nursing school in 1980-1989, one was given a nursing cap because she graduated from a diploma program. She never wore it again after graduation. She also wore a white dress uniform for several

years and then switched to scrubs. The other three never had a cap and never wore anything but scrubs. The cap and uniform were officially gone. When I ask nurses today in 2016 if they ever had a nursing cap with a black stripe on it to denote "RN" or wore a white uniform (dress or pantsuit), they do not know what I am talking about. When I ask nurses or patients over 55 years old, they remember caps, white uniforms, white hose, and polishing white leather dress uniform shoes—not athletic shoes worn today.

Dismayed that these symbols of a nurse are gone because they were so important when I in nursing school, this prompted me to ask a question of all of the participants because I wanted to know what the image of a nurse is now. When I had originally written this question, I asked: "What do you think of when you hear the word 'nurse'?" During the field test, the nurse, who graduated in the mid-2000s said things like scrubs, tired, and patient advocate. This was not what I was looking for. I wanted the visual description of what nurses think of when they think of a nurse. I wanted to know if they pictured the stereotypical female nurse complete with white cap and dress uniform that had been the iconic representation of nurses for over 100 years. I reframed the question to say, "When you hear the word 'nurse,' what is the physical image that you see?" Again, I did not get the traditional picture of a woman in a white dress uniform with a nursing cap. Instead, the participants provided the following descriptions of what they saw:

- "I see an older woman who is a slow listener but quick in terms of communicating….getting the job done….efficient and someone who really does care about people and making a difference" (P01).

- "A loving, soft, plain, caring, nurturing, matronly soft spoken gentle woman" (P02)
- "Sadly a woman. I don't picture the hat and the white uniform because nobody looks like that anymore" (P03)
- "Someone in scrubs with a stethoscope around the neck" (P04)
- "Someone tired and worn out after working all day. No white cap or pristine smile. When I think of a white cap I wonder how much MRSA is on it" (P05)
- "A healthcare professional" (P06)
- "A clean, neat, and pleasant person" (P07)
- "nurses in scrub suits…mostly women"(P08)
- "smile and neat" (P09)
- "professionalism, educated, honest, trustworthy, always putting patients first without compromise" (P10)

Even though the question asked for a physical description, most of the respondents provided attributes. The one remaining traditional identifying factor was that 40% said the nurse was female.

Years working. Rationale: *The amount of time a nurse has worked can have an influence on whether bullying occurs or not. It also impacts the present nursing shortage because nurses who should have retired in 2008 until today; did not, which artificially inflated the nursing shortage. Those who have worked many years (25+) have more incidents of Workers Compensation claims, are more prone to chronic illnesses, have*

more orthopedic injuries, and are at increased risk for being bullied. All negatively impact a hospital's bottom line.

The working range of nurses in this study covered a 54 year span. Table 10 shows the number of years each participant has worked as an RN. This much diversity in experience added a deeper dimension of richness to the nurses' lived stories.

Table 10

Years Working as an RN

Years Working	Number of Nurses
1-4 years	1
10-14 years	2
15-20 years	1
21-24 years	1
25-29 years	1
30-34 years	2
35-39 years	1
50-54 years	1

Type of nurse. Rationale: *This tells me whether I am dealing with a staff nurse, manager, faculty, or a student.*

Some of the nurses carried dual roles such as staff and charge. Ten indicated they were staff nurses, four were charge, one was a manager, and one did not presently work in the hospital, but worked out in the community. Many of the researchers who conducted studies since 2010 focused on who was doing the bullying, trying to determine if bullying was more horizontal or vertical. That question is not part of this study. The reason I asked the question was to determine if the circumstances surrounding each

nurse's story was similar to the rest of the sample. I discovered the stories are the same whether a staff nurse, charge nurse, or manager.

Nursing department. Rationale: *Some researchers purport that different nursing departments are more prone to bullying. What is the case in this study?*

The nurses worked in various departments throughout the hospital setting, both currently and in the past. Each of the studies I reviewed mentioned a different nursing department according to the area studied by the researcher as the one most prevalent for bullying. Looking at this globally proves that bullying occurs in all spheres of nursing. Table 11 lists the various nursing departments represented in this study. All of the nurses had worked in at least two different areas of nursing within a hospital setting, and one worked eight different areas so that the numbers will be more than 11 for the participants.

Table 11

Nursing Departments involved in bullying in this Study

Nursing Department	Number
Medical – Surgical (M-S)	10
Operating Room (OR)	2
Ambulatory Surgery	3
Recovery Room	3
Church/Community/Field Nursing	2
Long Term Acute Care Hospital(LTACH)	1
Newborn Intensive Care Unit (NICU)	1
Home Health	1
Nephrology	3
Pulmonary	1

Table continues

Observation Unit/Extended ED	1
Pediatrics (Peds)	1
Emergency Department (ED)	2
Intensive Care Units (ICU)	5
Oncology	1
Burn	1
Psychiatric	1
Post-Partum/Maternity	1
Newborn Nursery	1
Cardiology	2

Employment. Rationale: *Is there a predominant employment status that is bullied?*

Employment status revealed that eight nurses worked full time, two worked part time, and one volunteered. The nurse who volunteered worked full time and was forced to retire due to bullying. The two part-time nurses had been working full time when their bullying incidents occurred. In this study every nurse who was bullied worked full-time

Shift. Rationale: *Is there a theme that can be picked up between department worked, employment status, and shift? Is there a difference between shifts and bullying activity?*

The nurses were almost evenly dispersed between days, nights, and shift lengths. The correlation made from this information is that bullying occurs on every shift. Table 12 provides that information.

Table 12

Shift and number of nurses on each shift

Shift				
8 Hr Days	12 Hr Days	12 Hr Nights	10 Hr Days	Other
3	3	2	1	2

Gender. Rationale: *This study was written towards female nurses, as they comprise the majority of nurses. Is that still true for this study?*

Ten females (91%) and one male (9%) participated in the study. This figure correlates with the 9.6% male nurses in the United States (U.S. Dept. of Commerce, 2013, p. 2). The male nurse in this study denied being bullied as a nurse but stated he did see it occur with other male nurses. In the work world, 69% of bullies are male, and 57% of their victims are female (Namie, 2014a, p. 6). In the nursing work world, however, where the majority of the nurses are female, male targets account for 10% of those bullied (Namie, 2014a, p. 7). Whether a target is male or female, when the bully begins the process, at least 80% of targets will lose their jobs (Namie, 2014a, p. 8). The male nurse told of watching a male nurse mercilessly bullied. He said there was nothing he could do to help the bullied nurse because he was overweight, not handsome, and somewhat shy. The male nurse thought that these attributes were why the new nurse was bullied in the first place. The male nurse in this study also commented that he thought that was part of the reason why he did not get bullied because he had a bodybuilder's physique, was handsome, and outgoing. It could be that this nurse's physical appearance and warm personality deterred bullies, especially females.

Ethnicity. Rationale: *The majority of nurses is White, but as the United States is changing that configuration to include more diversity, is that true in this study?*

Race does play a part in bullying. Namie pointed out that Blacks are bullied or witness it 54%, Asians 53%, and Whites 44% (2014a, p. 9). In this study, seven (64%) nurses were White Americans, three (27%) were Black Americans, and one (9%) was Asian American. These numbers are comparable to the national average. Even though Whites make up the majority of nurses, their numbers are steadily decreasing. Table 13 demonstrates the changes:

Table 13

Change in Ethnicity 2000, 2008- 2010, 2016

Race	2000[a]	2008-2010[b]	2016, This Study
Asian	5.7%	8.2%	9%
Black	8.8%	9.9%	27%
White	80.4%	75.4%	64%

Note. Dept. of Health and Human Services, Trends in Supply and Education (2013)
[a]2000 census, long form. [b]2008-2010 HRSA analysis ACS (American Community Survey), three-year file found in DHHS citation.

One of the Black American female nurses told the story of how she was bullied when in nursing school because of her race. The Asian American nurse also stated the same thing but went on to say that even after nursing school the bullying continued.

Age. Rationale: *For the first time in history, four generations are employed together in the U.S. workforce:*

*Veterans/Traditionals: 1922 – 1945 (71 – 94)*ages for 2016*

*Baby Boomers: 1946 – 1964 (52 – 70)*ages for 2016*

*Gen X: 1965 – 1980 (36 – 51)*ages for 2016*

*Millennials: 1981 – 2010 (6 – 35)*ages for 2016*

Each generation embraces the work ethic in a different way, which can cause factions between coworkers. This can cause an increased number of bullies and bullied

In the U.S. DHHS, 2008-2010 ACS three-year file, 51to 55 year-olds made up 15% of the nursing workforce with the next highest percentage being the 46 to 50-year-olds at a little over 14% (2013, p. 22).

In this study, four were 30-39 years old = (36%)

- three were 50-59 years old = (27%)
- three were 60-69 years old (27%)
- one was 70-79 years old (9%)

According to Kelly et. al. (2015), Millennials (ages 21 to 35) suffered more burnout than the Gen Xers (ages 36 to 51) or Baby Boomers (ages 52 to 70) (p. 526). There is an interest in studying the work habits of Millennials vs. Boomers due to perceived differences in work ethics. It seems that the stereotypical picture of Millennials is one of leaving a job if not satisfied, whereas Boomers tend to remain and attempt to adjust.

The mix for the study represented all four of the generations. Neither the Millennial or the Gen X group would have experienced the cap and uniform wars or the major milestones in medicine that occurred in the 1970s because Gen Xers were ten years old in 1975 and Millennials were not born yet. By the time they entered nursing school, what the older nurses considered as high-tech—MRI and CT machines, blood glucose

monitors, kidney dialysis, heart transplants, and vaccines for most of the contagious diseases was now run-of-mill. The Gen Xers and Millennials are experiencing the technology boom in equipment and procedures that Baby Boomers and Traditionals only dreamed about. The perceptions regarding nursing care are quite divergent between nurses over 55 and young nurses who are 22.

Category 2: Bullying, RQ 1 and 2

RQ 1: What are the lived experiences of nurses being bullied by nursing colleagues?

RQ 2: What are the lived experiences of nurses who witness coworkers being bullied by colleagues?

When targets are bullied by coworkers and report the bullying to their managers, 71% are not believed, 20% are believed until the manager talks to the bully, and only 9% are believed from the first report (Namie, 2014b, p. 2). The problem that bullied employees must face is that upper managers will believe mid- and lower managers before they believe employees. If there have been past problems with the bullied employee, such as tardiness or a medication error, then upper managers definitely will not believe the employee about being bullied.

Start of bullying. Rationale: *Did the student come to nursing school having already experienced bullying? Did it start in nursing school or did it start after graduation at that first job? Multiple authors have stated they have found that it starts in nursing school.*

In this study, one participant stated she was bullied while attending nursing school. Three related that it started at the first job after graduation and the remaining seven indicated that it occurred at other times such as four years prior to retirement,

several years after graduation, five years ago, at the second job after graduation, the third job after graduation, and one is currently being bullied. There is no pattern or time frame related to when the bullying started.

Bullying has been documented even in the 1800s. Lim and Bernstein (2014) related that Florence Nightingale, better known as the "Lady with the lamp," displayed two distinct personalities (p. 124). On the one hand, she was always advocating for the patients and spent her time training nurses how to care adequately for their patients. On the other hand, she was noted to be quite inflexible, demanding, and mean (p. 124). When Ms. Nightingale opened her nursing school in England in 1860, there were 60 students. Four years later, only 25 remained (Lim & Bernstein, 2014, p. 125). During the Crimean War (1853-1856), Ms. Nightingale was in charge of the nurses. She started out with 229, 40 resigned, which equaled 17%, and by the end of the war, only 17 nurses were left including her (Lim & Bernstein, 2014, p. 125). Notes found from nurses that served under her during the Crimean War, described her as disrespectful and a difficult person with whom to work (Lim & Bernstein, 2014, p. 125). Workplace bullying was in full force even then. It can be argued that Ms. Nightingale did not bully her subordinates, but they were too sensitive to her strong leadership, which was needed when formalized nursing was in its infancy.

Absenteeism due to bullying—RQ1, RQ2. Rationale: *Absenteeism is a red flag indicating a person is being bullied. If there is a higher number of absent nurses on a regular basis, or certain nurses are absent in a distinct pattern may point to a bully problem within that department*

In this group, only one nurse could recall another nurse consistently missing work. By the time of our interview, that nurse was on a leave of some sort. The nurse, who was the manager, was not sure if it was medical or FMLA, but did suspect bullying outside of work.

The precursor to attrition is absenteeism. A part of absenteeism is presenteeism in which the nurse is present and has the outside motions of working but on the inside is far away from the job and disengaged from the situation at hand. Wilson et al. (2011) stated 95% of nurses affirmed absenteeism is an after-effect of bullying, and 20% of those stated they had done so themselves (p. 456). Nurses eventually must make a choice—quit the job, face the bully and risk losing the job, or avoid the bully by not coming to work. Nurses tend to call off work and avoid the bully rather than face them for another shift (Liu et al., 2015, p. 4). Again, this type of behavior is a detriment to the financial status of a hospital.

Shame. Rationale: *Shame keeps a nurse from addressing the bullying. It can be so devastating that it can cause all types of medical and psychological issues. The person experiencing the shame will deny there is any, but it will come out in his or her actions.*

P02 had this experience:

> I was "publicly disciplined in front of family members, other nurses. Being made fun of….laughed at….rolling the eyes….it just started from day one…the bullying …never being comfortable….never being able to ask questions without an attitude behind it…I remember I would come home and cry….it was awful."

> "I feel like I really can't talk to anybody about it because no one understands and then I feel like a crybaby and I look like a victim. I feel I have no one to talk to about it because if you're not a nurse and lived it…you don't understand because people don't understand how nurses can bully. Even hearing myself talk about it makes me feel like I'm this hypersensitive person. Until you've been through it….until you've suffered through it…it is ruthless…and …it…doesn't ….stop….it's cutthroat, nursing is….it's like war….it's psychological warfare out there….it's just really bad."

Bullying and Coworkers, RQ2. Rationale: *Witnesses have two experiences with bullying. The first one is observing the bullying between two coworkers. The second experience is in dealing with the feelings after deciding whether to help or not*

Attrition related to bullying amongst nurses has not been studied well with even less research regarding the impact on nurses who have witnessed bullying. While bullying amongst nurses has been studied extensively throughout the world, there is a paucity of literature in the United States (Simons & Mawn, 2010, p. 306). According to Namie (2014a), in the United States, 21% of employees have either witnessed a co-worker being bullied or they know of it happening to a coworker (p. 3). According to Stagg, et al. (2013), nurses who witness bullying are impacted more so than the bullied nurse (p. 333). Older nurses express humiliation and distress when they observe co-workers being bullied (Longo, 2013, p. 952). Those bullied and those who witness it sort through feelings and emotions that directly affect career decisions. The career decision will ultimately affect the hospital's bottom line.

When a nurse is bullied or witnesses another nurse being bullied, frequently there is physical and emotional distress. Namie discovered that witnesses suffer just as much trauma physically, psychologically, and emotionally as those who are actually bullied (2014a, p. 4). The stress of being bullied or witnessing it diminishes the nurse's concentration, and accidents occur, to the nurse or the patient in the form of medical errors. In a survey of 2000 participants, 7% stated they had made a medication error as a direct result of being bullied (Clarke, Kane, Rajacich, & Lafreniere, 2012, p. 270). I posit that 7% is a conservative number for medication errors, as nurses do not admit to making them in fear of retaliation, job loss, and a revoked nursing license.

Targets suffer blows from both the bully and the witness. First, by the bully and then second by the witnesses reasoning that if the target does not fight back, because either he or she cannot or will not, in either case, deserves to be bullied (Namie, 2014a, p 18). Namie asked targets if they believed that their coworkers helped them. Forty-one percent agreed their coworkers did nothing to help them, and when witnesses were asked the same question, 30% admitted they did nothing to help (Namie, 2014a, p. 13). There are many reasons as to why a nurse would not go to the aid of a coworker, and the first one is fear of retaliation and job loss due to the bully.

An interesting caveat to this study was the way the participants answered two questions about witnessing bullying. In the first question, I asked: "Are you currently witnessing a colleague being bullied?" P04 said "Yes" and then said "No." Telling a story of witnessing two nurses being bullied, relating that both the bullied and the witness had confided about their separate situations. Another participant who answered "No"

actually talked about witnessing bullying in others during the face-to-face interview. When asked about this, the nurse said I see "other nurses…other new nurses [getting bullied]…I think they would call it like initiation of a new hire, to see if they're going to make it per se….One person, the bullying lasted all her tenure here" (P06). I asked P06 if any other nurses had divulged they were being bullied, and the answer was "Yes." Another participant, P09, stated that a good friend who worked in another hospital had confided "she felt her manager was bullying her."

I asked another question "Have any other nurses come to you to tell you they have been bullied or have witnessed it?" Six said "Yes" and five said "No". Here is what they said in response to these questions:

- "Comradeship with them. I know how that feels"(P01)
- "I was mad. I wanted to get up in the other person's face and tell them that it wasn't right….felt shame and embarrassment for them…You don't want to rock the boat and say anything unless it gets really bad" (P04)
- "I had a range of emotions….it makes me angry to see them go through the same thing I went through. Of course, there's empathy for the person who's being bullied because you were in their shoes. Sometimes I would try to intervene with what was going on if I was able to. I would pull the coworker aside whether it was the bully or the person being bullied and have a conversation with them. Of course the ones that were doing the bullying weren't very willing to want to have a conversation…and then they'd turn their attention to me….I think sometimes for them (bullied) to know someone that has been in the same situation…and to

know that they have someone to turn to makes them feel a little bit better. We tried to make changes in the work environment, but unfortunately most times we were unsuccessful" (P05)

- P04 told me "In one instance…I asked her (bullied) 'How bad is this, do you feel like you have to leave or quit to get out of it?' She said 'No,' but she wished it would stop. She kind of toughened into it. She got a little feisty. By the time she left she was holding her own"
- "One of the nurses I trained told me he was being bullied….the other nurse said in front of the patient 'Oh my, you don't know what this is?' or 'you didn't do that?'….I let him know a couple of mistakes the other nurse made" (P09)

I asked the nurses this question: "How do you cope with the bullying?"

- P02 stated she "used to internalize it, but now she reports it, although it does not help"
- P03 said "talking with the person was the thing to do"
- P07 coped by "concentrating on doing a good job and prayer"
- "I was going to quit but a new person came to our unit…she helped me get through it until the next person came along and the bullies moved on to her" (P08)
- P10 is "thankful to have a job and does not let it bother her…I cannot help what people think or do….they're just jealous"

Another question I asked, "If your coworkers were asked if they were being bullied or have seen it in others, do they immediately deny it and don't want to talk about it—changing the subject, etc.?"

- P02 stated "Some nurses burst out in tears and cry their heart out…or I've had 'No, I'm fine' because they don't want to rock the boat…they don't want to talk about it…because they know it's the culture of the place….because people are desperate to keep jobs….but it's a fearful place"
- P04 stated her friend wouldn't talk about it because she was too close to the situation
- P05 related her experience was 50-50 between nurses that wanted to talk about what happened and those that did not. "I think they're just afraid of retaliation….they don't want to stir up trouble…..they don't want to talk about it"
- P06 had this to say: "your research has actually generated a lot of conversation…..I had someone ask me today how the bullying research is going"

After the research was completed, I talked to P06 again and was told that one of the other nurses who I interviewed had actually stepped down from charge position back to staff, and the reason was bullying.

There were two questions I asked in the demographic questionnaire that were telltale signs of a person being bullied. The first question was "Do you know anyone who has an 'I'm better than you' attitude?" Eight nurses indicated "Yes" and three indicated "No." The second question was "Do you know someone who is always "having a bad day, nothing goes right, no one cares, angers easily/has a 'short fuse', or cries easily for no reason?" Table 14 displays the results.

Table 14

Do you know someone who is always…

Do you know someone who is always…	
Having a bad day	8 = 73%
Nothing goes right	8 = 73%
No one cares	7 = 64%
Angers easily or has a "short fuse"	6 = 55%
Cries easily for no reason	2 = 18%

I was surprised to see such high percentages for each of the attitudes except the last one "Cries easily for no reason." Such a large proportion of these opinions demonstrates a far larger problem regarding bullying within the hospital setting. All of the participants checked more than one attitude in the demographic questionnaire, and two checked all five. Responses to these questions in the interview were:

- "Yes, the short fuse….there was a gloomy presence about her….quick to anger" (P01)
- "I've met so many nurses in the past that are angry usually due to management…lack of support, lack of help….lack of support against bullying" (P02)
- "Yes, I did know someone that was angry all of the time….because she was getting burned out and she felt that she was dumped on. She was willing to go the extra mile and management expected her to do it" (P04)
- P11 stated that the preceptor was "always angry…nobody ever did anything right at work…nobody ever did anything right but her….she's angry and nasty to people….When you said her name what followed it was 'she's nasty'"

Category 3: Choices, RQ 3

RQ 3: How does the bullying experience of nurses impact career choices post the bullying experience? (Bullied Nurse and Witness)

Choice. Rationale: *The choice a nurse makes regarding career choices affects the nurse and family. There can be medical and psychological consequences associated with the decision*

The intent to leave is a grave concern regarding nurses. Exposure to harmful behaviors and bullying increases the intent to leave, hampers motivation, and causes psychological upset and psychosomatic illness (Trépanier, Fernet, & Austin, 2012, p. 387). The manager should not be surprised when the nurse leaves, as 40% of bullied nurses will leave their position or the nursing profession after hinting at being dissatisfied with the job/work environment (Stagg et al., 2013, p. 333). Nurses, just like "regular" people, can only take so much stress. Nursing itself is a stressful job and adding bullying to the mix only cements in a nurse's mind that leaving is the only choice. Once the nurse hits that threshold and the decision to leave has been accepted in the mind, then the attitude changes and the hunt for a new place of employment becomes the top priority.

Namie (2014a) asked a similar question to mine: "What stopped the abusive treatment?" His findings revealed that 61% left their job, either voluntarily or by termination (p. 14). He also noted when the target chose to quit the job; it was due to increasing health problems and intolerable working conditions (Namie, 2014a, p. 14). I posit that some nurses will leave before their health deteriorates because they have admitted to themselves that the pain is not worth it.

I asked the question "What career choice did you make to stop the bullying?" Five of the eleven (45%) chose to do nothing while six of the eleven (55%) opted to move out of the situation. Then I asked, "If you had it to do over, would you have handled it the same way?" Four (36%) said "No" and six (55%) said "Yes."

- P08 stated "Nothing was done because someone new came along and they bullied them." "I don't think so (done anything differently). I might have been a little tougher skinned…I might not have come home and cried every night, or I might have confronted them sooner"
- P10 had stated the choice to do nothing career-wise did not solve the problem as it was currently happening
- "I was **relieved** when I left. I learned a ton, but I got burned out and I did contemplate leaving nursing forever" (P03)
- Another nurse, P04, stated that the choice of leaving the place she was at and going into a different nursing field was the best thing she had ever done. Now, she "works for a company that treats me like a human being"
- P05's reaction to speaking to the manager after being bullied did not solve the problem. "It needed to be brought to attention and talked about….You gotta weigh whether you can afford to lose that job. I did have to take that in to consideration"
- P01 felt forced to retire and was not happy with the decision. P01 stated, "I laid on the couch for the first five days with a migraine because you can't stop a freight train. You can't go from working 60 hours per week down to nothing. I

remember watching the trash truck come by. I had never seen that. I took pleasure in watching it pick up the trashcan and dump it in the truck"

- P04 commented regarding leaving the job. "By that point I was glad. At first, I was very angry that she made me feel worthless after it was all over and I got my new job and I realized that I could do something. I was really excited….I was glad that I left"
- P07 said, "Honestly, I was relieved and glad to get away from being blamed for all of the unit's problems"

I asked another question: "If you had not been bullied or witnessed it, would you have left the employer anyway?" Six (55%) said no and four (36%) said yes. One was unsure. P04 had said, "Yes." She added, "At the time I had intended to return after surgery but bullying got to the point that I left the hospital. I was bullied by my manager and more than one person was bullied by her"

Category 4: Bottom Line, RQ 4

RQ 4: How does the RN turnover rate impact the bottom line of a hospital, both indirectly and directly in costs?

Although the exact percentage of nurses who are bullied or have witnessed it is not known, it is known that the resultant outcomes of it are quite hazardous to a hospital's finances. In 2007, two million people left their jobs, which cost organizations an estimated $64 billion (Olive & Cangemi, 2015, p. 21). Bullying affects a hospital's reputation, it ability to recruit and retain top talent, and erodes into an already strained hospital budget. Papa and Venella (2013) noted that it costs one hundred times more to

fix a bullying problem than to take preventive measures (p. 4). Using the 11 participants for this study, I demonstrated how much it would cost a hospital to replace them. This exercise can be read in the "Direct Costs" section.

In 2012, Namie conducted an instant poll on his website and asked this question: "What will it take for the majority of U.S. employers to take workplace bullying seriously and stop it?" (p. 1). Here are the results:

- 31% will never stop, it serves a purpose
- 30% will stop when forced to by law
- 23% will stop when they lose enough money
- 12% will never stop because they do not know how to stop it
- 4% will stop it because it is the right thing to do (Namie, 2012, p. 1).

Fifty-seven percent of respondents believe the employer will stop bullying when it costs too much money to ignore it, the law forces them to, or they determine that it is the right thing to do to stop the bullying. The other side is that 42% do not believe it will ever stop.

Hospital executives and risk managers can be lulled into a deceptive degree of calm if there have been relatively few bullying incidents reported and none litigated, causing them to ignore what will probably happen in the next fiscal year (Papa & Venella, 2013, p. 6). It is this inaction that will profoundly impact the hospital's financial bottom line due to the lack of allocated funds to absorb the cost of even one litigated case.

Those involved in the day-to-day management of a hospital should be concerned about how bullying affects the bottom line. In the general workplace, the cost can run into trillions of dollars or about 7% of revenue for theft, vandalism, presenteeism, absenteeism, and clocking in late and out early (Siegel Christian & Ellis, 2014, p. 193). When a nurse burns out and has decided to leave the organization, the fear of the consequences of any deviant behavior is gone (Siegel Christian & Ellis, 2014, p.194). Destruction of property and theft can be a priority for the nurse, especially if trying to retaliate against a system and the people who have caused this dissatisfaction (Siegel Christian & Ellis, 2014, p. 203). Siegel Christian and Ellis noted in one study of nursing, 92% stated they had stolen property, and 32% had taken prescriptions from patients (2014, p. 202). Both of these statistics are alarming in light of the opioid addiction epidemic in the United States. It is quite unsettling to know that if a patient goes to the hospital and experiences pain, there may not be anything but plain water given in the IV or "sugar pills" given because the morphine, Dilaudid or other narcotics were stolen.

In 2013, Namie conducted a survey of U.S. business leaders that included owners/partners, administrators, and presidents/vice presidents (Namie, 2013, p. 1). In this survey, Namie asked the business leaders their opinion of workplace bullying. The results were 68% viewed it as a serious problem, 15% thought it was not important, and 17% never heard of it (Namie, 2013, p. 2). Namie then conducted an instant web poll of bullied employees, asking them what they thought their owners or upper management leaders' beliefs were regarding workplace bullying. The perception of how their leaders viewed bullying was this: 76% believed leaders felt that bullying was not significant, 9%

perceived that their leaders thought it was a serious problem, and 15% were of the opinion their leaders had never heard of bullying (Namie, 2013, p. 2). The comparison of these two questions confirmed that business leaders do not take bullying seriously. Fifteen percent of leaders thought it irrelevant and 76% of bullied employees agreed that their leaders thought it was irrelevant. Both were even in the belief that they had never heard of it—15% for bullied and 17% for leaders. The difference in opinion was in how leaders viewed bullying, which was (68%) vs. how bullied employees thought their leaders saw bullying (9%). It would appear leaders state that bullying is a serious problem because they want to sound socially appropriate to others, but within the workplace, they project a different attitude of not caring because employees do not see any advancement toward stopping the bullying.

Another interesting facet to this survey is the next question Namie asked leaders. He asked them what their companies were doing to address workplace bullying. Thirty-two percent stated they did not have bullying in their organization (Namie, 2013, p. 4). How can 68% of business leaders say that bullying is a serious problem, yet 32% then state there is no problem? That is almost half of the leaders denying what they just said. In Namie's survey, 88% of bullied employees indicated no action had been taken (Namie, 2013, p. 5). Additionally, 23% stated that HR handles bullying issues, which means the leaders are ignoring what is happening or else relying on HR personnel to do what is right, but not following up to make sure (Namie, 2013, pp. 4, 6). There is a popular trend for business leaders to outsource the HR department. In reality, neither the HR personnel nor the business leaders actually know what is going on. The other side to this

is that 18% were raising awareness, 16% had policies/procedures in place to address this issue, 6% had made it a top business priority, and 5% had acted in a bullied employee's behalf (Namie, 2013, p. 4). Bullied employees, however, only thought 4% had raised awareness and 33% believed that the policies in place were useless (Namie, 2013, p. 4). I would have to agree that the policies are not adequately implemented. If the department head is the bully, who is going to be enforcing the policy? In the hospital setting, nurses are held tightly to rules, policies, and procedures with the threat of dismissal always hanging overhead. This set up allows the bully to hide behind policies and procedures, carrying on the bullying with only a slight chance of being discovered.

Hospital administrators will not talk about bullying occurring within the walls of their hospitals. Neither will HR representatives. Consequently, there is very limited information regarding the costs that hospitals carry yearly related to bullying (Al-Ahmadi, 2014, p. 425). Papa and Venella posited that in a lawsuit, administrators could expect to pay $3.1 million per person/incident. The yearly cost has been estimated to be $120 billion (2013, p. 3). In trying to keep up with budgeted expenses, adding these types of numbers to a budget can be disastrous. The reason is fear if the public were to learn that bullying occurs in the hospital, then patients would not want to be treated at the hospital, and prospective healthcare personnel would refuse to work there. Eventually, the hospital would become insolvent due to the poor reputation.

When I was approved by the IRB to commence with research, I reached out to many HR representatives all over the United States through LinkedIn. No one would talk to me. Some stated they were afraid of losing their jobs. To figure out how the hospitals

were faring in the sample for this study, I had to use a different approach. I asked each nurse about salary and benefits. The results were discussed in the "Direct Costs" and "Indirect Costs" sections of this chapter.

There is more at stake here than just money. For every 10% of nurses who are dissatisfied with their jobs, 2% of patients will not recommend the hospital for future patient care (Ulrich, Lavandero, Woods, & Early, 2014, p. 65). If patients have a choice for their hospital care, they will not choose a hospital known for bullying, which affects the hospital bottom line further.

Nurses often change their opinions about their jobs after enduring bullying. Instead of working out of a desire to help others, they work out of a sense of pressure because they need the job, increasing the intent to leave the position as soon as another one is secured. Bullying affects the organization by negatively impacting the productivity and promoting deviant behaviors such as theft and sabotage (Fahie, 2014, p. 20; Olive & Cangemi, 2015, p. 21). The result is that the hospital the nurse left must now find a replacement, which can carry a hefty price tag. It is costly and time-consuming to recruit, hire, and train personnel just to have them go back out the door. Managers, nurse leaders, hospital executives, and policymakers need to make it a priority to make their hospital workplace safe and an inviting place to work.

Direct costs. Rationale: *Nurses may not be intimately acquainted with the actual costs that a hospital experiences, but they can provide a general idea, enabling the researcher to deduce the actual cost. These can then be compared with the information in chapter two.*

There are so many hidden or indirect costs to replace a nurse that calculating the costs can be daunting. Table 15 lists many of these costs

Table 15

Direct Costs When a Nurse Leaves a Hospital

Direct Costs	
Recruitment	Flyers, postcards, emails, letters, radio/TV/newsletter ads Headhunter fees Job fairs—open and invitation only Resume review Interview by HR, department manager, employee health Drug screen, vaccinations College visits to recruit Shadowing and student nurse tours
Hiring	Salaries/insurance/benefits Sign-on bonus Relocation/moving expenses
Training	Seminars Classes Orientation Brown-bag lunch lectures Yearly required training: CPR, ACLS, PALS, etc. Credentialing classes Mentorship after hire
Retention	Bonuses Tuition reimbursement Credentialing fees License fees Subscription fees
Table continues	Conference fees

	Travel reimbursement
Temporary Replacements	Agency nurse pay Overtime to staff nurses Lost wages Revenue loss r/t ↓ staff and disgruntled patients
Vacations/sick days	Pay for time off Short-term disability Long-term disability
Insurance	Medical/dental/vision/life Health & wellness support Workers Compensation FMLA Medicare taxes Malpractice Insurance
Insurance Claims	Medical Workers Compensation Short Term Disability, Long Term Disability
Health & Wellness	Subsidized gym memberships Smoking cessation Health & Wellness programs Lab screenings
Hardware	Furniture Office supplies
Legal	Discrimination suits, work comp claims, wrongful death, wrongful termination Malpractice claims

Siegel Christian and Ellis (2014) noted it takes 1.5– 2.5 times the nurse's salary plus benefits in replacement costs for each nurse (p. 203). I asked the nurses what their yearly wages were without overtime.

- $40,000.00 – $49,000.00 = 1 (9%)
- $50,000.00 - $59,000.00 = 2 (18%)
- $60,000.00 - $69,000.00 = 7 (64%)
- $70,000.00 - $79,000.00 = 1 (9%)
- $80,000.00 - $89,000.00 = 2 (18%)

The majority of nurses made between $60,000.00 and $69,000.00 per year. The national mean wage is $71,000.00 and the study state is $62,800.00. The 50th percentile for the nation is $67,490.00 and the state is $61,280.00 (U.S. Dept. of Labor, 2016, p. 1). The wages in the state used for this study reflect the national average. Table 16 shows how much it costs to replace a nurse's salary in this study without benefits at 1.5 and 2.5 times.

Table 16

Cost to Replace Nurses in This Study at 1.5and 2.5 Times Salary

Nurses Salary	Number of Nurses	1.5 x Salary	2.5 x Salary
$40,000.00 (low)	1	$60,000.00	$100,000.00
$49,000.00 (high)	1	$73,500.00	$122,500.00
$50,000.00 (low)	2	$150,000.00	$250,000.00
$59,000.00 (high)	2	$177,000.00	$295,000.00
$60,000.00 (low)	7	$630,000.00	$1,050,000.00
$69,000.00 (high)	7	$724,500.00	$1,207,500.00
$70,000.00 (low)	1	$105,000.00	$175,000.00
$79,000.00 (high)	1	$118,500.00	$197,500.00
$80,000.00 (low)	2	$240,000.00	$400,000.00
$89,000.00 (high)	2	$267,000.00	$445,000.00

Christie & Jones (2014) affirmed in 2012, it cost $92,000.00 to hire and orient a medical-surgical nurse and $145,000.00 for a specialty nurse (p. 3).

When I asked the benefits questions, many questions went unanswered either because the participant did not know how much was paid, or was on their spouse's insurance, or was retired. Regarding paid vacations, one knew there were two weeks of vacation, three did not get any benefits, and the remaining seven did not know how much vacation they had as they accrued it according to hours worked each week. If the average yearly wage is $64,000.00, the average 401K match is 4.16% = $2,662.40, and the benefits, health, dental, and vision, short-term disability, extra life insurance, and Accidental Death & Dismemberment equals $318.67; that is an additional $2,981.07 extra to add to the salaries.

Table 17 shows the cost to replace a nurse in this study with the following benefits:

Table 17

Average Cost Paid for Benefits by Nurses in This Study

	Average	Notes
Salary	$64,000.00	Range: $40,000.00 to $80,000.00
401k	4.16%	2% to 6%
Health insurance bi weekly	$227.00	Bi-weekly. $122.00 to $320.00 5 did not have health insurance.
Dental	$16.80	Bi-weekly. $10.00 to $25.00 7 did not have dental insurance

Table continues

Vision	$9.62	Bi-weekly. $7.00 to $12.00 7 did not have vision insurance
STD	$14.50	Bi-weekly. $12.00 to $17.00 10 did not have STD insurance
LTD	$0	No one had this or knew what they paid for it
Extra life insurance	$23.25	Bi-weekly. $9.00 to $35.00 7 did not have this
AD&D	$27.50	Bi-weekly $15.00 to $40.00 10 did not have this

In Table18 the adjusted costs including salaries and benefits are presented.

Table 18

Adjusted cost to replace nurses at 1.5and 2.5 times salary

Nurses Salary + Benefits	Number of nurses	1.5 x Salary	2.5 x Salary
$42,981.07 (low)	1	$64,471.60	$107,452.67
$51,981.07 (high)	1	$77,971.60	$129,952.67
$52,981.07 (low)	2	$158,943.20	$264,905.35
$61,981.07 (high)	2	$185,943.20	$309,905.35
$62,981.07 (low)	7	$661,301.23	$1,102,168.70
$71,981.07 (high)	7	$755,801.23	$1,259,668.70
$72,981.07 (low)	1	$109,471.60	$182,452.67
$81,981.07 (high)	1	$122,971.60	$204,952.67
$82,981.07 (low)	2	$248,943.21	$414,905.35
$91,981.07 (high)	2	$275,943.21	$459,905.35

At this adjusted rate, the cost difference between the salary and the salary/benefits is $4,471.60 at 1.5 times the salary/benefits and $7,452.67 at 2.5 times the salary/benefits.

The following exercise will bring into perspective what it would cost a hospital to replace these 11 participants' salaries and benefits. Take the figures from the 1.5 x column from the low end of each section and add them together as demonstrated below. The total cost to replace the 11 participants would be $1,243,130.84.

$64,471.60

$158,943.20

$661,301.23

$109,471.60

$248,943.21

$1,243,130.84

Conducting the same calculation with the high end of the salaries + benefits at 1.5 x would = $1,418,630.84. The cost to replace the 11 participants' salaries + benefits at 2.5 x would equate to $2,071,884.64 at the low end and $15,229,687.00 at the high end. Bullen (2013) related that the national nurse turnover rate is 20% (p. 3). Using 20% for our rate, to represent what it would cost using the 11 participants, they would have to come from a hospital employing 55 nurses. This exercise, however, does not include all of the other direct and indirect costs to replace one nurse. The American Federation of State, County and Municipal Employees (AFSCME) (2016) calculated the cost to replace 20% of a 400-nurse roster in one year. The cost to replace one general nurse was $10,800.00. The hospital would have to replace 80 nurses in one year. The direct costs may be about $800,000.00 per year, but this only shows 24% of direct costs for a general

nurse and adding the indirect costs makes the total closer to $4 million (p. 1). With numbers like these, it should be extremely disconcerting to a CFO and other upper management leaders when calculating the next year's budget, especially if the leaders deny that bullying is a problem within their organization.

Indirect costs. Rationale: *Nurses will be able to provide a much more detailed picture of indirect costs because they are affected by them: absenteeism, presenteeism, tardiness, poor morale, etc.*

Indirect costs are difficult to identify and quantify. Indirect costs are characterized by decreased employee commitment and effort (presenteeism) and wasted time in talking about the problems instead of working (Simons & Mawn, 2010, p. 306). Bullies will spend time setting up the nurse with such serious and potentially life-threatening actions as hiding lab tests, changing the medication drip rates on IV pumps, and purposefully sabotaging the patient charts. All of this leads to negative work performance, workers compensation claims from accidents, and medical leave for physical or emotional injuries (Gaffney et al., 2012, p. 1-2). Calculating indirect costs related to bullying on paper appears elementary, but the real problem occurs when researchers attempt to quantify the list. Refer to table 19 for a partial listing of indirect costs.

Table 19

Indirect Costs to a hospital

Indirect Costs	
Productivity	New RN orientation time = ↓ productivity
	Poor morale →poor quality of care→↓ productivity→ dissatisfied patients→complaints to insurance company→sanctions/decreased reimbursement
Damaged reputation	↓ staff, ↑workload, ↓patient satisfaction, ↓patient volume,↓reimbursement
Interviews	Lost time and money when managers meet with prospective employees
Absenteeism	Time off work
	Time for coming to work for part of shift and then home + overtime for nurses left to carry load
Presenteeism	Lost productivity
	Poor morale = poor patient care = dissatisfied patient = poor survey scores = decreased or no reimbursement by insurance or government
Tardiness	↑workload of nurses this shift OT pay for nurses on prior shift that must stay to cover workload → angry nurses→job dissatisfaction→nurses leaving
Poor quality of care	Can result in medical errors, extended hospital stays, dissatisfaction of patient/family, poor hospital survey results→↓ hospital reimbursement→↓revenue, poor reputation→↓patient volume
Tacit knowledge	Cost of lost knowledge when a nurse leaves

I asked the question, "When the nurses left (on leave or quit) how did this affect you?" P04 stated, "Financially, I got overtime. That was good….physically, it was more work, and I was more fatigued at the end of the shift. Emotionally, that was tough. I was close to them and hated to see them go." P09 stated the same thing. P06 said that "productivity drops." I asked P10 how many times a week does an employee call off, and you have to help carry the patient load. The answer was "every day for me. I work four days a week." I asked, "When nurses are not at work, how does this affect the remainder of the staff?" P04 stated that the workload increased because "we have to pick up the pieces, and we were already overloaded." P06 echoed the same feeling as well as P10.

Of particular note are absences. Absences and tardiness cost more than $3 billion in the U.S. yearly or the equivalent to 15% of payroll (Liu et al., 2015, p. 3). The costs related to absenteeism and presenteeism are increasing job dissatisfaction, increased last minute call-offs, repeated episodes of sickness, decreased quality of work, productivity, and engagement (presenteeism—the employee is physically present at work but not engaged in work), and eventual interpersonal and intrapersonal relationship difficulties (Lee et al., 2013, p. 263). Bullying is a contributive factor to the escalation of indirect costs (Longo & Hain, 2014, p. 195). Damage to a hospital's reputation can have significant financial repercussions.

Hospital administrators. Rationale: *Hospital administrators can bully managers and staff in the form of policies, rules, etc. This type of behavior is not routinely thought of as bullying.*

Hospital administrators in particular will not readily admit that bullying takes place within their walls because they are afraid of the ramifications of a tainted reputation and loss of revenue. These two situations seriously impede any accurate fact-finding of researchers (Gaffney et al., 2012, p. 1). Employers can either admit there is a bullying problem or deny it. Namie noted that 25% of employers deny there is a bullying problem within their organization, 16% do not believe it is a serious problem, 15% rationalize it as good for business, 11% defend it, and 5% actually encourage it (2014a, p. 12) totaling 72% with a positive attitude toward bullying. Since bullying is known to exist in the healthcare profession, then it would seem appropriate that it would exist as a tool for managers to use to increase productivity. Do managers, supervisors, and nurses use bullying as a management tool? This question provides some interesting thoughts. Barber (2012) stated that management styles range from laissez-faire to bullying with no clear-cut lines to let managers know they are bullying subordinates instead of encouraging them to be more productive. Those very people that use bullying tactics on subordinates to get more work done do not realize or even consider their actions as bullying because they believe they are utilizing a management tool.

The problem all nurses face is that they are under direct pressure to meet expectations from the federal government as well as their hospital administrators regarding patient care and outcomes. Hospital administrators are in fierce competition for every dollar, and demand the nursing managers in each department attain top ratings on each discharge survey so insurance and CMS will reimburse the hospital (Kelly et al., 2015, p.522). Those who do not gather top marks face bullying or termination, which is

vertical violence. It starts with the vice president and moves down to the department manager, who, in turn, bullies the staff nurses. There are cameras throughout the department, as well as tracking devices on each employee's name badge to make sure they are carrying out their assignments and meeting expectations. There are people—nursing supervisors, charge nurses, and peers who are watching each other's moves, which provides the bully an exceptionally easy access to attack prey. The concept of nursing as a nurturing, healing, and caring type of job has faded, replaced with corporate nursing because administrators are more concerned with the financial bottom line than the medical bottom line. Younger nurses (20%) will choose to leave the nursing profession within the first year of working (Kelly et al., 2015, p. 526), leaving the most experienced nurses to carry a more strenuous load. When nurses are strained beyond their capabilities, patient care suffers as nurses themselves suffer from compassion fatigue, leading to a decrease in patient satisfaction scores on the hospital surveys.

I asked the question, "If you are a manager, do you feel that the hospital administrators bullied you to make your employees perform up to expected standards?" P01 said "Yes…the bully bullied me. I was mentoring a nurse with problems. She was making progress, but the bully didn't like her. One day the mentoree took a vacation and never returned."

Managers who have agendas for climbing the corporate ladder will intimidate subordinates for two reasons. One is to show power over the employee and the second one is to be recognized by upper managers so a promotion can ensue. Managers use three tactics: Posting changed work schedules and policies without advising staff of the

changes, then writing up offending nurses; pointing out employee errors in nurse staff meetings; and using performance reviews as a veiled threat to coerce employees or terminate them (Longo & Hain, 2014, p. 195). Managers carry out their bullying by hiding behind established department policies.

I asked a similar question to those participants who were not in a management position. "Do you feel that your hospital administrators bully you through your managers or some other way?"

- P03 answered, "Not me personally, but people with the BSN stuff…I feel like they're fooling with them….Or they (upper management) would send out an email that on a certain day (that day) no one (Nurse Practitioners) will be here at night. None of the nurses on the night shift would know what was going on"
- P03 continued with explaining that upper management "would tell the nurses that they wanted their questions but had no answers because they were still working on a process that started in a few weeks and despite questions or complaints from the nurses, advised that they were going to go through with their plans"
- P09 stated, "All they're worried about is making money and the numbers"

Depending on the nurse's constitution, when she cannot face the bully anymore, she becomes physically ill to the point that she may have to take a medical leave in order to recover; an example of an indirect cost for the employer.

The last question I asked in each interview was "Do you feel free to talk to your nurse manager about being bullied or witnessing it?" Three (27%) said "No" and eight (73%) said "Yes." P03 related that she did not feel free to talk to her manager but that she would. "I don't think they'll do anything about it." P04 stated that, "It's my manager that is being bullied by her manager. We talk about it. She's trying to decide whether to return back to her previous setting so she doesn't have to face her anymore."

Summary

In this chapter, I presented the results of my study, focusing on answering the four research questions. There were 11 participants in this study, and each brought a different story but the same theme to the interviews. The theme was that they had, or currently were experiencing bullying and some had, or were currently witnessing it. Each nurse was dismayed this was happening and even though each one had made various attempts, there was nothing that stopped it. Each nurse spoke about being forced to make a career choice, whether it was to leave a loved job or retire. Some were at the point of considering leaving nursing altogether.

I experienced two different conversations after completing my data collection. One of the interviews I conducted was three nurses who worked in one facility. Before I even came to the facility to interview two of the nurses, the manager (one of the interviewees) stated there was much conversation about this "bullying research." Employees were talking about bullying, excited to hear about my findings. One of the nurses I interviewed was a charge nurse. During our interview, this nurse spoke of current bullying and stated rather matter-of-factly that it was understandable because the

other nurses were just jealous, admitting during the interview that bullying was not new—it had been going on most of this nurse's career. I spoke with this nurse's manager a little over a week later. The nurse had since stepped down from the charge nurse position, returning to a staff nurse position and publicly stated the reason was bullying. The manager was surprised.

The next incident occurred while I was writing up my findings. A nurse emailed me from the original mass emails, which no one had answered, and stated that she wanted to talk to me but was afraid to respond to my email at the time because she was being bullied and feared retaliation. She had since left the employer and was at a new nursing position. Now, she felt comfortable enough to talk to me about her experience because the bully could not hurt her anymore.

My study encompassed four research questions and the two vignettes that occurred after the data collection and analysis sum up what three of the questions were asking. I wanted to know what the lived experiences were of nurses who had or currently were experiencing bullying or witnessed it amongst coworkers and I wanted to know what career choices they had been forced to make. Words like "fear", "retaliation", "disempowered", "desperate", "crying", "hurt", "disbelief", "angry", "lost", and "no one understands" were far too frequently used during the interviews. A couple of the nurses had moved on because the bullying was over and they were in a place in their lives where they considered the events a blessing in disguise. One admitted to feeling shame because of it. All of them felt blindsided and did not know what to do to stop the bullying. Some tried to talk to and reason with the bully and reported that the tactic was unsuccessful.

Others became angry and sought to strike back by reporting the bully or bullying back. Neither approach worked. Some ignored it and hoped their resiliency and being a "better person than that" would get them through; it did not. Some were tearful and exasperated that no matter where they worked or how nice they tried to be to their coworkers, they were still bullied. All of the nurses had given up on trying to figure out how to stop the bullying and resigned themselves to working another job elsewhere or else leave the hospital for a different kind of nursing. No one had left the field entirely, but more than one had seriously considered it. All 11 participants stated they had been forced to make a career change, and at the time, did not like it. Again, the same words were used in addition to "set up and forced to leave", "things were so bad I had to leave", "couldn't stand it anymore", "hateful", "ignored", "laughed at", "disciplined in front of coworkers and patients", and "I really loved that job…I didn't want to leave, but was forced to."

The first three research questions tied into the fourth one. The fourth question explored the financial outcomes of bullying. There is no doubt that bullying impacts a hospital's bottom line, but the unanswerable question is "how much?" My literature search revealed that various authors had stated disgruntlement because they could not get hospital administrators or HR personnel to talk to them honestly about the effects of bullying on their financial ledgers or to even admit they had a bullying problem. I ran into the same dilemma when I was trying to find answers. I resorted to working around the problem and asked each participant 23 different questions about salaries, benefits, and other factors such as absenteeism. While the nurses were not able to provide me a complete picture, I took what I had from the literature and compared it with calculations I

made for the participants to demonstrate how much it would cost, conservatively, to replace the 11 participants if they all worked at the same hospital and all left. The results were much higher than what the literature sources had stated.

The final chapter, chapter five, provided the final thoughts about this study. Areas addressed were the interpretation of results, limitations, recommendations, and how/what social change can be activated.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Bullying is a growing problem within the work world. In this study, the purpose was to understand the perceptions and important choices nurses made regarding their careers when fellow nurses bullied them or had witnessed it when working in the hospital setting. I did this by interviewing 11 nurses who had been or currently were bullied or had witnessed other nurses being bullied. Each nurse shared his or her life story, and through these stories, a new understanding developed of how bullying affects nurses and their reactions to it.

Bullying is not confined to the person bullied or the witness to it. Bullying affects the financial health of the hospital as well. I questioned hospital administrators, HR personnel, and even third party HR vendors, but no one would talk about it. I had to find another way to calculate the cost. The 11 participants in this study answered 23 questions related to their salaries and benefits. From there, I was able to calculate part of the loss a hospital suffers when a nurse leaves the organization.

There were four categories in my study. The first one, Demographics, provided an overall picture of the participants. The second category was about bullying. Each nurse related multiple stories of how he or she was bullied. The reactions varied depending on when the bullying took place. The third category, Choices, explored what actions each nurse took regarding the bullying. I then asked if the nurses would make the same choice again and whether they would choose the same action again. Thirty-six percent said "No" and fifty-five percent said "Yes." The last category, The Bottom Line,

compared the findings from the literature review with results from the 11 participants. I calculated how much a hospital would pay for all 11 nurses if they left and even though I only had a small percentage of the direct and indirect costs, the range of numbers, from $1 million up to over $15 million were sobering.

Interpretation of the Findings

Conceptual Framework

In Chapter 2, I reported that Freire went to great lengths to teach the people that they could break free from their bondage. His main worry, however, was that in the process of breaking free, they could become oppressors (Freire, 1970/2005, p. 44). I brought up this statement because one of the participants in the study, (P05), told a story. The participant worked in a hospital. The unit clerk (head secretary of the department) sat at a desk that faced one of the hall walls. The unit clerk did not like the participant. One day, a member of upper management came through the department and talked with the participant about ideas to improve relations in the hospital. The participant suggested that an ugly old picture be removed and replaced with a bulletin board. It was on the wall that the unit clerk had to look at daily. The picture came down, much to the protest of the unit clerk, and the participant decorated the bulletin board in the most horrendous colors, as the participant said—a way to get back at the unit clerk for being mean to the participant. This story is what Freire was talking about; going from being oppressed to being the oppressor (Freire, 1970/2005, p.44). The action was not something that continued or to the degree that Freire discussed, but it was a good example of how quickly an oppressed person can act like the bully if given the chance.

Another point from Freire was once the oppression starts, it passed from generation to generation, becoming the norm with both oppressor and oppressed growing insensitive to the fact that it is wrong, then becoming normalcy (Freire, 1970/2005, p. 58). Nurses often do the same things to themselves. Some nurses have been practicing bullying (oppression) for so long they no longer realize they are doing it. Again, this same participant told of a time when, working in the float pool, there was a certain ICU unit that no one in the float pool wanted to go to because they were treated disrespectfully, not given complete information on policies and procedures, drugs, patients, and lab tests. When the float pool nurses brought up this treatment to their manager, a meeting ensued. The nurses, who purportedly treated the float pool nurses poorly, naturally said they were not aware they had been so forgetful about lab tests, etc. and promised to stop. The outcome was that the treatment did not stop; it only got worse.

Florence Nightingale promoted the belief to her students that nurses were subservient to doctors and therefore, nothing more than maids to do the doctor's bidding (Salsali & Mohammadi, 2012, p. 84). Diploma nurses who graduated nursing school before the mid-1970s retained this inferior belief, never knowing they were bullied. One of the participants was so surprised when, after over 20 years the treatment suffered had been bullying.

Caps and Uniforms

By the 1980s, many nurses had abandoned white uniforms for hospital scrubs. When they stopped wearing caps and white uniforms and began wearing colored scrubs, some patients felt insecure because they could not identify their nurse from the

housekeeper (Stokowski, 2011c, p.1). One nurse who graduated in the 1960s remembered the cap and uniform wars and agreed that nursing was different when nurses wore white uniforms, hose, shoes, and caps. When I ask nurses today in 2016 if they ever had a nursing cap with a black stripe on it to denote "RN" or wore a white uniform (dress or pantsuit), many do not know what I am talking about. Another participant said that the nursing cap and white uniform was not part of the picture of a nurse because nobody looks like that anymore. All that another participant could think about was how much MRSA was residing on a nurse's cap. By the time the next four participants graduated from nursing school in the 1980s, one was given a nursing cap because she graduated from a diploma program. The other three never received a cap from their nursing schools.

Gone are the visions of a smiling woman in a white uniform, cap, white hose, and shoes. Instead, there were two composite images of a nurse in 2016 from the participants in this study. The first one viewed the nurse in a romantic way, as an older matronly woman who is clean and neat in appearance, smiling, a great listener and communicator, honest, caring, nurturing, efficient, and putting patients first. The second vision was harsher and closer to the reality of today's nurses as an educated healthcare professional in scrubs with a stethoscope around the neck, tired and worn out after working all day, and not smiling.

Education

Aiken and Yakusheva revealed that in 2014 two-thirds of nurses graduated with an Associate's Degree instead of a BSN, which is insufficient to meet the Institute of

Medicine's guideline for an 80% BSN workforce by 2020 (2014, p. 3). In this study, one person held a diploma (9%), four held a BSN (36%), while six held an AD (55%). Even though this study is tiny, it is just slightly less than Aiken and Yakusheva's report that there were 66% AD nurses and 33% BSN nurses in 2014.

Age of Nurses

In this study, more of the nurses were over 40 years old than not. Longo stated that anyone who is over 40 years old is considered an older worker in the U.S. (2013, p. 950). In 2013, 53% of RNs working were 50 years and older (Budden et al., 2013, p. 7). Baby Boomers made up the majority of working RNs in 2016 as demonstrated in this study. Seven of the eleven nurses were between the ages of 50 to 79, which is 64%. All of them were still actively working in nursing. Two of the nurses in this study were planning on retiring; leaving nursing entirely within the next few years. One had already retired but was still actively providing nursing care to the community and one of the local nursing schools.

Another problem nurses over 45 years of age faced is that of returning to school to earn a BSN. Nurses over 45 were hesitant to go back to school, trying to determine if they could realize any ROI and if they want to remain in nursing. Those closer to 50 and over experienced the most difficult time because they were not ready to retire yet. They could work another 15 years but had no desire to return to school. One nurse was 64 and felt he was forced to retire although he did not want to yet.

Bottom Line—Direct Costs and Indirect Costs

To demonstrate how much it costs in 2016 to replace the 11 participants in this study, using salaries and benefits only, which are a minuscule part of the cost of replacing a nurse, I calculated that it could cost anywhere from $1.2 million to $15.2 million. Christie and Jones stated that it costs $92,000.00 to replace a medical-surgical nurse and $145,000.00 for a specialty nurse such as an ICU or ED nurse (2014, p. 3). Christie and Jones' figures would replace 14 nurses at $92,000.00 each to total $1,243,130.84 and 105 nurses at $145,000.00 each to total $15,229,687.00.

Depending on the nurse's constitution, when bullying has reached the breaking point the nurse becomes physically ill to the point that a medical leave is required to recover. Bullying is a contributive factor to the escalation of indirect costs (Longo & Hain, 2014, p. 195). The costs related to absenteeism and presenteeism are increasing job dissatisfaction, increased last minute call-offs, repeated episodes of sickness, decreased quality of work, productivity, and engagement (presenteeism—the employee is physically present at work but not engaged in work), and eventual interpersonal and intrapersonal relationship difficulties (Lee et al., 2013, p. 263). Absenteeism can be very costly to an employer's bottom line. Wilson et al. (2011) stated 95% of nurses affirmed that absenteeism is an after-effect of bullying, and 20% of those stated they had done so themselves (p. 456). In this study, I asked multiple questions related to indirect costs such as employees on different types of leave (medical, FMLA, Workers' Compensation) about absences and attitudes but fell short in finding answers. Only 1 of the 11 participants knew of a fellow employee on leave. The best indicator of indirect costs was

the attitude question, “Do you know someone who is always having a bad day, nothing goes right, no one cared, angers easily or has a “short fuse”, or cries for no reason?” Each of the 11 participants knew of fellow employees who engaged in these attitudes, which point to probable signs that those employees are experiencing bullying.

Hospital Administrators

Do managers, supervisors, and nurses use bullying as a management tool? This question provokes some interesting thoughts. The very people who use bullying tactics on subordinates to get more work done may not realize or even consider them as bullying because they believed they were utilizing a management tool. Freire warned of this type of behavior. It grows from the repeated uncorrected behavior long ago established as acceptable.

The concept of nursing as a nurturing, healing, and caring type of job has faded, replaced with corporate nursing. Administrators are more concerned with the financial bottom line than the medical bottom line. A way for hospital administrators to protect their bottom lines is to admit bullying exists and is responsible for uncontrolled economic losses, vigorously addressing and correcting those issues that are draining the budget.

Fifty-seven percent of respondents believe the employer will stop bullying when it costs too much money to ignore it; the law forces them to, or they determine that it is the right thing to do to stop the bullying. The other side is that 42% do not believe it will ever end. Instead of investing money into the latest medical machines, while denying hiring enough nurses to carry out expected care, hospital administrators that are truly

committed to addressing bullying need to do so. Many of the financial woes would be gone.

The business leaders were asked their opinion of workplace bullying. Sixty-eight percent viewed it as a serious problem, (Namie, 2013, p. 2). Next, he asked them what their companies were doing to address workplace bullying. Thirty-two percent stated they did not have bullying in their organization (Namie, 2013, p. 4). How can 68% of business leaders indicate that bullying is a serious problem, yet 32% then state there is no problem? Almost half of the leaders denied what they just said. In Namie's survey, 88% of bullied employees indicated no action had been taken (Namie, 2013, p. 5). The survey answers are clear that there is a disconnect between what business leaders think is happening ~~vs.~~ versus what is going on. Business leaders stated that bullying was a serious problem (68%), but no problem at their organization (32%). Denial is contributing to the frustration of researchers when attempting to quantify exactly how much bullying is costing America. I encountered the same problem. No one would talk to me, not even people in other states that were not affiliated with my geographical study area.

Intent to Leave

The majority of nurses do not feel safe enough to tell anyone about the bully amidst fears of what the bully might do to them. When the bullying becomes too much, and the nurse has decided to leave the organization, the fear of the consequences of any deviant behavior is gone. The nurse has lost all respect for the employer and, to strike back, thinks it is appropriate to steal and destroy property (Siegel Christian & Ellis, 2014,

p. 203). None of the nurses in this study admitted to this type of behavior, but they did realize their attitude and behavior changed for the worse toward their employer when they were forced to make a career change. For some, it was because the manager or higher was bullying them and this was a way to get back at them without having to speak to them. For others, it was a way to strike back at the employer because they felt the organization, as a whole, had not protected them from the bully.

Shameful Feelings

When a nurse experiences shame, it is easier to engage in self-silence and deny anything is going on than to stand up to the bully and risk losing the much-needed job. Self-silencing, withdrawal, and isolation are protective mechanisms the bullied victim uses to stave off further bullying episodes. P02 stated, "I was disciplined in front of family members and nurses. I was made fun of and laughed at. I would come home and cry. I really can't talk to anybody about it because no one understands."

Witness

When a nurse is bullied or witnesses another nurse being bullied, frequently there is physical and emotional distress. Namie discovered that witnesses suffer just as much trauma physically, psychologically, and emotionally as those who are bullied (2014a, p. 4). The stress of being bullied or witnessing it diminishes the nurse's concentration, and accidents occur, to the nurse or the patient in the form of medical errors.

Namie asked targets if they believed their coworkers helped them. Forty-one percent agreed their coworkers did nothing to help them, and when witnesses were asked the same question, 30% admitted that they did nothing to help (Namie, 2014a, p. 13). Stagg

et al. remarked that 83% of nurses revealed they did nothing when they witnessed bullying occurring because they were afraid the bully would come after them in retaliation for interfering and they needed their jobs (Freire, 1970/2005, p. 47; Gaffney et al., 2012, p. 4, and Stagg et al., 2013, p. 336). I asked, "Are you currently witnessing a colleague being bullied?" One said "Yes" and ten said "No." After further probing, three told stories of nurses that they witnessed being bullied. One recollected two nurses, another knew of many, and one remembered one nurse.

Another question asked was, "If your coworkers were asked if they were being bullied or have seen it in others, do they immediately deny it and don't want to talk about it—changing the subject, etc.?"

- P02 stated "some nurses burst out in tears and cry their heart out. Others stated 'No, I'm fine.' They don't want to talk about it because people are desperate to keep jobs."
- P04 said that "a friend would not talk about it because she was too close to the situation."
- P05 related "I think they're just afraid of retaliation. They don't want to stir up trouble. They don't want to talk about it."
- P06 told me "Your research has actually generated a lot of conversation. After completing the research, I spoke to P06 again and was told that one of the other nurses I interviewed had actually stepped down from charge position, and the reason was bullying."

Choices

I asked the question "What career choice did you make to stop the bullying?" Five (45%) chose to do nothing, 1 (9%) changed departments, 2 (18%) changed hospitals, 1 (9%) left the hospital for another type of nursing, 1 (9%) retired, and 1(9%) spoke with the manager. This equated to 45% did nothing and 55% did make a choice. Then I asked, "If you had it to do over, would you have handled it the same way?" Four (36%) said "No" and six (55%) said "Yes."

Limitations of the Study

Limitations Overall

In chapter 1, I listed six limitations. After conducting the study, the limitations have changed somewhat. Two of the limitations from chapter 1 remained. They were the small number of participants and the homogenous sample from one tiny area of one state of the United States. After the study, there were new limitations noted, specifically diversity. There were no nurses with graduate degrees, and there was only one male. More of both were needed. The LGBTQ nurses were not represented. Other ethnicities besides Asian, Black, and White were needed. Nurses who had worked in more types of nursing areas within the hospital setting were needed.

Limitations Related to Trustworthiness

While considering how to carry out this study, collecting data, analyzing it, and now presenting it, I had to ask myself some questions about the trustworthiness of this study.

- Is the goal of the study clear? I believe it is. The purpose of this study was two-fold. First, I wanted to hear the stories about bullying and to understand the choices nurses made regarding their careers when they were bullied by fellow nurses or had witnessed it. My second goal was to apply this knowledge to the financial area of a hospital's budget. I wanted to know just how deeply a hospital budget is impacted when a nurse leaves the organization.
- Why would anyone want to read this study? What is the significance of it? Bullying amongst nurses affects everyone's lives. Eventually, most everyone is a patient in the hospital. Patients pay for bullying in the form of higher costs for healthcare, compromised nursing care because of an overstretched workload, and unrealistic expectations from upper management.
- Does it present itself in such a way as to invoke a desire to learn more about the subject? Yes. When I talk to people about this study, once I state a few facts about what goes on in the hospital between nurses and in the financial losses, people are amazed. People want to know more. They want to learn more about this, even if their goal is to prove that this study is wrong because nurses are not equated with bullying.
- Would a colleague be able to take my data and transfer those concepts to another study (transferability)? There is no definite "Yes" or "No" answer to this question because it is a qualitative study. Qualitative studies are fluid, focusing on what was said and the emotions of it; not how many times something was said. Partial transferability is possible by applying findings in one study with others,

searching for the essence instead of exact replication. Even if the same participants were given the survey at another time, they might not provide the same answers (Simon & Goes, 2013, p. 273). In addition to this, the questions could be posed to another group, but the answers would not be identical to the results from this study (Simon & Goes, 2013, p. 273). A way to increase validity in this study, however, was through thick, rich description, affording the reader the ability to derive understanding from the presentations (Leedy & Ormond, 2005, p.100). The stories that each nurse shared with me were so rich in feeling; saturation was achieved with just 11 participants.

- Is the information from the data collection reflected accurately in the final narrative of this study (Confirmability)? Yes. I compared original interview transcripts with categorized, themed data.
- Will the information gleaned from this study fill a gap in the literature? Yes. It adds more to the knowledge pool. It adds another dimension to the understanding.
- Does the reader come away knowing the participants' information remained true (Credibility)? Yes. Multiple examples of direct quotes were presented in the study.
- Did I present my findings in a trustworthy, credible manner (Dependability)? Yes. I used peer-reviewed journals, scholarly articles, and books written by reputable researchers.

Limitations Related to Data Collection

The overarching limitation in this study was the limited number of participants regarding demographics. An interesting note was in 2011, there were over 3.5 million employed nurses in the United States (United States Department of Commerce, 2013, p.2). The latest figures from 2015 reveal there are only 2.75 million employed nurses in the United States (United States Department of Labor, 2016, p.1). Regardless of whether there is a drop in actively employed nurses across America, using one state in the U.S. prohibited an adequate representation of nurses across the U.S. I chose 11 participants from one state that employs over 126,000 nurses. Querying 11 nurses from this large number is impractical regarding demographics quality. Even though I had a diverse group within the 11, there was not enough variety to include representation from every group evaluated.

While 11 participants was a limitation regarding overall demographics of nurses, the number achieved saturation, phenomenologically, in the presentation of the stories, actions, and financial outcomes of nurses and hospitals in the United States.

Recommendations

When I began this journey, there were very few articles written regarding bullying amongst nurses in the United States. To derive a better understanding of nurses and bullying in the hospital setting, I had to expand my literature search to include the world. There was a wealth of information from a multitude of countries, and the overarching theme was the same: bullying exists. It is impossible to obtain an accurate count of how

many people are involved in bullying, either as a bully or as a target, and nothing seems to be able to stop it.

Additionally, researchers everywhere have experienced the same frustrations as I have regarding the implications of bullying on a hospital's bottom line. As stated earlier, hospital administrators will not talk about bullying existing within their institutions. If an accurate cost cannot be calculated, then how will the hospital's financial officers be able to project future losses and prepare for them?

Disseminating Results

I have multiple plans for educating both professional and lay people about this subject. Professionally, I have joined the American Nurses Association (ANA) and hope to work with them on a national level regarding policy and research. I have also joined my state's Nurses Association where I hope to work on the local and state area conducting research, teaching, speaking, and advocating for nurses. There are national researchers that I wish to contact to collaborate with on further research studies about nurses, and there are some well-known national organizations too. I noted during the data collection; the participants seemed eager to continue our talks, so I approached them about setting up a support group. They are for it. I plan to write at least two books about nurses and bullying, speak at conferences, and educate the public through TV talk shows. I will use LinkedIn to connect with researchers around the world to continue this work.

Recommendations for Further Study

There were a plethora of ideas for future studies from this research. I recommend 11suggestions for further studies. The first one involves male nurses. Male nurses

comprise a little over 9% of the nursing population. Where do they stand in their thoughts about bullying? How many have been bullied? Do male nurses witness it more than experience it? If male nurses do get bullied, is it by male or female nurses; peers or managers? What are the lived experiences of straight male nurses regarding bullying? Do male nurses act certain ways when working so they do not get bullied?

The second study would be about LGBTQ nurses. What happens when an LGBTQ nurse is bullied? How an LGBTQ nurse is bullied—is the bullying pointed toward the sexuality or is it because the nurse is "the new nurse on the unit"? Does ethnicity set up an LGBTQ nurse for bullying? And how many LGBTQ bullies are there and how many bullied?

The third suggestion is to study nurses of other ethnicities than Asian, Black, and White. In the studies I have read from around the world, all ethnicities get bullied in the same ways, however, there is a difference in some countries regarding the sex of the nurse and whether bullying is permitted or not to that gender. Culture, geography, and political climate are major influencers regarding bullying. An interesting study would be a meta-analysis of the literature worldwide, comparing and contrasting the findings.

The fourth suggestion concerns nurses over 40 years old who are forced to return to school to obtain a BSN. How does this impact the nurse and the nurse's family? What if the nurse cannot afford to return to school or does not want to—what alternatives are available for employment? What does the nurse do for employment while in school? Are nurses over 45 years of age bullied more frequently than younger ones when both are in nursing school because they were forced to get a BSN? There are few studies about

faculty—either bullies or bullied. What makes a professor bully students? Is it the students bullying the professor that turns the professor into a bully, or did the professor come to the position as a bully? What about nurses with graduate degrees such as MSNs (Advance Practice Nurses and Nurse Practitioners) and DNPs (Doctor of Nursing Practice)? Who bullies them? Is it more horizontal or is it more vertical? What happens when they are bullied? How are they bullied; is it different from what staff nurses experience?

The next suggestion is a study about nurse bullies. How many nurse bullies are there? How did they get to be bullies? Was it because they were bullied as children and now they bully others to protect themselves? Is there a particular set of attributes bullies possess but others do not? When did bullies discover they were bullies and what did they do when they did? Do they consider themselves bullies or is this something that they have been told or labeled? What is the difference between bullying and being a determined leader that demands more from workers? When is too far in demands, too far, and considered bullying? Does the shift or day of the week trigger a bully to bully others? What triggers bullies to bully; is it out of habit, the thrill of the hunt/game, hate for other people who are different from the bully, boredom, poor manners, or something else?

Suggestions six, seven, and eight are shame and bullying, emotional intelligence and bullying, and spiritual intelligence and bullying. What part does each of these areas play in the bully and the bullied' s actions and reactions?

The ninth suggestion examines witnesses to bullying. There is very little information about witnesses and more exploration into their feelings when observing the bullying, deciding whether to step in and help or not, and then dealing with the guilt and shame for not helping is needed.

To further close the knowledge gap regarding the choices nurses have made after being bullied, I would suggest an in-depth look at how each nurse came to the final decision to stop the bullying, which is suggestion number 10. Was the nurse forced into the decision? Did the nurse not see any other way to halt the bullying? Did the family influence the decision? After the choice was made, if the nurse had it to do over, would it have been the same choice? What would the nurse do differently in handling the bullying and consequential decision? What would the nurse do differently in handling the bullying and consequential decision?

The eleventh and last suggestion for further study will be the most difficult to conduct. It concerns understanding what hospital administrators think about bullying within their organization. When managers "actively" encourage their staff to be more productive, when does it change to bullying? What would happen if the hospital administrators admitted to the upper management that there was a bullying problem in the organization? What if they carried this further and openly announced it to the entire working staff of the hospital? Are hospital administrators bullied? If so, by whom? Finding a way to accurately determine the total amount it costs to replace a nurse through direct and indirect costs.

Implications

Positive Social Change

The expected outcomes of this study were that nurses and non-nurses would have a better comprehension of the choices nurses make when bullied or when they have witnessed it, that readers of this study would feel compelled to speak up for those nurses that cannot, and that positive social change will be realized through grass-roots efforts.

Individual. From the individual level, after reading this study, each person should be encouraged, enticed, and empowered to make a stand against bullying, supporting those that are bullied. Here, at the grass-roots level, one person can make a difference to society. It starts with belief in the subject and then moves on to intolerance to the behavior. Speaking up and standing up for self and those oppressed by bullying, determining not to be a victim anymore to the after-effects of bullying either witnessed or experienced.

When a bullied nurse reads this study, it should plant the seed that oppression by the bully is something that the bully needs to remain a bully. When bullied nurses realize that the bully needs them to maintain this power, they can revolt and stand firm, hard, and fast, quickly diminishing the bully. Building and maintaining resilience in the face of bullying is no easy task, but with each step forward, resiliency increases, thus strengthening the bullied nurse.

Family. The family needs to be involved helping to remove oppression from their families. Families need to show support, encouragement, and speaking out for family members when they cannot, and fighting for them until they recover enough to

fight for themselves again. Backing like this encourages the bullied nurse to recover and continue trying, even through job loss.

Organizational. Bullied nurses not only need to learn to defend against the wiles of the bully, but they also need the backing of the organization. It is most disparaging to hear hospital leaders say that bullying is a serious problem and then do nothing about it. Too many times upper management leaders rely on the HR personnel to contend with the bullying issues, totally ignoring what is happening out on the work floor. Hospital administrators need to get out among the employees and find out what is going on. How much of a bullying problem is there? When upper management leaders take the time to dig and find the root of the problem in their organization, they will be able to take decisive corrective action. Some suggestions would be to provide resources such as websites, phone numbers, and names of organizations where bullied nurses can go to get help that is not tied to the hospital. Providing resources that employees can actually use will be of more benefit than writing policies and procedures that can be circumvented.

Societal/policy. There is a responsibility required of society too. When patients see or hear of bullying amongst hospital personnel, it must be reported. A website, phone number, and name should be posted on the wall in every patient room advising whom the patient or family member can call to report bullying. Hospital administrators can utilize nurse case managers to make walking rounds to check on personnel and patients, acting as a resource for reporting bullying issues.

Conclusion

Nurses are bullied and are choosing to leave either the hospital that employs them or the nursing profession altogether. The purpose of this qualitative phenomenological study was to understand the choices nurses made regarding their careers when they were bullied by fellow nurses or had witnessed it when working in the hospital setting. Additionally, hospitals lost money due to bullying but have not moved forward to stop it. A gap remains in the literature understanding the choices of nurses who have been bullied, or have witnessed it amongst their peers as well as the actual cost loss to a hospital's bottom line as a result of bullying and witnessed bullying.

There were four research questions for this study. Research questions one and two regarded the lived experiences of nurses who had experienced bullying or witnessed it by their nursing colleagues. The third research question concerned the career choices nurses were forced to make after experiencing bullying or witnessing it while the fourth question examined the impact of the cost both directly and indirectly to replace nurses that had left the hospital.

Eleven nurses participated in this study and provided interesting information through telling their stories. For the majority, this was not their first experience with bullying. It had occurred on more than one occasion and at more than one job. All of them had built some level of resiliency although there was one wounded so badly from repeated bullying experiences that all this nurse had left was one spark of self-esteem. The nurses shared their career choice decisions with 50% being happy with their decision

to leave the employer and 50% vowing if made again, the choice would be a different one.

The most surprising discovery to me was the cost to replace 11 nurses using just the salary and benefits; it was between $1.2 million to $15.2 million. There are so many other direct and indirect costs associated with replacing a nurse. The costs, both direct and indirect to pay for the outcomes of bullying can be staggering. The nurse who is bullied, the witness to the nurse who is bullied, the patients, the patients' families/visitors, the remainder of the nursing staff in the department, and finally the community all suffer the consequences of bullying. For those nurses who are so wounded and unable to speak up for themselves, we as readers of this study must be willing to do it for them until they can do it for themselves.

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Appendix A: Bracketing

There are two rules concerning bracketing. The first one entails that the researcher identify all thoughts, preconceived notions about the end results of the study, and assumptions. The second is a constant review and reflection of these thoughts with the probability that the beginning notes will have emerged as new thoughts by the end of the research (Fischer, 2009, p. 584).

The beginning of this study started in 2010. I had just discovered that I had been bullied all of my adult working life and this was why I felt so much shame because of all of the jobs I was forced to leave. I could never figure out why I did not last long at a job. I came in early, went home late, rarely took a sick day even though most weeks I had migraine headaches three out of the seven days, and only took a day or two here and there for vacations. I did good work, was dependable, and trustworthy. I was so angry that I could not even talk about what had happened to me without exploding in anger.

I have experienced firsthand all of the categories in this dissertation—the cap and uniform wars, doctors throwing things at me, nurses laughing at my mistakes in front of the other nurses, being ignored and treated as if I did not exist. I was given the worst patient loads and no help when I floated to other floors. Information was withheld from me and racial slurs were levied at me in front of patients. I've been humiliated, denigrated, hated, and every other description of a bullied person.

At first, my intention was to prove that bullying did exist. In 2010 very few people were talking about it and it certainly was unknown in the nursing realm here in the United States. Within five years, though, many people were talking about bullying. It

was the new buzzword and the bullied had a story to tell. It took me six years to come to the place where I am at now, in 2016. Originally, I had set up my study to be completely online because I did not think I could be unbiased in my tone or body language. My chair, in his wisdom, forced me to change from online to Skype interviews. I was very upset and extremely afraid to do that. I just did not think I was ready. I discovered, though, that I had progressed enough in my healing that I actually enjoyed meeting face-to-face with other nurses and listening to their stories. I am at ease now. I can talk sensibly and calmly about my experiences.

There was one interview that was hard for me to complete. The nurse had been bullied so often and so hard, there was never any time to heal, even a little bit. Her mother had passed away two weeks before our interview and she was struggling with that and the way that she had been treated by her employer and peers just before her mother passed. I felt so bad for her as she struggled to not cry during the interview. She was truly very broken. At our interview, she was telling me she was going to look for yet another job. She had been at this one a little over 90 days and could tell it was not going to work out. She called me a few weeks later to advise that she was actively looking for work.

My expectations going into this study were that I would hear stories that were similar to mine and the countless others I had read about in the literature review. I was surprised at some of the things I learned. One nurse was still angry because of loss of pension benefits. One was nonchalant about what had happened and had moved on with life and the next job. Another one struggled with the bullying because that nurse stepped

down from a management position stating it was due to bullying. The announcement came a week after our interview. Even though my study was extremely small, I was amazed that the statistics generally followed the national statistics.

Concerning the financial section of this dissertation, I was at a crossroads with how to secure the information. I was pretty sure that no one working in the local hospital would talk to me, so I tried LinkedIn. I focused on HR personnel. Some were in the research area while others were scattered throughout the U.S. I received the same answers from everybody—"No." There was one reason—fear of job loss. During the literature review, I noted that researchers that had attempted to gather information were expressing frustration because they could not get upper management leaders or HR personnel to talk to them. I finally decided to attempt to figure out how much it cost to replace a nurse by asking the participants in my study about their salaries and benefits. The participants were as helpful as they could be, but most were on their spouse's insurance or else did not know what they paid for benefits.

The largest and most important factor in bullying is the threat of job loss. Most people have to work and cannot risk fighting back to a bully. Bullies know this and play on it. At this point I feel that to be involved in bullying is a no-win situation. Through observation, I learned that if a person actually stands up to a bully and fights back, the bully may back down. On the other hand, it may invigorate the bully further to bully that much harder. The odds are in the bully's favor.

I came to this study wanting to prove that bullying was not the target's fault because I would be vindicated for not being able to keep a job, which is extremely

shameful to me. Instead, I learned that some of it is the target's fault for being too nice, too accommodating, willing to do more than expected, and not one to complain. Spending time talking to other nurses that have been bullied and shared some of the same feelings gave me a broader perspective about this phenomenon.

Another preconceived thought that I had coming into this study was that all of the participants would be as angry and upset at their experience as I had been. What I learned, though, was that each participant had come to terms with his or her experience in a different way. The one male participant stated that he had never been bullied but had witnessed it. He felt badly for the ones that he witnessed bullied, but felt there was nothing that he could really do to help them. Another one was still angry after more than four years. Another one had been angry, but early on realized that losing the job because of the bully was a blessing in disguise. She moved on and was very happy in her next job. Another participant took it in stride as just "part of the job" and remained in the situation for several years before taking a job elsewhere. Another one had taken active steps to confront the bully for both her and others that she witnessed were being bullied. She related, however, that standing up to the bully did not help. She never lost a job because of a bully, but stated she was treated terribly as long as she worked with the bully. The one nurse that was so broken never did recover from any bullying episode before another one began. She went from job to job, running into bullies from the minute she started the job. She felt she was a victim and even though she tried to confront the bully, as she had been taught in her nursing classes, the bullying only worsened. She never had time to build any resilience. Another participant did not even realize she had

been bullied when in nursing school and expressed surprise when she realized it. Since it occurred over 25 years ago, at the time, she just accepted her treatment as normal. After graduation, she moved on and did not experience another bullying episode until some years later.

Appendix B: Initial Email Invitation

- Cover letter with instructions
- two attachments:
    - criteria selection (Appendix C)
    - demographic questionnaire (Appendix D)

Cover Letter

Greetings! ☺

My name is Brenda Williams. I am a doctoral student at Walden University. I am inviting you to take part in a research study about bullied nurses and nurses that witness bullying amongst their coworkers (nurses) in a hospital setting. I obtained your name/contact info via the Ohio State Board of Nursing.

The purpose of this study is to explore the perceptions of bullied nurses and those that have witnessed the bullying of co-workers, in addition to understanding the actions they take career-wise in order to stop the harassment. The overall objective of this study is to understand the personal experiences of each individual participant's life and how bullying has impacted their career choices.

There is one potential personal benefit from this study. For some people, talking about their bullying experience is a welcome relief from pent-up feelings, allowing release and possible closure. Otherwise, the potential benefits are to the readers of this dissertation, in learning about bullying amongst nurses, prompting a desire to make a social change in their community.

There are two parts to this study: the demographic questionnaire and the Skype interview. After successful completion of the criteria and the demographic questionnaire, which are included in this email, you will send this letter and both attachments back to me. The instructions are provided below. The next step will be a Skype interview. I will enter your name into a pool of candidates and will call you if needed, to set up the Skype interview. At that time, we will set a date and time that is convenient to both of us. If you do not have a Skype account, you can set one up for free, or if you prefer a phone interview, we can schedule that too. I will call you to set up the interview. The interview will last about an hour. Essentially, your participation is complete at the end of the interview unless I need to call you back for further clarification as I am analyzing the data. There will be no payment for participating in this study.

Participation in this study is voluntary but does involve some risk of discomfort. Examples would be physical illness due to emotional upset such as headache or fatigue, etc.; or psychological upset depending on your unique personal makeup. If you are pregnant, or under the care of a mental health professional, this may not be a study for you to participate in due to the physical and mental health risks; however, you are more than welcome to participate. The questions asked in this study will require that you recall bullying incidents, which may be uncomfortable. If at any time during the interview, you feel uncomfortable and wish to stop the interview, or if I detect that you are becoming distressed, I will stop the interview, we will discuss whether to continue or not, and if a decision to withdraw is made, there will be no repercussions. Instructions on how to receive free mental health care will be provided.

If you have questions at any time throughout your participation in this study, you may contact me at bwill001@waldenu.edu If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 800-925-3368, ext. 3121210 or 612-312-1210. The email address is: irb@waldenu.edu.

If you are still interested in participating in this study, you will be asked to:

- Determine your eligibility with a criteria test.
    - Open the attachment that is labeled "Criteria."
    - If you match all of the components of the checklist, then you may continue with the study
    - Save this attachment
- If you have met the criteria, open up the "Demographics Questionnaire" in the attachments. It will take about 4 minutes to answer 47 questions.
    - When finished, save the attachment
- Return this letter, the criteria test, and the demographic questionnaire to me.
        - List a preferred phone number and convenient time that I can call to schedule the follow-up Skype interview. I will need your Skype number at that time
        - If you prefer to conduct a phone interview instead of a Skype interview, please note that in your return email
- Save my email address; you will need it if you wish to contact me:
    - bwill001@waldenu.edu

Any information you provide will be kept confidential until the data analysis is at a point that the need to contact you clarify information is no longer needed. At that time all identifying factors will be deleted from the study. I will not use your personal information for any purposes outside of this research project and will not include your name or any other identifying factors in the study reports. I have no conflicts of interest related to this study. Data will be kept secure by storage on a flash drive, a password-protected computer, and paper in a locked office that only I have access. Once the study has been completed, all data on the password-protected computer files will be deleted, the paper will be shredded, and the flash drive will be locked in the office for at least five years, as required by Walden University. At that time, the flash drive will be scrubbed and destroyed.

The demographic questionnaire that you will complete and return within the next seven days (Friday, May 13, 2016, thru Thursday, May 19, 2016) consists of 47 closed-ended questions that require a yes/no answer or an "x" beside an answer. Here is an example:

1. What nursing degree do you currently hold?
    a. AD
    b. Diploma
    c. BSN
    d. MSN
    e. DNP
    f. DNSc/PhD

2. Have any other nurses come to you to tell you that they have been bullied or that they have witnessed it?
    a. Yes
    b. No

The interview questions will consist of both closed- and open-ended questions. The closed-ended questions will either be a choice or a yes/no answer, while the open-ended questions will require explanation. Here are some sample questions:

1. Tell me about your experience(s) being bullied

2. If your coworkers were asked if they were being bullied or have seen it in others, do they immediately deny it and don't want to talk about it?
    i. Yes
    ii. No

3. What choice did you make to stop the bullying or to not witness further bullying
    a. nothing
    b. changed shift
    c. changed department
    d. changed hospitals
    e. left hospital nursing for another type of nursing
    f. left nursing completely
    g. other—specify

Once the interviews are completed and I have transcribed our recorded conversation, I can send you a copy of the transcript for your review. If you see where corrections are

needed because I misinterpreted what you stated during the interview, please let me know so that we can discuss my error further. After you have reviewed the transcript and no further contact is required between us, I will delete your name, phone, and email address. If you would like a copy of your transcript for review, please place an X in the corresponding box below:

Yes, I would like a copy of my transcript so I can review it for errors ____

If you would like a copy of the final study results, check here _____. I will retain your email address and then delete it after the study results have been sent to you.

Your name and phone number: _____

A good day and time to contact you to set up the interview:

(Day)_____(Time)_____

Walden University's approval number for this study is **05-12-16-0096207** and it expires on **May 11, 2017.**

By completing the criteria test and demographic questionnaire, returning this letter, the test and questionnaire via email, implies your consent to participate in this study. Please print or save this consent form for your records.

Thank-you for your participation in this study about nurse bullying

Sincerely,

Brenda Williams, RN, BS, CCM, MBA, FCN, Ph.D. candidate

Appendix C: Criteria Test

Before you take the criteria test, it is important to understand what the term "bullying" means in this study.

Bullying is defined as any deliberate, planned, repetitive, and ongoing harassment of one person by another that is meant to show power over that person (Goldsmid & Howie, 2014, p.211).

The intent is to cause harm, and its outcomes are shame, humiliation, embarrassment, isolation, and loss of dignity both as a nurse and as a person (Goldsmid & Howie, 2014, p.211). This set-up is meant to prove the target as unworthy to practice as a nurse and to ruin the personal and professional reputation so the nurse may not be able to secure remunerative employment.

Therefore, any actions from one nurse to another that hinders that nurse's ability to practice nursing up to expected quality standards is considered bullying (Granstra, 2015, p.251).

If this definition defines what you have experienced or have witnessed others experience, you have qualified for the criterion "The bullying or witnessing took place or is currently taking place in a hospital".

In order to qualify for participation in this study, you must meet the following criteria:

- You must hold an active RN license Y____ N_____
- The bullying or witnessing took place or is currently taking place in a hospital Y____ N_____
- The hospital must be in the United States Y____ N_____
- You must have been, or currently are, being bullied by a coworker that is a nurse Y____ N_____

OR

- You must have witnessed, or currently are witnessing, a fellow nurse coworker being bullied by another nurse coworker Y____ N____

If you can answer yes to the license, hospital, and United States criteria and yes to either one or both of the bullying/witnessing criteria, then you qualify to participate in this study.

INSTRUCTIONS:

1. Save this attachment to send back to me later along with your demographic questionnaire
2. Follow the instructions in the letter

Appendix D: Demographic Questionnaire

1. What nursing degree do you currently hold?

a. AD

b. Diploma

c. BSN

d. MSN

e. DNP

f. DNSc/PhD

2. What was your initial nursing degree?

a. AD

b. Diploma

c. BSN

d. MSN

e. DNP

f. DNSc/PhD

3. Do you hold other degrees?

a. Yes

i. List them:

b. No

4. What year did you graduate from nursing school with your first degree:

a. 1930-1939

b. 1940-1949

c. 1950-1959

d. 1960 – 1969

e. 1970-1979

f. 1980-1989

g. 1990-1999

h. 2000-2015

5. How long have you worked as a nurse?

a. 1 month – 11 months

b. 1 yr – 4 yr

c. 5 yr – 9 yr

d. 10 yr – 14 yr

e. 15 – 20 yr

f. 21 – 24 yr

g. 25 – 29 yr

h. 30 – 34 yr

i. 35 – 39 yr

j. 40 – 44 yr

k. 45 – 49 yr

l. 50 – 54 yr

m. 55—59 yr

n. 60—64 yr

6. What type of nurse are you (can be more than one answer)

a. staff

b. charge

c. manager

d. supervisor

e. Director

f. NP

g. faculty

h. student

i. other

7. What nursing department do you currently work in?

a. Obstetrics/Labor-Delivery

b. Nursery

c. Pediatrics

d. Emergency Department

e. Intensive Care Units

f. Med-Surg

g. Oncology

h. Burn

i. Psychiatric

j. Operating Room

k. Orthopedics

l. Neurology

m. ambulatory surgery

n. recovery

o. other—specify

8. What nursing departments have you worked in throughout your career? (there can be more than one answer

a. Obstetrics/Labor-Delivery

b. Nursery

c. Pediatrics

d. Emergency Department

e. Intensive Care Units

f. Med-Surg

g. Oncology

h. Burn

i. Psychiatric

j. Operating Room

k. Orthopedics

l. Neurology

m. ambulatory surgery

n. recovery

o. other—specify

9. What is your current employment status

a. Full-Time

b. Part-Time

c. Flexible

d. Agency

e. Pool/call-in

f. Other—specify

10. What shift do you work?

a. 8 hr shifts

i. Days

ii. Evenings

iii. Nights

b. 12 hr shifts

i. Days

ii. Nights

c. 10 hr shifts

d. Other--specify

11. What is your gender?

a. M

b. F

c. Decline

12. What is your ethnicity?

a. White

b. Hispanic

c. African American

d. Pacific Islander

e. Native American

f. Mixture (list)

g. Other (list)

h. decline

13. How old will you be on your birthday this year?

a. 18-29

b. 30-39

c. 40-49

d. 50-59

e. 60-69

f. 70-79

g. 80-89

h. 90-99

14. When did the bullying start?

h. before nursing school

i. during nursing school

j. first job after graduation

k. other—specify

15. Are you currently being bullied?

a. Yes

b. No

16. How many nurses are absent from work each week?

a. Is it the same ones?

i. Yes

ii. No

17. Do you know anyone that has an "I'm better than you" attitude?

a. Yes

b. No

18. Do you know someone that is always (check the ones that are "Yes")

a. having a bad day

b. nothing goes right

c. no one cares, angry

d. "short-fuse"

e. cries easily or for no reason?

19. If your co-workers were asked if they were being bullied or have seen it in others, do they immediately deny it and do not want to talk about it—changing the subject, etc.?

a. Yes

b. No

20. Are you experiencing shame due to being bullied or witnessing it?

a. Yes

b. No

21. Are you currently witnessing a colleague being bullied?

a. Yes

b. No

22. Do you see nurses that have isolated themselves from the group?

a. Yes

b. No

23. Do you isolate yourself so that you do not have to witness the bullying?

a. Yes

b. No

c. Yes

d. No

24. Have any other nurses come to you to tell you that they have been bullied or that they have witnessed it?

a. Yes

b. No

25. Are there nurses in the department that appear worried, overwhelmed, and dissatisfied with their job?

a. Yes

b. No

26. What career choice did you make to stop the bullying or to not witness further bullying

a. nothing

b. changed shift

c. changed department

d. changed hospitals

e. left hospital nursing for another type of nursing

f. left nursing completely

g. other—specify

27. How many beds are at the hospital that you work(ed) at?

28. What is a general figure as to how much nurses make that work full-time on your unit annually, without overtime?

a. $30,000.00 – $39,000.00

b. $40,000.00 - $49,000.00

c. $50,000 - $59,000.00

d. $60,000.00 - $69,000.00

e. $70,000.00 - $79,000.00

f. $80,000.00 - $89,000.00

g. $90,000.00 - $99,000.00

h. $100,000.00 - $110,000.00

i. >$110,000.00

29. On average, how long does it take to replace a nurse in your dept?

30. Once the new nurse is hired, how long does it take before the nurse is self-sufficient?

31. While waiting for a new nurse to be hired, does your hospital use traveling nurses to fill the gap?

a. Yes

b. No

32. How many nurses are on leave in your department?

33. How many nurses are on medical leave on your shift?

34. How many nurses are on maternity leave on your shift?

35. How many nurses are on FMLA on your shift?

36. How many nurses are on workers compensation leave on your shift?

37. How many nurses have left your department in the last year because they were bullied or witnessed it?

38. How many How many nurses have left your department in the last year NOT related to bullying?

39. How many nurses on your shift habitually come in tardy?

40. How many nurses on your shift habitually come to work and then go home sick?

41. How many nurses on your shift display presenteeism—lack of engagement?

42. How many nurses on your shift display poor morale (always sad, angry, "don't care" attitude)

43. How many nurses on your shift provide less than expected quality of care?

44. Has your hospital dealt with any bullying cases that became public?

a. Yes

b. No

45. If you had not been bullied or witnessed it, would you have left the employer anyway?

a. Yes

b. No

46. If you are a manager, do you feel that the hospital administrators bully you to make your employees perform up to expected standards?

a. Yes

b. No

c. NA

47. Do you feel free to talk to your nurse manager about being bullied or witnessing it?

a. Yes

b. No

Appendix E: Questions to ask in both demographic questionnaire and Interviews

Master Question list

DEMOGRAPHICS QUESTIONNAIRE AND INTERVIEW QUESTIONS

EDUCATION

Rationale: By determining the nursing degree that the participant holds, I will know how to adjust questions further in the interview. EX: I would not ask an AD nurse questions that only a BSN nurse could answer

1) What nursing degree do you currently hold?
   a) AD
   b) Diploma
   c) BSN
   d) MSN
   e) DNP
   f) DNSc/PhD
2) What was your initial nursing degree?
   a) AD
   b) Diploma
   c) BSN
   d) MSN
   e) DNP
   f) DNSc/PhD

3) Do you hold other degrees?
    a) Yes
        i) List them
    b) No
4) How long after graduation with your initial nursing degree did you return to school to earn your BSN?
5) Have you ever been turned down for a job or not even apply because you did not have a BSN?
    a) If Yes, then:
        i) If you were turned down, what did you do?
        ii) If you did not apply, why not?
    b) No

GRADUATION

Rationale: This is a very important question because there was a great change that occurred in nursing during the 1970s. Nurses who graduated prior to 1980 (Baby Boomers and Vets/Traditionals), had a much different nursing school experience than those who graduated after 1980 (Gen X and Millennials). The Pill and Women's Lib, both established in the 1960s and 1970s, forever changed how women lived in the early 1970s. There were massive technological changes in the medical field such as the discovery of the CT (1971) and MRI (1971) machines, as well as blood glucose testing (1970). Most infectious diseases were eradicated via vaccines: measles

(1964), mumps(1967), rubella (1970), pneumonia (1977), meningitis (1978) and smallpox was declared officially dead in 1980. Dialysis, hip replacements, and transplants—all initially discovered in earlier years and used at large teaching hospitals, were now available to more people due to technology, which changed the course of medicine. Nurses were no longer "handmaidens" to the doctors, but were colleagues, working in conjunction with them instead.

6) What year did you graduate from nursing school with your first degree:
   a) 1930-1939
   b) 1940-1949
   c) 1950-1959
   d) 1960 – 1969
   e) 1970-1979
      i) If you graduated during the 1970s and had a cap: What degree did you earn to get your cap?
         (a) AD
         (b) Diploma
         (c) BSN
         (d) MSN
         (e) Doctorate
      ii) How long after you graduated did you wear your cap?
      iii) If you stopped wearing your cap, why?

iv) Were you bullied because you wore your cap after everyone else stopped wearing theirs?

(a) Yes

(b) No

v) When you were in nursing school were you able to identify the different caps from their respective schools?

(a) Yes

(b) No

f) 1980-1989

g) 1990-1999

h) 2000-2015

7) After you graduated, did you wear a white dress uniform to work?

a) If Yes, then:

i) Did you find the dress difficult to work in?

(1) Yes

(2) No

ii) How long did you wear a white dress uniform?

iii) Why did you quit wearing a white dress uniform?

b) No

8) After you graduated, did you wear a white pantsuit uniform to work?

   a) If Yes, then:

      i) How long did you wear a white pantsuit?

      ii) When did you switch to wearing scrubs?

   b) No

9) After you graduated, did you wear scrubs to work?

   a) Yes

   b) No

10) When you hear the word "nurse," what is the physical image that you see?

YEARS WORKING

Rationale: The amount of time a nurse has worked can have an influence on whether bullying occurs or not. It also impacts the present nursing shortage because nurses who should have retired in 2008 until present; did not, which artificially inflated the nursing shortage. Those that have worked many years (25+) have more incidents of Workers Compensation claims, are more prone to chronic illnesses, have more orthopedic injuries, and are at increased risk for being bullied. All negatively impact a hospital's bottom line.

11) How long have you worked as a nurse?

   a) 1 month – 11 months

   b) 1 yr – 4 yr

   c) 5 yr – 9 yr

   d) 10 yr – 14 yr

e) 15 – 20 yr

f) 21 – 24 yr

g) 25 – 29 yr

h) 30 – 34 yr

i) 35 – 39 yr

j) 40 – 44 yr

k) 45 – 49 yr

l) 50 – 54 yr

m) 55 – 59 yr

n) 60 – 64 yr

12) How many jobs have you had as a nurse?

13) What is the longest time that you were employed at one place?

14) When you were job hunting, was it before you left the hospital, or after?

a) If before, then: How long did it take you to find another job?

b) If after, then: How long did it take you to find another job?

15) How long did it take for you to get the next job?

16) When you were interviewed, what did you tell the interviewer why you had had so many jobs?

TYPE OF NURSE

Rationale: This tells me whether I am dealing with a staff nurse, manager, faculty, or a student

17) What type of nurse are you (can be more than one answer)

a) staff

b) charge

c) manager

d) supervisor

e) Director

f) NP

g) faculty

h) student

i) other

18) If you are a manager, do/did you feel that the hospital administrators bully(ied) you to make your employees perform up to expected standards?

a) If Yes, then: How?

b) No

NURSING DEPARTMENT

Rationale: Some researchers purport that different nursing departments are more prone to bullying. What is the case in this study?

19) What nursing department do you currently work in?

a) Obstetrics/Labor-Delivery

b) Nursery

c) Pediatrics

d) Emergency Department

e) Intensive Care Units

f) Med-Surg

g) Oncology

h) Burn

i) Psychiatric

j) Operating Room

k) Orthopedics

l) Neurology

m) ambulatory surgery

n) recovery

o) other—specify

20) What nursing departments have you worked in throughout your career?

(1) Obstetrics/Labor-Delivery

(2) Nursery

(3) Pediatrics

(4) Emergency Department

(5) Intensive Care Units

(6) Med-Surg

(7) Oncology

(8) Burn

(9) Psychiatric

(10) Operating Room

(11) Orthopedics

(12) Neurology

(13) ambulatory surgery

(14) recovery

(15) other—specify

EMPLOYMENT

Rationale: Is there a predominant employment status that is bullied?

21) What is your current employment status

a) Full-Time

b) Part-Time

c) Flexible

d) Agency

e) Pool/call-in

f) Other—specify

i) When did you retire?

ii) Did you retire because you wanted to, or were you forced to?

SHIFT

Rationale: Is there a theme that can be picked up between department worked, employment status, and shift? Is there a difference between shifts and bullying activity?

22) What shift do you work?

a) 8 hr shifts

i) Days

ii) Evenings

iii) Nights

b) 12 hr shifts

i) Days

ii) Nights

c) 10 hr shifts

d) Other—specify

GENDER

Rationale: This study was written towards female nurses, as they comprise the majority of nurses. Is that still true for this study?

23) What is your gender?

a) M

i) If Yes, then:

(1) Tell me about your bullying or witnessing experience

(a) Who bullied you?

(b) Who did you witness getting bullied?

(c) Do you know why they bullied you?

(d) Do you know why they bullied your coworker?

(e) When did it start?

(f) How long did it last?

(g) What actions did you take to stop it?

(h) Did you do anything to help your coworker?

(i) If Yes, then:

1. What did you do?

2. Did it help?

(ii) If No, then: Why not?

b) F

c) Decline

ETHNICITY

Rationale: The majority of nurses is White, but as the United States is changing that configuration to include more diversity, is that true in this study?

24) What is your ethnicity?

a) White

b) Hispanic

c) African American

d) Pacific Islander

e) Native American

f) Mixture (list)

g) Other (list)

h) decline

AGE

Rationale: For the first time in history, four generations are employed together in the U.S. workforce:

*Veterans/Traditionals: 1922 – 1945 (71 – 94)*ages for 2016*

*Baby Boomers: 1946 – 1964 (52 – 70)*ages for 2016*

*Gen X: 1965 – 1980 (36 – 51)*ages for 2016*

*Millennials: 1981 – 2010 (6 – 35)*ages for 2016*

Each generation embraces the work ethic in a different way, which can cause factions between coworkers. This can cause an increased number of bullies and bullied

25) How old will you be on your birthday this year?

a) 18-29

i) Do you see yourself always working on the floor?

(1) Yes

(2) If No, then: where do you see yourself 5 years from now?

ii) What is your ultimate Goal—to remain in nursing?

(1) If Yes, then: doing what?

(2) If No, then: doing what?

iii) Have you been injured while working?

(1) If Yes, then:

(2) Did you file a workers compensation claim?

(a) If Yes, then:

(i) How long were you off work?

(ii) Did you hire an attorney?

(iii) What was the outcome of your case?

(iv) Were you bullied when you returned to work?

1. If Yes, then: how
2. If No, then: were you treated differently, but not bullied?
   a. Yes
   b. No

(3) If No, then:

(a) Did you file a health insurance claim?

(i) If Yes, then:

1. How long were you off work?
2. Were you bullied when you returned to work?
   a. If Yes, then: how?
   b. If No, then: were you treated differently?
      i. Yes
      ii. No

iv) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

v) How many days/week are you affected by this(these) dx(s)?

vi) How many days/month do you miss work due to your dx?

b) 30-39

i) Do you see yourself always working on the floor?

(1) Yes

(2) If No, then: where do you see yourself 5 years from now?

ii) What is your ultimate Goal—to remain in nursing?

(1) If Yes, then: doing what?

(2) If No, then: doing what?

iii) Have you been injured while working?

(1) If Yes, then:

(a) Did you file a workers compensation claim?

(i) If Yes, then:

(ii) How long were you off work?

(iii) Did you hire an attorney?

(iv) What was the outcome of your case?

(v) Were you bullied when you returned to work?

1. If Yes, then: how
2. If No, then: were you treated differently, but not bullied?

a. Yes

b. No

(2) If No, then:

(a) Did you file a health insurance claim?

(i) Yes

(ii) No

iv) How long were you off work?

v) Were you bullied when you returned to work?

(1) If Yes, then: how?

(2) If No, then: were you treated differently?

(a) Yes

(b) No

vi) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

vii) How many days/week are you affected by this(these) dx(s)?

viii) How many days/month do you miss work due to your dx?

c) 40-49

i) Did you know that workers over 40 years old are considered “older workers”?

(1) Yes

(2) No

ii) Do you consider yourself an “older worker”

(1) If Yes, then: why?

(2) No

(a) Do you work full-time?

(i) Yes

(ii) If No, then: what hours/days do you work?

(b) Do you still work the floor?

(i) Yes

(c) If No, then: where do you work/what type of work do you do?

iii) How much longer do you plan on working the floor?

iv) Have you been injured while working?

(1) If Yes, then:

(a) Did you file a workers compensation claim?

(i) If Yes, then:

1. How long were you off work?

2. Did you hire an attorney?

3. What was the outcome of your case?

4. Were you bullied when you returned to work?

a. If Yes, then: how

b. If No, then: were you treated differently, but not bullied?

i. Yes

ii. No

(2) If No, then:

(a) Did you file a health insurance claim?

(i) Yes

(ii) No

v) How long were you off work?

vi) Were you bullied when you returned to work?

(1) If Yes, then: how?

(2) If No, then: were you treated differently?

(a) Yes

(b) No

vii) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

viii) How many days/week are you affected by this(these) dx(s)?

ix) How many days/month do you miss work due to your dx?

x) As an older nurse, have you been bullied by younger nurses?

(a) If Yes, then:

(i) Did they have more degrees than you?

1. Yes
2. No

(b) No

xi) As an older nurse, have you been bullied by those your age or older?

(a) If Yes, then:

(i) Did they have more degrees than you?

1. Yes
2. No

(b) No

xii) When did you find out that the treatment that you endured all these years was not "paying your dues" or "rite of passage" but bullying?

xiii) How did it make you feel?

d) 50-59

i) Are you still working on the floor?

(1) Yes

(2) No

ii) Do you work full-time?

(1) Yes

(2) If No, then: What hours/days do you work?

iii) Do you find it harder to work the floor now than five years ago?

(1) If Yes, then: How?

(2) No

iv) How much longer do you plan on working the floor?

v) Have you been injured while working?

(1) If Yes, then:

(a) Did you file a workers compensation claim?

(i) If Yes, then:

1. How long were you off work?
2. Did you hire an attorney?
3. What was the outcome of your case?
4. Were you bullied when you returned to work?

a. If Yes, then: how

b. If No, then: were you treated differently, but not bullied?

i. Yes

ii. No

(2) If No, then:

(a) Did you file a health insurance claim?

(i) Yes

(ii) No

(b) How long were you off work?

(c) Were you bullied when you returned to work?

(i) If Yes, then: how?

(ii) If No, then: were you treated differently?

1. Yes

2. No

vi) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

vii) How many days/week are you affected by this(these) dx(s)?

viii) How many days/month do you miss work due to your dx?

ix) As an older nurse, have you been bullied by younger nurses?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

x) As an older nurse, have you been bullied by those your age or older?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

xi) When did you find out that the treatment that you endured all these years was not "paying your dues" or "rite of passage" but bullying?

xii) How did it make you feel?

e) 60-69

i) Are you retired?

(1) Yes

(2) No

ii) Are you still working the floor?

(1) Yes

(2) If No, then: where do you work/what type of work do you do?

iii) Do you find it harder to work the floor/other dept now?

(1) Yes

(2) No

iv) How much longer do you plan on working?

v) Have you been injured while working?

(1) If Yes, then:

(a) Did you file a workers compensation claim?

(i) If Yes, then:

1. How long were you off work?

2. Did you hire an attorney?

3. What was the outcome of your case?

4. Were you bullied when you returned to work?
    a. If Yes, then: how
    b. If No, then: were you treated differently, but not bullied?
        i. Yes
        ii. No

(2) If No, then:

(a) Did you file a health insurance claim?

(i) Yes

(ii) No

vi) How long were you off work?

vii) Were you bullied when you returned to work?

(1) If Yes, then: how?

(2) If No, then: were you treated differently?

(a) Yes

(b) No

viii) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

ix) How many days/week are you affected by this(these) dx(s)?

x) How many days/month do you miss work due to your dx?

xi) As an older nurse, have you been bullied by younger nurses?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

xii) As an older nurse, have you been bullied by those your age or older?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

xiii) When did you find out that the treatment that you endured all these years was not "paying your dues" or "rite of passage" but bullying?

xiv) How did it make you feel?

f) 70-79

i) Are you still working?

(1) If Yes, then: where are you working/what type of work do you do?

ii) Do you work full-time?

(1) Yes

(2) If No, then: what hours/days do you work?

iii) Do you find it harder to work the floor/other dept now?

(1) If Yes, then: how?

(2) No

iv) How much longer do you plan on working?

v) Have you been injured while working?

(1) If Yes, then:

(a) Did you file a workers compensation claim?

(i) If Yes, then:

1. How long were you off work?

2. Did you hire an attorney?

(b) What was the outcome of your case?

(c) Were you bullied when you returned to work?

(i) If Yes, then: how

(ii) If No, then: were you treated differently, but not bullied?

1. Yes
2. No

(2) If No, then:

vi) Did you file a health insurance claim?

(1) Yes

(2) No

vii) How long were you off work?

viii) Were you bullied when you returned to work?

(1) If Yes, then: how?

(2) If No, then: were you treated differently?

(a) Yes

(b) No

ix) What medical conditions do you have—be specific with dx. and how long (let them tell me—use this list to prompt and check off):

(1) Hypertension

(2) Neurological

(3) Cardiac

(4) Asthma

(5) Lung/COPD

(6) Diabetes

(7) Obesity

(8) Liver/Pancreas

(9) Kidney

(10) Psychiatric/mental/emotional

(11) cancer

(12) Musculo-skeletal

(13) Migraines

(14) GI

(15) GU

x) How many days/week are you affected by this(these) dx(s)?

xi) How many days/month do you miss work due to your dx?

xii) As an older nurse, have you been bullied by younger nurses?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

xiii) As an older nurse, have you been bullied by those your age or older?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

xiv) When did you find out that the treatment that you endured all these years was not "paying your dues" or "rite of passage" but bullying?

xv) How did it make you feel?

g) 80-89

i) Are you still working?

ii) If Yes, then: where are you working/what type of work do you do?

iii) Do you work full-time?

(1) Yes

(2) If No, then: what hours/days do you work?

iv) Do you find it harder to work the floor/other dept now?

(1) If Yes, then: how?

(2) No

v) How much longer do you plan on working?

vi) As an older nurse, have you been bullied by younger nurses?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

vii) As an older nurse, have you been bullied by those your age or older?

(1) If Yes, then:

(a) Did they have more degrees than you?

(i) Yes

(ii) No

(2) No

viii) When did you find out that the treatment that you endured all these years was not "paying your dues" or "rite of passage" but bullying?

ix) How did it make you feel?

h) 90-99

i) Are you still working?

(1) If Yes, then: where are you working/what type of work do you do?

ii) Do you work full-time?

(1) Yes

(2) If No, then: what hours/days do you work?

iii) Do you find it harder to work the floor/other dept now?

(1) If Yes, then: how?

(2) No

iv) How much longer do you plan on working?

v) As an older nurse, have you been bullied by younger nurses?

(1) If Yes, then:

(a) Did they have more degrees than you?*

(i) Yes

(ii) No

(2) No

i) As an older nurse, have you been bullied by those your age or older?

i) If Yes, then: Did they have more degrees than you?

(1) Yes

(2) No

ii) No

j) When did you find out that the treatment that you endured all these years wasn't "paying your dues" or "rite of passage" but bullying?

i) How did it make you feel?

BULLYING

RQ 1: What are the lived experiences of nurses being bullied by nursing colleagues?
Bullied Nurse

START OF BULLYING

Rationale: Did the student come to nursing school having already experienced bullying? Did it start in nursing school or did it start after graduation at that first job? Multiple authors have stated that they have found that it starts in nursing school

26) When did the bullying start

a) before nursing school

i) If Yes, then: When?

ii) No

b) during nursing school

i) If Yes, then: When?

ii) Were you bullied when you were working on the floor as a student?

(1) If Yes, then:

(a) Who bullied you?

(i) Faculty

(ii) Students

1. In your class

2. In other grades

(iii) Employees—nurses/staff that worked the floor where you had clinicals

(iv) The head nurse, nurse manager

(v) Staff nurse

(vi) LPN

(vii) Aides

(viii) Other

(b) No

c) first job after graduation

i) If Yes, then: What happened?

ii) No

iii) When you graduated, did you work at the hospital that your nursing school was affiliated with?

(1) Yes

(2) If No, then: Where did you go for your first job:

(a) Same city

(b) Different city; same state

(c) Different state

iv) When you graduated, how long was it before you were bullied?

(1) What happened?

d) other—specify

i) Were you ever bullied when you were floating to another unit?

(1) If Yes, then:

(a) What did you do?

(b) Were there any repercussions?

(i) If Yes, then: What were they; what happened?

(ii) No

(2) When you had to float to the same floor again, were you bullied again?

(a) If Yes, then: What happened?

(b) No

27) Are you currently being bullied?

a) If Yes, then: tell me about your experience(s) of being bullied

i) How does this make you feel?

b) If No, then: When were you bullied?

i) Tell me about your experience(s) being bullied

ii) How did/does this make you feel?

28) Did you tell anyone?

a) If Yes, then: What did they say?

b) No

29) Were you afraid of retaliation if you said anything?

a) If Yes, then: How?

b) No

30) Did the bully retaliate against you?

a) If Yes, then: How?

b) No

31) How do you cope with the bullying?

32) How long would you be at a job before the bullying started?

33) How did the bullying start?

34) Did you know when it started or did you deny what was happening, but you knew that you were uncomfortable with how you were being treated?

    a) Yes

    b) If No, then:

        i) How long was it before you found out?

        ii) How did you find out?

35) Were you afraid that you would be labeled as a trouble-maker if you said anything?

    a) Yes

    b) No

36) Had others been labeled as a troublemaker for speaking out against the bully or reporting it the nurse manager?

    a) If Yes, then: What happened?

        i) How did you feel about them?

        ii) Did you treat them any differently—stay away from them, not talk to them, etc.?

            (1) If Yes, then: how did you treat them differently?

            (2) No

    b) No

37) How many times per week were you bullied?

38) How many times per week did you work?

39) How long has this been going on?

ABSENTEEISM DUE TO BULLYING RQ1,2 BOTH BULLIED AND WITNESS

Rationale: Absenteeism is a red flag indicating a person is being bullied. If there is a higher number of absent nurses on a regular basis, or certain nurses are absent in a distinct pattern may point to a bully problem within that department

40) How many nurses are absent from work each week?

41) Is it the same ones?

a) If Yes, then: Do you know the reasons why they call off?

i) If Yes, then: Why do they call off?

ii) Do you believe them?

b) No

42) Is there a pattern to their call-offs?

a) If Yes, then:

i) What is the pattern?

ii) Does it coincide with when the bully works?

(1) If Yes, then: Has anyone else noticed this pattern?

(a) Yes

(b) No

b) No

43) When they return, what is their attitude—are they:

    a) Angry

    b) Fearful

    c) Looking over their shoulder

    d) Here but not here--presenteeism

    e) Sad—tearful

    f) quiet

    g) isolating themselves from others?

    h) Other—specify

44) How does it make you feel when co-workers call off just before your shift starts?

45) How does that affect your attitude for the rest of the shift?

46) If you become angry because you have to carry additional patients on your workload, how does that affect your ability to give the high quality care that you want to give to your patients?

47) How does it make you feel when it is the same one that calls off repeatedly?

    a) What actions do you take?

48) Do you ever call-off to "get back" at your coworkers for calling-off and forcing you to carry their patient loads?

    a) If Yes, then: Does it make you feel better?

        i) Yes

        ii) No

    b) If No, then: Have you ever considered doing it?

i) If Yes, then: Why didn't you do it?

ii) No

49) If you call off to get back at your coworkers or because you are exhausted from carrying their load, how are you treated by your coworkers when you return to work (do they snub you, talk about you, side with you, etc.)?

50) Have you ever called-off because you did not want to deal with your bully that day?

a) If Yes, then: how did it make you feel?

b) If No, then: how did it make you feel?

51) What happened when you did return to work—did the bully come after you all the more?

a) If Yes, then: How?

b) No

Shame

Rationale: Shame is the shackle that keeps a nurse from addressing the bullying. It can be so devastating that it can cause all types of medical and psychological issues. The person experiencing the shame will deny there is any but it will come out in his or her actions.

52) Do you know anyone that seems angry all of the time?

a) Yes

i) Do you know why?

(1) Yes

(2) What is their reason?

(3) No

b) No

53) Do you know anyone that has an “I’m better than you” attitude?
    a) If Yes, then: Why do you think they are like this?
    b) No
54) Is this person a bully?
    a) If Yes, then: Why do you think so?
    b) No
55) Is this person bullied?
    a) If Yes, then: Why do you think so?
    b) No
56) Do you know someone that is always:
    a) Having a bad day
    b) Nothing goes right
    c) No one cares,
    d) Angers easily or has a “Short-fuse”
    e) Cries easily or for no reason?
        i) If Yes, then:
            (1) How does their attitude affect your attitude?
            (2) How does it affect your productivity for the shift?
            (3) Does their attitude affect other coworkers?
            (4) Does their attitude affect patients?
        ii) No
57) Have you ever asked them why they are having their ____ day?
    a) If Yes, then:
        i) What did they say?

ii) Did you believe them?

(1) Yes

(2) If No, then: Why not?

b) No

58) If your coworkers were asked if they were being bullied or have seen it in others, do they immediately deny it and don't want to talk about it—changing the subject, etc.?

a) If Yes, then:

i) Do you believe them?

(1) Yes

(2) No

b) If No, then: Why do you think they refuse to talk about it?

c) What do they do when you continue to pursue the issue?

59) Are you experiencing shame due to being bullied or witnessing it?

a) If Yes, then: Did you talk about it to anyone?

i) If Yes, then:

(1) Who?

(2) What happened?

ii) No

b) No

60) Do you feel that you have done something to cause people to bully you?

a) If Yes, then: What is it that you think you do that draws bullies to you?

b) No

61) Do/did you isolate yourself from co-workers so that you do not have to deal with the bully?
    a) If Yes, then:
        i) How long?
        ii) Does it work/help?
        iii) What happens when you begin to socialize with coworkers again?
    b) No
62) How has this isolation affected your relationships with your coworkers?
63) Have you talked to any of your coworkers about being bullied or witnessing it?
    a) If Yes, then: What did they say?
    b) No
64) Were you afraid of losing your job if you said anything?
    a) Yes
    b) No
65) Were you afraid of being blackballed and unable to find another job if you said anything?
    a) Yes
    b) No

66) How did this affect you:

    a) Financially

    b) Physically

    c) Emotionally

    d) Spiritually

67) Did you tell your family that you were being bullied?

    a) If Yes, then:

        i) Who did you tell?

        ii) Did they believe you?

            (1) Yes

            (2) No

        iii) What did they say?

        iv) How did this affect your relationships with the different members of your family?

    b) No

68) How many days (or nights) per week do/did you work?

69) How many times per week are/were you bullied?

70) How do you cope with the bullying?

BULLYING AND COWORKERS

RQ 2: What are the lived experiences of nurses being bullied by nursing colleagues? (Witness)

Rationale: Witnesses have two experiences with bullying. The first one is observing the bullying between two coworkers. The second experience is in dealing with the feelings after deciding whether to help or not

71) Are you currently witnessing a colleague being bullied?

a) Yes

b) No

72) Do you see nurses that have isolated themselves from the group?

a) If Yes, then: How does this make you feel?

b) No

73) Do you isolate yourself so that you do not have to witness the bullying?

a) If Yes, then:

i) How long has this been going on?

ii) Does it help the problem or make it worse?

(1) If yes/helps, then: Is this what you are going to continue doing in order to avoid witnessing the bullying?

(2) If No, then: What do you think will help you deal with this?

b) No

i) If you have witnessed others isolating themselves from coworkers, how does it make you feel?

74) Have any other nurses come to you to tell you that they have been bullied or that they have witnessed it?

a) If Yes, then:

i) Was it the same bully that you are dealing or have dealt with?

(1) Yes

(2) No

b) No

75) What did you say/do when they shared their story with you?

76) Were both of you then afraid of retaliation by the bully because you had talked to each other?

a) If Yes, then: What did you/or do you do?

b) No

77) Are there nurses in the department that appear worried, overwhelmed, and/or dissatisfied with their job?

a) If Yes, then: Do you know why?

b) No

78) Has anyone expressed that they may change jobs

(a) Shift

(b) Department

(c) Hospital

(d) type of nursing

(i) floor to office

(ii) floor to different type of floor nursing

1. ambulatory surgery
2. different type of clinical setting (floor to nursing home, hospice, etc.)?

(e) Leave nursing completely?

(i) If Yes, then:

1. How long ago?
2. Did they change jobs?
    a. If Yes, then: What did they do or where did they go?
    b. No
3. No

79) How did you feel when you witnessed co-workers being bullied?

80) Did you help them?

(a) If Yes, then:

(i) What did you do?

(ii) Did it help?

1. If Yes, then:
    a. How did it help?
    b. What happened to the person?
    c. What happened to you?
2. If No, then: Did you feel guilty?
    a. Yes
    b. No

81) What was your reason for not helping?

(a) Not my problem

(b) I need the job

(c) I have bills, children, spouse to take care of

(d) I am afraid that I will be next

(e) I do not want to deal with it

(f) Other

82) If you did help, what happened to the person and what happened to you?

83) After witnessing your co-workers being bullied, did this affect you enough to force a change in your work environment?

(a) If Yes, then: What did you do?

(b) No

84) How did you feel when you made your change?

85) How did it affect you:

1. Financially
2. Emotionally
3. Physically
4. spiritually

86) What actions/reactions did you observe between your peers/co-workers when they were bullied?

87) How many coworker bullying episodes have you observed?

(a) How did this make you feel?

(b) Did you help your co-worker?

(i) If Yes, then: How?

(ii) No

88) In each of these episodes, was it always the same bully?

(a) If Yes, then: How did this make you feel?

(b) No

89) How many bullies reside in your department?

90) How many people are in the bully's group?

91) What actions do/did you take to prevent yourself from being bullied?

92) What actions did you take to prevent having to witness bullying again?

93) Did you tell your family that you had witnessed a coworker being bullied?

a) If Yes, then:

i) Who did you tell?

ii) What did they say/what advice did they give?

iii) How did this affect your family?

b) No

i) If you did not, why not?

CHOICES

RQ 3: How does the bullying experience of nurses impact career choices past the bullying experience?

Bullied Nurse and Witness

Choice

Rationale: The choice a nurse makes regarding career choices impacts the nurse and family. There can be medical and psychological consequences associated with the decision

94) What career choice did you make to stop the bullying or to not witness further bullying?

a) nothing

b) changed shift

c) changed department

d) changed hospitals

e) left hospital nursing for another type of nursing

f) left nursing completely

g) other—specify

95) Did your choice of action solve your problem?

a) If Yes, then: Are you happy with the choice?

b) If No, then: What are you going to do next?

96) If you had it to do over, would you have done the same thing?

a) Yes

b) If No, then: What would you have done?

97) You were bullied for _____ (days, months, years). How many jobs did you leave because of it?

98) How did you feel when you left the job?

a) Sad

b) Mad

c) Relieved

d) Glad

e) Other—specify

99) How long did it take for you to get your next job?

100) When you interviewed for your next job, did you tell the interviewer that you had been bullied when they asked why you left your previous job(s)?

a) If Yes, then:

i) What did the interviewer say?

ii) If you did not get the job, do you think it was because of this?

b) If No, then: What did you tell the interviewer as to why you left?

BOTTOM LINE

RQ 4: How does the RN turnover rate impact the bottom line of a hospital, both indirectly and directly in costs?

Direct costs (questions 101-123, 127 are automatic questions to be asked of every participant)

* = demographic question

Rationale: Nurses may not be intimately acquainted with the actual costs that a hospital experiences, but they can provide a general idea, enabling the researcher to deduce actual costs. These can then be compared with the information in chapter two.

101) How many beds are at the hospital that you work(ed) at?*

102) What is a general figure as to how much nurses make that work full-time on your unit annually without overtime?*

a) $30,000.00 – $39,000.00
b) $40,000.00 - $49,000.00
c) $50,000 - $59,000.00
d) $60,000.00 - $69,000.00
e) $70,000.00 - $79,000.00
f) $80,000.00 - $89,000.00
g) $90,000.00 - $99,000.00
h) $100,000.00 - $110,000.00
i) >$110,000.00

103) Do you know how much you earn in benefits in addition to your salary?

a) If Yes, then: Provide a ballpark figure

b) No

104) Does your employer match your 401K or 403B contributions?

a) If Yes, then: How much does your hospital match you in your 401K or 403B contribution (usually a %)?

b) No

105) How much paid vacation to you get?

106) Does it increase yearly?

a) If Yes, then: By how much?

b) If No, then: How often does it increase?

107) How much do you pay for health insurance?

a) Bi-weekly or

b) Monthly

108) How much do you pay for dental insurance?

109) How much do you pay for vision insurance?

110) How much do you pay for Short Term Disability insurance?

111) How much do you pay for Long Term Disability insurance?

112) How much do you pay for extra life insurance?

113) How much do you pay for AD&D insurance?

114) How much do you pay for group legal services?

115) How much do you pay for personal excess liability insurance?

116) How much do you pay for tobacco use as a surcharge?

117) What other programs do you pay for and how much?

118) Do you know how much it costs to replace a nurse in your hospital?

a) If Yes, then:

(1) regular

(2) specialty

b) No

119) On average, how long does it take to replace a nurse in your dept?*

120) Once the new nurse is hired, how long does it take before the nurse is self-sufficient?*

121) While waiting for a new nurse to be hired, does your hospital use traveling nurses to fill the gap?*

a) Yes

b) If No, then: What do they use?

122) How many nurses are on leave in your department? *

a) Medical

b) Maternity

c) FMLA

d) W Comp

123) How many nurses are on leave on your shift?*

a) Medical

b) Maternity

c) FMLA

d) W comp

124) Of these nurses on leave, how many do you think are due to being bullied or have witnessed it?

125) Do you know if any of these nurses were bullied before they took a leave of absence?

a) Yes

b) No

126) If they were bullied or witnessed it and took a leave, did they take it because they were bullied or had witnessed it?

a) Yes

b) No

127) How many nurses have left your department in the last year because they were bullied or witnessed it?*

128) How many nurses are being bullied or witnessing it in your department now?

129) Are you one of them?

a) Yes

b) No

130) How many nurses have been bullied or witnessed it in your department in the last year?

131) Are you one of them?

a) Yes

b) No

132) How many nurses have left your department in the last year NOT related to bullying?

133) What were their reasons?

134) When the nurses left (on leave or quit) how did this affect you:

a) Financially

b) Emotionally

c) Spiritually

d) Physically

135) How many nurses have been sued in your dept in the last year ?

136) Have you ever been sued?

a) Yes

b) No

Indirect Costs

Rationale: Nurses will be able to provide a much more detailed picture of indirect costs because they are affected by them: absenteeism, presenteeism, tardiness, poor morale, etc.

137) How many people on your shift

a) Habitually come in tardy

b) Are habitually absent

c) Come to work and then go home sick

d) Display presenteeism – lack of engagement

e) Have decreased productivity

f) Display poor morale---sad, angry, don't care, etc

g) Provide less than satisfactory quality of care

138) When these people are not at work, how does this affect the remainder of the staff:

a) Workload

b) Productivity

c) Bullying

d) Morale

139) How many times/week does this happen—that you have to help carry their patient load?

140) Do you want to call off on your next shift because you are so exhausted from carrying more than your load?

a) If Yes, then:

i) Have you ever done it?

(1) If Yes, then: How often?

(2) No

b) No

141) Have you ever called off because you were tired of carrying your patient load plus part of another nurse's?

a) Yes

b) No

142) Has your hospital dealt with any bullying cases that became public?

a) If Yes, then:

i) What happened?

ii) How did this affect the hospital's reputation?

iii) How did it affect the staff?

b) No

143) Did you consider leaving because of the bad press?

a) If Yes, then: Did you leave?

i) Yes

ii) No

b) No

144) If you had not been bullied or witnessed it, would you have left the employer anyway?

a) Yes

b) No

Hospital Administrators

Rationale: Managers and staff can be bullied by hospital administrators in the form of policies, rules, etc. This type of behavior is not routinely thought of as bullying.

145) Do you feel that your hospital administrators bully you through your managers or some other way?

a) If Yes, then: How?

b) No

146) If you are a manager, do you feel that the hospital administrators bully you to make your employees perform up to expected standards?

a) If Yes, then:

i) How?

ii) Does it work?

b) No

147) Do you have to bully your staff then, in order to meet the demands of your hospital administrators?

a) If Yes, then: How does this affect your relationship with your staff?

b) No

148) Do you feel free to talk to your nurse manager about being bullied or witnessing it?

a) Yes

b) No

149) What will your manager do if you talk about being bullied or witnessing it?

Appendix F: Phone Script to Set up the Interview

Follow-up Phone Call to set up Skype Interview or Phone Interview

Hello.

Is this_____?

If no, apologize and hang up.

If yes, continue

This is Brenda Williams. I am the doctoral student that sent you an email on _____ regarding the study about nurses bullying nurses. You returned the criteria and demographic questionnaire to me on _____. I am calling to set up our (Skype or phone) interview.

What date and time looks good for you?

(have calendar ready)

If the date is good, then schedule a time

If not, then ask for a different date and time

Continue until a date and time can be scheduled

Before our interview, I need for you to find your benefits overview. I will be asking you questions about how much you pay for all of your benefits such as vision, dental, and life insurance.

Do you have any questions at this time about the study or the upcoming interview?

If yes, then answer them

If no, then continue with closing the call

Thank-you for agreeing to talk with me on (date)_____ @ (time)_____

I look forward to our call ☺

Appendix G: Phone Script for the Interview

At the Interview

Hello ☺

This is Brenda Williams. I am talking to _____ on (day)_____ (date)_____ @ (time)_____.

Before we begin the interview, I want to reiterate a few things:

- The call will be recorded so I can transcribe our conversation

If the person did not want the transcription, then move on to the next section—

(Length of Interview)

If the person agreed to receive a transcript go over that

TRANSCRIPTION REVIEW

- After the transcription is complete, I will send a copy of it to you for review if you indicated on the introductory letter that you would like to check your transcript. If you did not check the box but have decided that you would like a copy of your transcript, you may do so now and I will gladly email it to you. If there are any errors, please let me know so we can discuss my error and I can fully understand what you meant in our conversation

LENGTH OF INTERVIEW

- According to the answers that you provided in the demographic questionnaire, your customized interview will contain ____ questions.
- It will take us about ____ minutes to complete the interview

STOPPING AND/OR WITHDRAWING FROM THE INTERVIEW

- If at any time you feel uncomfortable from the questions, you may stop the interview and we can talk about it and determine if you wish to continue, or you can stop the interview and withdraw from the study.
- If you choose to withdraw from the study, there will be no repercussions and everything that we have discussed will be immediately deleted
- If at any time during the interview I determine that you are feeling uncomfortable, I will stop the interview and we will discuss and decide whether to continue or to withdraw.

CONFIDENTIALITY

- After the interview, I will transcribe our recorded conversation and will enter your information into my computer and a flash drive. Your name and preferred contact information will remain with your transcript until I am confident that your transcript information is correct. If you checked the box for the study results, everything will be deleted except for your email address and as soon as the results are emailed, the address will be deleted too

MENTAL HEALTH AND MEDICAL SERVICES

If you feel you need mental health or medical health services, the following places offer free access:

- If you are in crisis and are a danger to yourself or others or if your injuries are severe or life threatening, dial 9-1-1

- If you are considering suicide, call the 24/7 Columbus suicide hotline at 614.221.5445
- 24/7 mental health and alcohol/drug crisis intervention is available at netcare access. Call the crisis line at 614.276.2273 or go to 199 South Central Ave or 741 East Broad St

If, at any time during the study you feel that you need to be seen for mental health for medical care, email me and I will be glad to send you the complete list. I can email the list now if you would like to have it for future reference

Ok….let's get started! ☺

Ask the questions from the interview master list that have been customized for this participant

**MEDICAL AND MENTAL HEALTH INFORMATION TO EMAIL

Medical Care

1. **Mt. Carmel Outreach**

   rotating locations, 614.546.4200

2. **Columbus Public Health**

   240 Parsons Ave, 614.614.7417

3. **Vineyard Free Clinic**

    a. 171 E. 5th Ave, 614.259.5428

    b. 15187 Palmer Road, Reynoldsburg/Etna, OH 43068. 740-927-7729

    We offer these two clinics EVERY Wednesday NIGHT, from 6:30 to 8:30PM

        a. Free medical care for the poor and uninsured, EVERY Wednesday night. We have a medical doctor and nurses available. Prescriptions can be written and we give $4 gift cards to purchase one month's supply of prescriptions. We do not do narcotic drugs, nor do we have any drugs at the clinic. 6:30 to 8:30 PM EVERY Wednesday.

        b. Free pregnancy care clinic for any lady EVERY Wednesday. We offer free pregnancy testing, free ultrasound. We also offer mentor mothers, safe housing and new baby supplies for the first two months.

    All the clinics are completely free. No appointments necessary. People are served on first come first serve basis.

4. **Columbus Free Clinic**

    2231 N. High St, 614.404.8417

5. **New Life UMC Clinic**

   25 W. 5th Ave, 614.294.0134

6. **Xenos Free Clinic**

   1934 N. 4th St and 40 Chicago Ave, 614.823.6510

7. **Columbus Neighborhood Health Centers**

   614.645.5500

   a. East Health Center - 1180 E Main St
   b. John Maloney Health Center - 3781 S High St
   c. St Stephen's Health Center - 1500 E 17th Ave
   d. Columbus Northeast Health Center - 3433 Agler Rd
   e. West Family Health and Wellness Center-2300 West Broad Street

Mental Health, Alcohol and Drug (AOD) treatment

1. **Netcare Access**

   mental health, AOD assessment and outreach

   199 S. Central Ave and 741 E. Broad St, 614.276.2273/li>

2. **Alvis House**

   Multiple services to individuals & families

   1991 Bryden Road, 614.252.0660

3. **Columbus Public Health**

   AOD program

   240 Parsons Ave, 614.645.6839

4. **Jewish Family Services**

   Mental health and career counseling

   1070 College Ave, 614.231.1890

5. **Mental Health America of Franklin County**

   Referrals to mental health and AOD treatment

   538 E. Town St Suite D, 614.221.1441

6. **Columbus Area, Inc.**

   Mental health, AOD, and specialized reentry programs

   1515 E Broad Street, 614.252.0711

Appendix H: Transcript Review email

Dear _____,

Enclosed is the transcription from our (Skype, phone)_____ interview that took place on (date)_____ @ (time)_____.

Please review this transcription for accuracy, make comments, and return it to me within one week (date)_____ via this email .

I may need to contact you again for further clarification.

As soon as I am confident that I do not need to make further contact, all of your identifying information: name, phone, and email address will be deleted and there will be NO identifying factors that can connect you to this study.

If you also indicated that you wished to receive the results of this study, I will retain your email address only and will delete it after the final email has been sent to you.

Appendix I: Dissemination of Study Results

(I will have the email address only)

Greetings!

Enclosed is the study results from the recent (Skype, phone, face-to-face)_____interview that you participated in on (date)_____ . I hope that you will find the information useful to you in future use.

Thank-you for participating in my study.

Regards,

Brenda Williams, RN, BS, CCM, MBA, FCN, PhD candidate

Appendix J: Categories from Data Analysis

C1 Demographics	C2 Bullying	C3 Choices	C4 Bottom Line
Q01-05 Education	Q26-Q39 Bullying, Start of Bullying	Q94-Q97 Choices	Q101-Q136 Direct costs
Q06-10 Graduation	Q40-Q51 Absenteeism	Q98 Feelings when left job	Q137-Q144 Indirect costs
Q11-Q16 Years working	Q52-Q70 Shame	Q99-Q100 Next job and interviewing	Q145-Q149 Hospital Administrators
Q17-Q18 Type of Nurse	Q71-Q93 Bullying and Coworkers		
Q19-Q20 Nursing Department			
Q21 Employment			
Q22 Shift			
Q23 Gender			
Q24 Age			

Appendix K: Software and Tools used During Data Analysis Process

Software

Technology has made it exceptionally easy for the researcher to collect data and analyze it. There is virtually an "app" for every type of recording or data analysis need. There are also the tried and true "low-tech" tools available too, including such things as Excel spreadsheets, MS Word, and paper and pencil. There are software programs that not only record your interview, they transcribe it, sort it, and analyze it too (De Felice & Janesick, 2015, p. 1576). But there is one thing that all of the technology in the world cannot do and that is replacing the human mind for thinking. It still requires the thought capabilities of a human to direct these programs and to make sure that what has been identified during coding and theme-processing is correct. The following are the software and tools that I will be using for this study.

Skype. I will be using Skype to interview the participants. It allows for the free exchange of information in a simulated face-to-face setting. The advantage to using Skype for this study is that the participants are dispersed throughout the United States, making face-to-face interviews impossible (Salmons, 2012, p. 12). The interviews will be synchronous and recorded. This will be considered a private interview as each participant must agree to a time when the Skype interview will take place. Skype is a type of videoconferencing tool. The advantage of the webcam allows for both of us to see each other. This will assist me in crafting probing questions after I have asked the essential questions. Skype also has a chat function (much like instant messaging) and is usable when audio or video are not. The chat function is an ideal way to share

information such as interview questions, notes, or consent forms, as well as to conduct member checking (De Felice & Janesick, 2015, p. 1579). Salmons stated that there are four roles that are played in a Skype interview. The first one is the interviewer. The interviewer is responsible for conducting the research in a scholarly fashion, including ethical practices, being sensitive to the participant's feelings, and constructing the type of data collection questions that align with the problem and purpose of the study. The second one is the participant's role, which is to answer the questions honestly and completely. Additionally, the participant must engage in an exploratory conversation with the researcher to facilitate a clear understanding of the phenomenon, thus promoting further inquiry. The third role is the alignment between the problem statement, the purpose statement, and the research questions and the fourth role belongs to the computer and the Internet (Salmons, 2012, p. 6). Skype interviews are considered as primary Internet-mediated research because the information is directly obtained (Salmons, 2012, p. 5). Skype permits two people to see each other although they may be thousands of miles away. I chose to conduct online semi-structured interviews using Skype as a facsimile to actual face-to-face interviews. The reasons that I chose this type of milieu are: (a) the participants are not in my immediate area but in another state; (b) the use of semi-structured interviews with Skype provides real-time interaction; and (c) adds the dimensions of sight and sound to enrich the interview process. When a person's body language can be seen, it adds depth and a deeper understanding to the listener. In the case of online semi-structured interviews, the participant's body language will prompt me in how to add more probing questions. Online semi-structured interviews require more

rigor in the interview questions so it is important that before embarking on the interview process all parties are clear on what is expected from each, equipment needed by the participant, the purpose of the study, and how the data collected will be used (Salmons, 2012, p. 11). The participants will engage in two types of interviews. The first will be a structured, closed-ended demographic questionnaire that is part of the e-mail invitation. The second part consists of semi-structured open-ended questions that will be asked at the Skype interview. Structured interview questions allow for short answers without the capability for further explanation, while semi-structured questions balance the short answer direct questions with the freedom to expand by asking "What" and "How" questions (Salmons, 2012, p. 20). In addition to the e-mail invitation, criterion questions, and demographic questions, at least one avenue of mental health support will also be offered.

Call Graph. Skype has recording functionality, but in addition to this, I will utilize a program called Call Graph. Call Graph works independently of Skype but also in conjunction with it, providing secure additional recording (De Felice & Janesick, 2015, p. 1580). Another nice feature about Call Graph is that it converts the recording to an MP3 file and sends it directly to the computer desktop (De Felice & Janesick, 2015, p. 1580). As soon as the call is made and connected to Skype, Call Graph immediately starts recording (De Felice & Janesick, 2015, p. 1578). De Felice and Janesick noted that if the audio and video part of Skype disconnects, this is where Call Graph comes in as a backup (2015, p. 1579).

Express Scribe. The next step will be the transcription. After recording the interview in Call Graph, it can then go to a program called Express Scribe. To insure that all transcriptions will be saved, I can copy-and-paste the transcription into a Word document for a backup (De Felice & Janesick, 2015, p. 1580).

MS Word. The printed transcriptions go here. There will be two. The one I transcribe by hand from my notes and Call Graph and the one from Express Scribe.

Excel. For the data analysis, the primary place that data will reside is in Excel. It has been proven to work just as well with text as with numbers. A thorough proofing of the information that is now residing in Excel is warranted to insure that all information transferred correctly. Demographical data and qualitative analysis will be supported by Excel spreadsheets and NVivo. The first spreadsheet's purpose is to correlate a participant name with a 3-digit ID number and house the demographic questionnaire items. The second Excel spreadsheet's purpose is to categorize and code the data from the Skype interview. Since this is an a priori listing of what I think will be pertinent, it is assumed and expected that as the research progresses categories will be added, modified, or deleted.

NVivo. This tool promotes dependability and credibility to the study with three tools. The first is a text query that has the capability of identifying significant terms, concepts, themes, and codes. The researcher can then review what NVivo has found to see if there is something compelling that requires further investigation. The second tool is a coding query. This apparatus looks closely at all of the data that has been assigned to the specific code in query. This is useful for teasing out patterns that may require further

analysis. The third tool is the matrix-coding query, which enables the researcher to scrutinize multiple codes and their corresponding information at the same time; again, "looking" for similarities and dissimilarities. All three tools increase the accuracy of the participants' reports to the researcher and insure that their perceptions have been preserved (Houghton, Shaw, & Murphy, 2013, p. 15).

Tools

Notes/Memos. The third suggestion from Maxwell was to use notes (memos). Memos encourage an "out of the box" view of the phenomenon as well as a reflection of the data that is under study. They contribute thoughts, ideas, other theories, and questions such as "why," "why not," "how," "when," and "what". These ideas provide the incentive to search for patterns, exceptions, nuances, explanations, and alternative explanations that contribute to the development of themes and theories, ideas, and questions for further analysis in this study as well as future ones (Maxwell, 2013, p. 105). Categories, connectors, and notes provide the researcher with tools to mine the raw data and unearth the rich deposits of information that would otherwise not be found. The act of tearing down, rebuilding (categories), viewing information as a whole (connectors), and making notes provides a way to examine and explore data from different angles and depths.

Memos are a great tool to use when reflecting on data collected during analysis. It supports harmonizing, postulating, comparing, and contrasting, data. Memos can be incorporated into writing as a way of thinking, re-organizing, and re-building the pieces

into a new story; potentiating an additional type of theorizing (Mulvihill, Swaminatha, & Bailey, 2015, p. 1495).

Journals. Greene (2014) stated that a researcher conducting a qualitative study would be wise to keep three different journals. One is a personal journal—writing of emotional thoughts daily. An example would be to address what areas were encouraging and what areas were discouraging. A second journal would be a reflection journal. This is written from a more professional viewpoint, reflecting on the struggles and accomplishments that were experienced throughout the study. A combination of the personal journal and the reflection journal is what bracketing/epoché is (De Felice & Janesick, 2015, p. 1582). A third journal is a methodological journal. It diaries the researcher's presence and involvement with each participant, identification of my biases as well as the participants, data-gathering techniques and anything else that has to do with the actual mechanics of the study (p.8). The methodological journal is where the researcher writes the rationale regarding decisions made, the history of the project and its progression to the end, and the problems that were addressed—how and why and the outcome (Houghton, Shaw, & Murphy, 2013, p. 15).

Audit Trail. An audit trail can be a real lifesaver to the novice researcher. If the novice is questioned about a decision that was made, the well-kept audit trail will be able to answer any question satisfactorily (Houghton, Shaw, & Murphy, 2013, p. 14).