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Walden University

College of Social and Behavioral Sciences

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Dawn White

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Walden University
2018

Abstract

Workplace Bullying From a Nurse's Perspective

by

Dawn Reid White

MA, Walden University, 2013

BS, Old Dominion University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2018

Abstract

Bullying has long been associated with school children. In recent years, however, more attention has been paid to the bullying that has reached beyond the playground and into the workforce. One population facing this problem is staff nurses. To date, no one has found an effective way to address workplace bullying in the healthcare field, nor have effective methods been found for retaining trained nurses affected by this problem. The focus of this dissertation was on understanding nurses' lived experiences and how nurses decided to remain in their current working position despite these problems. Taking a phenomenological approach and using the conceptual framework of resilience, the study included telephone interviews of 2 pilot study participants and 12 main study participants. Recorded and transcribed participant responses to interview questions were coded thematically and analyzed. Three main themes emerged: stories of working with workplace bullying, challenges of the lived experiences of being bullied, and special techniques of nurses being bullied. Three subthemes also emerged: despair, love of being a nurse, and resilience. This study gave a voice to nurses affected by this problem, revealing special challenges they encounter and coping strategies they employ. Hospital administrators can use the findings of this study to create social change within nurses' working environment by implementing policies that will keep their nurses safe and happily employed. Future research should focus on workplace bullying in the nursing field and how it affects patient safety.

Workplace Bullying From a Nurse's Perspective

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Dedication

There are so many people that I would like to dedicate this dissertation too. I want to start by thanking my wonderful and loving husband, Dr. Timothy A. White. Fourteen years ago, we started our voyage together and through countless analytical conversations, at all hours of the night, we finished our journey together, you before me. It was such a pleasure for both of us to be studying and writing at the same time and it made the process easier. I always loved "No Homework Mondays," the best. I love you and it is so exciting to be Dr. and Dr. White.

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Now on to my next adventure, whatever it is!

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Chapter 1: Introduction to the Study

Introduction

Bullying was once thought of as a childhood problem and was often handled on the schoolhouse playground when the teachers turned their heads for a moment (Granstra, 2015). In the last 15 to 20 years, it has grown to become a more significant problem and has expanded from the playground into the workplace and even on the Internet with cyberbullying (Agervold, 2007; Granstra, 2015). Although bullying is a problem in many environments, I focused in this study on workplace bullying and how it pertains to nurses in healthcare. Workplace bullying within the healthcare industry is an ever-growing problem and leaves no new graduate or experienced nurse immune to its after-effects (D'Ambra. Andrews, 2014).

Nursing is a well-established field that has a high degree of honor and integrity (Newport, 2012). Nurses are perceived as professional and willing to help individuals who are in pain or in need of direct assistance. According to the Newton's (2012) Gallup poll report, 85% of people polled considered nurses to be incredibly honest. If these perceptions are accurate, then what could explain the overabundance of bullying within the nursing profession?

A number of authors have written about the increasing concerns of this unhealthy trend. According to Dellasega (2015, as cited in Townsend, 2015), nurses are known for "eating their young" (p. 4). In several journal articles, researchers describe this concept as older, more experienced nurses treating younger nurses abusively and consuming who they are (Etienne, 2013; Granstra, 2015; Townsend, 2015). They are left feeling alienated

and often exit the job they worked so hard to acquire. Frequently the outcome causes the victim stress, health issues, or job loss (Granstra, 2015).

Bullying is not only a problem for the victim, it is an issue for the entire working environment, including the patients they are treating. In some instances, workplace bullying affects nurses' home life and their overall health (Einarsen, Hoel, & Notelaers, 2009). Currently, no consistent method of eradicating workplace bullying exists. Until such time as that happens, tireless research needs to continue on this subject matter.

The focus of this qualitative research project is to describe the lived experiences and special challenges that contribute to the effects of workplace bullying. Additionally, there is a need to understand how nurses decide to retain their current job despite being bullied. Once healthcare administrators address these issues, society will have a clearer picture of workplace bullying, but more importantly, healthcare administrators may increase their ability to retain nurses they have spent money to train.

Chapter 1 provides background information on the phenomenon of workplace bullying in the nursing field, the problem statement, the purpose of the study, the research questions, and an overview of the study narrative. The chapter also includes working definitions associated with the study as well as the specific assumptions, limitations, delimitations, and a problem scope. Finally, the chapter gives the significance of the study and how it will foster social change.

Background of the Study

Researchers and hospital administrators have identified a continual need for well-trained nurses (Lachman, 2014; Laschinger & Fida, 2014; Read & Laschinger, 2013;

Townsend, 2015). Patients have an underlying need to demand a safe and reliable nurse to treat their illnesses. In return, hospitals administrators have a responsibility to ensure the safety of their patients and their employees. One study suggested if a nurse is not comfortable or feel as though they repeatedly need to develop ways to defend themselves, they cannot build the required interpersonal relationships with their patients (Karatza, Zyga, Tzlaferi, & Prezerakos, 2016). These connections are required to create a feeling of mutual respect between patient and nurse. Our nursing professionals must have a safe working environment to properly care for their patients without fear of bullying or harassment. Without specific standards in place, nurses are faced with minimal job satisfaction and the inability to become a successful in their profession.

Researchers have focused on a global bullying phenomenon in the nursing profession (Rodwell, Demir, & Flower, 2013; Vessey, Demarco, & DiFazio, 2010). The trend resulted in well-documented physical and psychological effects, which caused health problems, stress, and inability to concentrate (Vessey, Demarco, & DiFazio, 2010). Additionally, behaviors found to be associated with bullying include gossiping behind a colleague’s back, spreading rumors, calling names, telling jokes about a coworker or their family members, being vindictive, humiliating a coworker or group of coworkers, or not supporting a teammate (Dellasega, 2009; Yildirim, 2009). In the nursing profession, it is vital to work as a team while maintaining composure to ensure the safety of patients, and concentration during critical tasks, such as medication administration (Tre´panier, Fernet, & Austin, 2016).

Bullying did not fall neatly under the umbrella of physical or verbal aggression either. It occurs in nonaggressive and passive styles where the victims are unaware of its existence until a later time (Dzurec, Kennison, & Albataineh, 2014). These forms of bullying are just as harmful as many of the aggressive physical acts that occur. In fact, Heinrich (2007) explained how employees play games as a way to undercut coworkers or make their counterparts or bosses look at these coworkers poorly. Agervold's (2007) research included scapegoating as a passive way to inflict horizontal bullying. These games, whether verbal or nonverbal, are forms of bullying or passive aggressiveness that employees need to acknowledge when they decide to stay in their current working position or not.

Current trends forecast nursing shortages as detrimental to the field of nursing (Wilkins, 2014). The World Health Organization (WHO) estimated that by 2025 there would be a nursing shortage greater than 260,000 workers, while other researchers expected that number to reach 900,000 by 2030 in the United States alone (Juraschek, Zhang, Ranganathan, & Lin, 2012; Sanford, 2013; Wilkins, 2014). According to Yildirim (2009) nurses were identified as making up over 50% of the health care workforce and suggested over 40% of all nurse's experienced bullying each year. With numbers this high, the attention needs to shift towards maintaining trained nursing staff.

Maintaining nursing staff, referred to as *nursing retention*, is a focus for hospitals as well as private-sector doctors' offices. Retention is a primary reason this type of study merited additional research. If these trends and forecasted nurse shortages go unaddressed, the quality of our healthcare will rapidly decline. To date, no qualitative

research project has been conducted to ask bullied nurses who stayed in their positions why they remained. It became apparent it was time to go directly to the source for answers.

Problem Statement

Workplace bullying is a common phenomenon known to affect all industries, including health care. According to researchers, such the harassment caused decreased job satisfaction and job security (De Cuyper, Baillien, & Witte, 2009; Dellasega, 2009; Park & Ono, 2016). Sanford (2013) stated that by 2030 the United States will have a shortage of 900,000 nurses, indicating a high employability rate for the profession. With that current trend in healthcare, nurses will become highly pursued and employee retention will be essential. The focus of this study is on nurse retention, and reducing workplace bullying is one key element that will assist in this endeavor.

Researchers have gathered empirical data that scientifically explains various types and outcomes of workplace bullying for nurses. The data indicated many nurses leave their positions to seek employment elsewhere rather than endure harassment (Read & Laschinger, 2013). These repetitive fallouts call for an in-depth need to reduce workplace bullying and its effects. In fact, one study suggested nurses leaving their job increased when coupled with higher incidents of bullying (Emerald, 2014).

An extensive amount of research has addressed workplace bullying; however, there was no clear explanation for why some nurses remained on the job despite being subjected to workplace bullying (Blackstone, Harlos, MaCleod, & Hardy, 2014). Read and Laschinger (2013) posited that, if health care organizations want to retain their

nursing staff, future studies were needed to determine, through a nurse's voice, what could be done to retain them after they experienced acts of bullying. Additionally, Blackstock et al., (2014) suggested that self-reporting, as seen in qualitative research, is needed to obtain the sensitive statements required to understand nurses' ability to remain employed rather than quitting or moving. At the time of the study, no researcher had specifically interviewed nurses to understand their lived experiences, the challenges they faced, or their decision to maintain their current job despite being bullied.

Research Questions

The research questions for this study were as follows:

RQ1: What are the lived experiences of nurses who continued to maintain their position despite being bullied in the workplace?

RQ2: What are the special challenges nurses experienced workplace bullying, when faced with the decision to retain their position?

RQ3: What are the techniques nurses use to rationalize their decision to retain their current working position, after being subjected to workplace bullying?

Purpose of the Study

The objectives of this qualitative descriptive phenomenological study were to describe the lived experiences and special challenges that contributed to the effects of workplace bullying, and to understand how nurses decided to retain their current job despite being bullied. Nurse participants perceived individual problems as added stress, increased physical or mental exhaustion, decreased family involvement, or low job satisfaction when working with the colleagues who bullied them. To assess the problem, I

employed in-depth semistructured interviews to expand the understanding of their lived experiences compared to nonbullied nurses who enjoy their profession and engagement with patients and coworkers. Additionally, in this study I focused on understanding how these nurses continued to retain their position.

Conceptual Framework

Resilience provided a conceptual framework for understanding why nurses decided to stay in their current employment despite being bullied in the workplace. Van Heugten (2013) suggested resilience draws a parallel between workplace bullying and the flexibility to maintain control over a seemingly uncontrollable situation. In her study, Van Heugten (2013) indicated that if workplace bullying is dealt with appropriately, the victim can achieve resiliency even after being exposed to the adversity.

Resilience has been defined as an individual's capacity to modify his or her balance to preserve control over a terrible situation (Bishop, McCullough, Thompson, & Vasi, 2006; Jackson, Firtko, & Edenborough, 2007; Van Heugten, 2013). Nurses pride themselves on caring for patients, and all employees must work as a unit to be successful in their job (Hippeli, 2009). Jackson et al., (2007) explained that nurses encourage resilience with their patients, to help them deal with adverse situations or poor medical outcomes. If a nurse becomes exposed to workplace discourse, the trauma can persuade a well-trained and well-adjusted nurse to leave the position they loved and worked so hard to achieve, in search of a better life away from their current job (Jackson et al., 2007).

Werner (1989) used the concept of resilience to explain the results of a 32-year longitudinal study conducted to determine the degree of positivity or negativity displayed

by children living with adversity. The researcher used resiliency to describe outcomes associated with young children's positive development, despite coming from high-risk families or trauma, such as parental drug use or parental mental illness (Werner, 1995). Resilience, as a conceptual framework, deals with preserving and supporting the victim's mindset when confronted with aggression, helps describe factors that transpired from these interactions, and helps change the negative social challenges into positive learning experiences (Johnson & Wiechelt, 2004; Juraschek et al., 2012) The term *resilience* helped researchers explain potential outcomes and reasons nurses choose to stay in their current nursing position (Bishop et al., 2006). Additional definitions and explanations of bullying associated with young children, adults, and nurses, appears in greater detail in Chapter 2. Finally, the concept of resilience helped me in the development of the interview questions.

Nature of the Study

Qualitative Approach

I used a descriptive transcendental phenomenological research approach for the current study on nurses who have been bullied at work and decided to retain their existing nursing job. The intent of the analysis was not to form theory but to gain a perspective of the phenomenon of interest and learn from the participants' own lived experiences (Giorgi, 2012). The knowledge which emerged from this study added structure to the understanding of an increasing problem associated with nursing retention and addressed the on-going issue of bullied nurses leaving to work in other facilities or other positions within the same hospital organization. The phenomenological approach was the

appropriate method to use and produced a new standpoint, free of bias and personal beliefs, to explore the presented phenomenon.

In this study, the descriptive phenomenological approach (Giorgi, 2012) allowed the participants to explain their perceptions of being bullied, followed by their rationale for maintaining their job. The focus was to conduct face-to-face, telephone, or Internet-based in-depth semistructured interviews with each participant. Doing so helped gain detailed accounts and find common themes to explain why nurses were willing to stay in their job in the face of adversity. Focusing on how nurses react and respond to workplace bullying helped to determine the factors that allowed them to decide to stay in their position. Only the nurse participants would be able to define their justifications for this phenomenon and reveal their lived experiences through interpretation and profound descriptions. The knowledge gained will help researchers, hospital administrators, and other individuals understand why nurses choose to stay in their job.

Operational Definitions

Included are some definitions that may clarify and bring a sense of precision to the concepts addressed throughout this project. Some of the terms are specific to the nursing realm and healthcare facilities. Additionally, a few of the operational definitions listed were needed at the onset of data collection to identify the sample population.

Bullying: This is a social interaction between one person of low power (victim) and another with a perception of a higher power (bully). A bullying attack occurs against the perceived victim by a single person or group of people. The bullying act arises on a daily basis over an extended period (Agervold, 2007). The outcome of the bullying leaves

the victim feeling helpless. The act has also been referred to as mobbing or harassment and has graduated from the schoolyard to the workplace.

Horizontal bullying in nursing: This refers to bullying between coworkers, where one or more coworkers of equal status choose to alienate a colleague with comparable credentials. This type of bullying is different than *top-down* bullying where a manager, doctor, or administrator inflicts the harassment.

Nursing retention: This term refers to the percentage of nurses that remain in their job after becoming oriented and fully trained. The idea is to have a higher number of nurses stay on the job compared to the number of those who receive training and leave their position.

Resilience: An individual's capacity to modify their balance to preserve control over a bad situation (Bishop et al., 2006; Jackson et al., 2007; Van Heugten, 2013). Resilience shows a parallel between an undesirable occurrence and the flexibility to maintain unquestionable control over a seemingly uncontrollable situation.

Workplace bullying acts: Workplace bullying is an imbalance of power with repeated physical or psychological aggression to a person or group of individuals that do not wish to be harassed (Bishop et al., 2006; Dellasega, 2009; Van Heugten, 2013). This type of bullying occurs in the workplace and can consist of bullying by coworkers or groups of coworkers, managers, or administrators.

Assumptions, Limitations, Scope, and Delimitations

Assumptions

I made several assumptions while performing this study, which impacted the study design. One assumption was that the findings were based on an assumption of truthfulness by the nurse participants. In addition, I made the following assumptions:

1. Bullying occurs within health care, especially in the field of nursing.
2. Each nurse had earned an RN or equivalent degree and had worked in the field for an amount of time greater than one full year.
3. All participants were truthful in their information and no information was given without having occurring.
4. Each nurse participant felt comfortable enough with this process to share the workplace bullying experiences they encountered.
5. All participant had lived through workplace bullying as described by the working definition in the informed consent, in the informed consent, which they read and understood.

Limitations

At the onset of this study, I based sampling on detailed criteria, which included nursing staff subjected to workplace bullying in the last year who continued to work as a nurse in some capacity. Because of the small sampling size (n=12), the possibility of targeting all cultures, ethnicities, gender, or socioeconomic status was not possible to achieve.

The first limitation revealed results could not generalize across different cultures. The current study, done only in the United States, can only account for cultures found to exist within the same country. While the United States is known for being a melting pot of cultures, the possibility remains that participants would be native to their resident country. In line with the above assertion, the second limitation was the inability to obtain participants of both genders.

The third limitation transpired due to the many variations of nursing perceptions and experiences. The academic levels range from licensed practical nurse (LPN) with a two-year degree or less up to a doctorate level of nursing with many years in academia. Other variations come from different fields of practice, such as nurse manager, floor nurse, administrator, or even nurse practitioner. Finally, the last limitation was my lack of prior experience doing qualitative research and performing interviews during the data collection process. To address this limitation, I did a two-participant pilot study to address problems with qualitative research methodology and to practice the interview process.

Scope

The sample population of this study consisted of active registered nurses, from all aspects of the nursing profession and recruited the social media site Facebook. Even with the nurses coming from varying departments around the country, the findings cannot be generalized to the general population due to the lack of male participants and cultural variations. Volunteers needed to have been employed in their current working position for a minimum of one year. Additional requirements included the perception of being

bullied within the last year, and despite being bullied, having decided to remain in their current working position. The perceptions were based on an operational definition provided on workplace bullying in the informed consent and recruitment flyer (Appendix B).

To obtain the sample population of nurses, I posted a recruitment flyer on social media sites. The brochure included a working definition of workplace bullying and instructed qualified nurses to contact me with their intent to participate. The overall objective was to interview each participant in an attempt to understand their lived experiences of workplace bullying and to have their point of view in regards to why they chose to remain in their current working position despite these issues.

Delimitations

The study did not target any specific hospital or health care organization, but instead nurses from all areas of nursing and all geographic areas within the United States. Not covered in this research project were the general concept of bullying, health care policies addressing bullying, or any characteristics associated with the bully. During this research project, I used a qualitative phenomenological research approach, and the volunteers participated in telephone interviews with me. Nursing staff who met the minimum requirements represented the participant pool for the study. These individuals were the ones who had a genuine understanding and experience with bullying, how they dealt with the consequences, and most importantly, how they chose to remain in their current working position.

Significance of the Study

Once healthcare administrators learn the actual cost associated with bullying and nurses become familiar with the magnitude of changing careers due to workplace bullying, they can be implement schemes to halt additional problems. According to Juraschek et al., (2012) the ever-increasing population in the United States, combined with the advancing age of the population, has caused a natural deficit of nursing personnel. Unfortunately, the projected nursing shortage did not include added reasons for the shortage. The projected nursing shortage did not account for social and psychological reasons nurses left their positions, such as workplace bullying. (Juraschek et al., 2012; Sanford, 2013).

The Workplace Bullying Institute reported that nearly 60% of new nurses left their job within six months due to workplace bullying (Namie & Namie, 2014). Workplace bullying, defined as an imbalance of power with repeated physical or psychological aggression to a person or group of individuals that do not wish to be harassed (Bishop et al.,2006; Dellasega, 2009; Van Heugten, 2013). Having a quality and stable working environment, one with an atmosphere of reduced stress, adequate work space, safety, and ethical standards, allows nurses to be patient-centered (ANA, 2016). It also requires respect between working parties, ultimately, increasing the need for retention of seasoned nurses (Vessey et al., 2010).

This research project proved unique because it focused on the lived experiences of nurses. The victims of bullying in the workforce offered descriptions of the challenges they encountered and explained the reasons they elected to stay in their job, despite their

mistreatment. The results of this study provided insight for current nurses, nursing managers, and administrators on how to retain their trained nursing staff.

Implications for Social Change

If managers and hospital administrators can obtain workable information directly from the source on how to effectively address the problem of workplace bullying among nurses, social change will occur. Not only could it help reduce workplace bullying, but there is a possibility that retention of nursing staff will increase. The retention of nurses and the reduction of workplace bullying will save hospital industries money and the effort of training new nursing staff, ultimately leading to staff that is happy and willing to do the job they trained so hard to do.

Summary and Transition

Chapter 1 included an introduction to this qualitative descriptive phenomenological research study on workplace bullying among nursing. Bullying in the health care industry has caused more than just problems for the victim. It has also affected patient care and patient safety, caused financial burdens for the hospitals, and created distress with family and friends outside the workforce. Researchers put many hours into trying to understand this crisis, but a gap still existed with regard to understanding why some nurses can decide to retain their current working position and some opt to leave the profession. I used resilience as the conceptual framework for this study. It is this resilience that assisted each nurse in making these favorable decisions. In Chapter 2, I provide an exhaustive literature review.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative, descriptive phenomenological research study was to determine, through a nurse's own lived experiences, why they stayed in their current working position despite being bullied in the workplace. The phenomenon of workplace bullying routinely results in negative consequences for the victim and those close to them. The most severe instances of workplace bullying often make headlines for media outlets (Smith, 2016).

Workplace bullying in the healthcare industry, especially in the nursing field, has been studied for years, yet there is a growing need to find ways to decrease their occurrences (Esfahani & Shahbazi, 2014). According to Esfahani and Shahazi (2014), being exposed to or witnessing verbal bullying occurred to 97% of polled nurses. In addition, 72% of nurses who participated in a different study had observed bullying behaviors, such as physical or sexual harassment, passive and active confrontations, or inappropriate actions against others or self (Esfahani & Shahbazi, 2014). The Workplace Bullying Institute reported nearly 60% of new nurses left their job within six months due to workplace bullying (Namie & Namie, 2014, "Kaplan Survey", 2014) Unfortunately, not all instances of workplace bullying receive noticed by upper management or those able to do something to eradicate the problem. To a great extent, previous researchers of this phenomenon have adopted a quantitative approach; however, when researchers approached this topic from a qualitative approach, none took the time to speak directly to the nurses or listen to their opinion on the situations. For these reasons there was a need

to have in-depth conversations with the nurses who lived through workplace bullying and found a way to continue working in their current position.

Data combined with an extensive literature review helped answer the following research questions:

RQ1: What are the lived experiences of nurses who continued to maintain their position despite being bullied in the workplace?

RQ2: What are the special challenges nurses encounter, who have experienced workplace bullying, when faced with the decision to retain their position?

RQ3: What are the techniques nurses use to rationalize their decision to retain their current working position, after being subjected to workplace bullying?

The literature review summarized in Chapter 2 served to establish a current understanding of the topic. This information will increase the working knowledge found within the identified gaps and point to the need for future research on the subject. In addition, information gleaned from the literature review will contribute to supporting documents regarding the use of resiliency as a conceptual framework.

Literature Search Strategy

For this study, an extensive search of the Walden University Library and SKOR Library yielded a significant amount of literature. In conducting the review, I focused on peer-reviewed journal articles, prior studies, and published books, which helped describe workplace bullying, workplace bullying in the nursing field, resilience, and nursing retention. Included in these searches were administration, nursing, business and management, and psychology. CINAHL, ProQuest Nursing, Business Source Complete,

Digital Dissertations, and Psych Info as the primary databases used during the article searches. Additionally, initial searches occurred through ProQuest Dissertations, Google, and Google Scholar.

The terms I used in the initial search included *workplace bullying, workplace aggressing, nursing, nursing retention, retention, resilience, nursing shortages, bullying characteristics, bullying effects,* and *psychosocial resilience*. Additional sources that did not appear in the initial search were obtained in reference sections of identified journal articles. I read each article and identified central concepts to include in the literature review for this study. During this process, key elements regarding workplace bullying in the nursing field became apparent and were further researched.

Many scholars have assisted in the understanding, outcomes, health consequences, and top-down control of workplace bullying and nursing or nursing retention. The leading experts included Notelaers, DeWitte, and Einarsen (2010), DeCuyper et al., (2007) Namie and Namie (2011), Yildirim (2009), and Park and Ono (2016). Each of these researchers contributed to the needed research in the field of workplace bullying.

Conceptual Framework for Study

The phenomenon studied was that nurses bully other nurses. The study focused on nurses who had been bullied in the workplace and why these nurses retained their job despite these problems. During this study, participants' responses helped to reveal how to handle these situations. Typical responses ranged from doing nothing at all to leaving their current job despite these tribulations. The conceptual framework, resilience, helped

explain and identify leading characteristics of why some nursing staff, in the face of workplace bullying, decide to stay in their current working position. Throughout the literature, resilience as a framework routinely appeared in contemporary and peer-reviewed literature articles, not just those associated with nurse bullying.

The next section includes a discussion targeting essential characteristics of resilience. The articles used in this project helped define resilience and identified leading researchers in the field. It also served to unite aspects connected to resilience. Areas of interest included resilience as it pertained to children and adults and the beliefs which help construct life-altering decisions made by nursing staff.

Resilience

Resilience is considered a dynamic process and causes an ever-changing response to life stressors, worldly demands, and a multitude of adversities with the outcome of preserving a sense of steadiness. In the ever-growing field, researchers studying resilience have focused on the short-term and long-term responses to stressors. For many individuals, the strategies associated with daily stress and their ability to handle these pressures are what researchers have tried to comprehend. Examples of these stressors fall into categories such as death of a family member or loved one, war-time traumas, terrorism, natural disasters, or social/personal/relational violence like bullying (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014).

Resilience has been defined by researchers using qualities or characteristics instead of a firm, clear-cut definition. With that in mind, some researchers have interpreted resilience as the ability to bounce back or successfully rebound after being

exposed to particular circumstances that are unfavorable or difficult (Hart, Brannan, & De Chesney, 2014; Van Heugten, 2013). Other researchers added to this definition by including inner-strength, flexibility in managing stressors, remaining optimistic, the ability to face adversities head-on, internal locus of control, prosocial behavior, and empathy (Cusack, et al. 2016; Pines et al. 2012; Wagnild, 2009). Additionally, researchers have more specifically identified low and high levels of resilience. Individuals identified as having low resilience were found to be unable to counter-act situations that were changing. They often became disorganized when dealing with stressful circumstances or experiences categorized as trauma or distress (Eisenberg, et al., 2003). On the flip side, people with high resilience tended to be highly flexible and had an easier time coping or adapting to stressful conditions (Eisenberg, et al., 2003). Highly resilient people also made the best use of their problem-solving skills.

Researchers found that resilience existed throughout different developments throughout the lifespan (Johnson & Wiechelt, 2004; Masten, 2001). They also identified many traits that carried over from a very early age into adulthood. One principal researcher in the field of workplace psychological resilience was Rees (Rees, Breen, Cusack,L.,, & Hegney, 2015). Other researchers who identified different aspects of resilience in everyday life included Jackson, Firtko, and Edenborough (2007), Firtko (2011), and Cusack, et al. (2106).

Industrial and organizational psychologists have meaningfully focused on areas of resilience. Consequently, they have made abundant strides with the use of positive psychology. They also identified how individual strengths helped counteract life's

challenges or encounters found within any working environment (Happy, Umesh, & Pooja, 2016). In the field of industrial and organizational psychology, researchers have concentrated on antecedents of resilience and how it affected organizational commitments in adults (Happy, Umesh, & Pooja, 2016).

Resilience was chosen as the conceptual framework to help explain and identify leading causes of how some nursing staff who faced workplace bullying preferred to stay in their current working position. It will also help shed light on how resilience began in the younger population and carried into adulthood.

Resiliency from Childhood to Adulthood

The idea of resilience, first noted in a longitudinal study by Werner and Smith which started with an idea, as is often the case in research (Johnson & Wiechelt, 2004). The 1955 study took place in Kauai, a small island in Hawaii, and focused on a population of 505 children born into poverty. The children were of Japanese, Philippine, and Hawaiian descent, and the island was so poverty-stricken, that running water and electricity were only for the privileged. Because the study was longitudinal, research on the participants progressed through their lifespan from birth to adulthood (Werner & Smith, 2001).

Over the years, other researchers have duplicated the study and identified specific protective factors. There are three levels of protective factors: “the individual, the family, and the community” (Fleming & Ledogar, 2008, p. 8; Shpiegel, 2015). One study suggested if babies and children can have at least one close personal relationship or healthy attachment to an adult, they can form positive resilience traits (Werner & Smith,

2001). According to Johnson and Wiechelt (2004), following a longitudinal study ending in 1994, Masten suggested additional protective factors to include high intelligence skills, good performance in school, high socioeconomic status, and positive parenting styles. During these times, the idea of resilience alluded to children that were invincible to the point that in March 1976, *The Washington Post*, published an article entitled "Trouble's a Bubble to Some Kids" (Masten, 2001, p. 227).

More contemporary research on resilience revealed the definitions to be mostly the same, except the child being invincible. Because the idea associated with resilience included having significant trauma, daily battles, stress or being at risk for a poor outcome, most of the studies included these variables. Several researchers focused on adolescents and young adults, who have been dealing with cancer and the resulting treatments. These individuals are at an increased rate of having severe emotional and cognitive problems. The concept of resilience would explain their distinct ability to cope with these stressors in a way that promoted positive outcomes for themselves and those around them (Ishibashi et al., 2016). Frequently, across several studies, the adolescents and the young adults that received positive comments from supportive parents or other adults, about their need to stay strong and do the best they could, excelled (Ishibashi et al., 2016; Rosenberg et al., 2015). Interestingly, however, those that did not receive these positive comments from a parent, decided to continue with treatment which had similar results (Ishibashi, et al., 2016).

Even in the geriatric community, older adults can achieve resilience. One author related a story of a 70-year-old woman who had previously delivered a child with

meningitis. Her husband died when the child was 5 and the child died at age 10. She later remarried and had a joyous life until the couple divorced and she moved into an elderly community. Even at the age of 70 and having faced these agonies earlier in life, she remained positive, and amazing the authors by showing all the traits associated with resilience (Nimroz, Ahmedali, & Samir, 2016). When an older adult, without these resilient qualities enters into a nursing facility or hospital, they will feel overwhelming loneliness or depression. Not only is resilience, in the senior community, good for reduction of negative consequences, it is also responsible for increased positive health outcomes (Nimroz et al., 2016).

Resiliency Nursing

The jobs of professional nurses revolve around helping patients and their family members. Nurses assist patients by providing comfort and compassion through short- and long-term illness, palliative and hospice care, and death and bereavement issues (Brennan, 2017). Throughout each of these scenarios, nurses are responsible for putting aside their anxiety, uncertainty, and even their own needs. The emotional exhaustion resulting from these challenges can break down any human being, yet somehow, many nurses provide high-quality care for their patients and achieve a career that ends with the fulfillment only a nurse can understand (Brennan, 2017). This fact is a perfect example of resilience in nursing.

The role of resilience in in a nurse's life is crucial in combating the ever-rising nursing shortage (Brennan, 2017; Tusaie & Dyer, 2004). Just like children, adults are plagued with situations and stressors that are beyond their control. This is especially true

for adults who decide to become part of the nursing profession. These stressful situations and how they handle them are what make nurses who they are and guide how they ultimately solve problems they face on a daily basis.

One study suggested 33% of health care workers became stressed; this high percentage is second only to childhood adversities (Li, Cao, Cao, & Liu, 2015). One well-known stressor in the healthcare field is workplace bullying or horizontal violence (Altuntas, Altun, & Akyil, 2014; Cheung & Yip, 2017; Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013; Demir & Rodwell, 2012; Li et al., 2015). According to McDonald, Jackson, Vickers, and Wilkes (2016), "the concept of resilience is considered a primary factor in the resolution of such workplace adversities" (p. 124). Bullying is a stressor that, if dealt with robustly, can be turned around or eradicated. Despite challenges, such as these, when nurses are resilient, they have proper coping strategies to handle these destructive situations while maintaining a positive outlook on their career (Brennan, 2017).

Findings from a study of resilience factors suggested individuals who have a higher degree of peer support and problem-solving skills show a higher-level of resilience (Hsieh, Hung, Wang, Ma, & Chang, 2016). The promotion of Internal resilience comes with attributes such as purpose, faith or belief, empathy, self-control, emotional intelligence, and flexibility (Delgado, Upton, Ranse, Furness, & Foster, 2017). In the United States, religious beliefs have shown to increase resilience in individuals subjected to trauma during childhood (Brewer-Smyth & Koenig, 2014), and domestic violence in adults (Anderson, Renner, & Danis, 2012). External resilience is environmentally driven

and includes social networking, peer support, mentorship, and having a good role model (Delgado et al., 2017). Nursing administrators need to include internal and external resilience-building exercises in mandatory learning activities so that nurses can learn how to adapt to troubles as they happen during the workday.

Literature Review

Brief Introduction to the Literature

Bullying has long been a social problem studied in detail all around the world (Donegan, 2012; Granstra, 2015; Zych, Ortega-Ruiz, & Del Ray, 2015). The term, bullying is often defined as an intentional and repetitive assault of another individual, or group of individuals who is unable to defend themselves (Agervold, 2007; Barton et al., 2011; Namie & Namie, 2014; Vessey et al., 2010; Zych et al., 2015). The aggression, associated with bullying, is often unwarranted and unwanted and always happens over an extended period. Researchers in Scandinavia introduced the idea of bullying in the schoolyard in the early 1970s (Smith, 1997). Shortly after they identified the problem, scientists began conducting research. At that time, most of the face-to-face bullying research surrounded the younger community, specifically school-aged children. However, bullying has branched out to include mistreatment in the workplace and harassment delivered through technology, or cyberbullying (Adams, Beasley, & Rayner, 1997; Thornberg, Rosenqvist, & Johansson, 2012; Viljoen, O'Neill, & Sidhu, 2005).

Heinz Leymann, the founder of the international antibullying movement, was interested in the overall health difficulties individuals suffered from the effects of bullying (Esfahani & Shahbazi, 2014; Leymann, 1990). In the 1980s he created the Work

Trauma Institute in Sweden and focused on psychological terrorism, which he called mobbing (Namie, 2003; Leymann, 1990). Shortly afterward, a Swedish journalist Andrea Adams recognized bullying had moved beyond the schoolyard and infiltrated the workforce (Esfahani & Shahbazi, 2014). Adams coined the term *workplace bullying* as a way to separate the different facets of bullying (Adams, Beasley, & Rayner, 1997; Namie, 2003). In the late 1990's, Ruth and Greg Namie brought the term, workplace bullying, to the United States, where the phrase quickly became a source used by the legal community in academia and legal defenses (Namie, 2003).

Bullying has a hierarchy, and the top of the chain is the bully who is considered the instigator. Next on the list are the followers or assistants, the onlookers or bystanders who usually stay neutral, and the victim who received the brunt of the abuse. Unfortunately, there is one more possible layer of the hierarchy, which would be the bully-victim: someone who was once a victim but afterward becomes an aggressor (Donegan, 2012). The list applies to all ages, from the very young school-aged child to the adult administrator of a massive corporation. Since the identification of bullying, researchers have tirelessly worked to find a way to dismantle these aggressive behaviors. Furthermore, acts of bullying are terrifying to the victim but also cause problems for the victim's family, those around them, and entire corporate entities (Adams, Beasley, & Rayner, 1997; Donegan, 2012; Smith P. , 1997).

The act of bullying, in the workplace, can occur at any level of the workforce in any organization or industry. There is no discrimination between genders, race, or skill level as to who will become a bully to others. In the health care, specifically the nursing

field, the typical description used to describe such actions is lateral or horizontal violence (D'Ambra. Andrews, 2014; Vessey et al.,2010). According to researchers in the field, workplace bullying is on the rise among all levels of nursing, as noted throughout this literature review, thus requiring a need to reduce these problems. These days, most companies have harassment policies in place to address or minimize these challenges, but that is not always enough to negate or prevent the bullying.

Levels of Nursing Experience

According to Richardson's (2016) recount of the International Council of Nursing (2002), the definition of nursing included the promotion of health and well-being, care for the ill or dying, and the prevention of sickness or disease. The profession also involves becoming an advocate for patients while maintaining a safe environment, researching new and creative ways to assist ill patients, create new health policies, and building hospitals or facilities with caring management and administrators (Richardson, 2016). With this definition in mind, one can understand the overwhelming burden early nursing members encountered and eventually had to overcome.

Prior to advancements in modern health care, much medicine and caring came from their priests or high-ranking member of their Christian affiliations. In the middle to late 1800's, nurses provided medical assistance to soldiers injured during wartime, especially during the American Civil War. In December 1962, the now-famous poet Walt Whitman went to Fredericksburg, Virginia to check on his wounded brother. Once he got there, he observed how overworked the nurses were and quickly became part of the nursing staff. In the late 1800's, nurses did not have formal training and often learned

from their counterparts or the doctors that triaged the incoming injured soldiers (Hsu, 2010).

In recent years, the levels of nursing experiences, (student, experienced nurses, management, or administrator) differ drastically within a nursing field setting. The amount of education, coupled with the amount of responsibility each nurse is required to face, makes them who they are. The ultimate responsibility should be safe nursing practices, regardless of the number of years each nurse has practiced in the health care field. Unfortunately, this is not always the case. All nurses come to the table with the experience they need to do their job completely; what differs is how they decide to use this knowledge, and how they choose to treat those around them.

Student nurses are required to enroll in a college or university attend long classes, and participate in clinical site rotations. One of the quintessential components to student nurse learning is the practical experience they can only get by going into the hospital setting, psychiatric hospitals, or home care facilities, where they learn by watching and assisting (Logan & Clarke, 2016). Colleges assign clinical nurse instructors to help students; however, the experienced nurses who treat these patients are ultimately in charge of allowing the students to observe or watch and assist. The students are expected to jump in and aid where they are assigned. During this time, staff nurses and managers have an opportunity to examine the students and take notes of who excels. If done correctly, such experiences will foster student nurses to become exceptional candidates for future positions (Logan & Clarke, 2016).

When this procedure fails, or managers hire a student into a dysfunctional working environment, problems will ensue. In the health care field, a significant amount of workplace bullying includes a rival between experienced nurses and new practitioners coming fresh out of nursing school (Granstra, 2015). The well-known term "eating their young" is often used to explain how the older, more experienced nurses treated their novice counterparts (Etienne, 2013; Granstra, 2015; Huntington et al., 2011; Longo, 2014; Townsend, 2015). One would equate this practice to fraternity hazing or initiation into a college sorority. New nurses, starting out treating patients should be concerned with the proper way of administrating medication and communication with patients, doctors and other nurses instead of worrying about being bullied in the workplace. One report suggests up to 50% of older nurse have participated in harassing new, inexperienced nurses (Granstra, 2015). One factor, identified by Granstra is a hierarchical workplace culture that creates this cycle of unhealthy behavior. In the research, he strongly alluded to the fact that the older nurses have grown up in a culture accepting that bullying occurs on a regular basis (Longo, 2014). The researcher also suggested that, since experienced nurses have gone along with this behavior, regularly bullying may have happened because in past instances they had no recourse or were unaware of how to report the negative behaviors (Longo, 2014). To get away from these practices, organizations such as the Joint Commission on Accreditation on Healthcare Organization (JCAHO), a highly-recognized hospital accreditation review board, require workplace cultures that cultivate relationships at all hierarchical levels (Szutenbach & Stechschulte, 2008). A nurse's chief focus should always remain on the safety of each patient entering

the hospital for care. The responsibility for mediation and implementation of such practices lies with proper management of nursing and health care staff (Park & Ono, 2016).

Bullying in Nursing

Bullying behaviors look different in most environments; however, one thing is clear: The acts of bullying are unwanted by the victim and the management staff, even if the management staff is the one exhibiting the bullying behaviors (Van Fleet & Van Fleet, 2012). One study suggested bullying can be brought on by cliques within the working environment (Barton, et al., 2011). It begins with a group of people that have similar interests and want to fit in with the others in the group. To maintain their power or remain dominate, members of the group will bully others less prominent. The nursing industry is especially vulnerable to these behaviors (Cheung & Yip, 2017; Szutenbach & Stechschulte, 2008; Van Fleet & Van Fleet, 2012). In fact, one set of researchers identified one sign of a clique is an outsider's feeling of being left out or exclude entirely. Through the study, nursing students were surveyed one month before graduation and found they had high expectation of saving the world, one patient at a time; but, three months after graduation they quickly realized they were the odd-one-out and often felt bullied (Barton, et al., 2011).

Another study very similar emerged from a Turkish community. The researchers (Ovayolu, Ovayolu, & Karadag, 2014) sought to determine what characteristics were present to initiate workplace bullying. What they found indicated an association between socioeconomic status and new hire status when it came to bullying younger nurses,

whose lack of professional experience set them up as targets. The results also indicated that older, more experienced nurses were less likely to be plagued with workplace bullying (Ovayolu et al., 2014).

These types of issues are accurate for most new or novice nurses, who comprise a very vulnerable population, while workplace bullying creates a very stressful working environment. Berry, Gillespie, Fisher, Gormley, and Hayes (2016) posited that the peer-to-peer or mentor-to-new hire bullying occurred due to the increased workload the mentor encountered when training the apprentice nurse. This is an especially vulnerable time for the new nurse and positive reinforcements are what should be taking place.

Bullying in the nursing field is toxic to the health care environment (Berry et al., 2016; Karatza et al., 2016). Empirical data, according to Cheung and Yip (2017), posited workplace bullying against nurses occurred at a rate of 10 - 50% but has been measured up to 87% in hospital settings in Westernized countries such as the United States. The researchers further suggested the number could be greater due to recall bias, since participants were requested to remember instances spanning the last year. These results, as compared to other research studies with high percentage rates, showed recorded verbal bullying as high as 90% (Cervolo et al., 2012).

Frequently, bullied nurses report struggles like exhaustion, headaches, cardiac or gastric complications. If the instances of workplace bullying persist for any length of time, the nurses' coping mechanisms begin to decrease which, in turn, increases the potential for psychological issues. Adverse psychological characteristics often reported include depression, stress, anxiety, or low self-esteem, all of which are highly correlated

with workplace bullying (Berry et al., 2016). If the attacks are not resolved, other long-term effects, such as Post Traumatic Stress Disorder (PTSD) can follow these traumatic events. Once bullying events occur, nurses suffer the consequences of hyperarousal, loss of interest in work and home life, nightmares, and avoidance syndromes (Berry et al., 2016). In fact, one study of working nurses (n=72) confirmed that 44%, of these nurses exposed to workplace bullying received a PTSD diagnosis (Teharni, 2004).

Types of Bullying in the Workplace

The act of violence prevention routinely is a problem for all societies. Historically speaking, the criminal justice system, sociologists, psychologists, and criminologists were the principal source of research or prevention for these acts of violence. Over the last few decades, the violence has filtered into the healthcare industry. Because of the sensitive nature of what healthcare workers do, the World Health Organization (1996) adopted resolution WHA49.25, labeling violence a global public health problem that, if not handled or addressed, will escalate beyond control.

With the adoption of this resolution, the WHO adjusted their definition of violence to be "the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community, that either results in, or has a high likelihood of resulting in, injury, death, psychological harm, maldevelopment, or deprivation" (WHO, 2014 Code: WHA49.25). WHO also differentiated between physical and non-physical acts of violence. The next section of this chapter addressed these actions at length. Outside of the health care industry, research has acknowledged forms of violence to include spousal abuse or intimate partner abuse, sexual cruelty, harassment,

and child abuse. In the workforce, especially in the healthcare industry the violence, lateral violence, or workplace bullying is toxic to the working environment (Barton, et al., 2011).

When individuals begin talking about the different categories of bullying that occur in the workforce, several types come to mind. Think of these as being on a long continuum, where they progress from non-physical acts (passive or verbal) to discrimination or physical acts (sexual harassment or mortality), the latter of which is often considered more than a work-related bullying problem (Van De Griend & Messias, 2014). Within the United States, sexual harassment typically involves court proceedings because of its illegal nature (Cave, 2013). Introduced in 1997, the Protection from Harassment Act (PHA) legally protected an employee against harassment. Additionally, the PHA ensures any person found to harass an employee will be sanctioned by civil or criminal proceedings (Cave, 2013).

This section will discuss the different manners by which individuals documented bullying throughout the years. It is important to note, however, that all these categories occur in the healthcare field, as well as, outside of the medical field. The literature reviewed provided information on companies or industries outside of health care, as well as nursing staff found within the health care field.

Nonviolent to Violent Bullying

Beginning in early childhood, gossip could at first be considered benign. The actual act of gossiping in the nursing workforce could include spreading rumors, watercooler talk behind a coworker's back, interpersonal or professional degrading talk,

offering an ineffective handoff, during shift change, that would impact the overall care of a patient and their family members (N.A., 2012; Chipps et al., 2013). Not only could these types of issues be misleading, but they can also cause harm to other patient outcomes because not enough time is earmarked for a proper handoff on patient care.

Lupton (2012) explained how a nurse could alter a coworker's opinion by giving information that is not relevant to the care of the patient. In the given scenario, the nurse going off duty began to provide a handoff to the oncoming nurse about the assigned patients. Unfortunately, the preceding nurse explained how the sister of one patient was extraordinarily problematic and caused a lot of inconveniences. During the handoff, other nurses joined in and confirmed they experienced problems across the board. Because the conversations lasted significantly longer than necessary, the handoff regarding other patients became hurried. Situations like this set nurses up for unnecessary struggles. Ultimately, incorrect information can have adverse consequences for patients and leave the nurse feeling out of control in their setting.

Gossip does have its benefits and can sometimes come with positive undertones. For instance, positive chatter can be responsible for circulating vital information to a large number of employees, allowing employees the feeling of belonging or creating a positive bond between people or workgroups. The gossip that offers negative undertones is the most damaging, and the ones that cause industry problems. As shown by prior researchers, gossip can lead to disorganization, disruptive work areas, harmful or dysfunctional social and professional relationships, and conflict (Altuntas et al.,Chipps et al., 2013). If done incorrectly, the improper distribution of information can be a tool for

inflicting psychological harm leading to a damaged profession or reputation, both of which are signs of workplace bullying.

Unfortunately, some bullying is invisible to the common collective or unseen when it occurs. For instance, passive bully also referred to as a freeze out, consists of an overload of work, setting coworkers up to fail, holding back info or equipment, or exclusion from conversations, luncheons, meetings, and social events. Regardless of how they may appear, perpetrators of this form of bullying do meant to inflict pain on the victims (Szutenbach & Stechschulte, 2008). New hires and newly graduating nurses are particularly vulnerable to these practices. According to Seibel (2014), young nurses are working towards achieving status in their field and being bogged down with a needless overload of work, which incorrectly gives the appearance they cannot handle their workload.

When gossip and passive attempts at purposely making others look or appear inferior become violent, the harassment shift to verbal bullying. Verbal abuse includes screaming at others, making degrading comments, or talking poorly about a coworker in front of peers or management. Habitually, initiation occurs by a coworker, physician, or manager, and nurses worldwide are subjected to this practice (Brewer, Kovner, Obeidat, & Budin, 2013; Chapman, Styles, Perry, & Combs, 2010; Gascon et al., 2013). In a quantitative study done with nurses (n=320) outside of the United States, Cheung and Yip (2017) captured data showing nurses endure verbal abuse at a rate of 73%. Brewer et al., (2013) conducted a national study within the United States, surveyed staff nurses (n=1000) and nurse managers (n=1000). The researchers found 82% of staff nurses and

77% of nurse managers are verbally abused on average at least five times per month. The findings of both studies suggest the numbers are too high and indicate further research is needed.

As bullying continues, over an extended period as the definitions imply, the acts become harsher and more physical towards the victim (Park & Ono, 2016). Sexual harassment and physical violence are the two worst-case scenarios associated with workplace bullying. In these instances, the imbalance of power between the perpetrator and victim or group of victims is significant (Park & Ono, 2016). Researchers have identified sexual harassment to include the following; vulgar gestures; offensive emails text or notes; inappropriate touching; blackmail for position or favors; and sexual advances (Gillespie, Fisherb, & Gates, 2015). Gillespie et al., (2015) go on to define physical violence as an act of aggression that creates a risk to health and safety. If not stopped and addressed quickly, the acts of physical bullying can have numerous harmful results, up to and including suicide (Adamset al., 1997). All of these types of bullying (Namie & Namie, 2011) involve intimidating behaviors with an ultimate goal of causing unwarranted terror.

Characteristics of Workplace Bullying in the Nursing Field

Researchers have identified the harmful effects workplace bullying has on all aspects of bullying, to include, the target, bystanders, the organization, or the bully themselves (Emdad, Hagberg, & Jensen, 2013; Esfahani & Shahbazi, 2014). Workplaces include all aspects of industry, not just those associated with nursing or health care. Thus, it is necessary for administrators to understand the outcomes of workplace bullying

before actually discussing the characteristics. Researchers from all parts of the world have written about the effects of bullying (Lee, Bernstein, Lee, & Nokes, 2014). They consist of psychological, emotional, and physical disturbances and can linger for the duration of the victims' work-life or even their entire lifetime (Ovayolu et al.,2014).

Prior researchers found women are bullied more frequently than their male counterparts (Gillespie et al., 2015). Not only is this true in the United States, but also around the world (Lee et al., 2014). Astoundingly, women bully each other in equal numbers as male's bullying women. In fact, according to one study ("Kaplan Survey," 2014), women are targets 60% of the time, while men are targets 40% of the time. These figures are exceptionally relevant in the nursing field. Historically speaking, the nursing field is predominately female, with a few male nurses sprinkled throughout the hospital settings (Gillespie et al., 2015; Halloran, 2009; Juliff, Russell, & Bulsara, 2016).

When bullying occurs in the medical field, the target is not the only one that will feel the aftermath. The patients, the organization, the family members, and of course the victims are at risk for harm (Altuntas et al., 2014; Ariza-Montes, Muniz, Montero-Simo', & Araque-Padilla, 2013; Cheung & Yip, 2017; Chipps et al., 2013; Snavely, 2016). Physical effects of being bullied may include weight loss, hypertension, sleeplessness, headaches, and even gastrointestinal problems (Barton, et al., 2011; Lee et al., 2014). Psychological impacts include anxiety, depression, low self-esteem, helplessness, oppression, distrust, PTSD, and in some cases suicidal thoughts or attempts (Harrington, Rayner, & Warren, 2012; Li et al., 2015). The impact of bullying on the victims' occupation includes decreased attachment to their job, the need to find a new less

stressful work environment, absenteeism, or leaving the nursing field entirely (Ariza-Montes et al., 2014; Li et al., 2015).

Generalized Bullying in the Workplace

Workplace bullying is not much different than domestic violence (Namie & Namie, 2014). The aggressor inflicts pain on whomever they want, and whenever they want. The harassment comes on quickly, for no apparent reason, and the aggressor tends to keep close watch over the target, much like an abusive spouse over the targeted spouse. The key characteristic of this relationship tends to be dominance (Namie & Namie, 2011). The full extent of the phenomenon commences when the perpetrator begins to dehumanize the victim. The full extent of the phenomenon occurs when the perpetrator begins to dehumanize the victim. The act of bullying is not a childish prank, rudeness, harmless coarseness, or lack of respect. It is a true form of verbal or psychological violence, and if not treated or dealt with, in extreme cases can lead to physical hostility, battery or murder (Namie, 2003).

Park and Ono (2016) indicated that workplace bullying begins when the aggressor feels insecure in their job. In their study, the researchers used the variable job insecurities to explain workplace bullying and aggression. Their premise was to identify job insecurity as an interpersonal process that creates, in individual’s, a negative feeling towards their working environment. The reduction of security created a pathway for making one employee feel better by reducing the well-being of another, otherwise known as making someone look bad (Park & Ono, 2016). The results indicated that job insecurity was indeed a stressor that inadvertently caused bullying.

Obtaining the antecedents of perpetrators is done by using self-reports submitted by individual bullied in the workplace. Since the focus of this study is understanding aspects of being bullied, and many bullies do not feel they have done anything wrong, common characteristics of the targets merit clarification. According to Baillien, Neyens, De Witte and De Cuyper (2009), a bully may identify potential victims based on the perception of being weak or shy. The researcher called this a predictor trait that may be one-way people become targeted. Bullied individuals also tend to be submissive, avoid conflict at all costs, and show signs of poor coping skills (Baillien et al.,2009). When investigating reported instances of bullying, Human resource employees need to understand these characteristics to reduce biased decisions.

Workplace bullying is a real problem for human resource departments. After management's initial intervention following workplace bullying instances, the presumed impartial employees of the human resource department become involved. Studies suggested human resource members are essential players who gather information from the target, victim, and managers (Cowan, 2012; Fox & Cowan, 2015). Cowan (2012) explains human resource departments are not the ones creating these policies, even though they are the ones that deal with the aftereffects. For them, handling these types of disputes happens almost every day. Fox and Cowan (2015) posits ant-bullying policies are not a high priority in the United States. In another study, this one from the United Kingdom, researchers explained that, even with antibullying policies in place, resolution is not always possible due to fear of retribution from the managers and administrators, especially when the bullying is instigated by them (Harrington et al.,2012). According to

Granstra (2015), organizational management and those who are responsible for imposing the policies, such as human resource personnel, should have a clear understanding of their company's policy on bullying. They should also make it clear to staff what the outcome will be for such actions in the workforce (Granstra, 2015).

Bystander Effects

Considerable attention has focused on aspects of bullying and, with research spanning school-aged children through adulthood (Smith, 1997). One facet of bullying, which is receiving less attention but causes countless problems, is the role of the bystander. Bystanders of bullying are equivalent across the lifespan. In school settings, 70% of students have self-reported standing by and allowing others to bully their classmates, without doing anything to stop them (Midgett, Doumas, Sears, Lundquist, & Hausheer, 2015). The role of the bystander is part of the ripple effect, which occurs from either the nonviolent or violent aspects of bullying. Bullying bystanders have been defined as a witness to the victimization and categorized as neither the bully nor the victim (Van Heugten, 2011, 2013). The bystander will also make the personal choice to either assist or stay out of the situation altogether.

Students have reported negative complications associated with idly standing by and observing bullying behaviors. They have reported difficulties such as depression, stress, resentment, and in extreme cases substance abuse (Midgett et al.,). Luckily for the school-aged students, all 50 states in the United States, have implemented laws and policies to address the problem of bullying (Stopbullying.gov, 2015).

Just like in the school system, these same issues exist throughout adulthood. Quite frequently, when companies, industries, and healthcare organizations speak about or make policies against workplace bullying, the principal focus is how to address and handle the bully and keep the victim or victims safe from harm. One challenge often overlooked is how bystanders stand by and watch what is going on. Some individuals linger and do absolutely nothing while others instigate or encourage the bullying behaviors. In either case, they are typically not wholly innocent of the situation. In fact, according to Van Heugten (2011), bystanders have been seen as a passive observer, one that stays neutral during these social occurrences; however, that may not always be the reality.

Van Heugten (2011) showed that exclusion from social occasions not only compromised trust between coworkers but also reduced meaningful communication in workgroups. Often the passive nature of the bystander will empower bullies and increase their need to gain power over the target or group of targets while giving them an active audience (Park & Ono, 2016; Van Heugten K., 2011). The sad reality is bystanders may have contributed unknowingly to the process of intimidation (Dzurec, Kennison, & Albataineh, 2014). According to Dzurec et al., (2014), the bystander's unwillingness to jump in an assist sends a clear message to the victim of "you don't exist" or "you're not worth my time" (p. 285). The conclusion is the victim feels complete social isolation, while the bully enjoys rewards of success and accomplishment (Park & Ono, 2016).

Social isolation is often one of the most prominent effects of being bullied. It causes great distress to targets, leaving them feeling overwhelmed and withdrawn (Park

& Ono, 2016; Van Heugten K. 2013). Through significant research over the years, Van Heugten identified several characteristics of the workplace bystander; when addressing school-aged children, the same results held true. The researcher categorized the attributes into three distinct components of a bullying situation: the person or group of people that became aligned with the bull; the person or group of people who remained passive or in the shadows while bullying occurred; and the colleagues or cohorts that actively supported the target (Midgett et al.,2015; Van Heugten, 2011)

Each type of bystander had exclusive ties to different elements associated with bullying. For instance, those aligned with the bully tend to be friends with or employees of the bully. These bystanders were individuals the bully felt they could manipulated or taken advantage. Based on the results of a study conducted in a Chinese coal mining company, Park and Ono (2016) suggested that coworkers that observed workplace bullying were more likely to assist in the bullying versus supporting the victim or remain neutral.

According to Van Heughten (2011) the majority of bystanders were passive. These people assumed that hiding or staying in the shadows and not getting involved, in the disputes, would keep them safe and unnoticed. These bystanders encounter panic and worry regarding the bully turning on them. However, they also experience lingering feelings of guilt over not assisting the target during the attack (Emdad et al., 2013). Such guilt will leave the bystander with feelings of stress, depression, or powerlessness (Emdad et al.,2013). For the victims, however, these types of bystanders created the most hardship. Their inability to act causes distrust in colleagues and isolation for the target or

group of targets. Workgroups become divided, and the incivility becomes apparent to the general public, a problem that many businesses try to keep under wraps. In the nursing field, the last thing that needs to happen is for ill patients to realize their nurses are not producing at the standards required to ensure their safety.

The final type of bystander is the one that actively supports the target. Unfortunately, few people fall into this category. The number does tend to grow if and when the victims declares the desire to move on to another job or quit altogether. When this happens, the bystanders tend to take a stand and begin backing the victims and the harsh treatment that has been plaguing them (Van Heugten, 2011).

Nursing Shortages

Nurses are responsible for creating the most massive shortage of healthcare providers in the United States and elsewhere in the world (Snavely, 2016; Twigg & McCullough, 2014). One solution to the rising problem of nursing shortages, is to ensure each nurse a chance for a productive and safe career. The nursing field is one that increases and decreases every year, based on the number of new graduates entering the workforce and those leaving or retiring (Juraschek et al., 2012). With the nursing staff aging and younger nurses abandoning their career, the health care industry is in danger of creating substantial problems and keeping up with the increased health care demands (Rongen, et al., 2014; Wallis & Kennedy, 2013; Twigg & McCullough, 2014). Karatza et al., (2016), identified several characteristics associated with nursing shortages, including: (a) stress related to a highly frantic work pace, (b) the perceived lack of quality nursing care to patients, (c) lack of recognition, (d) staffing cutbacks, (e) burnout, (f) nurses not

feeling they have support from management, and (g) conflict between nurses, management, and co-workers. On many occasions, the conflict turns to harassment and, over an extended period, became workplace bullying.

The same nursing shortage in the United States exists in other countries (Juraschek et al., 2012; Twigg & McCullough, 2014). Using the supply model, Juraschek et al., (2012) explained how to predict future nursing shortage. Supply model assumes the demand stays consistent, the number of nursing students remains equal, and the number of nurses does not increase. The researchers began their study by creating seven age brackets between 16 and65 plus and asked each member if they were interested in working in health care as an RN. Juraschek et al., conducted the survey in all 50 states found in the United States. All affected states were categorized, and different results became very apparent between the "projected RN demand and the RN supply" (Juraschek et al., p. 244). These findings predicted the grim reality of nursing shortages by 2030, and the future of health care in the United States. The regions projected to have the most significant nursing issues were the Western states of California, New Mexico, Nevada, Arizona, and Colorado, and the Southern state of Florida.

Similar results were documented by Wallis and Kennedy (2013) when they discovered 44.7% of working RN's are over the age of 50. An additional reason researcher identified as a cause of RN shortages in the USA, is the passing of the Affordable Care Act (ACA) of 2010 (Snavely, 2016; Wallis & Kennedy, 2013). Some researchers exclaimed the ACA was put in place to ensure that all Americans have access to health care (Wallis & Kennedy, 2013). Within their data, Snavely (2016) and Wallis &

Kennedy (2013) suggested by creating this program the number of individuals heading to the hospital or doctors' offices will multiply, requiring additional nursing staff. All of these stated factors in regards to nursing shortages are all things over which the health care industry has little to no control.

Nonetheless, health care providers do have control over other causes for nursing shortages. One in particular is workplace bullying and how it affects or drives nursing shortages. According to Sanford (2013), by 2030, the United States will have a shortage of 900,000 nurses, which indicates a high employability rate for that profession. Nursing staff members, in Australia will notice nearly 129.9 million deficiencies by 2025, up from 21,000 in 2016 (Twigg & McCullough, 2014). The sheer magnitude of this shortage is cause for hospital administrators and government officials to take notice. Immediate attention needs to shift to nursing retention and reduction of nursing turnover reduction.

Nursing Retention/Turnover

When registered nurses talk about that moment they decided to change their lives and begin nursing school, they would likely explain their desire to help patients and the feeling of satisfaction that would follow. They would reflect on their sense of peace, calming, recovery, and how they would change the world through their giving. What they would not describe is the feeling of distress and the challenges that surely accompany some of the decisions they are yet to face. Additionally, they would not describe the feeling they get for wanting to leave their nursing career after they worked so hard to achieve their goals. These are all feeling that need to be addressed. In this study, I discuss what nursing retention for trained nursing personnel is, and how to reduce turnover rates

in hospital settings for this same population. Additionally, I discuss how bullying affects turnover rates, and what potential predictors have been empirically examined in prior literature and research, in hopes that a resolution will slow these workgroup reductions. What hospitals need is a way they can properly retain their nursing staff.

Turnover is a distressing word within the health care industry. It describes the inability to retain the professional nursing staff the hospital managers and administrators have trained so tirelessly. It represents money wasted, time spent, and, most of all, the inability of nurses to connect with their coworkers and patients (Tomietto, Rappagliosi, Sartori, & Battistelli, 2015). In fact, this failure to connect endangers patient care delivery and safety. The need for health care facilities to control these internal issues is paramount to the overall success of their organization. The aftereffects of these types of shortages have long-term consequences, such as critical nursing shortages. Researchers, however, have yet to pinpoint the exact total shortfall figures (Twigg & McCullough, 2014).

Turnover materializes for many different reasons, some of which administrators have control over and some which they do not. A noncontrollable reason is that baby boomers will soon retire from the workforce, creating a huge natural deficit in the working population (Laschinger & Fida, 2014; Longo, 2014). Not only will these retired nurses leave hospitals shorthanded, but they will also become part of the increasingly aged population of patients. For these reasons, hospital administrators need to shift their focus on how to retain new nurses and sustain the welfare of their healthcare workforce (Laschinger & Fida, 2014). An example of a controllable reason involves workplace bullying or harassment, which is an intricate part of this research. Workers at hospitals

and nursing facilities experience workplace bullying at high levels (Cheung & Yip, 2017). These unrelenting threats lead to a direct reduction of professional nurse standings, occupational status, and destabilization of the nursing field as a whole (Twigg & McCullough, 2014).

According to the WHO (2002), the nursing field is one of the largest regulated health workforces in our country. The United States healthcare system has more than four million active nurses in their workforce (Snavely, 2016). In other parts of the world, similar numbers exist. Nurses make up over 50% of health care workers in Canada (Laschinger & Fida, 2014). Huntington et al., (2011) noted that New Zealand's health care industry nurses account for 65% of all medical workers.

The nursing shortages seen throughout the health care industry is cause for panic, especially when there are ways to make it better. Health care organizations administrators carefully watch turnover rates and current trends around the globe, with Colosi (2016) describing the turnover rate inching higher each year. The national turnover rate for floor nurses climbed from 16.4% in 2014 to 17.2% in 2015, up almost a full percentage (Colosi, 2016). Additionally, new nurses entering the workforce have seen higher turnover rates of 18%, within their first full year of practicing (Spence-Laschinger, Grau, Finegan, & Wil, 2012). Health care organizations need to be super diligent in the pursuit of nursing retention.

Nursing retention is on the other end of the continuum from turnover. It is one of the main factors with which health care industries are concerned, due to a substantial amount of funding it takes to train staff members. Retention represents the number of

workers that remain in their profession over a stipulated period (Colosi, 2016). Building workgroups that can learn to identify signs and effects of bullying will help eliminate turnover. Horizontal and vertical violence, as seen in the nursing field are highly related to workplace bullying, which reduces job fulfillment (D'Ambra. Andrews, 2014). The effects of constant bullying and ridicule include poor self-esteem, depression, stress, and the inability to fit in or build a working relationship that would encourage retention (Wallis & Kennedy, 2013).

For nursing retention to occur, D'Ambra and Andrews (2014) suggested fostering a healthy working atmosphere, with a good first step being to reduce workplace incivilities. Taking the concept one step further, Cervolo et al., (2012) created the "quality improvement project" Positing the need to have a workplace that offers a respectful employee culture (p.599). The researchers concluded workplace violence brings on undue stress that leads to unhealthy personal and administrative results. By removing workplace bullying, the nursing staff will begin to regain the inner feeling of commitment towards their patients and organization (Cervolo et al.,2012).

An additional way to increase nursing retention is by creating a smooth transition of new nurses into the health care field (Spence-Laschinger et al., 2012). To do this, an organization must create a workplace that stimulates positive growth and development and allows the nurses to think and feel as if their thoughts are appreciated. In such an environment, the nursing staff will benefit from increased self-esteem, optimism about their current profession, and will have an easier time keeping up with the high demands this type of job entails (Spence-Laschinger et al., 2012; Van Heugten, 2013).

Impact on Employers

Why should healthcare employers care if their employees become subjected to bullying in the workplace? More importantly, why should big industries, such as those found in healthcare facilities, care if workplace bullying is happening? One answer is the detrimental effect such actions have on their working environment. Research have documented that nurses working in a hospital setting have the third highest rate of being bullied in the workplace (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Workplace bullying can cause loss of job, potential lawsuits, reduced job security of trained employees; at the same time, managerial cost increase, productivity severally declines, and turnover rates skyrocket, fracturing the mere existence of normality within the workplace (Ariza-Montes et al., 2013; Karatza et al., 2016).

Other factors about which employers should be extremely concerned are absenteeism, burnout, and the cost of replacing the staff members who choose to leave their position (Trepanier et al., 2014). In a hospital setting, the stakes are much higher. The act of bullying causes toxic working environments. Unfortunately, nurses face many obstacles, including decreased motivation to do their job, a lack of concentration when performing their daily duties, an increase in absenteeism, and, worst of all, a growing number of on-the-job errors (Karatza et al., 2016; Trepanier et al., 2014). These mistakes that have the highest potential for an adverse outcome when the error is related to patient medication.

Employers need to keep a close watch for all types of workplace problems, even those which are nonviolent. For instance, as noted above, gossip is very detrimental to the

wellbeing of any organization. Not only is there a need to keep employees safe, but employers and administrators need to keep organizational secrets under wraps. If gossip goes unmonitored or is improperly monitored, such destructive acts of gossip have the potential to tarnishing an establishment's credibility through the dissemination of fabricated or deceptive knowledge (Altuntas et al., 2014). Eventually, this type of malicious gossip can subject a company to financial demise. If administrators do not monitor gossip well, especially in the medical field, patient care will suffer and teamwork disruption will increase. Nurses are the central component of all hospitals, and without proper communication techniques, the quality of care will begin to suffer (Altuntas et al., 2014).

Workplace bullying has both financial and nonfinancial. The monetary cost of workplace bullying can exceed 4.2 billion dollars per year (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Nonmonetary cost includes reduced productivity, low job satisfaction, problems with morale, and nurses leaving their position. If retention of nursing staff goes untreated, due to workplace bullying, the patients will suffer. As teamwork areas become chaotic, patients and their families may view the nursing staff as unwilling to assist (Speroni et al., 2014). According to Twigg and McCullough (2014), the best way to reduce nursing shortages is to keep employees safe and create positive working environments.

Summary

For over 25 years, researchers have tackled the subject of workplace bullying, yet the problem still exists and is still growing. Despite the overall total of research studies

aimed at understanding and addressing workplace bullying in the nursing field, a gap remains. A majority of studies on this topic come from a quantitative point of view, but these questions need a qualitative point-of-view by obtaining knowledge from a nurse's lived experiences. The focus of this study was to understand how nurses decided to stay in their current working positions despite being bullied in the workforce. Additionally, I sought to understand what special challenges and techniques these nurses encounter when making these decisions.

As is evident from this in-depth literature review, specific elements of workplace bullying can increase or decrease the prevalence and severity of the act. Researchers have linked workplace bullying to depression, stress, and loss of sleep. It is also associated with reduced patient safety, lack of trust between coworkers, and leaving the job these nurses trained too hard to acquire.

The conceptual framework selected for this study is resilience. The characteristics of resilience helped explain the positive responses some nurses have when faced with the stressors and anxiety of daily harassment. In the health car field, nurses focus a majority of their time on helping patients and family members manage disease and illness. If nurses are unable to adequately care for themselves, they will not be able to care for their patients. Several researchers suggested peer support, mentorship, and having a solid social network increased the likelihood of a positive working environment (Altuntas et al., 2014; Hsieh et al.,2016; Li et al., 2015).

In Chapter 2, I have provided an extensive literature review, as well as support for the conceptual framework resilience. The concept of bullying in the nursing field has

inspired a plethora of studies, with results published in articles, books, and peer-reviewed journals. This chapter also includes an in-depth discussion of bullying within the health care field of nursing, which addressed specific outcomes for the victims, their family members, patients, and employers. Through this extensive review, a gap emerged, indicating the need to go directly to the source (nurses) and ask them for illumination into what gave them the power to beat the odds and remain in their current working position despite being bullied in the workplace.

Chapter 3: Research Methods

Introduction

When an individual decides to be a nurse, extensive schooling and dedication follow. If you ask nurses why they chose he nursing field, they would likely say they had a desire to help people in need. Unfortunately, many nurses have found helping their patients gets interrupted by extreme adverse situation beyond their immediate control. These cases are often distressing and distracting in their daily job duties.

The field of nursing comes with many daily stressors over which they have no control. Past researchers have revealed an overwhelming number of nurses plagued by workplace bullying. Nurse staff members often see these senseless acts as putting patients at risk for violence. Administrators can and should find ways to control and eliminate workplace bullying, which fuels this study. Through my literature review, I identified a gap that can only be closed through speaking directly to the nurses.

The objectives of this qualitative descriptive phenomenological study were to describe the lived experiences that shaped the effects of workplace bullying, and to understand how nurses decided to retain their jobs, despite being bullied. Nurse participants who had been bullied perceived the resultant problems as added stress, increased physical or mental exhaustion, family involvement, or low job satisfaction when compared to nonbullied nurses that enjoyed their profession and engagement with their patients and coworkers. Additionally, through this study I sought to understand how these nurses continued working with the colleagues who bullied them by describing special challenges and techniques they employ. In an attempt to assess the problem, I

used in-depth semistructured interviews to expand the understanding of these nurses' lived experiences.

Chapter 3 is broken down into several major sections with each section providing detailed accounts of the process used. In this chapter, I illustrate why this study transpired through a qualitative descriptive phenomenological approach versus another technique. The discussion includes data collection and procedures that I used to conduct this study. In the subsequent sections, I explain in detail the use of a particular group, along with the selection process for this study. The final sections include instrumentation, the pilot study, data collection, and finally ethical considerations and how I addressed them.

Data from this study came directly from staff nurses with a minimum of 1 year of service in their current position. Additionally, I selected only participants who had been subjected to workplace bullying within the last year and stayed in their current job. In an attempt to capture the nurses lived experiences, I conducted semistructured interviews during which each nurse described their feelings, emotions, techniques, and thoughts when dealing with workplace bullying.

Research Design and Rationale

The phenomenon for this study was the lived experiences of staff nurses when bullied in the workforce. I established the following research questions to evaluate this problem qualitatively:

RQ1: What are the lived experiences of nurses who continued to maintain their position despite being bullied in the workplace?

RQ2: What are the special challenges nurses encounter, who have experienced workplace bullying, when faced with the decision to retain their position?

RQ3: What are the techniques nurses use to rationalize their decision to retain their current working position, after being subjected to workplace bullying?

For this study, I chose a qualitative research methodology because qualitative research allows for expression of thoughts and experiences. By gathering a shared interpretation from a group of individuals exposed to the same phenomenon, the data begins to create a story (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017). The results provided several psychological identifications of the central topic, known as themes. Through themes analysis, the thoughts generated by the individuals become apparent, and a storyline or an understanding develops (Creswell, 2013).

The research design I used for this project was a qualitative, phenomenological approach. This type of approach was appropriate because I was trying to understand experiences or shared experiences groups of individuals had about a single phenomenon (Creswell, 2013). Edmund Husserl, the founder of qualitative phenomenological approach to research, posited that the described phenomenon came from human consciousness and their thoughts associated with the phenomenon (Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). Husserl referred to these lived experiences as “lifeworld” (Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). This approach was best suited for this research because the aim was to understand the personalized lived experiences these nurses endured during the acts of workplace bullying.

Other qualitative approaches were not appropriate for this set of research questions. Grounded theory research did not fit, as there was no intent to form new theories based on the outcome of the data collection. Ethnographic research would not be suitable due to the inability to go into the field and view acts of bullying. Research indicated bullying is often done, so management or others are unaware of their actions (Park & Ono, 2016).

A quantitative approach to research was inappropriate due to the multitude of quantitative investigations already done on this topic (Szutenbach & Stechschulte, 2008). Organizations such as the Workplace Bullying Institute have spent considerable amounts of time researching this topic quantitatively (Namie & Namie, 2014). It was time to help fill the gap by going directly to the source of the phenomenon and interviewing the nurses affected by this problem. Therefore, a descriptive phenomenological methodology best suited the production and expansion of knowledge needed to understand the participants' responses to workplace bullying.

Role of the Researcher

As the researcher, my primary role was to conduct the qualitative research study from construction through analysis and interpretation. During that time, I addressed special considerations such as obtaining access to the intended population, receiving approval from the Institutional Review Board (IRB), maintaining confidentiality, collecting and analyzing the data, and writing up the final analysis.

A qualitative phenomenological research study requires conversations with individuals, as opposed to a quantitative approach which would provide objective

statistical data. It was, therefore, important for me to create a list of open-ended interview questions focused on the central phenomenon of this study. The research questions directed the interview questions. The process, according to Creswell (2014), was for the researcher to build “patterns, categories, and themes from the bottom up” (p. 45) in an attempt to identify general and comprehensive information regarding their topic of concentration.

In this process, it was my responsibility to become the instrument of data collection and perform interviews with each participant. Participant recruitment occurred through social media sites including Facebook and LinkedIn, Internet sites such as findparticipants.com, and snowball recruitment. The intent was to interview 5 to 15 volunteers who met the recruitment criteria. During the process, I maintained the responsibility to preserve confidentiality, obtain consent from each participant, conduct the interviews, record the conversations, and finally send out the audio recordings to Rev.com for transcription services of the interviews. At the onset of the study, I informed each participant that the length of the discussions would not be more than 60 minutes. That length of time was subject to change based on the information gained during the pilot study. Other potential changes created by the pilot study included the accuracy of the instrument. At the beginning of each interview, I introduced myself, provided a short synopsis of my academic career, and explained the purpose of this study. At the end of the allotted interview time, if the participant had more they needed to share, I made them aware of our time and gained permission to continue.

Due to personal experience with the topic of workplace bullying and work in healthcare, (not as a nurse), I recognized the need for special considerations needed to ensure no bias contaminated this study. Husserl believed one way to decrease bias was through epoche or bracketing (Willis et al., 2016). Beyer (2016) believed a phenomenological approach should appear only in the first person, as the storyteller is the only person that can successfully describe the phenomenon of interest. According to Pitney and Parker (2009), the researcher begins bracketing by having an awareness of their preconceived thoughts and beliefs about the phenomenon. By putting away their notions, the researcher could focus on the event from the participants' perspective. In going through this process, I was able to filter preconceived biases, while the suspension of these ideations allowed for neutrality (Creswell, 2013). I achieved bracketing through journaling thoughts and feelings as they appeared throughout the process. By writing ideas down, I had a better opportunity of really understanding how deep the bias was, and allowed avoidance by reducing assumptions through open-mindedness (Pitney & Parker, 2009).

Methodology

Being touched by a phenomenon happens to everyone on a daily basis. Some of these experiences can be good, while others are not. Researchers explained the best way to understand these phenomena are by interview the individuals affected by the phenomenon (Creswell, 2013; Englander, 2012).

Participant Selection Logic

The current body of literature was far-reaching. The intent of this study was to focus solely on the nursing staff who had experienced bullying at work. The overarching intention was to fill the gap, as identified from the literature, by asking each staff nurse to share their lived experiences of workplace bullying, and describe the challenges and techniques they used in deciding to remain in their current working position.

A phenomenological study required each participant to have lived through a shared experience (Creswell, 2013). By doing so, each participant was able to articulate their conscious thoughts on the topic. Because of this personal involvement all participants were able to articulate their conscious thoughts on the topic. I intended to recruit 5 to15 staff nurses through social media sites, Internet-based recruitment, and snowball recruitment. For a phenomenological research study, Creswell (2013) suggested to having between 5 and 25 participants so as to acquire an in-depth collection of data. The exact number was unknown until the researcher hit saturation. Saturation could only occur when no new information or themes came from within the data or from increasing the number of participants (Guest, Bunce, & Johnson, 2006).

The United States is home to many nurses, but the experiences of these nurses vary depending on their departmental responses; their experiences of being bullied and reasons to stay in their current working position varied, as well. The proposed participants for this study were nurses. Walden University Institutional Review Board (IRB) approval was mandatory to access the needed population. Once the IRB approved this study, I recruited qualified participants on nursing social media groups (including

Walden groups), Internet-based participant finding sources, and other nurses (snowball recruiting via recruitment flyers). On each website, I posted a recruitment flyer providing full details of the study, an operational definition of workplace bullying, a description of the requirements needed to participate in the study, and a copy of the IRB approval number. It also included all details for setting up appointments.

The initial participant criterion was a minimum of one-year experience as a staff nurse in their current working position. Individuals must have been subjected to workplace bullying or harassment, on a regular basis within that last year, and decided to retain their same position. Potential participants found the flyer on their social media sites, on recruitment type internet websites (such as findparticipants.com), or found via snowball recruitment with instructions to contact the research via email. The recruitment flyer contained an operational definition of workplace bullying, which allowed the participant to determine if they met the criteria. The digital recruitment leaflets also shared information such as my telephone number, email address, and mailing address if further questions needed answering.

If a potential nurse participant felt they were a good fit for the study, they were to contact me and set up a time for a face-to-face, telephone, or web-based (Skype) interview. After they contacted me, I asked potential participants to provide a time or location for this meeting, with the requirement that it must be a quiet setting to reduce noise, confusion, and increase confidentiality.

Instrumentation

The primary instruments, for this study, were the researcher and researcher-developed interview questions. Data collection came from semistructured, open-ended interview questions. The interviews occurred via telephone and web-based (Skype) in a setting that was specified by the participants. The in-depth interview questions aligned with the research questions and the literature reviewed for this study.

The initial portion of the conversations included demographics of each participant, such as their length of service as a nurse, how long they practiced in their current position, the frequency of bullying in their current job, and their ability to speak English fluently. The purpose of obtaining this demographic information was for the establishment of participation criteria (Appendix C; screening instrument). The second tool (Appendix A; Interview Questions) was the interview protocol initiated based on the research questions. I developed the interview questions, which successfully guided the semistructured interviews. The interview questions included prompts if the participants needed extra assistance in answering the questions. I then uploaded audio-file of each interview onto my private computer and forwarded them to a transcription service to be transcribed.

Pilot Study

Before conducting the formal study, I performed a pilot study. Prior research indicated conducting a pilot study was equivalent to a prestudy or a ministudy (Van Teijligen & Hundley, 2002), which allowed the researcher to identify overlooked ideas before the beginning of the actual study. A pilot study also allowed the researcher to

account for and address any methodological problems that arose, such as if the items flowed smoothly (Van Teijligen & Hundley, 2002). Finally, the pilot study allowed me to address any other factors needing attention.

The chief purpose of conducting a pilot study are to determine if the interview questions are an appropriate means of answering the research questions (Van Teijligen & Hundley, 2002). Based on the pilot study results, I decision to discard questions that did not validate the research questions. A second factor included determining the ideal length for the actual interviews. The anticipated interview length was no more than 60 minutes. Setting clear expectations for the participants was important. It was their time, and a researcher should not unnecessarily take advantage of their willingness to assist in the process. One additional benefit associated with doing a pilot study, was the ability to identify biases of which I may have been unaware. Overall, identifying and understanding anticipated data collection issues decreased problems later in the study (Van Teijligen & Hundley, 2002).

Upon IRB approval from Walden University, I solicited two research participants who had an understanding of the study and met the qualifications. Creswell (2013) suggested a two-interview pilot study would provide experience in the process, as well as, identify potential issues that may arise during the actual collection of data. Data analysis occurred after scheduling, performing, and transcribing of the interviews. Hand coding the data started the initial analysis phase. During that time, I captured notes and keywords that stood out during the meeting. It was these notes that would later become part of the themes used to interpret the results. The next phase included uploading the

professionally transcribed documents into NVivo to evaluate additional common themes. The knowledge gained provided me with a better understanding of the issues, gave practice to me as the interviewer, and built sound bases for which to perform this study (Creswell, 2013; Pitney & Parker, 2009; Van Teijligen & Hundley, 2002).

Procedures for Recruitment, Participation, and Data Collection

Recruitment

Before recruitment began, Walden University required appropriate Institutional Review Board (IRB) approval. The IRB's primary focus was to ensure responsibility for protection and ethical concerns of the participants (Bersoff, 2014). Once IRB awarded approval, the recruitment of participants began. To each person who volunteered to become part of the study, I distributed a guarantee ensuring they would undergo minimal risk during the data collection (Patton, 2002).

As I sought to acquire 5 to 15 participants through a recruitment letter via social media sites (Facebook, LinkedIn), electronically sent recruitment flyers to professional nursing contacts, dispersing flyers to locations nurses congregate (e.g., uniform shops), and posted a call for volunteers on findparticipants.com or other viable internet websites. Additionally, I utilized a purposeful, snowball sampling strategy. No individuals were local to the researcher; however, several names became part of the study via snowball sampling strategy. These individuals received a recruitment flyer directly into their preferred email account. Upon making positive contact with all participants, I used the screening instrument to ensure each participant met inclusion criteria for participation.

Upon final IRB approval, I reached out to volunteers based on the specified criteria, and scheduled interviews with the potential participants at their earliest convenience. To ensure proper approval to participate in the study, each participant received an informed consent via email. All volunteers were solely responsible for reading through the consent form and responding with the words "I Consent" if they were willing to proceed with the study. If they were unwilling to participate, they were to do nothing or respond with "I do not consent." Included in the document was a statement that addressed the safety and privacy of the volunteers.

The flyers provided ways for the potential participants to contact me and make appointments for participation. During the initial contact, I introduced myself as a researcher working on my dissertation at Walden University. Following these introductions, I presented an overview of the study to each nurse. The only nurses who were eligible to participate needed to have been employed in the field of nursing over the last year. During the screening process, I received more request to become part of the study than the intended 5 to 15 individuals. No aggressive means of recruitment transpired during the recruitment phase of the study.

Participation

A flyer or web post instructed participants to contact me and schedule an appointment for participation. Snowball sampling was satisfactory to find a sufficient number of participants for the study. According to Palinkas et al., (2015), snowball sampling is a purposeful sampling technique widely used in phenomenological research studies, when the intention was to "narrow variations and focus on similarities" (p. 536).

As each person responded to the flyer and showed interest in being interviewed, their names went on a list of prospective participants. The screening instrument (Appendix C) was helpful in narrowing the pool of applicants. Individuals who met the requirements of participation received a request to schedule their interview at a time and location of their choosing (if face-to-face). If I did not hear back from the potential recruit, the assumption was made they chose not to continue. If participants were local to me, then their interviews would take place face-to-face. The, highly suggested, location requirements included a room that was quiet and confined to control for background noise and confidentiality. If the interviewee did not live close to me, a telephone interview was more appropriate. In that instance, participants selected a location in which they would be more comfortable and not easily distracted. In human subject research, established informed consent must be acquired before the interview procedure begins (Dunn, Prochazka, & Fink, 2012). Each participant received an emailed informed consent with the instructions to read and return with “I consent” attached.

At the onset of each interview, I, as the researcher and primary interviewer, had an in-depth conversation with the participant to ensure they completely understood the process, including an understanding of their responsibility as a participant. Individual participants, which agreed to participate but did not get chosen, received a thank you email from the researcher explaining the number of needed participants reached saturation.

Data Collection

The population for this study consisted of actively working registered nurses within the United States. The nurses needed to have a minimum of one year of experience, able to fluently speak and write English, been bullied over the last year, and decided to retain their nursing position. The progression of resilience becomes apparent in times of adversities, such as workplace bullying (Gillespie et al., 2015). Potential nursing recruits who met the criteria were enlisted for this study.

Following IRB approval, the recruitment process began. A considerable amount of effort went into the assurance that recruitment followed the approved application to the IRB. Upon identification of potential participants, I began to schedule the interviews. Data collection lasted for one month and ended once participant saturation occurred.

Conducting the interview was the sole responsibility of the researcher. Before the interviews began, I contacted all interested parties to ensure each participant met the inclusion criterion set forth by this study. The only demographic information received included items listed on the inclusion criteria, a yes/no question to determine if they felt they were a resilient person, and if they spoke fluent English., No other demographic question associated with their special characteristics, or place of employment were asked.

Each interview began the same way: by asking if they read and understood the informed consent. Once established, a scripted definition of resilience and a question asking them if they felt they were a resilient nurse. It was during this time participants made the decision to proceed or drop-out, without penalty. Each person who volunteered

to become part of the study received an assigned code of Main Study Participant (MSP): MSP 1, MSP 2, MSP 3, and so on.

All scheduled interview occurred via telephone, with me contacting the participants at the agreed upon time using MP3 Skype Recorder. I also utilized a battery-operated back-up digital recorder on the outside chance of an energy failure. The recording started as the phone began ringing and lasted until the interview concluded and the phone call disconnected.

Sample in-depth semistructured interview questions included: “Can you describe one to two occurrences in which you felt bullied, describe how you feel workplace bullying affects your performance, and identify some strategies you use to help deal or cope with workplace bullying?” Each interview was scheduled for a maximum of 60 minutes. If the interview had the potential to go over the allotted time frame, both the interviewee and I needed to agree to an extension of time.

During the interviews, I asked the interview questions as written, and when needed added probes, to assist. No questions were asked that pertained to an individual’s place of employment or the hospital institution each participant worked. Eliminating this identifying element diminished participants’ feelings of being uncomfortable or unwilling to answer interview questions. The employed technique ensured each nurse maintained the feelings of being comfortable to answer interview questions honestly and openly.

At the end of the interview, I thanked participants for their assistance in the study and told they would receive a copy of the transcripts once they became available. The interview questions (Appendix A) followed Moustakas (1994) formulary by first asking

what the phenomenon of interest they shared then by asking how they shared the phenomenon, through personalized recounting of their lived experiences. I place great effort into implementing active listening techniques and not including any personal reflections during the interviews. I once again confirmed confidentiality, and assured each participant their documents and associated audio recordings would be concealed in a locked box and password protected computer.

Data Analysis Plan

The purpose of a phenomenological data analysis was to describe, through in-depth statements, how participants felt about a central phenomenon. Qualitative research looks for meanings gleaned from experiences or occurrences and allows the storytellers to verbalize thoughts into spoken words (Petocz & Newbery, 2010). These spoken thoughts are what researchers use to form relationships and themes from the words. These acts and objects of consciousness are experiences individuals learn to identify. In the literature review, Patton (2002) referred to this as intentionality of consciousness stating that the "knowledge of intentionality required people to become present to ourselves and things" found to exist in the "world, that we recognize that self and the world are inseparable components of meaning" (p. 484).

The interviews were audio recorded and saved in an audio file on my password protected computer. After the completion of each interview, and upon my receipt of a signed confidentiality agreement, the professional transcriptionist company Rev.com, received and transcribed the recordings. To preserve confidentiality, coding of each participant's name took place. I placed coded names with a pseudonym, such as

participant 1, Participant 2, Participant 3 and so on. Before beginning to read through the data, Dey (1995, as cited by Creswell, 2013), posited there are three subjective I's qualitative researchers use, they are; "insight, intuition, and impression" (p. 182). Pitney and Parker (2009) affirmed these words, suggested researchers should first stop and thoroughly read the research questions, and the purpose statement. This would enable them to prepare for a critical evaluation of the information newly obtained from the data analysis.

Upon receipt of the transcribed interview, I read and evaluated all transcripts, saving two copies of each and storing them on my password protected computer. This ensured no data could be lost or destroyed before data analysis was completed. Reading of transcribed documents and preliminary coding took place for interview questions relating to the research questions. Preliminary codes included attributes associated with the conceptual framework of resilience, such as peer support, mentorship or flexibility in the workplace.

During the initial phase of recruitment participants provided an email address for future correspondence related to the study. Each participant had to read through their transcript to ensure correctness of the verbiage. An aspect used to increase the credibility was member-checking and epoche, or bracketing. Member-checking is a critical aspect of data collection, which allowed all participants to review and approve their transcripts before official data analysis and coding began. According to Madill and Sullivan (2017), consultation between the researcher and stakeholder becomes a partnership that improved the impact of their research. Member-checking is a form of interview follow-up (Madill

& Sullivan, 2017, p. 3). During this process, participant had the opportunity to change their mind if they felt the information was incorrect. Each participant received seven days to return the transcripts with additions, corrections, or deletions, with the understanding that any unreturned documents would progress as is. If both researcher and participant found the documents satisfactory, data went in the qualitative data analysis software program NVivo (2010), for analysis.

Organizing and analyzing data is a crucial part of knowing what information is important. Moustakas' modification of the Stevick-Colaizzi-Keen method provided a detailed outline of how to handle such transactions (Creswell, 2013). The process began by obtaining a full description of the lived experiences, from each participant. Once obtained, the process then shifted to the evaluation of content, beginning with a true understanding of meaning from their experience. During this time, I needed to make a list of all relevant nonrepetitive words or statements. These clumps of words or phrases set the stage for an overall establishment of experiences, which eventually became the themes or units upon which analysis was founded. It is good to remember to incorporate dialog verbatim through the process to ensure lived experiences are captured. Finally, I needed to have a time of reflection of the words and themes.

Computer-assisting software has been in existence since the 1980's, and through the years, the software consistently becomes more refined to help researchers quickly and efficiently identify common themes and topics found in the data (Creswell, 2013). For the analysis portion of this qualitative phenomenological research study, I first initiated hand-coding followed by use of NVivo 11 qualitative data analyzing software. I chose NVivo

11 due to the prior experience I had working with the program. Additionally, NVivo 11 offers strict security when storing confidential files. NVivo 11 also allowed the researcher to manipulated the data while creating graphs and tables for display.

NVivo provides an auto coding option that assisted in the initial step of the software process. In comparing the NVivo codes against my preliminary codes and themes, subthemes and patterns began to emerge. I searched for repetition through words and groups of words. Coding techniques included line-by-line analyses, along with categorization of groups of words and topics. According to Braun and Clark (2016), themes are like “discrete things, out there in the world” or “diamonds scattered in the sand waiting to be plucked-up by a lucky passer-by” (p. 740). To ensure alignment of the research questions, I coded together all interview questions pertained to each research question.

Throughout the coding process, themes and key phrases started to appear, with epoche employed to avoid challenges in correctly identifying these themes. Epoche required me to look at the phenomenon with fresh eyes. Taking on the viewpoint of epoche allowed the researcher to set aside judgment and personal bias while increasing the rigor of the study (Patton, 2002). As a last step, the identified codes and themes went through a peer review to ensure the coding was appropriate. The peer reviewer acted as the “devil’s advocate” to keep me honest in the interpretation process, ultimately increasing the reliability of the study (Creswell, 2013, p. 251; Lincoln & Guba, 1985).

Issues of Trustworthiness

Trustworthiness, also referred to as methodological integrity, is a "reasonable claim to methodological soundness" (Pitney & Parker, 2009, p. 62). It is important to address several areas to ensure the accuracy and quality of a qualitative research study, namely credibility, transferability, dependability, and confirmability (Levitt et al., 2017).

Credibility

Credibility, according to Pitney and Parker (2009) included "the plausibility of the study findings" (p. 63). The term "credibility" in qualitative research is similar to the term "validity," which exists in quantitative research (Levitt et al., 2017). To maintain credibility, a researcher must convey an incident with the assurance it occurred as properly reported by the participant (Pitney & Parker, 2009). Most importantly, credibility is geared towards the participants.

In the current study, credibility appeared post member-checking. After dictation of the participant's interviews was complete, interviewees received a copy of their interviews for close evaluation. By doing so, the participants had an opportunity to validate their words, add to their thoughts, or remove such areas they felt uncomfortable conveying. After all, the participants, of the study, are the only ones that actually understood the phenomenon and could verify the legitimacy of the results.

Transferability

Transferability, or what is known as external validity in quantitative research, is the "ability to apply the findings to similar environment" (Pitney & Parker, 2009, p. 63). In quantitative research, the researchers attempt to generalize their results across

experiences of their participants. In this qualitative study, the investigator's job remained to thoroughly explain the framework and assumptions central to the study. Detailed descriptions of this continue in future chapters.

Dependability

Dependability in qualitative studies is equivalent to reliability in quantitative research. The overarching focus, with dependability, shapes our ability to use the same process, under different conditions, and find consistency. One way to achieve reliability appeared with the assistance of audio recording and transcribed interviews. In this study, an additional way to address dependability originated with researcher initiated audit trails. Qualitative researchers often include audit trails as a transparent description of all steps taken during the project (Lincoln & Guba, 1985). This audit trail included a detailed account of the study's progression from the beginning to the end. In addition, I incorporated scheduled meeting with participants into the audit trail to include conversations regarding the set-up of interviews, raw data, analysis procedures, management, and data reporting.

Confirmability

The final stage of trustworthiness associated in this study is confirmability. Its co-equivalent in quantitative research is objectivity. In an attempt to address the issues associated with confirmability, I incorporated bracketing. Bracketing helped to reduce personal bias during the data collection and analysis phases of the study. Finally, an additional way I enhance confirmability was by having another researcher read over the results using a critical lens.

Ethical Procedures

The all-encompassing desire to maintain a study that has the best interest of the participants at the forefront of a researcher's mind. According to the Belmont report, researchers are required to remain cognizant to respect, beneficence, and justice (Government, 2009). To maintain these high standards, I completed a required online training class on human subject research. The Collaborative Institutional Training Initiative (CITI) offered courses which contained human subjects research material geared towards informed consent and other ethical considerations associated with human subject data collection. The primary ethical considerations for this study included: maintaining confidentiality and privacy, risk and benefit, security of obtained data, and controlling bias (Government, 2009). Careful consideration, of these topics, existed during this process.

The Walden University IRB grants approval in adherence to study ethics and provides a model for the ethical design of all research. Subjects should remain free from harm and the research benefits should always outweigh the risks (Bersoff, 2014). Required ethical considerations of anonymity and confidentiality necessitate placing great detail into the study design. Ensuring the confidence of participant identities merited assigning pseudonyms in the transcribed data and withholding personal details through redaction.

In adherence to legal and professional standards of ethics, each potential participant received an informed consent to read and sign (Bersoff, 2014). Informed consent, policy 46.116, is known to be the gold standard for the ethical and legal

protection of human subject research (Hall et al.,2012). The policy stipulates all subjects are entitled to autonomy, allowing the patient to make decisions on their own accord. Factors that influenced the informed consent included that each subject was presumed able to comprehend the study, participation remained entirely voluntary, and each potential recruit maintained the right to leave the study at any point without repercussion. Finally, each participant collected a complete list of expectations necessary to make it through the process (Hall et al.,2012). Each individual was encouraged to ask questions about concerns or interpretation of the consent.

All research acquired data remained confidential, and the only parties having access to the raw data and transcripts were me, the dissertation committee, the transcriber, and the peer reviewer following computer software analysis completion. All individuals who had access to the raw data signed a confidentiality agreement.

Compiled information included individual audio files from each participant, written transcripts, and journals kept by the researcher during the data collection progression. I password-protected my computer and locked all papers and written transcripts in a file. At the completion of the study, the standards for length of time data should be stored differs. Federal regulations required a minimum of three years; however, Walden University demands no fewer than five years (Walden, n.d.). During collection and afterwards, the data will remain password protected until five years pass, at which point I will delete it from my computer’s hard drive. At no point, will the subjects name or any identifiable characteristics become publicly available.

Summary

I chose a phenomenological approach to address workplace bullying in the nursing field, using purposeful snowball sampling to find 5 to15 nurses who had been exposed to workplace bullying and retained their current position. Each potential member of the study was required to be employed over the last year, been exposed to workplace bullying, and kept their current position. In-depth Skype calls allowed me to record interviews. Throughout the study, the intent remained that all participants explained their lived experience with this phenomenon. A pilot study established the length of the interview, ensure each question was appropriate the flowed suitable, and allowed practice for the researcher.

Upon completion of all interviews, Rev.com transcribed the data, and each subject had an opportunity to review the transcripts. If both parties agreed to the dictated documents, initiation of the software analysis program, NVivo began. NVivo offered stringent security built into the program to ensure confidentiality of the files. There were other ethical considerations to ensure the privacy of each individual. For example, each person received a pseudonym, such as Participant 1, Participant 2, Participant 3, to reduce the chance any person information inadvertently becoming available to the general public or the management of any hospital organization. At the close of the study, each person received a special thank you for taking part.

Chapter 4: Research Results

Introduction

The objectives of this qualitative descriptive phenomenological study were to describe the lived experiences and special challenges that contribute to effects of workplace bullying and to understand how nurses decide to retain their current job, despite being bullied. I designed three distinct research questions to detail the lived experiences of nurses bullied at work. The research questions for this study were as follows:

RQ1: What are the lived experiences of nurses who continued to maintain their position despite being bullied in the workplace?

RQ2: What are the special challenges nurses encounter who have experienced workplace bullying, when faced with the decision to retain their position?

RQ3: What are the techniques nurses use to rationalize their decision to retain their current working position, after being subjected to workplace bullying?

This chapter begins with an overview of the study results concerning workplace bullying from a nurse's perspective. The details to follow will include the pilot study, research setting, demographics, data collection procedures, interview process, data collection, data analysis, evidence of trustworthiness, and finally the results. In Chapter 5 I will provide limitations, recommendations, and associated finding of the study.

Pilot Study

Following approval from Walden's IRB # 08-29-17-0418151, I commenced a pilot study. The IRB approval allowed for the recruitment of participants through social media,

recruitment flyers via professional contacts, and websites such as findparticipants.com. The social media sites used for the recruitment of the pilot study participants were Facebook and LinkedIn. Before data collection began, as suggested by Creswell (2013), I conducted a two-nurse pilot study. Data received from these two nurse participants would help determine whether the interview questions would accurately answer the three research questions used in this study.

Included in the pilot study were two nurses who met the criteria set forth by this study. Both participants responded to a recruitment flyer (Appendix B) on Facebook, to become part of this study on workplace bullying. Following recruitment, each participant received a request, via Facebook messenger, to submit an email address she would prefer to use throughout the study. After being contacted by the participants, the researcher requested a copy of their email address. Immediately following, I sent an email to both pilot study participants. The initial email included a copy of the recruitment flyer (Appendix B) as well as a copy of the informed consent. Along with these forms, a note accompanied the email with a request for a contact telephone number, the need to read through each document, and if agreeing to the informed consent, to respond to the email with the words “I consent.” Additionally, I requested a list of dates and times to schedule interviews. Before making any telephone calls, I confirmed the returned informed consent and printed a copy for the confidential files.

After signing and returning a letter of confidentiality to me, the transcription service Rev.com transcribed interview audio files. Since each conversation occurred via telephone, special considerations needed to be made to record each interview accurately.

Audio only Skype was the vessel which the interviews took place, with Skype MP3 recorder employed to capture each word, along with a freestanding digital recorder as a back-up. In case of Skype MP3 recorder failure, this back-up recorder captured a second recording of the interviews. Rev.com requested each audio file submission following an MP3 recording formatting style, so dictation could be obtained.

At the agreed upon times, I contacted the participants. Before the recording began, I called each participant to let them know I would be calling from a Skype account. This proved to be an essential step because my name did not appear on the caller ID when using Skype. At this time, I also went through the Screening Instrument (Appendix C) to verify volunteers appropriately qualified to participate, and to see if they had any additional question about the informed consent. Upon completion of the screening process, I hung up the telephone and prepared for the actual interview call via Skype.

Each participant in the pilot study received the pseudonym Pilot Participant 1 or Pilot Participant 2, for confidentiality. Each participant had an interview packet, which included a copy of the screening instrument, their name and contact information, the date and time of the interview, and the interview questions. The interview packet included plenty of room to write notes during the call.

Once connected with the participant, via telephone interview, I introduced myself and verified that they had read through the informed consent and returned it in an email with the words “I consent.” Each participant acknowledged she consented to the interview and returned the document via email to me. We discussed basic qualifying data

including (a) how long they had been a nurse, (b) how long they had been in their current position, (c) whether they had been bullied in their current position, and (d) whether they spoke fluent English.

A researcher is indebted to their participants so, a thank you was extended to each participant at the beginning and again at the end of each interview. The transcription company's policy is to have dictation done within 24 hours of submission. I advised participants that a copy would arrive for their evaluation and requested that they read through the transcripts to ensure the words and meanings captured their emotions. I instructed participants to return the transcripts to me after checking them with a message indicating whether they were correct or whether they would like to discuss adding, removing, or changing any part of the transcription.

A pilot study allows methodological problems to arise, which the researcher can then be accounted for and address, such as if the questions are appropriate or if there is proper flow (Van Teijligen & Hundley, 2002). The small, two-nurse participant pilot study fulfilled the pilot study quota by pretesting the interview instrument tool used for the main study. At the completion of the interviews, the transcription service transcribed the recording, which each participant received within 24 hours, for member checking. Participants read through their transcript and return to me upon completion. Both study participants returned their transcripts with a positive note of how the words and meanings were correct and no adjustments were needed. Each participant also agreed that the interview questions were accurate, addressed the main issues, and allowed them to tell

their story. In fact, during each interview, the stories the participants were depicting led directly into the next interview question, showing a natural flow.

The purpose of the pilot study was to refining the interview questions, and no results from the pilot study will appear in the dissertation. The two pilot study participants were recruited from Facebook using a copy of the recruitment flyer (Appendix B) and after the initial agreement with the participant, informed consent. Each interview averaged approximately 40 minutes and provided abundant examples of lived experiences resulting from workplace bullying. The computer program selected to analyze the data, along with the hand coding of data was NVivo 11. Neither of the pilot study participants suggested revisions to the interview questions. Since the results from the pilot study did not require any adjustments, the IRB department of Walden University needed no further contact.

Research Setting

Data collection from the main research study occurred through telephone conversations using Skype audio recording software. The study sample consisted of 12 nurses across the United States including Hawaii. Through the use of the screening instrument (Appendix C) participants underwent a screening process to ensure they met minimum eligibility requirements.

Facebook was the primary source for participant recruitment. I bought and placed a “Workplace Bullying from a Nurses Perspective” page, on Facebook, for a one week. Additional recruitment ensued via public Facebook nursing sites. I contacted administrators from Facebook nursing sites to gain initial permission to advertise for

participants. Even though the sites used were open sites, I felt it was polite to contact site administrators and request permission, and thus sent each administrator a private message seeking approval to post on their page. Included in the note was a copy of my recruitment letter along with a copy of the IRB approval letter and number. Once the administrator approved the posting, I uploaded the information to members of the nursing Facebook groups so they would have access. Included was a request stating that, if they feel they met participation qualifications, to please contact me either by the email address, phone number, or Facebook's private messenger system.

Participants that felt they did, indeed, meet the requirements stated on the recruitment flyer and showed an interested in the study sent a private message to me via messenger or the Walden email account I had provided. I responded to each potential volunteer individually, and supplied them with the recruitment flyer, informed consent, and a request they read through the information. Additionally, if they wish to participate, they were asked to please return the email with the words "I Consent" as verification they wanted to proceed. After obtaining their informed consent, I sent an email back to them requesting they provide a good time and date for the interview to take place.

At the designated time and date that best suited the needs of the participant, I called the phone number they provided. During the initial conversations, I used the screening instrument (Appendix C) to verify their qualifications of being a nurse for over a year, their having an experience of being bullied in their nursing job, the need to still be in the nursing position in which they were bullied, and finally, their ability to speak English. After establishing these criteria, I told them I would be calling them back from

my Skype audio-only account, because it was necessary for recording purposes. A second audio recording, using a stand-alone digital recorder, was made of each interview as a backup in case any technology failures occurred. A password-protected computer and a lock box ensured all data remained secure.

All interviews took place in a secluded room with the door closed so no other individuals would be able to hear any part of the conversation, something I encouraged for each participant. Maintaining confidentiality was important. At the end of the interview, I thanked each participant and provided final instructions, namely that I would upload each audio file and forward it to a transcription service that had signed a letter of confidentiality. Return of transcription documents would occur within 24 hours, and I would read through them to look for errors. Once the initial reading occurred, participants obtained a copy for member checking. During this time, each participant was to read over the transcripts and make sure the information was accurate. Also, participants received instructions to look for problems. If they saw any errors or areas they feel should be omitted, added or adjusted, they were to send me an email. If they agree with the words, they were to return an email to me saying they approve the document.

Demographics

The inclusion criteria for this research project were that each participant (a) had been an RN for a minimum of one year, (b) had been bullied, (c) had stayed in the current position in which she was bullied despite being bullied, and (d) speaks fluent English. The participants were nurses from different areas of the United States and worked in diverse facets of the nursing industry. All 12 nursing participants were female; however,

gender was neither a documented nor defined demographic. Each participant received a pseudonym ranging from Main Participant 1 through Main Participant 12. Four additional individuals initially agreed to participant: however, upon speaking with them I found they did not meet the minimum requirement of the study. One of the parties is no longer actively working in the nursing field, two nurses have recently moved from their position, and the final nurse transferred to another state due to her husband relocating with the military. No participants dropped out of the study after agreeing to participate and meeting the study criteria. Finally, I did not personally know any of the main study participants.

Table 1

Participant Demographics

Main study participant ID	Years as a Nurse	Years in current nursing position	Have you been bullied in current position?	Do you speak fluent English?
MSP 1	25	11	Yes	Yes
MSP 2	17	17	Yes	Yes
MSP 3	1.5	1.5	Yes	Yes
MSP 4	33	20	Yes	Yes
MSP 5	1.5	1.5	Yes	Yes
MSP 6	21	7	Yes	Yes
MSP 7	1.0	1.0	Yes	Yes
MSP 8	6	3	Yes	Yes
MSP 9	39	20	Yes	Yes
MSP 10	13	1.0	Yes	Yes
MSP 11	13	10	Yes	Yes
MSP 12	20	1.0	Yes	Yes

Data Collection Procedures

Data collection began once Walden Universities IRB granted final approval to conduct this study on August 29, 2017. The IRB approval number is # 08-29-17-0418151. Moustakas (1994) posits the collecting of data, using personal interviews, provides a phenomenological researcher a vast amount of robust information. These intimate conversations allowed the participants the ability to describe their lived experiences of being bullied in the workplace. It also gave the researcher the chance to understand the predominant reasons these same nurses decided to remain in their position despite instances of being bullied.

The first step in the data collection process was to gain access of 5 to15 nurses who met the criteria set forth by this study. I created a Facebook page in an attempt to

recruit participants. Although permission to post on public Facebook groups does not require approval from an administrator, I nonetheless reached out to administrators of nursing Facebook pages to gain permission to post the recruitment flyer (Appendix B). After obtaining permission, I posted a copy of the study's recruitment flyer (see Appendix B) to the social media page. I also attempted to use LinkedIn to recruit participants but was unsuccessful.

Each person who reached out to me who thought they would qualify for the study received a copy of the recruitment flyer (Appendix B) containing minimum requirements each participant must meet to take part. Information regarding my contact information and participants' rights appeared on the flyer, as well. After initiating contact, I vetted the participants through the screening instrument (Appendix C) to ensure they met all aspects of the assigned criteria. Following acceptance, I sent a copy of the informed consent to the email address they wished to use in the study.

Upon return of the consent via email with the words "I consent, I scheduled individual, semistructured in-depth Skype interviews. The interviews took place from September 1, 2017, through September 22, 2017, with each lasting an average of 40 minutes. I asked four interview questions to answer Research Question1, and three questions each to answer Research Question 2 and 3. The wording of each interview question allowed for detailed assessment of participant's lived experiences with workplace bullying.

The Interview Process

The Interview Process began by making initial contact with each participant through a telephone conversation. During this call, I asked each participant clarifying questions about her qualifications. At this time, any question and answer session occurred. The intent was also to verify the participants understood the informed consent and a detailed explanation of the study events. The informed consent had previously been emailed to me before the initial contact via Walden's email account with the words "I consent."

Following the initial contact, participants needed to find a quiet location where they could focus on the interview. Each participant received instructions the next call would be from my computers Skype account and would show up on their caller ID as an unknown caller, because I was unable to adjust the Skype account to show my name on the caller ID. Once this was cleared up I confirmed they had met the qualifications, I hung up the telephone and called them back from my computer's Skype account.

To ensure confidentiality, I sat in a private office in my home with the door closed. I typed in the telephone number, initiated the call, and began to record the call using Skype MP3 recording software as the primary recording device, and a portable battery-operated digital recorder as a backup. Each person received a a pseudonym and a number: Main Study Participant 1 (MSP), MSP 2, and so on.

Each conversation began with the following questions; (a) How long have you been a nurse? (b) How long have you been in your current position? (c) Have you been bullied in your current position? and (d) Do you speak fluent English? Following these

answers, each person verified she had read through the informed consent and returned it to my email account with the words, “I consent.” The questions provided an understanding that each participant did, in fact, meet the minimum standards to become part of the study.

Data Analysis

The initial plan was to interview between 5 and 15 nurses for this study. In response to the Facebook posts, 14 nurses contacted me wanting to be part of the research by telling their story. Of the 14 interviewed, the first two participants were part of the pilot study. Data saturation occurred when and remaining 12 participants were interviewed for the main portion of this study. The average interview time was approximately 40 minutes, in length.

The interviews yielded a considerable amount of data provided from two audio recording devices, personal notes which included a one-word definition of the participant’s stories as they spoke, reflective memo after the interviews, and finally, reactions to their comments. Upon completion of the interviews, I uploaded the Skype MP3 recording to Rev.com transcription service website for dictation. Notes written during and immediately after the interviews helped the experiences begin to resonate.

I am not a nurse, but I have been in the healthcare field for the last 29 years. During that time, I experienced workplace bullying firsthand, which allowed me to pull from my personal experiences during reflection and bracketing. It helped me set aside any bias or assumptions with the phenomenon in this study, to prevent these issues prejudicing the data analysis. Epoche helped remove any preconceived notions,

judgments, or personal beliefs when beginning to search for themes. Participants remarks were viewed objectively to eschew any bias.

Before coding or analysis, each participant was given a copy of their transcribed interview for member checking. Member checking adds to the trustworthiness, of the study, in this case allowing the interviewee an opportunity to read through her words to guarantee her complete agreement with the transcribed material. During this phase, respondents had an opportunity to add, subtract, or change what they had said. They also could provide additional clarification to their spoken words. If they approved of the transcripts, they sent me an email saying they accepted the transcribed interviews for use. If not, the email was to state they needed to have a conversation about the document before final approval for use. All respondents sent emails stating their documents were approved for use. Finally, the transcripts and their summaries went for peer review, in an attempt to garner additional feedback.

In the initial phase of coding, I read through the transcripts and compared them to the field notes and one-word descriptors, which I had handwritten during the live interviews. In an attempt to hand organize the data, I began to formulate specific identifiers that correlated with their spoken words and placed them under the specified research question. Moustakas (1994) suggested considering each statement concerning the description of the experience, and then relating and clustering invariant units into themes. During this time, recurring words became apparent. Research Question 1 yielded one theme and three subthemes while Research Question 2 and Research Question 3 yielded one major theme each (Figure 1).

Along with using a manual process of coding, I imported the data into the software program NVivo 11 to help label and categorize the data. These two methods provided the means for creating a detailed and exhaustive interpretation of the collected data. In both techniques, themes emerged and assisted in the accurate description attributed to the lived experiences of the nurses interviewed during this process.

Evidence of Trustworthiness

Credibility

Boosting of credibility occurred by conducting a pilot study to test the methodology associated with the researchers-created instrument tool. Credibility, according to Pitney and Parker (2009) is “the plausibility of the study findings” (p. 63). The researcher’s responsibility is to assure the readers that the incidents transpired and were accurately narrated (Pitney & Parker, 2009). My participation in the CITI Program, which is a web-based program for the protection of human rights participants, brought light to the many possible ethical and bias situations a researcher can encounter during research. I followed all guidelines taught throughout this course.

Before any interviews started, an initial telephone call helped verify the volunteer’s qualification and enabled a short conversation about the process. The reason for this exchange was to allow the participants and me to get to know each other, and assisted them to feel free in opening a dialog. It is vital for each volunteer to feel comfortable enough to share potentially sensitive and painful lived experiences.

At the conclusion of the interviews, I thanked each nurse and advised her an outside company would transcribe the conversations within 24 hours, thus providing

assurance of confidentiality. Once I received the returned transcribed interviews, I emailed a copy to the participants for member checking. This provided an opportunity for volunteers to read over the answers and report back to me if they approved or needed adjustments. The participants authorized all transcript's without amending.

Data triangulation was achieved by creating two separate audio soundtracks of all interviews. Along with the recordings, I created a packet that included a copy of the screening instrument (Appendix C) and the interview questions (Appendix A) stapled together. During each interview, I would write down field notes, and any time a theme appeared, I would note it under that question. To finish out the triangulation, I created memos in NVivo 11 software program to assist in data uniformity and stability. Finally, peer review of transcripts occurred following the return of a signed letter of confidentiality.

Transferability

Transferability, also known as external validity in quantitative research, is the "ability to apply the findings to similar environment" (Pitney & Parker, 2009, p. 63). In a qualitative study, it is the investigator's job to thoroughly explain the framework and assumptions that were central to the study. A clear-cut outline detailing the structure of the study will allow for future researchers to reproduce the study. All study documents, including the interview questions (Appendix A), are part of the dissertation. NVivo 11 facilitated organization, registration, and condensation of all data.

Dependability

Dependability is equivalent to reliability in quantitative research. The overarching focus is the ability to use the same process under different conditions, and find consistency. Obtaining dependability comes by creating an audit trail, which in this study, consisted of email conversations, field notes, audio recordings from Skype Recorder and a separate digital recorder, and data processed through hand-coding and NVivo 11 software. Qualitative researchers use audit trails to create a description of steps taken during their project (Lincoln & Guba, 1985), In this case, collecting field notes during each conversation and later comparing them. I used bracketing for researcher bias and implementing self-reminders to not allow personal thoughts during the collection of data and allow the free-flow of ideas and feeling from the nurses lived experiences to become center stage. Dependability came from proper documentation of data analysis, instrumentation, and applied research methodology.

Confirmability

Confirmability, according to Coa (2007), is “the research findings being reflective of the inquiry and not the researcher’s biases” (p. 443). With confirmability, it is the researcher’s responsibility to ensure the findings are grounded in the data versus the thoughts, opinions, or personal bias of the researcher. In this study, confirmability transpired by using two recording devices which allowed for transcription of the participants lived experiences alone. Member checking took place as each participant reviewed and returned her transcripts, with none of the nurses requesting any changes. Finally, an additional way to enhance confirmability is by having another researcher read

over the results using a critical lens. During the final stages of analysis, the collected data, transcribed member-checked documents, and NVivo 11 collaboration of themes underwent peer review by a fellow researcher who had signed a letter of confidentiality.

Results

Once verifying qualification requirements for each participant, I scheduled interviews at a convenient time and date for each participant. I conducted the Skype audio interviews in private and reassured all participant that their transcripts would remain confidential and neither their names nor identification of any sort would appear within the final document. Participants' responses served to answer the study's three research questions, each of which was composed of either three or four interview questions, along with a final question allowing each volunteer to offer any final thoughts on the topic.

Each participant was able to answer the question in great details, of their lived experiences of being bullied, special challenges they encounter after being bullied, and techniques they employ to rationalize their decision to stay in their current nursing position. All participants were eager about their ability to share their lived experiences of being bullied. They were candid with their answers and were willing to share intimate details of being bullied. Few appeared to hold back thoughts during their in-depth descriptions. Figure 1 depicts a hierarchy of the studies research questions, interview questions, and associated themes.

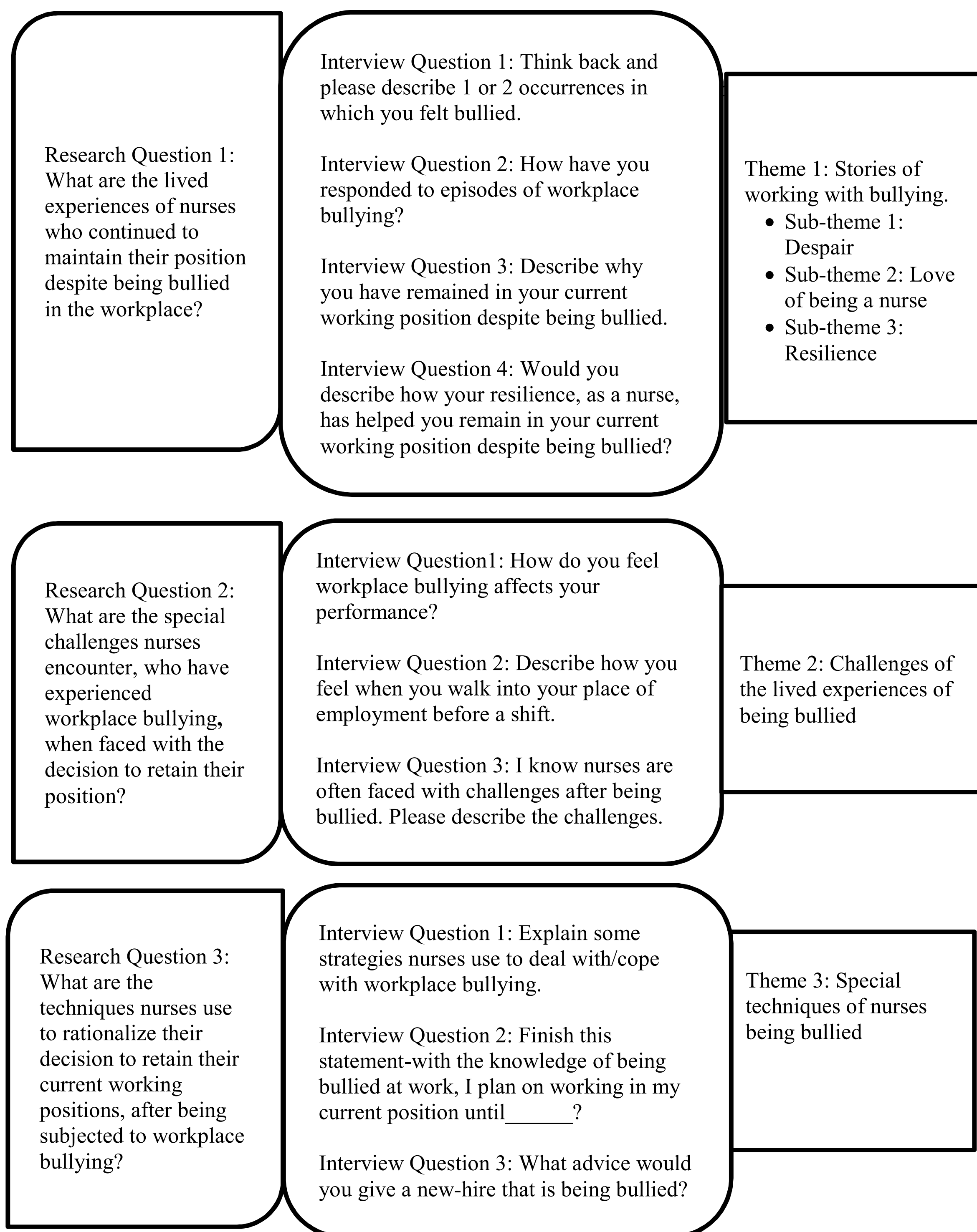

Figure 1: Research Questions, Interview Questions, Themes and Subthemes

Research Question 1

Theme 1: Stories of working with bullying. The first research question was broken down into four interview questions to examine the lived experiences nurses encounter who maintain their position despite being bullied at work. The first semistructured interview question was "Think back, and please describe 1 or 2 occurrences in which you felt bullied". The primary focus of this question was to provide an opportunity to bring the occurrences of bullying to the forefront of each participant's memory. It also allowed the participant and me a chance to continue to build a rapport.

Respondents described negative feelings associated with their lived experiences, for example, memories of passive and verbal bullying that created anxiety, hypervigilance, avoidance, and an overarching need for documentation and an increased communication. MSP 4 tells the following story:

> While I was in class, I was doing a lecture, and she came to the door and she knocked, and stuck her head in, and she said, "would it be okay if I addressed the class for a moment? Because we need to talk about their election of class officers."
>
> And I said, "sure, come on in." So, I sat down on the opposite side of the room from the door. And the students were between me and the door. So, I was sitting there, and she talked about choosing officers, and they voted right then and there, and they selected their class officers. And then she says, "now, I understand that some of you have some complaints about your nursing teacher." That was me. She said, "we're going to talk about those, while she's here."

She let them, 45 minutes of bashing me. From my voice, the way I walk, everything. Everything. And someone asked me later why I didn't leave, and I said, because I couldn't get out of the room, they were between me and the door. I couldn't get out. And I had to sit there, and listen to them for 45 minutes

And when they were done, she said, "now, don't you feel better? Don't you worry, I will fix this." And she walked out of the room, she walked out of the building, down to her car, and left for a vacation for two weeks. And the only thing that I could say, all the students looked at me, and the room was really quiet, they all looked at me, and I said, "why don't you go to lunch?" And they all got up and left, and I picked up my things, and I was headed back down to my office, and one of the students stopped me in the hall, and she said, " did you know that she was coming up to talk to us?"

And I said "no." And she said, "I didn't think so, because when I looked at you, all the blood had drained out of your face." She said, "you had turned white." And I went, into my room, into my office, and I just put my head down and I just cried.

MSP 9 describes her personal feelings of being bullied the following way:

It's really hard to get out of the house and go to work when I'm probably going to get yelled at first thing in the morning. I hate that, I hate that. Being spoken to in a harsh tone of voice, there is no excuse for that. Talk to me like I'm another adult. Don't talk to me like I am eight and I forgot my homework.

MSP 1 describes how she feels anxious after being bullied in the workplace. She says: “I think it makes you feel nervous, and it makes you second guess yourself”. She then finishes her statement with “if you do encounter a challenge during the day you have to call that person as a resource, then you’re nervous because you’re worried about being attacked. You’re worried about being bullied again, and you’re worried about that person second guessing you, and undermining you as a valued employee.”

Subtheme 1: Despair. The next interview question required participants to describe how they have responded to instances of workplace bullying. After I had established specific episodes of workplace bullying and tried to gain a sense of what each participant had endured during these events, I allowed for them to elaborate what they did in an attempt to elude or respond to the bully’s attacks. Some of the more common thoughts were those of reporting the incidents. MSP 10 and MSP 7 described the need to standing up for yourself and have a pep talk to make it through the situations. MSP 7 said, “I learned to develop a thick skin.” and followed with “I go in, I put on a smile, and I just do what I need to do.” MSP 10 expresses how she handled the situations with a direct response to the bullies. She told the bully “if you want to manage the patient and keep her, then I will give you report and you can stay here at bedside.”

Other nurse participants suggest the need for avoidance. They felt if they could avoid the individual, they would not be faced with the anxiety or pain associated with the bullying. According to MSP 4:

> His behavior toward me got to the extent that when the other nurses on the unit saw him coming, they would come and tell me, “John’s coming, John’s coming.”

> And I would go hide. I would hide in the patient's bathroom, or I would hide behind the curtains, or hide in the hopper room. I would hide anywhere, so that John wouldn't see me, so that he wouldn't look so angry at me. So, he wouldn't speak to me in such a hateful way, I would just hide from him.

She related that these instances of bullying were so bad, she suffered a physical response, stating "I developed a stutter, I could barely get a word out, I had a horrible stutter. I was crying."

MSP 5 also uses avoidance as a response to episodes of workplace bullying. She was fortunate that her bully, at the time of the interview, had just left the month before. With the feelings fresh in her psyche, she told me "I used to go to work scared she was going to be there that night because I didn't want to be around her. Now I go to work less… stress-free, and now I can enjoy my work a little more."

Finally, about responding to episodes of workplace bullying, participants explained how they divert their attention onto the patient. In general, nurses are advocates for their patients. Their overarching obligation is to the welfare of those individuals unable to fully care for themselves without medical interventions. With this in mind, several of the nurses expressed ability to put the patients' needs over their own needs. This is done through patient advocacy. MSP 6 said:

> I just try to do the best that I know to make sure that this ward is a proficient and competent ward. Make sure that our patients are receiving the best possible care, and they are reaching their goals and they are being discharged from the hospital, back into community and able to function on the outside.

In line with this statement comes feelings from MSP 10 when she describes her feelings on becoming the patient's advocate. She has had firsthand personal and professional experience with patient advocacy and explained her thoughts in the following way:

> I've been on the receiving end, crappy care and bullying patients who were my doctors, my personal doctors and as a patient, I know what it's like when a floor is busy and hectic and people are stressed and people start yelling and are ... You can see the bickering without even hearing it sometimes, right, the tension. I feel like it's important to me to do everything I can to make sure that patients don't experience that. you'll hear doctors talking or residents talking and you're like, really, would you say that or want somebody to say that about your daughter or your cousin or your sister. And they're like, oh, okay. Yeah, you're right. It's just ultimately remembering that we're there for the patient. That's what it comes down to.

Subtheme 2: Love of being a nurse. The third interview question associated with Research Question 1 required participants to describe why you have remained in your current working position despite being bullied. Learning why these nurses decide to stay despite being bullied is crucial to understanding how to address one of the most substantial and costly problems in nursing- retention- with this population. Of the 12 interviewed, eight of them said the reason they stayed in their position was that they loved being a nurse. The other three nurses said they remained for financial reasons. Looking through their transcripts, I began to realize just how passionate these nurses

were about the career they had chosen. MSP 1 responded by saying "I think it is because I love what I do" and "I wouldn't have someone just bully me out of my position." MSP 3 commented "it was kind of like a dream job, knowing what I know about people who are bullying and rude in my workplace, I know they're going to be out of there faster than I would because I really love what I do."

MSP 4 is a nursing professor who describes how she loves working with her nursing students. She expressed how much she had to offer each of them and how she loves the continued contact with them after they graduate and become part of the workforce. She explains how they still call her and it gives her great pride. MSP 6, MSP 7, and MSP 10 all answered "I love my job"; however, MSP 10 does go on to say "I absolutely could not dream of doing anything else."

Subtheme 3: Resilience. The last question associated with Research Question 1 was one of the most significant. The conceptual framework for the study is resilience and how it plays into the ability for a nurse to retain their position despite being bullied. At the onset of the interview, I read to them the definition of resilience and explained we would get to that question later in the conversation. After reading the meaning, I asked if she considered herself a resilient person, to which they all replied.

In the interviews, every one of the nurses agreed she had a resilient personality and how important that factor is when becoming a nurse. The interview question was, "would you describe how your resilience, as a nurse, has helped you remain in your current working position despite being bullied?" MSP 1 illustrates that in her job:

> It's so challenging emotionally and physically that you develop some kind of strength inside you to deal with the challenging things. And also, other things that doesn't seem life threatening seem to kind of be easier to cope with. Because say you see patients dealing with these tough situations, and you're dealing with someone's attitude, or someone trying to bully you, and you just feel…. You develop a sense of strength, and that helps you to be more resilient I think. And it makes you stronger.

MSP 2 tells her story of strength, relating "I have a great amount of strength, and I love my job with a passion, and I would never let her take that from me, because I have a lot go give to those patients." MSP 3 offers the same sentiment and added that she tries to let "things roll off of her back". MSP 4 describes her lived experience by stating "I have a strong sense of professionalism, and ethics, and community, and I think more than anything, I wanted to make sure that I fulfilled the duty that they expected of me". MSP 6 said her strength and resilience comes from her faith, and continues:

> Christian faith, was number one. Number two, my oath that I took the day that I stood before my family members and along with my classmates when I graduated as an LPN to do the best that I could do and do no harm to my patients, and respect them and provide for them, at all times, no matter what.

MSP 10 said "it's like anything else in life. I make a conscious choice every day to get up and go to work. It's a matter of pushing through" and "looking at the bigger picture. Finally, MSP 11 explained:

> I know what I'm doing things for and who I'm doing things for and I do it for the people that I really can help and that's part of it. I always think of that as there's these people out there that I'm really helping that I'm really taking care of. I think of my kids and I think of my husband and I think of my life and I think of everything that I need to do to continue to be the provider that I am for both my patients and my family.

Research Question 2

Theme 2: challenges of the lived experiences of being bullied. On any given day, nurses face challenges they have to overcome. The nursing participants, of this study may perceive individual problems as added stress, increased physical or mental exhaustion, family involvement or low job satisfaction, when compared to nonbullied nurses who enjoy their profession and involvement with patients and coworkers. Research Question 2, "What are the special challenges nurses encounter, who have experienced workplace bullying, when faced with the decision to retain their position?" Within this question were three interview questions devised to help shed light on these challenges.

The first interview question required each participant to relate how workplace bullying had affected their performance. Some of the most common responses were their increased level of anxiety, reduced confidence, avoidance, and their need to become hypervigilant. In response to this question, MSP 11 describes her challenges the following way:

> I think it makes me look over my shoulder a lot more than a lot of other nurses would and it definitely takes up a little more time because I am extra, extra careful to cross all my T's and dot all my I's just because I wanna make sure that I am never in another situation where somebody's just following behind me, waiting for me to screw up. It's more of an almost hypervigilance to make sure that I don't make any mistakes whatsoever.

MSP 4 describes her hypervigilance by stating, "You become very careful and you're worried that you're going to make mistakes, that you're going to do something, and that person's going to be angry with you. That he's going to report you." Others describe how bullying affected their performance by discussing their anxiety. MSP 1 said "I think it does make you nervous, and it makes you question yourself." She continued if the bully is around, "it makes you nervous, and second guess yourself, and it can make you not as confident in your performance." MSP 10 replied by saying "it had made for a much more stressful environment." She said "it's good to be on your toes, but to be fearful and wary, I guess to an extreme, is not always good." Almost to an extreme MSP 6 describes her anxiety as a similar extreme:

> If I feel on the inside like I can't keep it together, then I'll go to the bathroom or whatever and I won't scream out loud but I'll make the motion. You know, in the bathroom like I'm screaming or jumping up and down. I feel like I need to cry a few minutes, I'll cry and get myself together, then I'll go back and go to work. I never try to let, as that commercial used to say, "Never let them see you sweat!"

Of all respondents' comments made about how bullying had affected their performance, one participant stood out. MSP 9 said her continued ordeal has made her "less patient with her patients and that's not okay."

The next interview questions required participant to describe how they feel when they walk into their place of employment before a shift. With this question, the intent was to identify what barriers they perceive while trying to handle these special challenges. What does it take to make one go into a possible awful situation?

The answer for MSP 1, MSP 3, MSP 5, MSP 8, and MSP 10 included their need to know if the bully was going to be at work when they arrived. Will the person bullying you be there? will you have to deal with them? These were all questions they had to contemplate. According to MSP 1:

> If the person who bullies me is around me I would not want to go to work. I don't feel like I want to go to work, I feel sick, I feel like I cannot face the day. If the person is not around then I would feel more confident, happier going to work. I think being bullied has made me feel like you're not contributing, you're not values, you're not respected, and really, you're not wanted. And people just don't have confidence in you, or value your opinion or contributions. And when you feel that way and going into the workplace where that person is around it makes you feel all those things.

MSP 3 said, "it makes for a worse day. I can walk in, and as soon as I see them, I'm like oh, it's going to be a great night. I can just tell. It's definitely not a good feeling." MSP 5 elaborates by saying:

> Prior to her leaving, she just left within the last week, I was just really nervous all the time. I'd always kind of see, I'd ask, "Is she going to be here tonight? Is she around?" Just because I would be way more anxious. I'm a pretty anxious individual as it is, but she just kind of tops that for me, and I think it definitely had an effect on just my attitude at work. I'd be a little guarded, but now I'm just, I have a different really attitude walking into work. I'm much happier.

The last interview question associated with Research Question 2 was almost a direct extension of the Research Question itself: I know nurses are often faced with challenges after being bullied. Please describe the challenges. The answers to this question were all over the map. MSP 11 describes her challenges as follows:

> The challenge of hypervigilance, and the challenge of just making sure that I'm doing everything up to par. Most days, just trying to be that duck that looks calm and is paddling like hell underneath because I'm spending 90% of my day paddling underneath, making sure that I'm walking that fine line of taking care of everybody and getting everybody's needs in order.

According to MSP 12, a lot of nursing is word of mouth. If you stand up to a bully, especially if it's a boss, "they tend to tell others," and then finding another job can become very challenging. At that point, she explained, the challenge is, "they dub you as a problem, and it can become very difficult" and you can be "stuck in your job" even if you don't want to be surrounded by bullying. MSP 2 believed her biggest challenge was "trusting the people around me." She says "I was very, very leery of my coworkers,

because I didn't know who was going to her or who was watching, because she does have people [I wasn't] sure who I could trust."

MSP 4 deems her biggest challenge as a complete loss of confidence, which she attempts to turn around by giving herself a pep talk before a shift. She told me "I've been doing this for a long time without a problem. So, if you have a problem with my practice as a critical-care nurse, that's your problem, not mine." MSP 7 says her biggest challenge was trying to remain hypervigilant in her job. She related being afraid her bully was "going to turn me in for something to either try to get me fired, or moved from the unit." MSP 6 affirms her challenge is keeping her composure and trying to stay professional. She said her bully is passive and tends to go behind her back, which she feels is inappropriate for a nursing unit. MSP 1 revealed her trial revolves around her confidence level, the moral aspect, and respect between coworkers. Finally, according to MSP 5, her chief challenge is confidence level. She said

> When you're not confident in something, it can definitely have an effect on patient care, because patients pick up on that kind of stuff, especially with new nurses. See, I've had patients tell me, "I could tell this nurse was a little hesitant," when they were doing something. I mean it's definitely, you just kind of double, second-guess yourself basically, because you want to make sure you're doing something right.

Research Question 3:

Theme 3: Special techniques of nurses being bullied. In Research Question 3, the overarching idea is to find the techniques, bullied nurses have used to deciding to stay

in their current position. The Research Question is: What are the techniques nurses use to rationalize their decision to retain their current working positions, after being subjected to workplace bullying?

The starting interview question was for participants to explain some strategies they use to help deal or cope with workplace bullying. The two main answers were having a support group and having outside activities that help separate their work life from their home life. Participants described outside activities with great excitement in their voices. While they were talking, I could tell how much they enjoyed keeping these aspects of their life separate. In fact, MSP 12 confirmed “inside work, I’m pretty much, no this isn’t gonna happen, we’re not going to do this. I know what you are doing so stop playing games.” Then she said, when “I go home, I’ll vent like crazy, and when I’m done I’ll go ziplining.” MSP 6 has figured out a way to do both, as well. At work, she says “a lot times we have a courtyard where we take the patients,” and when “going outside in that fresh air, I can take deep breaths and it’s like cleansing.” When she gets off work, she continued “I’ll desensitize myself by sitting in my car before I come home so I don’t bring my work stress home.” Other outside activities, according to MSP 11 include watching a funny show on Netflix or going shopping. She said “me at home is not the same as the me at work.”

Other nurses suggested finding a support group to talk out problems they have been enduring. MSP 7 expressed the need to speak with coworkers as her primary strategy. Once she said she talked to a colleague and he told her, “you’re a leader. You know what you’re doing. You have the confidence.” He said, “don’t let her get to you.”

She realized it was really a pep talk from her coworkers and her family that helped her deal with these issues. MSP 3 affirmed how important a good support group could be, relating how one of the members pulled her and said “they’re going to be rude sometimes. You can’t let that bother you.” She said peer counseling was really good between herself and her fellow nurses. At the end of this interview question she said “I don’t really have any specific strategies, but just try to remain positive in a crappy situation.” Ultimately, this is the result of have resilience.

The next interview question involved each participant to finish a sentence: “With the knowledge of being bullied at work, I plan on working in my current position/department until_____?” It was an attempt to decipher just how much pain from bullying they would be willing to endure and to find out if resilience was an underlying reason. As expected participants had different reason for continuing. Of the 12nurse interviewee’s five (MSP 1, MSP 3, MSP 6, MSP 10, MSP 11) said they would stay until they finish their higher education; three (MSP 2, MSP 4, MSP 7) said they would stay until they retire; two (MSP 5 and MSP 8) said until they would stay until they were transferred (military), and two (MSP 9 and MSP 12) said until they could not take the bullying anymore.

Among the participants who were in school, MSP 3 said “I really don’t think bullying will be the reason that I leave” this position. Since she had only been in nursing for 14 months, she believes she needs more education before leaving her current position, even with being bullied. MSP 10 says she could not imagine doing anything other than nursing, and believes in “the end, no matter what your position is, no matter what your

role is, we're all there to take care of the patients." Ultimately, she said she would certainly stay in her position until she could "finally go through the paperwork to go back to school." Most of the participants suggested they would not be bullied out; however, two of them did not feel the same way. MSP 9 and MSP 12 said they were staying until they could either get a new job or cannot take the bullying anymore. MSP 12 exclaimed:

> We deal with patients that are coming in to beat the crap out of us, sometimes, and everything. And we just don't need the co-workers mentally beating us up all day. I always tell my husband, I've been saying it a lot lately, that I'm like I think I need to get out of nursing. But I just I can't let it go. I love nursing, and I've been in it forever. There's really nothing else I want to do. I'm continually going to classes and I just I think I would probably find something else. I think PRN, I'd just stay for a very, very long time. Even with all the bullying.

The final question associated with Research Question 3 was meant participants analytically think about being in the driver's seat. The interview question read; "What advice would you give a new-hire that is being bullied?" I liked this inquiry best, because the older nurses had to think back to when they were fresh out of school while the younger nurses had an opportunity to talk to those nurses much like themselves. It was an opportunity, for all nurses, to give themselves advice.

When nurses exit the confines of academia, an assigned preceptor often assists in their journey of being a nurse. Preceptors are there to help answer questions and field problems, much as a mentor would do. MSP 5's advice to a new hire being bullied would be:

> I just definitely say to have confidence in their abilities as a new nurse. I know it's definitely hard when you're so new, and you're new to policies and procedures, but kind of finding a mentor, whether it be someone they're orienting with or another friend on the unit just to kind of re-affirm their abilities, that kind of stuff.

MSP 7 had the same thought process and said "I would have to say don't let it get to you, that people are going to test you and see how far they can push. Develop thick skin to begin with and always find that co-worker that will have your back, no matter what." Also, MSP 10 said "They need to find somebody that they trust, that they can confide in" and "figure out a way to fix that communication and how that bullying can be remedied." She also expressed how important that was for "a new hire to find a mentor," And how vital communication is to the overall wellbeing of a nurse.

Near the completion of the interviews, I asked one last question to see if the participants had any final thoughts on bullying that had not been addressed or upon which they would like to elaborate. MSP 1 believed "bullying was something that's very common in nursing." She also felt that "nurses need to better about protecting each other and standing up for each other and not throwing each other under the bus." MSP 12 felt "the whole culture of nursing needs to change," beginning in the nursing "schools and realize that your co-workers are not your enemy."

MSP 6's final comments were, "I would just like to share that bullying can make or break a nurse…If you have a person that is not strong-willed, bullying can sometimes lead them towards a state of depression; they cannot overcome. Her advice on how to resolve the problem was:

> We just need to try to educate our nurses, our older nurses that, when those new nurses come out, don't say "Okay, I'm going to see what they're made of" We need to take them, and we need to like a mother bird would do with her baby, put that nurse under our wings and care for them and lead and guide them and help them grow.

Summary

When a researcher does a qualitative phenomenological research study, the intent is to learn about a phenomenon through personalized lived experiences. This study was no different. Chapter 4 provided an overview of the study dynamics. It included a description of the participants, sampling methods, data collection, data analysis, and trustworthiness, as well as a synopsis of thoughts and memories based on nurses' lived experiences of workplace bullying.

Participants were gathered through social media and vetted to ensure they met the minimum requirements to participate. Sample demographics appeared in Table 1. I collected rich data from qualified individuals through one-on-one, semistructured telephone interviews lasting an average of 40 minutes each. I analyzed data first through hand-coding, and later through NVivo 11 using Moustakas' (1994) modification of the Stevik-Colaizzi-Keen method. The analysis process led me to identify three major themes and three sub-themes, as shown in Figure 1.

Chapter 5 contains an interpretation of finding from the themes and sub-themes found to exist in the collected data. It also includes a discussion of specific limitations,

recommendations, implications and, finally, how the results could translate into social change.

Chapter 5: Conclusion

Introduction

Bullying was once thought of as a childhood problem occurring on the schoolhouse playground when the teachers turned their heads for a moment (Granstra, 2015). Through the years, this phenomenon has been found to exist among adults as well, in all industries, including higher education and healthcare. Workplace bullying in the healthcare industry is an ever-growing problem and leaves no new graduate or experienced nurse unaffected (D'Ambra. Andrews, 2014; Townsend, 2015; Yildirim, 2009).

The objectives of this qualitative descriptive phenomenological study were to describe the lived experiences and special challenges contributing to the effects of workplace bullying, and to understand how nurses decide to retain their current job despite being bullied. Nurse participants perceive individual problem as added stress, increased physical or mental exhaustion, decreased family involvement, or low job satisfaction, when compared to nonbullied nurses who are able to enjoy their profession and involvement with patients and coworkers.

Chapter 5 provides an overview of this study, including findings, limitations, recommendations, implications, and the potential for future research. Finally, I will describe how the results can create positive social change. I obtained these results by interviewing 12 nurses and learning about their lived experiences of being bullied. The participants answered 10 main interview questions, with a final open-ended inquiry if they had any other thoughts they would like to share. The lived experiences of nurses

who had experienced workplace bullying contributed to a comprehensive description of what they endured and how they worked past their problems and made the decision to stay in their position.

Interpretation of the Findings

At the conception of this study, it became abundantly clear, based on personal experience and an overview of the literature on workplace bullying in the health field, that workplace bullying existed long before it had a title and showed a need for further evaluation. The focus of this study was to discover detailed lived experiences of workplace bullying directly from the nurses who experienced it firsthand, which was quite different from the other studies found throughout the literature. Since very little research on workplace bullying from a nurse's perspective exists, I set out to answer questions about their experiences, challenges they face, and techniques used the decision to stay in their position. From the analysis performed through in-depth semistructured personal interviews, the following themes began to emerge: Theme 1—stories of working with bullying, Subtheme 1—despair, Subtheme 2—love of being a nurse, Subtheme 3—resilience, Theme 2—challenges of the lived experiences of being bullied, and Theme 3—special techniques of nurses being bullied. Before an overview of the findings, a recap of the conceptual framework appears.

Conceptual Framework

In Chapter 2, I described the association of everyday living from a resilience standpoint. The conceptual framework, resilience, help explain and identify leading causes for some nursing staff who, in the face of adversity and workplace bullying,

decide to pick their head up and make the decision to stay in their current working position. Resilience is a process that is very dynamic and causes an ever-changing response to life stressors, worldly demands, and a multitude of adversities with an outcome of preserving a sense of steadiness.

At the onset of each interview, the participant listened to the definition of resilience to help them gain a clear understanding of the term. Each of the nurses declared herself a resilient person and nurse; however, when I was listening to their words and later reading their transcripts it seemed there were multiple levels of resilience. One participant, MSP 2, when attempting to describe how resilience helped her to remain in her position, described how she felt the need to have witnesses around her when she was near the bully, instead of describing inner strength, like many of the other nurses did. This is not to say she is not resilient, but her idea of resilience is very different than the others.

Most frequently, the nurses who described their resilience referred to their love of the job. They were able to push aside their problems and put their focus on the welfare of their patients. MSP 1 described it by saying “it’s so challenging emotionally and physically that you develop some kind of strength inside you to deal with challenging things.” Comments like this describe the lived experience of a resilient nurse. The comments are also in alignment with Brennan (2017) who believed nurses, despite these challenges, had proper coping strategies to handle adverse situations maintaining a positive outlook on their career.

Researcher Question 1:

Theme 1: Stories of Working with Bullying. For this study, all of the participants who agreed to the interview process had an understanding of what the term *bullying* meant. Through firsthand experiences, they also had an understanding of how bullying occurred in the workplace. Each participant gave detailed descriptions of these encounters, revealing that her awareness of bullying was at the forefront of our conversations. Thankfully, they spoke of the situations with a matter-of-fact attitude rather than that of being fragile or beaten down. All had their accounts; however, most of them had the same underlying story.

Some participants spoke of passive bullying and others of verbal bullying. The participants relived prior instances of bullying as they told their stories. One of the most memorable stories consisted of a nursing professor being held in a classroom while the dean and the students spoke of their ill feelings towards the teacher. During the story, she told me she was horrified at the dean's unprofessionalism to discuss such problems with students right in front of her. I could tell how difficult it was for her to relive the ordeal and, as her voice began to crackle, I asked her if she wanted to go on. She proclaims she wanted the world to know about her injustice so it did not happen to others. The following day, I gave her a call to make sure she was doing well. She said she was glad she told her story, and felt she is a stronger person because she was able to discuss it and also stay in her job. She was not willing to allow the dean to disgrace her out of the job she loved so much. The story is indicative of the strong nature possessed by the nurses I interviewed.

Subtheme 1: Despair. The nursing participants described their firsthand instances of bullying in the workplace and the pain and despair they encountered. For them, bullying provoked feelings of marginalization and confusion, demonstrated as opposite ends of a continuum. On one end, they described the bully and the treatment that ensued, and on the other end, how much they loved their coworkers.

Despair is the first subtheme listed within the first theme. This subtheme was revealed in descriptions of passive and verbal bullying that each of these nurses encountered. During multiple interviews, I noticed that participants reminisced about how they stood up to the bully or the need to give themselves a pep talk in an attempt to remain on the job. As they looked back over their lived experiences of being bullied, they explained how they responded by documenting and reporting acts of passive and verbal abuse. One person often said she would just let it go or in bigger instances, she would avoid them all together.

One participant struck me when she said she was the union rep at her hospital. She explained that she was the one others went to if problems arose. Over the last year; however, the tides shifted and she became the target of bullying. She explained how difficult it was. Later during the interview, she decided the bullying was directly related to the person being angry about her going to Human Resources on behalf of other nurses. Finally, after some time went by, MSP 9 went down to Human Resources and complained, as the common practice had been for the others. Of course, stated MSP 9, the bully reported that the reason for the issue was her consistently leaving work late. She said that she did not know now how to handle the situation but declared it “won’t break

her." Other nurses decided the best practice was to stay to themselves, to develop a thick skin, or to "put on a smile, and just go and do what I need to do until she has to leave." The sad reality is, as a community, we need to build up our nurses. Bullies are creating havoc for nurses while the general health care population notices a need for more nurses.

Subtheme 2: Love of being a nurse. Over and over again throughout the entire interview process, each nurse expressed the love for their job. I could tell by the way they spoke, they were there for their patients. The words MSP 1 uttered shows the essence of what a nurse feels. She acknowledged the patient-centric nature of nursing by saying, "I think it's because I love what I do, and I feel like I just wouldn't have someone just bully me out of my position." Echoing MSP 1's sentiment, MSP 6, said "I love what I do," and feels accomplished as a nurse when she gets a positive response from a patient. She said she came back from vacation and "as soon as I walked through the door, one of my patients said, 'Here is [MSP 6], a nurse that'll get something done. We are so glad to see you.'" Stories, such as this capture the essence of what a nurse must feel daily.

Along with these sentiments, one other nurse did elaborate on her earlier life and what led her towards nursing and her love of her job. As a child, she had been sick and spent a lot of time in the hospital. During that time, she realized she wanted to become a nurse and help others. She told me she "could not dream of doing anything else" with her life. She also said she frequently witnessed doctors bullying nurses, yet the doctors did not know she was hearing and witnessing the bickering. She concluded with, "I feel like it's important to me to do everything I can to make sure that patients don't experience that" during their hospital stay. Finally, like so many of the participants, MSP 7 said, "I

love [it] and I know that's where I'm meant to be, so nothing's going to change my mind for being here." At the conclusion of her response, I agreed and told her how important I felt nurses were for every community.

Subtheme 3: Resilience. Resilience is the conceptual framework associated with this research study. One of the interview questions found as part of Research Question 1 specifically addressed how each nurse felt resilience helped explain her overall lived experiences of being bullied and her desire to stay in her current position. I love asking this question to get an understanding of how each nurse feels about their ability to push forward despite negative situations at work. At the onset of the interviews, as stated in Chapter 4, I provided each nurse with a clear definition of resilience and asked her to describe how resilience is related to her personally. Each of the nurses who participated, in my opinion, gave a good overview of resilience. As the interviews went on, I noticed how all of the nurses ultimately related the same thoughts of how resilience played a factor in their lives, both personal and professional. They not only described resilience during this subtheme, but sprinkled it throughout the entire interview.

Some intimate thoughts came out of the interviews. For instance, MSP 1 said; "you see patients dealing with these tough situations, and you're dealing with someone's attitude, or someone trying to bully you…. [You] develop a sense of strength, and that helps you to be more resilient, I think." At the end of her statement, she explains that "it makes you stronger." MSP 2's words complemented that statement, as she related, "I love what I do, which makes a big difference. It's going to work every day as hard as the

job is, is I get such great satisfaction from my job." It is irrefutable how much these nurses genuinely care for their patients.

Research Question 2:

Theme 2: Challenges of lived experiences of being bullied. Bullying is a personal attack on an individual by another individual or group for an extended period. Under these participants were clearly all bullied and had felt the associated challenges firsthand. Research Question 2 provided the participants an opportunity to delve into the challenges, they suspect are associated with being bullied and staying in their profession. Widespread statements of their lived experiences included reduced confidence in themselves, feelings of anxiety, working while trying to avoid the bully and the need for increased communication between participant and bully, especially if the bully is the manager. Lived experiences also involved a feeling of becoming hypervigilant at work to ward off the possibility of being bullied due to their presumed poor job performance.

Knowing how complex nursing can be, I would imagine going to work knowing someone would be there to make me look and feel inadequate could cause undue pain and stress. Instances like that appear to be the underlying motivation for these nurses to have reduced confidence in themselves and their work. It also is why so many nurses felt and discussed feelings of anxiety. MSP 1, MSP 3, MSP 5, MSP 8 and MSP 10 all relived these thoughts during the interview.

On 13 occasions, between the three interview questions associated with Research Question 2, nurses recalled feelings of anxiety: "It has made for a much more stressful environment"; "I was afraid that she was going to turn me in for stupid things, little

things"; and finally, "[Is she] gonna say something to me? Did I screw something up? Did somebody say I screwed something up or am I cool?" Such statements all relate the anxious thoughts these nurse encounter.

Because of these special challenges, two nurses explained how being bullied has caused a physical response. One nurse began stuttering when faced with her bully, while another nurse said she feels sick and has a hard time tackling the day. No individual, especially those who help ailing patients, should be confronted with a response causing physical illness or distress.

Research Question 3:

Theme 3: Special techniques of being bullied. Research Question 3, communicated using three separate interview questions, was meant to decipher what methods nurses use to justify staying in their position. Some of these means included finding a support group, being active outside of work, becoming a patient advocate, and practicing hypervigilance. The two most talked-about techniques were finding a support group and outside activities. Even though they were from different parts of the country and had diverse jobs within the nursing field, the nurses all portrayed similar stories

Participants who talked about finding a support group were adamant about trying to help coworkers who have experienced the same issues. In fact, MSP 5 set out to find individuals who had similar experiences with the same bully. She said, "They have seen it firsthand, and it's not just me who's been bullied by this individual, and just being able to talk and not bottle it up inside has definitely helped."

Interviewees MSP 6, MSP 8, MSP 9, MSP 10, and MSP 11 all describe leaving work and taking the time to decompress. They also depicted activities such as running, spending time with friends, going out to eat, and even zip lining as a special technique that allow them to separate work life, essentially putting them in two different boxes. MSP 10 started baking as a release from work, saying this hobby "is what did it for me. I would do it in the middle of the night so that nobody would bother me. It was kind of like my therapeutic time." Like so many of her nursing counterparts, she found a way to disconnect.

When asked about advising a bullied new hire, many of the nurses discussed the need to find a mentor to help those being bullied understand what was happening. By doing so, not only can they get advice on how to handle these situations, but they can, as MSP 5 explained, find a "friend on the unit just to kind of reaffirm [your] abilities as a nurse." One of the best statements, in my opinion, came from MSP 7, who, when talking about her mentor, stated, "She's been great with keeping me grounded and making sure I'm not going to fly the coop." All the interviewed nurses said they stayed in their job because they love what they do, and they are there to advocate for their patients.

Limitation of the Study

As with any type of research, a qualitative study has methodology limitations. Through the current study I set out to explain, through lived experiences, thoughts associated with nursing retention despite being bullied. The first limitation is the results not being generalizing across different cultures. As the current study took place only in the United States, results can only account for cultures found to exist within this one

country. While the United States is known for being a cultural melting pot, a strong possibility remain that participants would be native to the country of origin.

Secondly, as noted by Longo (2013), the field of nursing has historically remained predominately female. While there are more male nurses joining the ranks lately, the possibility of obtaining only female nurses as participants existed. As was the case, 100% of the participants were female, meaning the results were not generalizable across gender lines. The third limitation transpired due to the variations of nursing perceptions and experiences, as the academic levels of nursing range from licensed practical nurse (LPN) with a two-year degree or less, up to a doctorate level of nursing with many years of academia. Other variations consisted of the different fields of practice, such as nurse manager, floor nurse, administrator, or nurse practitioner. A final limitation was my lack of knowledge in conducting qualitative research and performing interviews during the data collection process. To tackle this limitation, I conducted a two-participant pilot study to address problems with the methodology and to practice interviewing.

Implications and Recommendations

For years, researchers have studied workplace bullying in the health care industry, and especially inside the nursing field, yet still there is a growing need to find ways to decrease such occurrence (Esfahani & Shahbazi, 2014). According to Esfahani and Shahazi (2014), 97% of nurses polled have witnessed or endured verbal violence. In addition, 72% of nurses who participated in a different study observed bullying behaviors such as physical or sexual harassment, passive and aggressive confrontations, or inappropriate behaviors against others or self (Esfahani & Shahbazi, 2014).

The Workplace Bullying Institute reported nearly 60% of new nurses left their job within six months due to workplace bullying (Namie & Namie, 2014). Unfortunately, not all instances of workplace bullying get noticed by upper management or individuals able to do something to eradicate the problem. To a great extent, data on this phenomenon is quantitative; however, when researchers approached this topic using a qualitative approach, none took the time to speak directly to the nurses about their sentiments. For that reason, I chose to conduct in-depth conversations with the nurses who had lived through workplace bullying, yet still found a way to continue working in their current position.

A recommendation for future research involves a discussion of bullying and patient safety. Becoming a patient advocate was a common topic sprinkled across the interview answers. The participants made a point to discuss their fear of the patient not getting the care and attention they felt were needed. These nursing caregivers need to have the ability to tend to their patients without the intrusion of outside negative forces.

A second recommendation would be for future researchers to concentrate on a specific field of interest. The current study did not focus on job title demographics; however, through the interview process, I learned five of the 14 participants practiced nursing in a labor and delivery unit. Perhaps a closer look at the dynamics of bullying would help these participants grasp how to reduce workplace bullying and ultimately increase nursing retention. Finally, creating a support group within the health care organization would be beneficial for bullied individuals.

Social Change

Bullying has long been a social problem that researchers have studied in detail all around the world (Donegan, 2012; Granstra, 2015; Zych et al., 2015). According to the literature, workplace bullying among all levels of nursing is on the rise, revealing a need to reduce these problems. Most companies have harassment policies in place to address or reduce these problems, but that is not always enough to negate the harassment. Thus, I dedicated this study to understanding the lived experiences of these nurses and to find ways to create social change.

The nurses who participated in this study made meaningful contributions, offering accounts of their lived experiences from being bullied in the workforce. Through these individualized reports, nurses across the spectrum can benefit from the positive social change, thus creating a personal and/or professional positive effect on the future of nursing. Not only was their time valuable, but their words will resonate throughout the nursing community.

Suggestions given by the participants included creating mentorship programs for the nurses, or programs to ensure the safety and well-being of their patients to avoid exposing them to the negativity that plagues the nursing field. Another good idea is creating a timeout area or a safe, tranquil space a nurse can use to get away from negative overtures created during a bullying attack, whether passive or verbal. By allowing nurses to step away for a few moments, both victim and bully have an opportunity to change the temperature of the debate. If these small ideas could be implemented, nursing retention would increase. According to Colosi (2016), retention is one of the main concerns within

the health care industry due to the substantial amount of funding it takes to train their staff. After all, nursing retention is one of the largest and most costly problems in the healthcare industry. Finding a way to preserve trained staff will increase the likelihood of saving money for the medical community. Finally, social change can come by addressing the effects of workplace bullying on the members of the organization. Health Care administrators, managers, and departmental leaders can use these findings to create additional ways to address episodes of workplace bullying within their organization.

Conclusion

While there is an abundance of research committed to workplace bullying, especially in the nursing field, past researchers failed to give a firsthand account of the personalized lived experiences of bullied nurses. As a result of the current study, 14 nurses (two in the pilot study, 12 in the main study) were given the chance to offer a better understanding of their lived experiences.

Each nurse’s story revealed the distressing widespread presence of workplace bullying in the nursing profession. It is not an uncommon tale, but one often told with sentiments of pain and anguish. The nurses who participated told stories of being verbally or passively bullied and how the fear caused them to want to avoid the bully at all costs. Some spoke of bullying so bad it caused physical responses, such as illness and stuttering. No one should be expected to work in such a hostile environment, nor should anyone feel threatened with regard to personal safety. Through this phenomenological qualitative research study, I examined what it really takes for bullied nurses to make the decision to retain their current position, and asked for their opinions of techniques and

challenges they used to overcome these barriers. Through their voices, it is my hope that other nurses will have the opportunity to one day go into their healthcare facility and be able to dutifully do their job without ridicule or harassment. Each and every one of these participants has shown a considerable amount of courage that will one-day assist others so they will not have to be bullied in the workforce.

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Appendix A: Interview Questions

Participants Name: ____

Date of Interview: ____

Location of Interview: ____

Interview Start Time: _________________**End Time**: ________________

Participant Identifier: Participant # ______Pilot Study _____ Main Study________

Demographic Information

1. How long have you been a nurse?
2. How long have you worked in your current Nursing position?
3. Would you explain yourself as a nurse that has experienced bulling in your current position?

Resilience is defined as an individual's capacity to modify their balance to preserve control over a bad situation. Resilience shows a parallel between an undesirable occurrence and the flexibility to maintain unquestionable control over a seemingly uncontrollable situation.

Would you consider yourself as a resilient person? If yes, would you please explain how you define resilience and how it has assisted or hindered you during these times? If no, what is it that you feel has allowed you to stay in your position despite situations of being bullied in the workplace?

Interview Questions

RQ1: What are the lived experiences of nurses who continue to maintain their position despite being bullied in the workplace?

1. Think back and please describe 1 or 2 occurrences in which you felt bullied.
2. How have you responded to episodes of workplace bullying?
3. Describe why you have remained in your current working position despite being bullied.
4. Would you describe how your resilience, as a nurse, has helped you remain in your current working position despite being bullied?

RQ2: What are the special challenges nurses encounter, who have experienced workplace bullying, when faced with the decision to retain their position?

1. How do you feel workplace bullying affects your performance?
2. Describe how you feel when you walk into your place of employment before a shift?
3. I know nurses are often faced with challenges after being bullied. Please describe the challenges.

RQ3: What are the techniques nurses use to rationalize their decision to retain their current working positions, after being subjected to workplace bullying?

1. Explain some strategies you use to help deal with/ cope with wpb
2. Finish this statement –With the knowledge of being bullied at work, I plan on working in my current position/department until _____?

3. Finish this statement: With the knowledge of being bullied at work, I plan on working in my current position/department until _____?
4. Probe: How much are you willing to take?
5. What advice would you give a new-hire that is being bullied?

Final Questions:

Is there anything else about being bullied that you would like to share? Anything I have not addressed during this interview?

Thank you for taking the time to answer these questions today.

Appendix B: Recruitment Flyer

Nurses Needed for a Research Study

Workplace Bullying from the Nurses Perspective

- Have you been a nurse for over 1 year?
- Do you feel you have been bullied in the workforce?
- Did you stay in your same position despite being bullied?
- I am PhD Student conducting a research study to understand how nurses, who have been bullied, decide to stay in their position despite being bullied. I am also trying to understand what special challenges and techniques you use to make these decisions.

What is Involved

Each participant will be asked to share their experiences via telephone, skype, or face-to-face interviews, lasting no more than 60 minutes. I will be asking you to share your lived experiences about being bullied at work, special challenges you have faced, and techniques you have used to counteract these occurrences. There is no compensation for participating in this study.

Operational Definition

Workplace Bullying: an imbalance of power with repeated psychological and physical aggression to a person or group of individuals that do not wish to be harassed. This type of bullying occurs in the workplace and can consist of bullying by coworkers or groups of coworkers, managers, or administrators.

If you feel you meet these requirements and would like to help with this research study, please contact me via email at dawn.white2@waldenu.edu. If know anyone that would meet these requirements, please forward this flyer to them.

This study has been reviewed and approved by the IRB of Walden University.

Approval number 8-29-17-0418151

Appendix C: Screening Instrument

1. How long have you worked as a nurse?

2. How long have you been in your current positions?

3. Have you been bullied in your current nursing position over the last year?

Do you speak English?