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# The Effect of Self-Esteem, Bullying, and Harassment on Nurse Turnover Intention

Joyce Richelle Arand  
*Walden University*

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# Walden University

College of Social and Behavioral Sciences

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Joyce Richelle Arand

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2019

Abstract

The Effect of Self-Esteem, Bullying, and Harassment on Nurse Turnover Intention

by

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MS, Wright State University, 1996

BSN, Indiana State University, 1986

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Industrial and Organizational Psychology

Walden University

April 19, 2019

## Abstract

Currently there is a high rate of registered nurse (RN) turnover due in part to bullying and harassment among peers fosters lower quality nursing care, jeopardizes patient safety, and increases healthcare costs. The purpose of this quantitative nonexperimental study was to examine the relationship between inpatient nurses' individual self-esteem and reported bullying and harassment with their intent to leave their job. Two theories were used to provide structure to this work: cognitive experimental self theory and oppressed group theory. Data were collected using the Negative Acts Questionnaire, the Rosenberg Self-Esteem Scale, and the Turnover Intentions Measure. All RNs in a Midwestern state ( $N = 78,889$ ) were emailed an invitation link to the instruments housed on SurveyMonkey. Only those respondents who claimed to be inpatient RNs were included in the study. The three research questions asked about bullying and harassment among inpatient RNs, about the self-esteem of RNs who experienced bullying and harassment and those who have not, and if those RNs who experienced bullying and harassments intent to leave their jobs. With a 2.1% response rate, results indicated that there was a relationship among RNs and bullying and harassment, the self-esteem of RNs who did not experience bullying and harassment was higher than those who did experience bullying and harassment, and there is a positive relationship between RNs experiencing bullying and harassment and their intent to leave their jobs. This research contributes to social change and is important because if bullying and harassment patterns among RNs are identified sooner, RN turnover can be reduced, patient care quality and safety can be improved, and U.S. healthcare costs can decrease.

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## Dedication

This work is dedicated to the memory of my mother, Meryl June Hoggatt, a teacher, who inspired me to pursue higher education from a young age. She taught me in kindergarten and spent hours with me during my early years teaching me to write creatively. I only wish she could have been here to read and critique this paper. It is also dedicated in honor of my husband, Dale Arand, who showed patience with me giving me both emotional and financial support throughout the years while I chased my educational goals. Lastly this work is dedicated to my youngest daughter Angela, who is pursuing a career in nursing. I hope this research in some way helps your journey Angie, in a rewarding, yet challenging profession.

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## Chapter 1: Introduction to the Study

In the United States (U.S.), there is a Registered Nurse (RN) shortage (Nardi & Gyurko, 2013). A nursing shortage negatively affects U.S. healthcare quality (Li & Jones, 2012). Economically, the shortage is proving to be a burden to healthcare organizations as well (Li & Jones, 2012). This shortage is due to a multitude of reasons. One of those reasons is bullying and harassment between nursing peers (Weaver, 2013). Bullying or harassment behaviors between nurses include being ignored or excluded having rumors spread about one nurse by another, ignoring colleagues' professional opinions, withholding relevant work information from colleagues, colleagues humiliating or ridiculing each other about their work, the silent treatment, and passive aggression (Cleary et al., 2010; Stanley, Martin, Michel, Welton, & Nemeth, 2007; Weaver, 2013).

If bullying and harassment that leads to RN turnover could be decreased, it would be a positive social change exemplified by saving U.S. healthcare dollars and increasing quality and safety of nursing care which would affect the U.S. healthcare system and U.S. citizens positively overall. More research examining bullying and harassment among nurses and the effect it has on nursing turnover intention would be of benefit because little is known as to why bullying and harassment is so prevalent in the nursing profession. Weaver (2013) said that the cause for bullying and harassment between nurses is because of the oppressed group theory, which will be examined in detail later in chapter one.

Bullying and harassment among nurses has been researched by several nurse scholars. However it was noted that many nursing scholars and authors jump to solutions

for the bullying and harassment among nursing peers, without the knowledge as to why this phenomenon occurs so frequently among nursing ranks. Matheson and Bobay (2007) stated that oppressed group behaviors in nurses is supported in the scientific literature yet “oppressed group theory has not been studied as a distinct phenomenon” (p. 232).

In order to address bullying and harassment among nurses it is essential that we better understand the oppressed group theory. The request for more research specifically examining bullying and harassment in nursing or horizontal violence in nursing was requested by several researchers (See Simons & Mawn, 2010; Stanley et al., 2007; Trepanier, Fernet, Austin, & Boudrias, 2016; Vessey et al., 2009; Vessey et al., 2011). Several researchers made the call for more research in the area of bullying and harassment within the nursing profession and its relationship to turnover intention (See Araujo & Sofield, 2011; Berry, Gillespie, Gates, & Schafer, 2012; Blackstock, Harlos, Macleod, & Hardy, 2014; Houshmand, O’Reilly, Robinson, & Wolff, 2012; Wilson et al., 2011). Others made the request for more research in the area of turnover intention and nurses (See Brewer et al., 2012; Mackusick & Minick, 2010; Tukov-Shuser, & Djukic, 2011). A few researchers have looked at self-esteem and nursing and request more research in this area (See Losa Iglesias & de Bengoa Vallejo, 2012; Strum & Dellert, 2016). Purpora and Blegen (2012) called for more research on horizontal violence, oppressed group theory, and strategies for addressing horizontal violence. Trépanier, Fernet, Austin, and Boudrias (2016) called for more research looking at bullying in nursing from the individual, group and organizational level. Vessey, Demarco, Gaffney, and Bubin (2009) would like to see researchers conduct studies on all aspects of bullying



and harassment/horizontal violence among RNs. The need for more research around bullying and harassment within the field of nursing is apparent. There are many different aspects of this problem that warrants scholarly detailed review before solutions can be dictated to reduce the bullying and harassment that takes place between nursing peers. This study addresses some of those gaps.

In Chapter 1, the background of this social problem will be reviewed. A summary of the problem itself will be discussed, the purpose of the study will be shared, and the research questions and hypotheses will be revealed. The theoretical/conceptual framework being used for the study will be looked at in depth, and the nature of the study will be defined along with the independent and dependent variables. Oppressed group theory will be further discussed. The research problem that the study addresses will be described. The boundaries and limitations of the study will be identified, and the identified potential contributions and significance of the study regarding positive social change will be provided.

### **Background**

The U.S. is currently experiencing a shortage of nurses that is predicted to grow to a deficit of 285,000 by 2020 and 500,000 by 2025 (Nardi & Gyrko, 2013). There has been a cyclical nursing shortage in the U.S. since “the late 1800s” (Egenes, 2012). The International Council of Nurses, the largest worldwide health professional organization, declared that the nursing shortage is a healthcare concern for all (Nardi & Gyrko, 2013). It is not only a problem of recruiting nurses, but also an issue of retention. A high nurse

turnover rate fosters lower quality nursing care, thus jeopardizing patient safety and increasing hospital costs (Sellgren, Kajermo, Ekvall, & Tomson, 2009).

Numerous studies have already been conducted on the relationship among bullying and harassment behaviors and nursing turnover (e.g., Brewer, et al., 2012). Schein's (2010) work on enculturation into a profession, might help explain how bullying and harassment perpetuate within the field of nursing. It maybe because of how nurses are enculturated into the profession. Schein reported that occupational cultures can and do exist and that they are a "product of joint learning leading to shared assumptions about how to perform and relate" among peers within the profession (p. 21). Based on this definition, the occupation of nursing has its own culture. Once a group has a culture, the elements of that culture are passed along to the next generation of group members (Schein, 2010).

Strong socialization during the educational and training process of a group of professionals such as lawyers, physicians, and nurses results in learned beliefs and values that are assumed to be stable within that occupational culture even when the professional is not working with others within their profession (Schein, 2010). Entry level nurses learn in their training that they are to be subservient to physicians. The common verbiage used to communicate a patient's plan of care from physician to nurse is referred to as taking physician orders (Gjerberg & Kjølørød, 2001). Patients are admitted to a hospital only if they are associated with a physician's name as their attending physician, while nurses provide direct care to the patient that is dictated and ordered by the physician (Croft & Cash, 2012). These types of terms, i.e. physician's orders, indicates subservience of the

nurse to the physician (Croft & Cash, 2012; Gjerberg & Kjølrsrød, 2001). Because of this ongoing socialization during the educational process, nurses have developed a type of self-loathing that is best defined using the oppressed group theory (Roberts, 1983). An oppressed group is defined as one who is dominated by another group. The members of the oppressed group are frustrated, but cannot express their frustration to the group in power over them for fear of reprimand or increased dominance (Freire, 1970). Instead the members of an oppressed group turn their frustrations upon each other. (Freire, 1970).

Nurses have also been stereotyped in the media as the doctor's handmaidens, battle-axes, sex objects, or not smart enough to attend medical school (Hoeve et al., 2014). Nursing sits in terms of hospital hierarchical structure at the bottom (Croft & Cash, 2012). Hospitals are layered organizations and RNs are subordinate to administrators, physicians, regulators, and patients (Croft & Cash, 2012). This type of constant messaging that nurses are handmaidens and not smart enough to attend medical school is relayed to nurses throughout their training and subsequent career. It defines for the nurse their value and place (Levine, 2013). The process of becoming a nurse is an integral part of the formation of self-esteem (Randle, 2001). Randle (2001) reflected on the education process of RNs and stated the nursing educational process may affect nurses' personal and professional identity, negatively lowering the RNs' self-esteem. As the oppressed group theory indicates, this self messaging leads to decreased self-esteem of the individual nurse (Randle, 2001). Nurses feel powerless to change their situation and this oppression causes nurses to engage in negative self-stereotyping (Croft & Cash, 2012).

According to Ditmer (2011), nurses are three times more likely than other groups of professionals to experience violence. One explanation of this might be that unlike police who experience violence predominantly from the public, nurses experience violence at the hands of their patients, patient family members, physicians, and their own nursing peers, driving the number of violent incidents up. To give some point of reference to the amount of violence/injury that occurs in the field of nursing, the U.S. Occupational Safety and Health Administration (OSHA) shared the 2015 nonfatal occupational injuries statistics per occupation recently and nurses had the second highest rate of violence and injuries at 12 incidents per 100 full time equivalents (FTEs) in terms of nonfatal occupational injuries (Occupational Safety and Health Administration [OSHA], 2015). Police were close behind at 11.3 incidents per 100 FTEs. (U.S. Department of Labor [DOL], 2015).

Ditmer (2011) explained that 80% of nurses experience some act of verbal abuse, aggression, and harassment during their career. On average, 27% of all nurses experience verbal abuse each shift they work (Ditmer, 2011). Aggressors who are responsible for this disruptive behavior are primarily physicians and nursing peers (Ditmer, 2011). Stanley et al. (2007) reported that 65% of the nurses surveyed in their study witnessed incidents of horizontal violence. Horizontal violence is defined as one coworker acting out toward a peer coworker. Vessey, Demarco, and DiFazio (2010) found that anywhere from 17-76% of all nurses have experienced horizontal violence in their career. These studies' results provide a wide range of percentages of nurses affected by bullying and

harassment. The actual percentage of nurses who are victims of bullying and harassment is elusive because many acts of bullying and harassment go unreported.

However, there remains a gap in the literature regarding identifying relationships between self-esteem, bullying and harassment, and nurse turnover intention. No studies were found in the U.S. or European literature looking at the linkage between these three variables. One study was found by Choi, Lee & Kim (2013) that was written in Korean only. The title however was written in English and reflects that the Choi, Lee & Kim (2013) study looked at the same three variables as this study. If relationships are confirmed between self-esteem, bullying and harassment, and nurse turnover intent in this current study, it will expand on what is known about all three variables and could possibly lead to new avenues of study.

### **Problem Statement**

Among RNs in the U.S., 17.5% of new nurses leave their jobs within the first year (Kovner, Brewer, Fatehi, & Jun, 2014). Kovner & Brewer (2010) report that 26.2% of new nurses leave their jobs by the second year. Roulin et al. (2014) found that nurses are quitting their jobs and leaving the profession altogether. Porter-O'Grady and Malloch (2007) reported that 38% of new nurses are leaving the profession and many nurses leave a certain subspecialty or profession because of the way they are treated by peers. The current rate of nursing turnover is anywhere from 14% to 28% (Ditmer, 2011). Many nurses leave their jobs reportedly due in part to nursing peer bullying and harassment (Simon, 2008; Weaver, 2013).

What is missing from the research and what is not currently known are causes for bullying and harassment among RNs. The incidents of bullying among all workers globally is 11-18% according to Nielsen & Einarsen, (2012). The incidents of bullying and harassment among nurses varies among sources. It ranges from 17% to 76% per Vessey, et al. (2011) to greater than 50% per the American Nursing Association (ANA, 2015). Many nursing researchers attribute the high incident of bullying and harassment among nursing colleagues as being due to the oppressed group theory (See Dong & Temple 2011; Dubrosky 2013; Hinchberger, 2009; Roberts, 1983; Roberts, DeMarco, & Griffin, 2009; Roberts, 2015; Rodwell, Demir & Flower, 2013; Rodwell & Demir, 2013; Stanley, Martin, Michel, Welton, & Nemeth, 2007). Nursing is known as a profession of caring. The oppressed group theory helps rationalize how a caring professional can lash out toward a peer so maliciously. The oppressed group theory states it is because of their frustration with those who are in control. However, there have been few studies that have tried to validate that the oppressed group phenomenon is present among the nursing ranks. The cardinal symptom of an oppressed group is low self-esteem (Freier, 1970, Roberts, 1983; Purpora & Blegen, 2012). Prior research has shown that there is a positive correlation between bullying behavior and nursing turnover intentions (See Araujo & Sofield, 2011; Berry et al., 2012; Blackstock et al., 2014; Houshmand et al., 2012; Wilson et al., 2011). What has not been examined before in a study about RNs is the relationship between bullying and harassment, self-esteem, and turnover intentions in the U.S. or in Europe.

According to Roulin, Mayor, and Bangerter (2014), retaining nurses is currently a major issue for healthcare organizations. Blackstock et al. (2014) found in a study of 103 Canadian nurses that being a victim of bullying significantly increases their intent to leave the organization. Cho, Lee, Mark, and Yun (2012) examined the reasons new graduate nurses might leave their job, and reported that negative interpersonal relationships including bullying (referred to as horizontal violence) resulted in a “significant increase in the hazards of leaving the first job” (p. 67).

Actual nursing turnover rates are hard to pin point, because nursing turnover is measured by different systems in different ways. Some systems include retirement of a nurse in turnover some include voluntary and involuntary resignations, some include transfers between departments within the same organization and some do not (Kovner, Brewer, Fatehi, & Jun, 2014). Voluntary turnover is defined as the intentional decision by the RN to leave the organization (Blackstock, et al. 2014; Simons, 2008). High nursing turnover has been an issue for a number of years in the nursing profession. If the rate of nursing turnover could be decreased, this would positively affect the nursing shortage.

Nursing turnover has a significant impact on a hospital system’s finances and on the U.S. government as they are one of the largest payers for health care. Kovner, Brewer, Fatehi, and Jun (2014) said that the U.S. government was paying for 44% of current patient hospital bills via Medicare and Medicaid benefits. Contributing information to reduce this problem could lead to important social change. When an organization loses a nurse, it is losing money in two ways. First, the hospital is losing the intellectual capital of the nurse who left (Li & Jones, 2013). Nursing’s intellectual capital

is exemplified by the ability of an experienced nurse to recognize deteriorating patient conditions early, their ability to perform complex procedures competently, and their understanding of complicated hospital policies all which come from experience and ongoing education. It is estimated that a nurse takes about 2 years to become fully competent in a new clinical setting (Benner, 1984), Taking a RNs annual average salary \$68,000 plus the cost of preceptor training it is estimated that it costs an organization approximately \$145,000 per RN who leaves (Li & Jones, 2012; Porter-O'Grady & Mallach, 2008). Secondly, while recruiting a new nurse, the hospital will have to pay another nurse overtime or bonus dollars to work the shifts of the nurse who left the organization. This will have an impact on productivity of the unit, negatively affect employee engagement, and possibly affect patient safety.

To find a nurse to replace the one who left is no easy task, especially with the reported increasing nursing shortage. To replace a nurse, hospitals need to recruit, interview, hire, orient, and educate the new registered nurse. Li and Jones (2012) estimated that the annual costs for turnover and replacement of new nurses in the U.S. is \$856 million for healthcare organizations collectively and \$1.4 to \$2.1 billion for American taxpayers. Decreasing RN turnover would help reduce the financial burden on the U.S. government and American taxpayers.

Roberts (1983) described nurses as an oppressed group. Roberts pointed out that nurses lack power and control in their own workplace, which leads to low self-esteem. Oppression causes nurses to engage in negative self-stereotyping (Roberts, 1983). It was noted by Rainer (2015) that nurses have little self-worth and remain silent when they



should speak up in critical situations to avoid medical errors in fear of social pressure and medical power. This behavior attributes to medical errors and decreased safety for patients as outlined in the Institute of Medicines (IOM) report *To Err is Human*. (Kohn, Corrigan, & Donaldson, 1999). This report shared that over 100 thousand Americans die annually due to medical errors (Kohn, Corrigan, & Donaldson, 1999). This number has decreased slightly since 1999, but medical errors due to lack of effective communication is still the number one reason for medical errors according to The Joint Commission, (TJC) the entity who monitors health care institutions for high quality and safe patient care (TJC, 2008) In addition to remaining silent when they should speak up, nurses demonstrate covert aggression to their peers similar to other oppressed groups (Rainer, 2015).

The ongoing nursing shortage is only projected to worsen as baby boomers age (Li & Jones, 2012; Nardi & Gyurko, 2013). In order to mitigate this lack of nurses, the cause must be determined as to why nurses are leaving the profession after they have worked years to earn their nursing degrees and licenses. One reason why nurses leave the profession or at least their current job is related to bullying and harassment from peers (Ditmer, 2011). Low self-esteem has also been cited as problematic for nurses (Begley & White, 2003; Roberts, 1983). Low self-esteem can position the individual to be a victim of bullying or lead the individual to become a bully themselves (Einarsen et al., 2009). Randle (2001) found over a 3-year timeframe that nursing students' self-esteem was lower than what it was at the beginning of their 3-year nursing education program. This finding suggests that the way we enculturate new nurses into the profession leads to

lower self-esteem for new nurses. Roberts (1983) noted that low self-esteem in the nursing population pointed to the determination that nurses are indeed an oppressed group. Further examination is needed to determine if new nurses are being enculturated to think of themselves as oppressed from the start of their professional careers.

In order to decrease nursing turnover and avoid a bigger public health crisis, there needs to be ways to identify nurses and/or nursing units that are struggling with bullying and harassment. Leaders cannot address bullying and harassment within their ranks if they do not know it exists. If links between lowered self-esteem and bullying and harassment are verified or negated, researchers can add to the knowledge base. Einarsen, Hoel, Zapf, & Cooper, (2011) make the point that bullies in general can have either low or high self-esteem, the research has shown in different cases that some bullies have high self-esteem and in other cases bullies have low self-esteem. Why that is has not been determined as of yet. It has been supported in the literature that indeed there is a relationship between bullying and harassment and nurse turnover intention. When bullying and harassment are reported to be present, there is an increase in nursing turnover intention (Blackstock et al., 2014; Cho et al., 2012). There has not been a study previously that has looked at the relationship between all three of these variables that was conducted in in Europe or the U.S. This current study has the opportunity to add to the body of knowledge regarding bullying and harassment, self-esteem, and nursing turnover intention. This research will help in dispelling or upholding whether there is a relationship between all three variables.

High self-esteem is not typically associated with the nursing profession (Van Eckert, Gaidys, & Martin, 2012, p. 903). Low self-esteem has been connected with the nursing profession (Begley & White, 2003; Dimitriadou, Koukourikos, & Pizirtzidou, 2014; Losa Iglesias & de Bengoa Vallejo, 2012; Van Eckert et al., 2012). Self-esteem as measured by the RSES was found to be statistically significantly higher in nurses who trained through a baccalaureate program (13.32) versus an associate degree or diploma program (12.03) (Van Eckert et al., 2012). However, post training, nurses are found to have lower self-esteem than the general public (Begley & White, 2003). Being the victim is associated with having low-self-esteem (Losa Iglesias & de Bengoa Vallejo, 2012). Some believe that being the bully is also associated with having low self-esteem. The rationale is that the bully feels inferior thus they need to make others think less of themselves so they can feel superior (Whelpley & McDaniel, 2016).

According to Dimitriadou et al., (2014), the nursing education process is thought to lower an individual's self-esteem instead of enhancing it. If nurses in general have low self-esteem, and low self-esteem is also known to be a cardinal attribute as part of the oppressed group theory, this pervasive low self-esteem among nurses may be attributing to the perpetual bullying issue within nursing. The gap noted in the literature is that no studies conducted in the U.S. or in Europe have addressed the self-esteem of nurses as related to bullying and intent to leave.

### **Purpose of the Study**

The purpose of this quantitative study was to examine the relationship between inpatient RNs' individual self-esteem and reported bullying and harassment with their

intent to leave the organization. There is a gap in the literature and more studies need to be conducted on turnover intention and verbal abuse in the field of nursing. The long-term intent of this study was to promote social change by assisting nurse leaders by providing a testing template to use to help identify nursing units prone to nursing turnover related to bullying and harassment in time to intervene and stop RNs from leaving their place of work due to bullying and harassment from their peers. This will lead to social change by decreasing the amount of nursing turnover, which will save the health system and the U.S. taxpayer's money in actual replacement costs, loss of intellectual property and decreased patient care quality and safety.

### **Research Questions and Hypotheses**

*RQ1:* Are there significant relationships among inpatient nurses' reported bullying and harassment experience as assessed by the Negative Acts Questionnaire (NAQ) and their individual self-esteem as assessed by the Rosenberg Self-Esteem Scale (RSES) with intent to leave the organization as assessed by the Turnover Intentions Measure (TIM)?

*H<sub>01</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem do not predict their intent to leave the organization.

*H<sub>A1</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem predict their intent to leave the organization.

*RQ2:* Will self-esteem as measured by the RSES of inpatient nurses who report having experienced bullying and harassment as measured by the NAQ be higher or lower

than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ?

*H<sub>02</sub>*: Inpatient nurses who report experiencing negative acts as measured by the NAQ will not have a lowered self-esteem score as reported on the RSES.

*H<sub>A2</sub>*: Inpatient nurses who report experiencing bullying and harassment as measured by the NAQ will have a lowered self-esteem score as reported on the RSES.

*RQ3*: Are there higher reports of bullying and harassment as measured by the NAQ among inpatient nurses who report higher intent to leave as measured by the TIM?

*H<sub>03</sub>*: Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will report intent to leave as measured by the TIM.

*H<sub>A3</sub>*: Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will not report intent to leave as measured by the TIM.

### **Theoretical Framework**

By looking at the culture of nursing using both psychology and sociology theories, I hope to explain the dynamics of nursing culture that are universal. There are two frameworks that were used in this research. One is the psychological concept of self-esteem, specifically, Epstein's cognitive experimental self theory and the second is the oppressed group theory.

#### **Cognitive Experimental Self Theory**

Self-esteem is a concept that plays a vital role in bullying and harassment activity among nurses. Self-esteem is defined by social psychologists as the "overall attitude

toward ourselves” (Baron, Branscombe, & Byrne, 2008, p. 129). Rosenberg (1965) first described self-esteem and defined it as a positive or negative attitude towards one’s self. Rosenberg’s developed a measurement scale of self-esteem, the Rosenberg Self-Esteem Scale (RSES). The RSES measures self-esteem using 10 questions that score between 1 and 4 points or zero to 3 points, the researcher choice. The score of 20-30 (or 10 to 20 if using the zero to 3 scale) on the RSES are considered an average level of self-esteem, above 30(20) is high and below 20 (10) is low (Department of Sociology, 2015).

Self-esteem among nurses has long been average or low (Begley & White, 2003; Dimitriadou et al., 2014; Losa Iglesias & de Bengoa Vallejo, 2012). Self-esteem can also be described as the way one evaluates themselves either positively or negatively (Losa Iglesias & de Bengoa Vallejo, 2012). Begley and White (2003) conducted a descriptive quantitative comparative study of 72 nursing students completing a 3-year diploma educational program in southern Ireland in 1995. The students took a combined survey that included the RSES during their first year of training. They repeated the same combined survey during the last two months of their training. The findings revealed that nursing students’ self-esteem rose during their training, from 19.2 to 20.6 on the RSES, but the highest ratings were only average at best. Begley and White (2003) suggested that individuals attracted to the field of nursing may have lower self-esteem compared to the general public. They also suggested that some nursing preparation can build up students’ self-esteem instead of decreasing it as they progress through the program.

Dimitriadou et al. (2014) conducted a literature review and found that nursing education lowered student RN self-esteem. Nursing students start their training with

average self-esteem, but upon completion of their programs, their self-esteem was lower (Dimitriadou et al., 2014). They noted that nurses with low self-esteem experience greater communication problems with their patients and colleagues (Dimitriadou et al., 2014). More research needs to be conducted on what type of nursing education environment builds student self-esteem. It also needs to be noted if a positive change in nurse student self-esteem attributes to decreased bullying and harassment among nursing peers that is so prevalent within the profession.

Losa Iglesias and de Bengoa Vallejo (2012) said that 17% of the nurses they surveyed reported to have been a victim of peer bullying. Eight percent of those nurses reported being bullied weekly or daily (Losa Iglesias & de Bengoa Vallejo, 2012). Individual nurses who reported that they were victims of being bullied displayed significantly lower self-esteem ( $p = 0.004$ ) than their counterparts (Losa Iglesias & de Bengoa Vallejo, 2012).

Self-esteem is composed of two distinct parts: competence and worth (Cast, & Burke, 2002). Competence describes the degree to which one feels they are efficacious and capable (Cast & Burke, 2002). Worth is described as being the degree to which someone “sees themselves as being of value” (Cast & Burke, 2002, p. 1042). The two factor theory of self-esteem is the model that had been supported by a number of theorists including Epstein. Mruk (2013) points out that high self-esteem is a basic human need.

Epstein’s cognitive experiential self-theory is that there are what Epstein calls four notions of information (Mruk, 2013). These four notations are what a person uses to organize information about their world. The four notions are (a) information

(experiences), (b) organization (concept information), (c) representation (a system of concepts organized hierarchically), and (d) the process of development (Epstein, 1998). Epstein (1998) defined human development as a cognitive process that allows individuals to make sense of the world around them by identifying and interpreting the events, people, experiences, and patterns and responding to them. This process makes up one's self theory.

Self-esteem is a vital part of the human cognitive process in that the individual is always trying to maintain their self-esteem (high or low), which thus affects how the person will behave and feel (Mruk, 2013). Bullying too is used as a self-regulating process that helps to maintain the perpetrator's self-esteem (Einarsen et al., 2011; Hauge, Skogstad & Einarsen, 2009). "Individuals who have a very high self-esteem are more prone to aggressive behavior" (Baron et al., 2008, p. 358) like bullying and harassment. Einarsen et al. (2011) said that low self-esteem can lead to aggression in the form of bullying.

Regarding whether bullies have high or low self-esteem, research is mixed. Nurses historically have lower self-esteem in general compared to other professionals and the public (Begley & White, 2003; Dimitriadou et al., 2014). For this study, the self-esteem of the RNs at the individual level was examined using the RSES. If a group is oppressed, it would make sense that all members or at least a majority of them would have low self-esteem.

According to Schein (2010), adults categorize themselves according to their professions. Nurses are a good example of professionals who have categorized



themselves as Schein suggested. Nurses conceptually categorize themselves as being of less importance and of less value than their healthcare colleagues (Hoeve et al., 2014; Willetts & Clarke, 2014). Professional nurses are acculturated to believe that they are subservient to physicians and business administrators who are not necessarily trained in patient care (Hutchinson, Vickers, Jackson, & Wiles, 2006; Willetts & Clarke, 2014). This enculturation could lead to the lower self-esteem found in the nursing community. What has not been explored in the research is whether this resultant feeling of lowered self-esteem due to maltreatment is correlated with certain nursing units or nurses' intent to leave.

The nursing profession has struggled for decades to be identified as a true profession (Willetts & Clark, 2014). The attributes of a true profession according to Greenwood (1957) include a systematic body of theory, professional authority, a code of ethics, recognized by the community as a profession, and the existence of a professional body that regulates, monitors, and controls professional performance. Nursing has embraced all of these attributes fully except one, the existence of a professional body that regulates, monitors, and controls professional performance (Willetts & Clarke, 2014). The regulation of nursing practice has come from entities other than nursing's own professional body. Nursing practice is regulated by many groups, one being state government. State laws are known as Nursing Practice Acts in each state, which have been influenced by lobbyists outside of the nursing profession, who regulate the extent to which a nurse can practice in that state (Hoeve et al., 2014; Keepnews, 2012; Kleinpell et al., 2014). Within the hospital, committees such as Practice and Therapeutics and

Medical By-Laws committees, which are developed by administrators, pharmacists, and physicians, also control the boundaries of nursing practice (Kleinpell et al., 2014).

Hutchinson et al. (2006) said that nurses are not usually involved in financial decisions that affect them thus they are not autonomous in their practice, but under the power and scrutiny of those in positions of authority such as hospital administrators and physicians.

While in training, nurses are taught that nursing is an autonomous profession (Keepnews, 2012; Sabatino, Kangasniemi, Rocco, Alvaro, & Stievano, 2014). Once practicing professionally, a nurse can quickly determine that nursing practice is not controlled by nurses alone (Ditmer, 2011; Sabatino et al., 2014). This conflict leads to lower self-esteem of the individual nurse and the collective nursing profession (Willette & Clarke, 2014). Lowered self-esteem is a basis for nurses' identification as an oppressed group (Martin et al., 2008).

### **Oppressed Group Theory**

Oppressed group theory built on the belief that dominated people feel devalued in a culture where the dominant group promotes their own attributes (Fanon, 1963; Freire, 1970, Roberts et al., 2009; Weaver, 2013). The theory is that when dominated, individuals start to devalue themselves and believe that they are powerless and inferior (Weaver, 2013). This leads to their own lowered self-esteem (Roberts et al., 2009; Weaver, 2013). In retaliation and out of frustration, some oppressed group members will develop aggression, anger, and horizontal violence against those in their own group (Roberts et al., 2009). Roberts (1983), DeMarco et al., (2008); Weaver, (2013). have all linked RNs to this theory because the nursing profession is dominated by others in the

field of healthcare Nurses feel frustrated, powerless, and unable to fully recognize the cultural ideologies that legitimize medicine's dominate status over nursing (Levine, 2013; Martin, Stanley, Dulaney, & Pehrson, 2008). Because of this feeling of powerlessness RNs vent their frustrations on one another (Martin et al., 2008).

Nurse bullying and its effects on retention are consequential (Weaver, 2013). Wilson et al. (2011) conducted a retrospective descriptive cross-sectional design study of 130 RNs in a southwest U.S. community hospital. The nurses were asked if they had witnessed or been bullied and if they were planning on leaving their current jobs because of the bullying. Of the 130 nurses, 85% reported that they had seen or experienced bullying, 20% reported that they had called in absent to avoid being bullied, and 40% reported they intended to leave their current position because of bullying (Wilson et al., 2011).

Horizontal or lateral violence, bullying, incivility, and counterproductive behavior are the terms used to describe a negative and emotionally or physically violent interaction between two nurses of similar standing (Hutchinson, 2013; Simon, 2008; Weaver, 2013). The most common of these bullying or harassment behaviors from one nurse to another nursing peer include being ignored or excluded, having rumors spread about one nurse by another, having one nurse's professional opinion ignored, withholding relevant work information withheld, humiliating or ridiculing coworkers about their work, silent treatment, and passive aggression (Cleary et al., 2010; Stanley, Martin, Michel, Welton, & Nemeth, 2007; Weaver, 2013). Harassment differs from bullying in that it takes place against an individual in a protected class. Protected class categories include race, color,

religion, sex (including pregnancy), age, disability, and genetic information (U.S. DOL, 2011).

Three different studies all found that higher than desired nursing turnover rates could be attributed to bullying and harassment or horizontal violence (Cleary, Hunt, & Horsfall, 2007; Stanley et al., 2007; Weaver, 2013). Simons and Mawn (2010) noted 31% of new nurses who had practiced fewer than 3 years in the state of Massachusetts reported having experienced bullying behaviors from another nurse in the previous 6 months. Answers to narrative questions from the new nurses were categorized into four different types of bullying and harassment. These four types included structural bullying, where a manager or leader was the bully; nurses eating their young, where the respondent used those exact terms to describe how peer nurses treated them, making them afraid to ask questions due to fear of ridicule. The third type of bullying and harassment according to the new nurses was feeling out of the clique, where respondents described being made to feel not part of the group because of educational status, race, religion, or being pregnant. A final type of bullying and harassment is leaving the job, where new nurse respondents talked about leaving the unit where they worked, the hospital, or even the profession of nursing altogether because of their bullying experiences from their peers (Simons & Mawn, 2010, p. 307-308). The new nurses described their orientation as a period of hazing (Simons & Mawn, 2010).

Blackstock et al. (2014) noted that bullying among nurses is an international problem. Blackstock et al. found that negative informal alliances (bullying) and misuse of organizational processes (favoritism and not following policies) predicted bullying

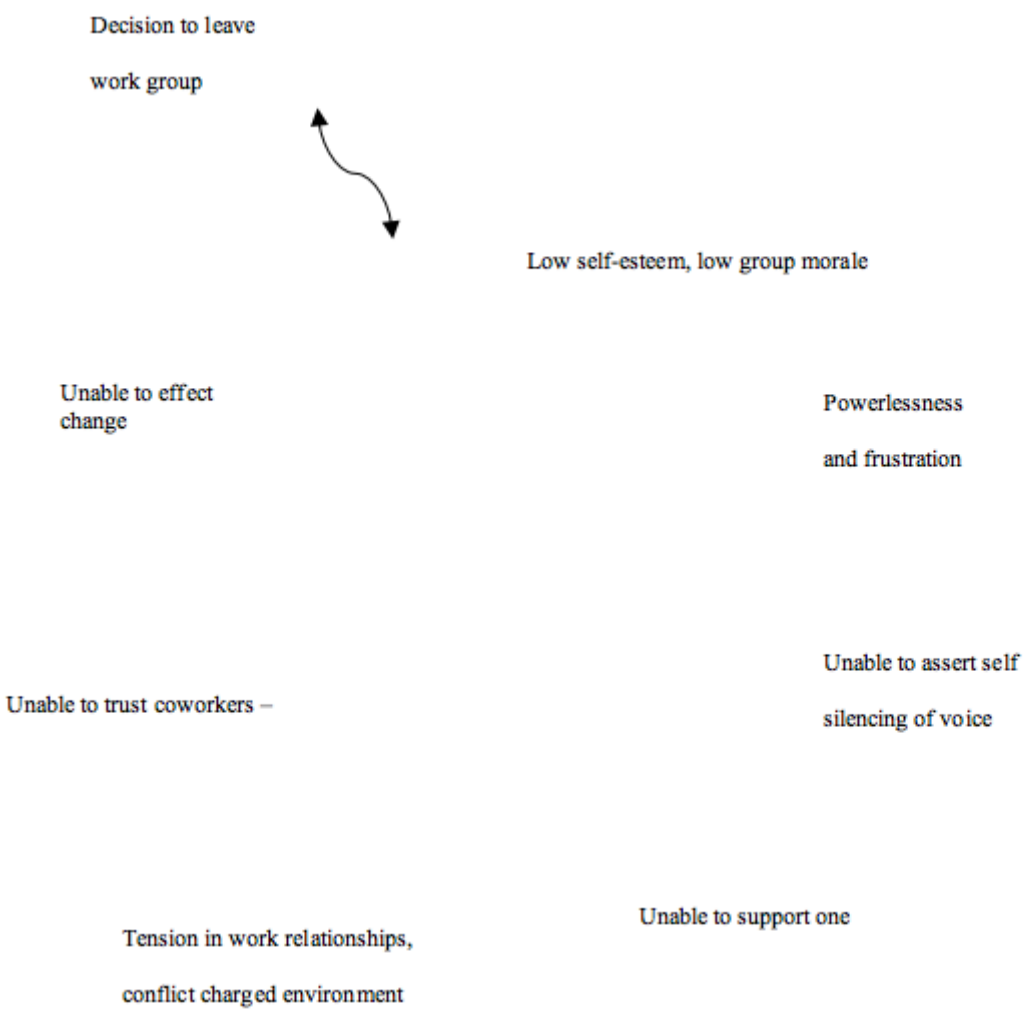
behaviors among Canadian nurses. Bullying behavior led to nurse turnover (Blackstock et al., 2014). The solution to the problem according to Blackstock et al. (2014) is that nursing leadership needs to follow organizational policy and hold staff accountable.

Choi, Cheung, and Pang (2013) examined the effect of work environment on nurses' intent to leave. They found that 1,271 Hong Kong nurses working in 35 different nursing units felt five things directly affected their intent to leave their place of employment: the professionalism of the nursing staff, the manager(s) of the participants, staffing and resources, unit practices, and poor coworker relationships (Choi et al., 2013). They found that nurses who were married, worked in rural hospitals, or came from a higher socioeconomic background were more likely to leave their organization within the first year (Choi et al., 2013). Nurses who worked in unionized hospitals were more disgruntled but had lower rates of turnover (Choi et al., 2013).

Wilson, Diedrich, Phelps, and Choi (2011) surveyed 135 inpatient nurses in a community hospital in the southwest U.S. They compared the degree of what they referred to as horizontal hostility or lateral violence between RNs and turnover intention. They found that there was indeed an association between lateral violence and turnover intention. Wilson et al. called for more research to be done on the relationship between what they call horizontal violence and the intent to leave among all nurses not just newly graduated or hired nurses (p. 454). This study will address that gap.

Martin et al. (2008) theorized how oppression in the field of nursing cycles into bullying, and eventually the victim leaving the workplace. Martin et al. (2008) depicted this cycle in a model of how oppressed group behavior explains horizontal violence in

nursing. The model shows how the oppressed group theory is a cycle of low self-esteem feelings of powerlessness, frustration, and lack of trust among RNs. This leads to unhealthy interactions among RN peers, which ultimately causes RNs to leave their jobs. The nursing exiting the oppression cycle or leaving their workplace is depicted in the model by the double headed line (Martin et al., 2008). There are no directional lines in the model, depicting that cycle or relationship of the variables is not yet defined (see Figure 1).



*Figure 1.* Oppressed group behavior model (Martin et al., 2008).

This theory supports the saying that nurses eat their young, which means there is a lack of compassionate training of newer or younger nurses by their older or more experienced peers (Ditmer, 2011). Eating their young is a description of engaging in acts of bullying (Araujo & Sofield, 2011; Ditmer, 2011). Araujo and Sofield (2011) described the phrase of eating their young as a symptom of the oppressed group theory. When members of an oppressed group feel frustrated, they feel they cannot voice their frustration to their superiors so instead they lash out at peers whom they feel superior to, usually a younger or newer nurse.

Roberts (1983) coined the term horizontal violence to describe how nurses treated other nurses. Oppressed groups are defined as individuals who are controlled and exploited by others (Fanon, 1963; Freire, 1970, Simons, 2008). The dominant group holds the belief that their values and norms are the only correct ones (Fanon, 1963; Freire, 1970, Simons, 2008). The dominant group uses their power to force their values and beliefs on the less powerful group (Fanon, 1963; Freier, 1970, Simons, 2008). The less powerful group starts to believe that their own values and beliefs are less than sufficient (Fanon, 1963; Freier, 1970, Simons, 2008). They begin to doubt their group's worth, and they begin to express aggression and anger toward their own group members since they are powerless against their oppressors (Fanon, 1963; Freier, 1970, Simon, 2008). Roberts (1983) linked nursing to this theory because the nursing profession has been controlled by the medical profession for many years.

The oppressed group theory is one common theory that has been used to describe why there is a high prevalence of bullying and harassment in the nursing profession (Hutchinson, 2013; Martin et al., 2008; Stanley et al., 2007). Hutchinson (2013) said nurses who engage in the bullying of others are often popular, intelligent, and influential. They do not necessarily demonstrate low self-esteem as it thought most bullies do (Hutchinson, 2013; Lewis, 2006). Nurses in general according to the oppressed group theory lack autonomy, control over their work, and self-esteem (Sheridan-Leos, 2008). Some nurses lash out against other nurses, as described by the oppressed group theory, in the form of bullying and harassment. The oppressed group theory also provides a framework to look at self-esteem, bullying and harassment, and turnover intention. Both the oppressed group theory and self-esteem are further explored in Chapter 2.

### **Nature of the Study**

A quantitative nonexperimental descriptive comparative study approach was adopted as the research strategy. The quantitative research design was used to determine if there is a relationship between self-esteem, bullying and harassment, and intent to leave among inpatient nurses. Finding or dispelling bullying and harassment among nursing peers as a reason for inpatient nurses' intent to leave their organization is the focus of this study.

When looking at how I would collect data it was noted that response rates to online surveys vary. According to Baruch and Holtom (2008), the average survey response rate is 35.7% for organizational research. Ziegenfuss et al. (2014) found that in a mailed survey of physicians, and nurses the response rate was 53.9%. Dykema, Jones,



Piche, and Stevenson (2013) reported that the costs of an online based survey make them attractive for researchers to use, but historically, the response rate for online surveys are less than traditional mail surveys. Fazekas, Wall, and Krouwel (2014) found that altruistic appeals in the survey cover letter resulted in higher cooperation rates than egotistic, complex, and lengthy appeals. This methodology, on average, receives 4% more response rates than other methods (Fazekas et al., 2014). I determined that I would invite a large number of RNs to participate (all RNs licensed in the state of Ohio) if only a small percentage respond, I would still have enough participants to allow this study to yield worth., which was targeted at 208 responses needed though a power analysis. The cover letter asked for the participants' help in gleaning new knowledge about the nursing profession to entice a higher level of participation.

I looked at turnover intention and how bullying and harassment and self-esteem may be related to each other. I made a predictions based on how these variables might relate to each other based on current literature. There are three instruments used in this study: the RSES, Negative Acts Questionnaire revised (NAQ-R), and Turnover Intention Measure (TIM).

Low self-esteem is the result of oppression; however, both high and low self-esteem have been attributed to bullies (see Appendix A). The visual model hopes to clarify how these variables are hypothesized to work together. The study results will determine if this assumption is correct or not.

The statistical process used to find and predict a correlation is called regression (Gravetter & Wallnau, 2007). Regression analysis is a statistical analysis technique that

enables one to describe and test the existence of predictable relationships (Mertler & Vannatta, 2013). Ordinal logistic regression analysis of the data was used. The reason ordinal logistic regression was used is because the survey tools in this study used a Likert-type scale. The Likert type scale is an ordinal frequency scale that measures attitudes (McLeod, 2008). Ordinal variables have two or more variables that are ranked or ordered. They are ordinal because each question can be ranked on each of the surveys from most positive to neutral to least positive. Using ordinal logistic regression, one can rank the categories, but no value as to one being better or different than another can be assigned. The predictor variables of bullying and harassment as well as self-esteem along with demographic data were examined for the effect each has on the dependent variable of turnover intention of inpatient nurses. By using the process of ordinal logistic analysis, more accurate predictions of the effect each predictor variable has on turnover intentions were able to be gleaned.

Statistical power analysis is a mathematical formula that is used to determine the number of participants needed in a study to assure that a null hypothesis will be rejected given that in fact it is false. (Faul, Erdfelder, Buchner, & Lang, 2007). A power analysis using G\*Power (a statistical power analysis tool) determined that the number of nurses needed in the study was a minimum of 208 to render statistical power (see Appendix B). Because only approximately one third or less of the surveys were expected to be returned, all RNs licensed in the state of Ohio were asked to participate in the study so at least 208 surveys were received back from the population sample. The 208 surveys needed were determined by running a power analysis using G\*Power. Z tests and logistical regression

were entered into the program along with H1 of 0.25, H0 of 0.15, an alpha error of 0.05, and a beta error of 0.90. With that input, G\*Power calculated that 208 participants would be needed.

Regression analysis analyzes the relationship between multiple independent variables and a dependent variable to yield a predictive equation (Polit & Beck, 2012). In this study, there are two independent variables (self-esteem and bullying and harassment) and one dependent variable (turnover intention). Using a logistic regression analysis showed the effects self-esteem and bullying and harassment have on nurse turnover intention.

### **Definitions**

*Bully*: is defined as the individual who inflicts psychological or physical pain on another (Dellasega, 2011). The term bully is interchangeable with the term aggressor for the purpose of this study.

*Bullying*: When an individual is persistently exposed to negative and aggressive behavior of a psychological nature with the effect of humiliating, intimidating, and frightening or punishing the target (Einarsen et al., 2009). Bullying can involve evolving and often escalating hostile work relationships over a period of time (Einarsen et al., 2009). Harassment is also assessed by the NAQ-R and refers to sexual harassment (Einarsen et al., 2009).

*Horizontal violence*: The bullying or harassment that occurs between two peers (Matheson & Bobay, 2007). For this study, it is defined as bullying and harassment between two inpatient direct care giver RNs.

*Incivility:* Term that is used by some incorrectly as interchangeable with bullying or harassment. By most definitions, incivility is considered a less severe act of disrespectful communication (Roberts, 2015). It is an ill-mannered act such as not responding to inquiries or not being cordial (Yang, Caughlin, Gazica, Truxillo, & Spector, 2014).

*Inpatient RNs:* Are nurses who work within a hospital caring for patients at the bedside. For the purpose of this study inpatient RNs work in the areas of critical care, emergency department, medical-surgical unit, obstetrics, oncology, operating room, pediatrics, or psychiatry.

*Intent to leave or turnover intention:* An employee's plan, aim, or objective to resign or leave their current position or organization.

*Mobbing:* Per Leymann (1990), mobbing means the ganging up on someone at work. Usually those responsible are peers or leaders (Leymann, 1990). It is a type of bullying that occurs with more than one person attacking a target.

*Registered Nurse (RN):* Per Ohio Board of Nursing, (2017, December 13) A person who has specialized knowledge, judgement, and skill and training and holds a current valid license that is authorized to practice nursing as a registered nurse.

*Self-esteem:* A positive or negative attitude toward the self (Rosenberg, 1965).

*Target:* The individual who is the victim of being bullied or harassed by others (Dellasega, 2011).

*Turnover:* The voluntary or involuntary act of vacating a position to move to another position within or outside an organization (Hayes et al., 2012).

*Workplace mistreatment:* Incivility, bullying and harassment, and violence in the workplace. This is the overarching broad term for inappropriate behavior in the workplace (Yang et al., 2014).

### **Assumptions**

Several assumptions were made prior to the start of this study based on what was gleaned from the literature review on the topic, the population being surveyed, and the survey tools being used. It was assumed that the sample population did not bias their survey responses by not responding truthfully. It was assumed that all participants completed the survey in its entirety. It was assumed that the data obtained from the participants were able to be applied to the general population of inpatient RNs in Ohio. It was assumed that the survey instruments used in this study proved to be valid and reliable for measuring this particular population, since all have been used in previous research studies.

### **Scope and Delimitations**

This study includes inpatient RNs located in Ohio. The nursing shortage is affecting all nurses. However inpatient nurses who care for patients at the bedside are the type of nurses whose absence would affect the safety of hospitalized patients and hospital operations the most.

Vessey et al. (2009) conducted a study on a group of inpatient nurses to validate frequency patterns and types of units where bullying behavior is experienced by RNs across the U.S. The focus was to identify the types of perpetrators, the frequency of bullying by the nurse's work unit type (i.e. critical care, emergency department, operating

room etc.), and personal and professional consequences of bullying. Vessey et al. (2009) said that bullying occurs most frequently in medical-surgical (23%), critical care (18%), emergency (12%), operating room/post anesthesia care units (9%), and obstetrical (7%) areas. Perpetrators included senior care nurses (24%), charge nurses (17%), nurse managers (14%), and physicians (8%) who publicly humiliated, isolated, excluded, or excessively criticized the staff nurses (Vessey et al., 2009).

The current study was limited to looking at inpatient RNs only. The reason for this is that 61% of RNs work in inpatient hospital settings (U.S. Department of Labor, [DOL], 2018). By examining the area where the majority of RNs work, it was felt that a better assessment of the relationships between bullying and harassment, self-esteem, and turnover intention could be conducted. The study did not include licensed practical nurses (LPNs), patient care assistants (PCAs), or health unit coordinators (HUCs). Participants needed to have a RN license in the state of Ohio and work full or part time in an inpatient care area as a bedside RN. This study's participants was not limited to new graduate nurses or newly hired nurses, but included all inpatient nurses who were licensed in Ohio.

Bullying and harassment toward all RNs come from a variety of sources. Physicians, patients, supervisors, and peers were noted in the literature to be sources of bullying and harassment toward RNs (Ditmer, 2011; Vessey et al., 2009). For the purpose of this particular study, only bullying and harassment between nursing peers was explored. This type of bullying and harassment according to Vessey et al. (2009) found that peer senior nurses were reported to be the perpetrators 24% of the time.

Generalizability of this study's results should be applicable to other RNs located in Ohio who work within a hospital as a staff nurse in an inpatient care unit.

### **Limitations**

Limitations of this study include the results of this study are not generalizable to the general nursing population. The study was conducted in Ohio, and therefore it would be hard to generalize the findings of this study to nurses from other parts of the country. Only inpatient RNs were accepted as participants. It was assumed that bullying and harassment occur in outpatient settings and in academic settings as well, but the study needed to have parameters set to control the study size. This study was conducted using online surveys. Historically, surveys have a low response rate and/or are not fully completed by all participants. The data obtained were self-reported by the participants, so therefore could include response bias. Response bias is when participants answer the questions to put themselves in a positive light even if that answer is not truthful. Instructions were given asking participants to answer the items honestly to mitigate this bias as much as possible. The potential for a low response rate was addressed by including all licensed RNs in the state of Ohio in the original request to participate to ensure the number needed could be obtained as indicated by the power analysis. While this study is not generalizable to the general nursing population, it should be generalizable to inpatient RNs located in Ohio.

### **Significance**

The significance of this study bridges a gap in the literature linking self-esteem, bullying, and harassment to intent to leave the organization. Araujo and Sofield (2011)

pointed out that more research needs to be conducted linking verbal abuse to the intent to leave the nursing profession. Roberts (1983) stated that the oppressed group theory applies to nurses yet no study has linked the cardinal sign of oppression, which is low self-esteem, with nurses bullying and harassment and intent to leave. This study examined the relationships between self-esteem, bullying and harassment, and intent to leave. The practical significance of this study is that this work could contribute to social change by providing new knowledge and information that would help to reduce nurse turnover, improve patient care, and change many inpatient nurse units from an unhealthy to healthy work environment. The focus of this work was to proactively determine and prevent nursing turnover to create a positive impact on the nursing shortage by leading to fewer nurses leaving their positions due to bullying and harassment from their peers.

Unhealthy work environments and high nursing turnover rates negatively affect patient safety and the quality of patient care (Ditmer, 2011; Li & Jones, 2013; Purpora, Blegen, & Stotts, 2012). To improve the safety and quality of care for U.S. citizens when admitted to a hospital, bullying behavior among nurses needs to be studied to help identify techniques to reduce or ideally eliminate it. Nursing leaders could create interventions to increase nursing self-esteem and reduce bullying and harassment. This could lead to an increase in nursing retention and quality patient care, both of which would affect U.S. society positively. By reducing nursing turnover, the money that would have been used to recruit and hire new RNs could be used for the healthcare needs of U.S. citizens. Examining the forces that cause nurses to leave both their work and their profession and using this information to look at ways to mitigate the loss of these nurses



could add to improved patient care, make a significant contribution to the field of nursing, and lead to significant positive social change that includes keeping nurses at the bedside, which increases the quality of patient care and reduce U.S. healthcare costs.

Direct costs entail the RNs' salary, benefits, and replacement costs. Indirect expenses includes the skills or clinical expertise that was gained from training at the expense of the hospital. It also includes the replacement strategies used by healthcare organizations, for example recruitment fees (Hayes et al., 2011). When these healthcare dollars are spent on replacement of nurses, these dollars cannot be invested in the latest technology, facility upgrades, and quality and safety initiatives. Many times, a RN cannot be replaced quickly, so temporary or agency RNs are used in the interim. Those RNs who are less experienced and not as familiar with the environment have been shown to lead to less positive patient outcomes such as infection, medication errors, decubitus ulcers, injury, or even death due to medical errors (Hayes et al., 2011). This has a direct impact on the U.S. public who are cared for in a healthcare facilities (Dellasega, 2011). Reducing nursing turnover will have a positive effect on the citizens of the U.S.

### **Summary**

There is a gap in the literature regarding the relationship between nurses' low self-esteem and bullying and harassment and intent to leave. The cardinal sign of oppression is low self-esteem (Freier, 1970; Roberts, 1983). In this quantitative nonexperimental descriptive comparative study, I explored the effects of self-esteem and reported bullying and harassment among inpatient nurses on turnover intention. This study was conducted in the state of Ohio. All registered nurses in the state of Ohio were

emailed a survey. Those responding who currently reported working full or part time as an inpatient RN in a hospital in any of the following units critical care, emergency department, medical-surgical, obstetrics, oncology, pediatrics, perioperative or psychiatry were included in the study.

This study aimed to determine if bullying and harassment and self-esteem have an effect on each other and in turn affect inpatient nurses' intent to leave their position. Determining the effect of bullying and harassment, self-esteem, and intent to leave has on one another, and if any of these behaviors or inclinations would increase awareness of the presence of bullying and harassment in particular nursing work groups i.e. the critical care unit, the obstetrical care unit etc., is the first step toward mitigating the ongoing trend which plays a part in the shortage of nurses throughout the U.S. and internationally. In Chapter 2, literature discussing theories regarding bullying and harassment, turnover intention, and the concept of self-esteem are examined in more detail.

## Chapter 2: Literature Review

The purpose of this quantitative study is to examine the relationship between reported bullying and harassment, self-esteem, and turnover intention among inpatient RNs. There is a gap in the literature linking the popular oppressed group theory to horizontal violence among RN peers. No study prior to this one has tried to identify a relationship between low self-esteem (a cardinal symptom of oppression) and bullying and harassment among nurses and their turnover intention in the U.S.

Identifying a link between low self-esteem and bullying and harassment would help support the concept that the oppressed group theory applies to nurses as a reason why they bully and harass each other. Knowing the causes or reasons why bullying and harassment in the profession of nursing is so prevalent would help nurse leaders and psychologists find ways to mitigate the problem and may lead to a decrease in the turnover rates of nurses. Examining the relationship between self-esteem, bullying and harassment, and turnover intention will help remove that gap.

The practical problem is that there is a nursing shortage across the U.S., the cause of which is multifocal. One known reason for this shortage is bullying and harassment among nurse peers (McNamara, 2012). Peer bullying and harassment is known to attribute to nursing turnover, which negatively affects patient safety and quality of care (McNamara, 2012; Roberts, 2015; The Joint Commission [TJC], 2008). The causation between these bullying behaviors and their relationship to nursing practice is unclear.

The search strategy that was used is shared in this literature review. The oppressed group theory and Epstein's theory of self and general knowledge about self-

esteem are addressed. Literature on bullying and harassment and horizontal violence between peer RNs and turnover intentions is also examined. The method of statistical analysis for this study is outlined and this chapter will be summarized and concluded.

In the nursing profession, it is not uncommon for RNs to be bullied and harassed by their own peers (Dellasega, 2011; Ditmer, 2011; Vessey, 2007). Ditmer (2011) said that this phenomenon happens in all healthcare settings and countries, not just a few hospitals that might have a work culture that is lax in addressing this type of unacceptable behavior.

### **Literature Search Strategy**

The literature was searched using the EBSCOHost database search engine and Google Scholar. The databases searched included CINAHL Plus, PsycINFO, PsycARTICLES, SocINDEX, Business Source Complete, and Medline. Terms searched were *bullying, bullying and harassment, lateral violence, horizontal violence, nurses, nursing, mobbing, incivility, nurses eating their young, nurses self-esteem, nurse turnover, nurse turnover intention oppressed group theory, self-esteem, turnover, turnover intention, turnover costs, workplace violence, workplace mistreatment, and workplace aggression*. The reference sections of collected articles was also searched to find additional articles not found via in EBSCOHost or Google Scholar searches. The number of articles found on workplace bullying in general was vast and thus had to be streamlined in order to make this study manageable. The focus of the search was peer-to-peer bullying and harassment.

There were a large number of studies found that were conducted in Europe, Canada, and the Scandinavian countries. Only articles written in English were considered. Using these search terms resulted in 3,552 peer-reviewed articles. A majority of those articles were found in the nursing literature: 2,892. When looking at the most recent peer-reviewed articles from 2008 to 2016, 568 articles were found. There were no articles on bullying and harassment found before 1980, when the phenomenon of bullying and harassment or workplace violence began as a research topic of interest. Many of the earlier studies originated in the Scandinavian countries, Australia, and Europe. Later studies originated in Canada, Asian countries, and even later in the U.S. Seminal work articles on the topics of self-esteem, attributes of a profession, and oppressed group theory ranged in dates from the 1960s-1990s.

### **Workplace Bullying**

There are no agreed upon definitions for workplace bullying and harassment. Leymann (1990) defines bullying (he calls it mobbing), as a hostile and unethical communication that is systematically directed by one or more individuals toward one individual who is pushed into a helpless and defenseless state. Leymann (1990) also includes that to be labeled mobbing the activity needs to occur at least once per week for a duration of at least 6 months. Einarsen & Skogstad (1996) define bullying as repeated harmful behavior over time where the targets cannot defend themselves. It is not bullying if the parties are equal in strength or the incident is isolated. Namie and Namie (2000) define bullying as repeated harmful behavior over time where the targets cannot defend themselves. It is not bullying if the parties are of equal strength or the incident is isolated.

Bullying is repeated health harming verbal mistreatment of a person by one or more workers. The conduct is threatening, intimidating or humiliating. It is sabotage that prevents work from getting done. It is psychological violence, sub-lethal, and nonphysical, a mix of verbal and strategic assaults to prevent targets from performing work. Based on what researchers define as bullying and harassment and for the purpose of this study, it is defined as repeated harmful and unethical behavior systematically directed by one or more individuals toward another who cannot defend themselves.

### **Workplace Bullying and Harassment in General**

In 1990 Leymann developed a new research field in Sweden: he described mobbing at work as persistent negative treatment (Zapf & Einarsen, 2005). Leymann use the term mobbing to describe this phenomenon. The term *workplace bullying* was introduced to the U.S. by Namie and Namie in 1998 (Namie, 2003). Namie and Namie started the Workplace Bullying Institute, a research organization dedicated to the study of workplace bullying in the U.S. because R. Namie had been a victim of workplace bullying that only stopped after leaving the workplace (Namie, 2003). The Workplace Bullying Institute provides statistical data that is updated yearly on the prevalence of reported overall workplace bullying as well as academic research studies and other pertinent information.

Bullying can be physical or verbal and is viewed as intolerable by the receiver (Vessey, DeMarco, & DiFazio, 2011). It includes the following actions: gossip, silent treatment, social exclusion or ignoring, name calling, intimidation, marginalization, sarcastic comments, withholding need-to-know information, unwarranted criticism,

assignment of excessive or inappropriate workloads, condescending behavior, sabotage, passive-aggressive behavior, physically shoving, and slamming things (Christianson, 2015; Purpora & Blegen, 2012; Vessey et al., 2011).

Horizontal or lateral violence is also referred to as workplace violence by some (Ditmer, 2011). The term *workplace violence* is used broadly in reference to bullying and harassment. It is known that nurses who comprise the “largest group of healthcare providers, are assaulted more often than any other employment demographic in the U.S.” (Ditmer, 2011, p. 15). Ditmer (2011) reported that the healthcare sector leads all other industries in incidents or workplace violence according to the American Nurses Association (2009) and the U.S. Department of Labor (2015). The Occupational Safety and Health Administration (OSHA, 2015) noted the following:

Statistics based on the Bureau of Labor Statistics (BLS) and National Crime Victimization Survey (NCVS) data both reveal that workplace violence is a threat to those in the healthcare and social service settings.... Between 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings.... Workplace violence in the medical occupations represented 10.2% of all workplace violence incidents. It should also be noted that research has found that workplace violence is underreported—suggesting that the actual rates may be much higher.

According to Ditmer (2011), 80% of “assaults against healthcare workers” (physicians, nurses, aides etc.) go unreported. Nurses are not only assaulted by each other but by patients, visitors, and physicians (Ditmer, 2011). Criminal justice specialists and

researchers have divided workplace violence into “four distinct categories in an effort to identify the root causes and correlate interventions” (Ditmer, 2011, p. 18). The four categories are defined in Table 2. Type three is the category in which horizontal violence or bullying and harassment fall and is the type that is addressed in this study.

*Table 1*

*Types of Violence*

Types of Violence in Healthcare	Definitions as defined by the Injury Prevention Research Center (2001) and McPaul and Lipscomb (2004)
Type 1 Criminal Intent	Violence erupts during the commission of a criminal act. Nurses who are most commonly exposed to this type of violence are those who work alone or on the night shift in home care or hospice.
Type 2 Customer/Client	A patient or client becomes violent while the nurse is performing routine care. Nurses in the emergency room or in a psychiatric unit are most prone to this type of violence. These aggressive acts are viewed by most nurses as part of the job.
Type 3 Worker on Worker	Disgruntled current or former employee (RN) verbally or physically assaults a fellow employee (RN). Violence escalates following a work related or interpersonal dispute. Unresolved anger and constant stress attribute to frustrations, which then can irrupt into violence.
Type 4 Domestic Violence at Work	Current or former spouse, girlfriend or boyfriend violence begins in the home and then spills over into the work setting.



Adapted from “Violence in the house of healing; Recognition and response to violence in healthcare”. By Ditmer (2011) *The Forensic Examiner*, 20(1) 15-29. And adapted from “When nurses hurt nurses: Recognizing and overcoming the cycle of bullying”. By Dellasega, (2011). Indianapolis: Sigma Theta Tau International

Throughout the literature, numerous terms are used interchangeably for bullying and harassment. Harassment is defined by several U.S. laws and is limited to a protected class as being the target. Harassment occurs to workers who are not in one of the protected classes defined by law and currently there is no law to protect them (Namie, 2009). According to the Equal Employment Opportunity Commission of the U.S. (n.d.), harassment is defined as follows:

Harassment is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967 (ADEA), and the Americans with Disabilities Act of 1990 (ADA). Harassment is unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. Harassment becomes unlawful where (1) enduring the offensive conduct becomes a condition of continued employment, or (2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

There has not been any agreed-upon definition of the term *bullying* by researchers or by legislators to date; many terms for bullying can be found throughout the literature. What is consistent is that bullying occurs over time, a minimum of six months (Einarsen et al., 2011). Bullying or horizontal violence includes a wide variety of actions from the

bully toward the target. A central feature is that bullying is an imbalance of power (Einarsen et al., 2011). Yang et al. (2014) attempted to categorize the many terms found in the literature, incivility, aggression, and bullying they often use interchangeably and refer to broadly as *workplace mistreatment*. Yang et al. (2014) conducted a meta-analysis review of the literature on workplace mistreatment and found that workplace mistreatment can be divided into three levels of severity: Level 1 incivility: defined as low-intensity mistreatment consisting of disrespect and rudeness (Yang et al., 2014); Level 2 is workplace aggression defined as overt physical or nonphysical aggression or abuse that harms the employee (Yang et al., 2014); lastly, Level 3 is bullying, which is defined by Yang et al. (2014) as a long-term exposure to abuse and offensive behavior that the target has difficulty defending themselves against and occurs over a long period of time. In their review of the literature, Yang et al. (2014) found that in Europe and North America, about 10-15% of the entire workforce experiences workplace bullying. These statistics are troubling given that employees exposed to bullying and harassment at work show less job satisfaction, organizational commitment, experience burnout, and also engage in counterproductive behaviors (Trepanier et al., 2013).

Prevalence rates of bullying and harassment between nurses varies from study to study. This is because of the fear of reporting and because of the way the surveys are constructed (Einarsen et al., 2011). It is difficult to pinpoint a consistent prevalence rate. Dellasega (2011) reported that about 90% of nurses have witnessed bullying and harassment either firsthand or of a peer. Randle (2003) shared that RNs who witness bullying and harassment of peers tend to internalize the behavior and become a bully

themselves in the future. It is easy to see how this behavior could then have become the normal accepted culture within the profession of nursing.

Bullying can occur between men and women with either being the aggressor. It can also occur between men and men, and between women and women. Half of all reported bullying is woman to woman (Namie, 2003). Einarsen et al. (2011) reported that women, because of their gender, are taught to be less assertive and hold less powerful positions in organizations, and because of this, they have a tendency to be the victim more often than men in reported bullying and harassment incidents. Leymann (1993) found that male teachers, nurses, and librarians who were in minority positions were all bullied more than their female counterparts. Bullying is described as being nearly invisible since it is nonphysical (Namie, 2003).

Bullying is mostly covert psychological violence, both in nature and impact (Namie, 2003, p. 2). Leymann (1990) estimated that 10% of suicides in Sweden are related to workplace bullying/mobbing. Yildirim and Yildirim (2006) reported that among the 505 Turkish nurses who participated in their study of inpatient nurses' who experienced mobbing, 10% reported considering suicide as an option to the workplace mobbing they were suffering. Adams (1992) pointed out that there are clues to bullying taking place in an organization that include staff turnover, absenteeism, prolonged sick leave, and decline in productivity.

In the U.S., few studies were found that have been conducted by U.S. psychologists looking at bullying and harassment between peers specifically in the profession of nursing. Many of the studies conducted in the U.S. on RN peer-to-peer

bullying and harassment are conducted by what appear to be nurse researchers. U.S. researchers are still looking at prevalence rates or suggesting that the cure is education of new nurses around the handling of peer-to-peer bullying. It is noted that these studies are not as robust as some of the studies conducted in other countries, which can be expected since research on the topic of bullying and harassment in nursing started there several years ago. U.S. studies are focusing on the prevalence of bullying (Hinchberg, 2009; Stanley et al., 2007). Several scholarly articles are found on the topic, more so than research papers by nurses. More robust research on bullying and harassment in the profession of nursing needs to be conducted to identify the cause before studies on mitigation plans are attempted. However, as can be noted some studies have tried to mitigate the issue before the rationale for the issue is understood (e.g., Griffin, 2004).

Griffin (2004) taught newly graduated nurses from Boston using cognitive rehearsal how to handle someone who is trying to bully them at work. They also provided the new graduate nurses with cue cards and badge backer cards (to hang on the back of their identification badges at work for quick access for reference) that listed professional responses to the most common lateral violence activities that were crafted to dispel the lateral violence activity as it occurred. Most Frequent Forms of Lateral Violence in Nursing Practice and Professional Responses by Griffin (2004) are listed in Table 3.

Table 2

*Forms of Lateral Violence*

Most Frequent Forms of Lateral Violence in Nursing Practice by Griffin, 2004	Professional responses advocated in Griffin's 2004 study
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‘table continues’

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Nonverbal innuendo (raising eyebrows, face-making)	“I sense from your facial expression that there may be something wanted to say to me.”
Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses)	“The individuals I learn the most from are clearer in their directions and feedback. Is there some way we Structure this type of situation?”
Undermining activities (turning away, not available)	“When something happens that is different or contrary to what I thought or understood, it leaves me with questions. Help me understand how this situation may have happened.”
Withholding information (practice or patient information)	“It is my understanding that there was (is) more information available regarding this situation. I believe if I had known (know) that information, it would (will) affect how I learn.”

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After six months on the job, Griffin (2004) interviewed 26 new nurses.

Videotaping their conversations that consisted of six structured questions, they found that their education proved to be helpful to the new nurse’s ability to handle such situations.

Griffin did not address the reason for the bullying taking place.

Stanley et al. (2007) conducted a mixed methods study in the southeastern U.S.

Their work focused on the prevalence of lateral violence (bullying and harassment)

within one tertiary hospital. They used oppressed group theory as their theoretical framework. They did not look at self-esteem, which is the cardinal symptom of oppression.

The qualitative piece to this study was expressed by the survey participants (663 RNs) answering four narrative questions. Using grounded theory methodologies, these answers were bucketed into three themes of responses perceived seriousness, oppressors, and mediators with suggestions from the RNs on what each group could do improve lateral violence on their nursing units. Per Stanley et al. (2007), the analysis supported the use of the author developed tool the Lateral Violence Nursing Survey (LVNS) for the quantitative part of the study. No reliability or validity data was shared.

Using the LVNS, a 23-item survey that was developed by the researchers, 663 RN from 35 inpatient units were surveyed on their witnessed occurrence of bullying and harassment or lateral violence as they referred to it, between nursing peers (Stanley et al., 2007). They received a 36% response rate. Their results showed that 46% of the nurses of the 663 RNs in their study described lateral violence behavior between nurse in their work areas as serious and 65% reported observing it frequently among peers (Stanley et al., 2007). Stanley et al. did not make any suggestions for further studies.

Demarco et al. (2008) also developed a tool to measure oppression among nurses: the Nursing Workplace Scale (NWS). They used the oppressed group theory as their theoretical framework. They engaged 904 RNs from Massachusetts to enroll in their study. They found that more evidence of construct validity is needed for their tool to be

useful (Demarco et al., 2008). Further studies using the NWS were recommended by the researchers to obtain more evidence of construct validity (Demarco et al., 2008).

Simons (2008) was a U.S. study conducted by a nurse researcher that examined the relationship between bullying and RN intention to leave their organization. Simon reported that the target population was newly licensed RNs in the years 2001-2003 in Massachusetts. Using the Massachusetts Board of Nursing database, 1,000 names were randomly selected and mailed a survey that consisted of the NAQ-R and a subscale of the Michigan Organizational Assessment scale looking specifically at intent to leave (Simon, 2008). Response rate was 54.4%. Of the respondents, 31% reported that they experienced bullying in the last six months (Simon, 2008). A bullying score was then obtained by summing the results of the NAQ-R (Simons, 2008).

Per Simons (2008), this scale demonstrated reliability with a Cronbach  $\alpha$  of .88. When tested with a  $t$  test there was a statistical difference  $t_{157} = -12.06, p < .0001$  between nurses who reported being bullied and those who were not (Simons, 2008). Simons (2008) reported that a significant correlation was found between the bullying score and the intent to leave ( $r = 0.51, p = <.001$ ).

Simons (2008) postulated that bullying had a significant effect in making the RNs in this study want to leave their organization. Simons stated that one limitation of her study is that the findings were not stratified according to work setting; it is not known if there is any difference between the types of hospital units (p. E56). More similar studies are recommended by Simons that include not only new RNs, but all RNs, to help

determine prevalence of workplace bullying and its effect on intention to leave the organization (Simons, 2008).

Hinchberge (2009) performed a prevalence research study among 126 student nurses in Chicago. Results showed that 100% of the nursing students had either been a victim or witnessed bullying of another student (Hinchberge, 2009). They also reported that 50% of these bullying incidents were conducted by nursing peers (Hinchberge, 2009). They used the oppressed group theory as their theoretical framework. Hinchberge did not include in their study any validation of oppression within the ranks of nurses. Hinchberge (2009) noted that National Institute for Occupational Safety and Health stated that “nurses are more likely to experience violence than any other professional group” (p. 38). A list of items that hospitals and leaders needed to do to decrease bullying among nurses was given but no further recommendations for research were shared.

The purpose of the study by Vessey et al. (2009) was to validate perceptions of frequency and patterns of bullying across the U.S. A SurveyMonkey survey was linked to an article published in 2007 in *Nursing Spectrum*, a free biweekly nursing news magazine. It is distributed to 1 million RNs across the nation. Only 212 responses were returned and able to be utilized (Vessey et al., 2009). Bullying occurred most frequently in Medical Surgical units at 23%, Critical Care units at 18%, Emergency Room at 12%, Operating Room at 9%, and Obstetrical areas at 7% according to Vessey et al. (2009).

Vessey et al. (2009) found that peer senior RNs were the most common perpetrators, followed by charge nurse (17%), nurse manager (14%), and physicians (8%). The conclusion of this study was that “bullying among U.S. nurses is indeed a



problem with significant workforce and workplace implications” (Vessey et al., 2009, p. 305). The focus of the study was to define prevalence, not cause. Vessey et al. (2009) called for more research to be done in the area of intervention strategies and the effect of bullying on nursing care rendered.

In Cincinnati, Ohio, 197 nurses took part in a qualitative study by Berry et al. (2012). The focus was novice nurses productivity following workplace bullying. A large percentage of the novice nurses (72.6%) reported workplace bullying in the previous month. Almost 60% (57.9%) of those reported being the target. The perpetrators were reported to be nursing peers. Productivity was noted to decrease in the novice nurses who were targets of bullying.

Spector, Zhou, and Che (2014) conducted a quantitative review of over 136 nursing and violence studies. Their review included 151,347 nurse participants and found that 39.7 % or over 1/3 of all nurses worldwide are bullied. They also noted that most nonviolent acts against nurse are committed by their own nursing peers (Spector et al., 2014). Spector et al. (2014) noted that violence in general is a true hazard of the nursing profession. They called for more research to be done in regard to violence of all kinds with in the profession of nursing to help find an effective solution (Spector et al., 2014).

Park, Cho, and Ja-Hong (2015) looked at cross-sectional data from a prevalence study done in Seoul, South Korea in 2013. The study included 940 RNs from 47 nursing units (medical surgical, intensive care, operating rooms, outpatient, and oncology) at one University hospital (Park et al., 2015). Using the medium-sized Copenhagen Psychological Questionnaire work demands, trust, justice, and violence were measured

(Park et al., 2015). It was noted in this study that the intensive care units had the highest incidence of bullying and violence than any other type of nursing unit. Violence toward nurses was primarily identified as coming from patients, but “bullying was perpetrated mostly by nursing colleagues (68.1%) across all nursing units” (Park et al., 2015, p. 90). Younger or newer nurses were found in this study to be the primary targets of bullying and Park et al. (2015) noted that this finding supports the saying that nurses eat their young. Several of these studies looked at differences of bullying levels within different types of nursing units. Of all these nurse-conducted studies focusing on bullying and harassment, only one tried to focus on the cause of the issue. Some tried to determine prevalence; others tried to determine ways to mitigate the problem prior to knowing the actual cause. Other researchers focused on the physical or psychological effect bullying has on the nurse.

The physical and psychological effects of bullying on an individual can be devastating (Neilsen & Einarsen, 2012; Trepanier et al., 2015). Reknes et al. (2014) found a positive link to bullying and poor psychological health, namely anxiety, depression, and fatigue. The healthcare workers studied who were victims of bullying suffered from burnout and had lowered job satisfaction (Neilsen & Einarsen, 2012). According to McNamera (2012), burnout is a major symptom suffered by the victim of bullying. Other physical effects on the victim include stress, weight loss or gain, gastrointestinal symptoms, cardiac palpitations, headache, hypertension, sleep disorders and fatigue (McNamara, 2012). Neilsen and Einarsen (2012) reported that as a result of their meta-analysis work looking at empirical data over 30 years, bullying affects the

victim both mentally and physically. Post-traumatic stress disorder, anxiety, depression, decreased self-perception, increased sleep disturbances, and increased mental illness were all supported as being increased as a result of bullying in the workplace.

Pilch and Turska (2015) ascertained that workplace bullying is a multicausal phenomenon. Leymann (1990) asserted that the real reason that bullying occurs is unknown. Whereas Sperry (2009) presented that psychologists have deemed that there are three causative factors that attribute to workplace bullying or mobbing the individual as a “bad apple”; the work team as “bad apples” or the organization itself as a “bad barrel.”

When considering the bad apple concept, it is thought that an individual’s personality leads them to be either a bully or a target but limited research has been done on specific personality traits of a bully or a target (Sperry, 2009). It is hard to identify bad apples as bullying and harassment in nursing as it is covert and hard to pinpoint even by the victim. It is also under reported (Berry et al., 2012). Someone who has low-self-esteem and has a high anxiety level is more likely to be bullied (Sperry, 2009). Other researchers have found bullies tend to be narcissistic and egocentric (Sperry, 2009). Bullies are also characterized as being aggressive, low in emotional intelligence, and high in social anxiety (Sperry, 2009). Einarsen et al. (2011) reported that when someone has low self-esteem, they may display more aggressive behavior. Differences in individual characteristics may predispose them to being a bully or a target (Pilch & Turska, 2015).

Someone with low self-esteem can be either the bully or the target (Einarsen et al., 2011; Sperry, 2009). Within the field of nursing, Lewis (2006) asserted that bullying

is learned behavior from one nurse to another. It is not unrealistic to think that a young nurse who is bullied as a novice nurse will in turn become the perpetrator to newer, younger nurses when she/he is more experienced. The mantra that nurses eat their young comes into play. It is not possible at this time to build a profile of someone who was a bully or a target. Research has not yet been done to enable psychologists to build a solid personality profile for either the bully or the target (Sperry, 2009).

Sperry (2009) ascertained that there are three work orientations in which individuals can be categorized. Those three categories include job, career, and a calling (Sperry, 2009). In the first category individuals consider their job just that, their job, nothing more (Sperry, 2009). The individual considers their job as just a means to a financial end (Sperry, 2009). In this mindset, the person thinks that their job and the money earned from it are the necessary means that allow them to engage in things outside of work that are more meaningful to them (Sperry, 2009). In the second category, career, the individual values the prestige, pay and the promotion that their work can provide them (Sperry, 2009). Sperry (2009) shared that in his experience as a consulting psychologist for many years, it is the individuals in this category that are prone to being targets and who experience considerably more distress and disability when faced with bullying. The final category, a calling orientation, envelops those individuals who perceive their work as a mission to make the world a better place (Sperry, 2009). Work is their passion and it provides the individual with much job satisfaction (Sperry, 2009). Nursing is often described as a calling. However new nurses are often disillusioned once

they get into the workforce. This could be another reason for the frustration that could lead to the bullying and harassment behaviors.

The workplace environment, or the way a person reacts to stress, may all be causes of workplace bullying (Berry et al., 2012; Pilch & Turska, 2015). Hospitals are now organized as businesses focusing on cost containment, downsizing, skill mix changes (fewer RNs, more ancillary staff), life and death situations, decreases in staffing, no autonomy to control their own work environment, and lack of power all attribute to the nurse feeling oppressed (Croft & Cash, 2012; Embree & White, 2010). In the Korean study of 970 nurses from 47 nursing units, “high work demands” of nurses were found to be “significantly associated with workplace violence,” “but cannot be considered causal” (Park et al., 2015, p. 87).

Sperry (2009) asserted a group of individuals in a workplace behave as a unit or in-group. Their cohesiveness helps them focus on the same goals and group pride develops as in-group members feel proud of themselves. One thing that cements in-group cohesiveness is the focus on an out-group as an enemy to the in-group (Sperry, 2009).

Lastly, organizational dynamics is also thought by psychologists to be one of the causative agents to bullying and harassment in the work setting (Sperry, 2009).

Organizational dynamics refers to influences of the interplay among the organization’s subsystems (Sperry, 2009). Referred to as the work environment hypotheses, it has been found that more victims of bullying report a more negative work environment than those who were not being bullied (Sperry, 2009).

The cause or reason for bullying and harassment to take place has not been identified, yet its prevalence is apparent. Workers from North American and European report being subjected to workplace mistreatment more frequently than gender discrimination; sexual discrimination; or racial harassment (Youn, Bernstein, Lee, & Nokes, 2014). The effect of workplace mistreatment is not only devastating for the individual but for the organization in the way of turnover and lost productivity (Youn et al., 2014).

McCormack, Casimir, Djuckovic, and Yang (2009) found that there was a positive correlation between workplace bullying and turnover intention in teachers. In this study McCormack et al. looked at 142 high school teachers in China. It was interesting to look at bullying and harassment in China since the national culture in China is one of high power distance, thus one would expect hierarchical and authoritative work relationships (McCormack et al., 2009). The NAQ was used to measure bullying and harassment prevalence, the affective commitment was used to measure loyalty to the organization, and intent to leave was measured by using a two item questionnaire asking if the teacher intended to leave the school in the next 12 months, or if they intended to leave teaching in the next 12 months. The findings significantly supported that teachers who reported experiencing bullying and harassment have a higher intent to leave ( $b=.43$ ,  $p < .001$ ) than those who do not experience bullying and harassment despite their affective commitment ( $b=.39$ ,  $p < .001$ ) to the school (McCormack et al., 2009).

McCormack et al. (2009) also reported that the relationship between affective commitment and intent to leave was also significant ( $b = .19$ ,  $p < .001$ ). McCormack et al.

(2009) ascertained that most studies focus on correlations between bullying and associate variables such as illness or on prevalence (p. 2108) and not on bullying and harassment, self-esteem, and turnover intention; which was the focus of this study.

Violence, as defined by Young (1990, as cited in Dubrosky, 2013), is a social justice issue that is directed at members of a group simply because they are members of that group. Violence gains legitimacy when it goes unchallenged and is tolerated (Dubrosky, 2013). Nurses are victims of violence on several fronts, from peers, supervisors, patients, and visitors (Dubrosky, 2013). Bullying is a form of violence (Dubrosky, 2013; Einarsen et al., 2001; Young, 1990). Einarsen et al. (2011) explained that there is an escalation process of bullying, which is not unlike the domestic abuse process. The cycle proceeds as follows: In phase one there is an initial conflict occurs that starts the cycle. Usually an indirect act that may be difficult to pin down, recognize, or confront because of its discrete nature. In phase two the bully projects more direct negative acts toward the target. The target at this stage feels more humiliated, ridiculed, and isolated. The target finds it difficult to defend themselves and may suffer from a wide variety of physical stress-related symptoms. Sick leave and absences may be utilized by the victim to escape the bullying. Phase 3 is demonstrated by an expulsion from the situation by the target usually by leaving the workplace either by dismissal or voluntarily.

Usually no one will step in or stand up to the bully on the behalf of the victim (Einarsen et al., 2011). This could be because they fear being the next victim of the bully. It is not uncommon for the victim to be met with disbelief when they do bring forward their complaints about bullying to leadership (Einarsen et al., 2011). Many times the

victim is treated like the source of the problem (Einarsen et al., 2011). Most often, the victim or target is the one who leaves the department or the organization, not the bully (Namie, 2003).

There are some constructs of workplace bullying that are consistent throughout the literature. Bullying is not a single act (Leymann, 1990). It occurs over at least a six-month timeframe (Einarsen et al., 2011; Leymann, 1990). It can be defined as verbal comments or actions that are negative, unethical, and intentional that cause psychological distress to the target or victim (Einarsen & Skogstad, 1996; Leymann, 1990; Namie & Namie, 2009). It is described as an imbalance of power and thus the target cannot defend themselves (Zapf & Einarsen, 2005).

Zapf and Einarsen (2005) reported that a central feature of mobbing (bullying) is an imbalance of power between two parties. The power imbalance can run along organizational formal lines, for example, a supervisor bullying a subordinate (Zapf & Einarsen, 2005). Bullying can also occur between peers with one peer having more power by the way of more knowledge, experience, or the support of someone in an official supervisor role (Zapf & Einarsen, 2005).

The only difference between bullying and harassment as defined by U.S. law is that harassment is a legal term when bullying occurs toward someone in a protected class (U.S. DOL, 2015). The NAQ-R, the tool used in this study, questions subjects on both bullying and harassment. The focus for this study, however, is bullying in general but it could be reported by the subjects as harassment on the survey tool.



In summary, there are some consistent gaps noted in the literature. For example there are fewer studies on the topic of bullying published in journals that are not nursing journals. Also, there were no studies found that look at self-esteem of nurses as related to bullying and turnover intention. The several international studies that have examined bullying within the nursing profession seem to look at it from a reactive vantage point. They focus on the effects bullying has had on individuals, physically symptoms, work outcomes, and quality patient care. This focuses on a more proactive angle when looking at bullying within the profession of nursing. What might be the cause of this unique phenomena within the profession of nursing? What predictive testing could allow a nurse leader to identify that nurses are wanting to leave the profession or at the least their current position because of bullying? Nurse leaders could intervene and support those nurses and mitigate actual nursing turnover. If they could predict bullying was occurring and turnover was being considered they could have a direct impact on the nursing shortage and truly positively affect social change by saving health care dollars and by lessening the impact of nursing turnover on quality patient care.

### **Theoretical Foundation**

Freire (1970) theorized that oppressed group behaviors occur when the powerless are silent and submissive in confrontation with authority (or presumed authority) and consequently low self-esteem results. Low self-esteem then leads to anger and aggressive behaviors toward one's own group members (Freire, 1970; Rodwell & Demir, 2012; Roberts, 2015). Dong and Temple (2011) shared that the word *oppression* dates back to the 1300s and is derived from the Middle English word *oppression*, which defined means

“pressing down” (p. 169). According to Matheson and Bobay (2007): “Paulo Freire created a model of oppression based on his observations of Brazilians who had been taken over and dominated by Europeans” (p. 226). Over time, the Brazilians internalized the values of the Europeans (Matheson & Bobay, 2007). Studies of oppressed groups include colonized African, Latin Americans, American Negro, Jews, and more recently women (Araujo & Sofield, 2011, p. 461). The oppressed, according to Freire, believe that they can overcome the oppression by becoming more like their oppressors (Matheson & Bobay, 2007).

Leaders in the oppressed group try to be successful by assimilating their behaviors to mirror the dominant group norms, but then they become marginalized because they cannot be full members of the dominant group and they no longer are full members of the oppressed group (Freier, 1970; Matheson & Bobay, 2007). As the oppressed group tries to assimilate to the dominant group’s norms and values self-hatred and low self-esteem develop (Freire, 1970; Matheson & Bobay, 2007). The continued oppression creates feelings that lead to what has been called submissive-aggressive syndrome, which was first described by Fannon (1963). The subordinate group is submissive to the dominant group but hold internalized anger toward themselves and their own group; which can lead to acts of horizontal violence and aggression (Araujo & Sofiel, 2011).

Roberts (1983) was the first to connect Freire’s oppressed group theory to the field of nursing and the bullying and harassment behaviors observed commonly in this group (Matheson & Bobay, 2007; Roberts, 1983). Roberts explained how colonized Africans and Latin Americans, black Americans, Jews, and women are all oppressed

groups. Roberts described the characteristics of an oppressed group, the dominant group looks and acts differently than does the oppressed group, for example, White versus Black, men versus women. The “norms and the values of the dominant group become highly regarded” while the norms and “values of the oppressed group become negatively valued” (Roberts, 1983, p. 22).

Roberts (1983) reported that oppressed group tries to assimilate by fitting into the norms and values of the dominant group. It is more difficult for the oppressed group to assimilate when the differences are, for example, gender or skin color (Roberts, 1983). When the oppressed group member tries to assimilate, they have to reject their own group norms, which leads to self-hatred and low self-esteem (Roberts 1983). Fear of aggression toward the dominant group develops as a result of two things: (a) the subordinate group could be destroyed if they were to attempt a revolt; and (b) Fear of change itself, having lost their own identity, the oppressed have little faith in their own ability (Roberts, 1983).

Roberts (1983) postulated that there are three mechanisms that reinforce the state of oppression: (1) education: If education is controlled by the dominant group, little conflict will occur; (2) reward for behavior preferred by the oppressor, and (3) occurs when there is a threat of revolt and a token appeasement is given to the oppressed by the oppressors; for example, Roberts gives in “during times of social unrest welfare programs are given to halt the momentum toward change” (Roberts, 1983, p. 24). Roberts (1983) stated that leaders in the oppressed group who have tried to assimilate into the dominant group are usually “controlling, coercive, and ridged”; these “characteristics stem from

low self-esteem and hatred of their own kind developed because they want to be like their oppressors” (p. 25).

Nursing’s dominance, according to Roberts (1983), can be traced back to the 1900s when the sick became institutionalized and medicine became dominant. When working in the community in patients’ homes, nurses were much more autonomous (Roberts, 1983). Roberts shared that once patients were being seen in hospitals, education of nurses became controlled by physicians. More recently, nursing education has moved to the university setting versus being educated in the hospital based diploma programs (Roberts, 1983). Roberts reported that nursing is compared with medicine; one example is that all nurses have experienced someone “expresses disbelief” when a nurse states she wanted to be a nurse and not a physician (Roberts, 1983, p. 27).

Roberts (1983) reported that nursing’s negative self-opinion stems from being defined as inferior by other members of the healthcare team. Nurses have internalized the values of the physician and the medical model, losing sight of their own identity (Araujo & Sofiel, 2011). From Roberts’s work, many articles and research studies within the field of nursing have used oppressed group theory as the rationale for bullying and harassment in nursing. However, none have tested self-esteem and turnover intention’s relationship to bullying and harassment as this research study will do.

Over the last 20 years, bullying among nurses across all subspecialties and work settings has been shown to be a persistent problem internationally with strong links to turnover (Blackstock et al., 2014). Some studies have been conducted on bullying in the nursing work setting primarily by U.S. nurse researchers. Few researchers specifically

address the issue of bullying and harassment between nursing peers. Spector et al. (2014) conducted a qualitative review looking at all violence related to the nursing field and found that 39.7% of all nurses worldwide have been bullied and that commonly the bully is one of their peers. To learn why this occurs at such a high rate, more robust research needs to be conducted on this specific type of horizontal violence among nurses.

Rodwell and Demir (2012) conducted a study on 273 Australian RNs who worked in one organization in both a hospital setting and in an aged care nursing unit (or nursing home). They developed a survey, which was validated, to gather data that examined the psychological consequences of bullying; examine demographic factors such as tenure and employment type; and look at negative affectivity of each RN (Rodwell & Demir, 2012). Based on the oppressed group theory, Rodwell and Demir wanted to clarify the ways workplace aggression manifest itself. They wanted to learn more about what leads to bullying and violence experienced by RNs (Rodwell & Demir, 2012).

The participants were mailed surveys where they self-reported their personal experiences with aggression; either violent events from external sources such as patients and visitors, and/or bullying events, from internal sources such as supervisors and peers (Rodwell & Demir, 2012). In the surveys, the RNs were asked if they had experienced bullying at work in the last six months; they were queried on the frequency of aggressive events (Rodwell & Demir, 2012). They were surveyed on select antecedents based on the demand and control model, which included job demands, job control, supervisor support, coworker support, negative effect, and outside work support (Rodwell & Demir, 2012). Their answers were compared to demographics that were also collected from the

participants (Rodwell & Demir, 2012). They had a 37% response rate, which represented 273 returned surveys from the hospital nurses and 208 surveys were returned from the nursing home RNs representing a 43.8% response rate (Rodwell & Demir, 2012).

Using descriptive statistics and ordinal regression using Predictive Analytic software antecedents of bullying and violence were conducted (Rodwell & Demir, 2012). Rodwell and Demir (2012) reported that the demographics examined included tenure and shift worked. For bullying two antecedents were identified negative affect ( $b = 0.008, p < 0.01$ ) and job schedule ( $b = 0.06, p < 0.05$ ). Those nurses who had high reports of negative affect were associated more with bullying acts. Those nurses who worked on the day shift were more prone to experience bullying from peers. Those nurses who were less tenured, nine years or fewer, had a higher incident of experiencing violence from patients and visitors ( $b = 16.8, p > 0.001$ ). Nurses who reported low job control ( $p < 0.05$ ), low supervisor support ( $p < 0.01$ ) and low coworker support ( $p < 0.01$ ) were statistically significant for reported bullying (Rodwell & Demir, 2012). Overall findings showed that workplace bullying and aggression are serious problems within nursing (Rodwell & Demir, 2012). It also supported oppressed group theory as being applicable to nurses (Rodwell & Demir, 2012).

Young (1990) defined oppression as the “disadvantaged and injustice some suffer not because of tyrannical power coerces them, but because of the everyday practices of a well-intentioned liberal society” (p. 41). Oppressed group theory is further described and defined by Young, using the Five Faces of Oppression. The Five Faces of Oppression include exploitation, powerlessness, marginalization, cultural imperialism, and violence

(Dong & Temple, 2011; Dubrosky, 2013; Matheson & Bobay, 2007; Young, 1990). To qualify as being oppressed a group has to fit the criteria for at least one of the Five Faces (Young, 1990). Dubrosky (2013) argued that nurses meet the criteria for an oppressed group in all five faces.

Exploitation was defined by Young (1990) as people who exercise their capacities under the control, according to the purposes, and for the benefit of others. Workers suffer loss of control and self-respect (Young, 1990). Nursing as a profession experiences a lack of control of their practice (Dellasega, 2011). Dubrosky (2013) argued that the field of nursing started out as being considered women's work. Dubrosky explained that in the era when nursing emerged as a profession (in the 1700-1800s) nurses were almost unanimously women and thus, nurses were politically invisible. Comparatively, physicians who were also emerging as a profession around the same time were predominately male, thus held more political power because of their gender (Dubrosky, 2013).

In the early years of the profession, nurses were trained by physicians and the result of this training was that nurses rarely spoke in public and were described as the eyes and ears for the physician (Dubrosky, 2013). Rainer (2015) shared the story of a young patient who was undergoing surgery and subsequently died because the anesthesia team could not access her airway via intubation. After the incident, many nurses who were in the room shared that they thought an emergency tracheotomy should have been performed, none, however, spoke up during the incident to share their thoughts (Rainer,

2015). Rainer stated that the oppressed group theory may provide a partial explanation as to why these RNs did not speak up as patient advocates.

Marginalization was defined by Young (1990, as cited in Dubrosky, 2013) as serious disruptive justice that involves the deprivation of conditions for exercising capacities in a context of recognition and interaction. Nurses are thought to become marginalized when they become nurse leaders. In a leadership role, they are still unable to change the balance of power and are not able to bring about effective change in the work environment because of constraints imposed by hospital administrators and physicians (Dubrosky, 2013).

Powerlessness is defined by Young (1990) as a lack of decision making power, inability to develop one capacities to their fullest, and being exposed to disrespectful treatment because of their status (Dubrosky, 2013). Workloads, type of tasks they can perform, and hours worked by the nurse are all decided by administrators. Nurses also take orders from physicians for patient care. Nurses have been socialized to the practice of being silence about their own contributions to patient care (Dubrosky, 2013). This has led to frustration that is internalized as ingroup bullying and harassment (Dellasega, 2011).

Cultural imperialism is defined by Young (1990) as the process of the dominant group's culture being defined as the norm (Dubrosky, 2013; Roberts, 1983). It is well known that the medical model is the standard in healthcare and has been so long that nursing has forgotten its origins (Dubrosky, 2013; Roberts, 1983). Medicine became dominant because the profession initially was made up primarily of men. The current



healthcare structure limits the earning power of nurses and serves to keep them in their place (Dubrosky, 2013).

Per Young's (1990) definitions, nurses are an oppressed group. Oppression can be seen through objective reporting, but an individual might not realize that they are oppressed if they have never experienced not being oppressed (Dong & Temple, 2011). Oppression can be evaluated by observing group behavior. Passive/Submissive-aggressive behavior and low self-esteem can be observed and measured as indicators to oppression (Dong & Temple, 2011; Matheson & Bobay, 2011; Roberts, 1983; Young, 1990).

There are several research studies in nursing that use Oppressed Group Theory as their framework (See Blackstock et al., 2014; DeMarco et al., 2008; Hinchberger, 2009; Iglesias & de Bengoa Vallejo, 2012; Rodwell & Demir, 2013; Stanley et al., 2007; Simons, 2008; Vessey et al., 2009).

In the field of psychology, most theoretical frameworks are based on one of four causes of bullying and harassment at work. They include organizational culture, social culture, individual behavior, or perceptions (Einarsen et al., 2011). Einarsen et al. (2011) explained that the underlying cause or central feature of bullying is usually a power imbalance. One can assume that the social phenomenon of bullying is characterized by multicausality (Einarsen et al., 2011). There has been little research conducted to date by researchers on peer-to-peer bullying and harassment specifically in the field of nursing. Yet over one third of nurses' worldwide report being bullies usually by a peer (Spector et

al., 2014). What was found in the literature review was that most of the research conducted on bullying in the field of nursing in the U.S. has been conducted by nurses.

Many of the articles written by nurses on the subject of bullying in nursing were not research articles at all, but scholarly peer reviewed articles. There were many assumptions that oppression was the cause of the bullying phenomenon in nursing but no articles were found that really tried to prove that nurses were oppressed. It has also been noted that few studies to date have examined the attribute of self-esteem, which is known to be decreased in individuals who are oppressed in correlation with the negative acts of bullying and harassment, which is also a known outcome of oppression. RNs report consistently in studies that bullying and harassment from their peers is a major contributor to their intent to leave their current position (Araujo & Sofiled, 2011; Blackstock et al., 2014; Cho et al., 2012).

Most psychology based studies attribute leaders and the work culture to an environment or work culture that supports or promotes bullying and harassment between peers. Many authors stated that nursing leaders do not educate their nursing staff or hold their nursing staff accountable thus not addressing horizontal violence aggressively enough allowing it to persist between peers (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Cleary, Hunt, & Horsfall, 2010). The work culture theoretical framework and the oppressed group theory are not necessarily adversarial. Both point to an imbalance of power as being the root cause of workplace bullying. Oppressed group theory provides a rationale for why the prevalence of bullying and harassment or horizontal violence is so high as compared to other work industries (Einarsen, 2003).

The question remains what is the cause of a work culture in the field of nursing that feels oppressed and seems to cross over organizational, state, and country boundary lines? In the nursing field, it could be argued that it is oppression from multiple sources. This study's aim was to examine if there is decreased self-esteem in RNs who report bullying and harassment through the NAQ-R and high turnover intentions since low self-esteem is a cardinal attribute of oppression (Garon, 2012; Freire, 1970; Randle, 2001).

### **Self-Esteem**

Self-esteem is the largest determinant of behavior and nothing is more central to an individual's beliefs about themselves than self-esteem (Bandura, 1995). Self-esteem evaluates the emotional side of an individual; it depicts "how I feel about what I am" (Dimitriadou et al., 2014, p. 7). Rosenberg (1965) was the first to describe self-esteem as one's own opinion of their own self-worth. Rosenberg (1965) developed a survey that one could test themselves for their level of self-esteem. Self-esteem is the individual's opinion of themselves and is a basic human need (Mruk, 2013). Epstein (1985) and Tafarodi and Swann (1995) noted that self-esteem was more than just a person's opinion of their own self-worth, but that a second dimension is also present, the dimension of competence. Epstein (1998) further explained how self-esteem was created in the mind of a person by evaluating their experiences their concept of that information is formed then they organize the information they were receiving in a hierarchical format, and then they developed their opinion of their own worthiness and their own competence this opinion is defined as self-esteem (Epstein, 1998).

Low self-esteem is a major problem in the nursing profession (Dimitriadou et al., 2014). Self-esteem is a relative stable personal trait; like most perceptions, it may change over time especially when the person is stressed and unable to cope with a job or a relationship (Ling, Marshall, Xu, & Lin, 2014). Nurses within hospitals have several demographic conditions that may affect a nurse's self-esteem (Ling et al., 2014). Nurses with positive self-esteem are better at communicating and have better relationships (İlhan, Sukut, Akhan, & Batmaz, 2016). Nursing students who have low self-esteem display negative attitudes and behaviors. Within the nursing profession, nursing students are indirectly taught to think of themselves as less valuable than their physician colleagues (Roberts, 1983).

Historically, nursing students are trained to be able to pass the licensure exam, answering questions as would be found on the exam and not learning to articulate their thoughts and opinions on patient care or diagnosis based on their knowledge. Nurses who have a healthy self-esteem are confident, feel good about themselves, take pride in their work, and demonstrate respect and concern for colleagues and patients (Unal, 2012). The roots of high self-esteem may lie in the educational process (Unal, 2012). During the education process, the nursing student is socialized and acquires the concept of her/himself as a nurse (Unal, 2012).

The stereotypical nurse that the general public views on television has done nothing to raise the self-esteem of nurses (Dellasega, 2011). Nurses are typically displayed as "sexy sluts or hard-headed bullies" (Dellasega, 2011, p. 8). The nursing profession attracts individuals who want to care for others at many times at their own

personal expense. Nurses are known to put others needs before their own. They have a preponderant tendency for low self-esteem. Low self-esteem is a defining characteristic of oppression (Freire, 1970).

Low self-esteem has been linked to social anxiety and negative evaluation (Begley & White, 2003). Begley and White (2003) found in their descriptive comparative research with Irish nursing students ( $n = 72$ ), that their self-esteem levels raised as they neared the end of their classwork. However, their highest levels were only at an average level for the general population using the Rosenberg self-esteem scale (Begley & White, 2003). RNs lack professional control, autonomy, and self-esteem (Freshwater, 2000; Roberts, 1983). According to Randle (2001), "Self-esteem influences how RNs think, feel, motivate themselves, and act" (p. 294). Randle (2001) asserted that when someone has a healthy self-esteem, they hold the opinion of themselves as being worthwhile, competent, adequate, secure, and confident. It is an acquired set of beliefs about one's self (Randle, 2001).

Losa Iglesias and de Bengoa Vallejo (2012) conducted a descriptive research study in northern Spain to determine the prevalence of bullying and harassment and levels of self-esteem among 538 RNs, which included 89% female, mean age of 37.7, 41% were staff nurses (not in any type of leadership role). Most were unmarried (57%). Surveys were mailed to all nurses registered to practice in this area (5,997).

The survey instrument consisted of the RSES to measure self-reported self-esteem, the NAQ-R to measure bullying and harassment in the workplace and demographic data to measure prognostic factors of bullying in the workplace (Losa

Iglesias & de Bengoa Vallejo, 2012). To analyze the data, the researchers used t-student, chi-square, and regression analysis procedures (Losa Iglesias & de Bengoa Vallejo, 2012). Statistical significance was used to determine the  $p$  value at a 95% confidence interval.

Results showed that 17% of these RNs had experienced bullying and harassment (Losa Iglesias & de Bengoa Vallejo, 2012). Some RNs (8%) reported experiencing bullying and harassment daily (Losa Iglesias & de Bengoa Vallejo, 2012). RNs who reported having low self-esteem per the Rosenberg scale ( $\leq 27$ ) also showed significantly higher bullying rates ( $p = 0.004$ ) (Losa Iglesias & de Bengoa Vallejo, 2012). Those with higher self-esteem scores ( $>27$ ) showed significantly lower bullying and harassment rates ( $p = <0.001$ ) (Losa Iglesias & de Bengoa Vallejo, 2012).

Einarsen et al. (2011) reported that in Averill's (1982) examination of episodes of anger in adults, a common cause of anger was identified as loss of self-esteem. One's low self-esteem may lead to aggression (Einarsen et al., 2011, p. 213). This supports the school of thought that bullies have low self-esteem.

Losa Iglesias and de Bengoa Vallejo (2012) determined that their study does not support oppressed group theory among nurses because results showed that only the nurses who reported high bullying and harassment activities on the NAQ-R also showed to have low self-esteem on the RSES. They felt that to be supporting of the oppressed group theory all nurses surveyed would have scored low on the RSES or have low self-esteem (Lose Iglesias & de Bengoa Vallejo, 2012). Repetition of this study in another

group of nurses would be interesting to note if the outcomes were similar since lowered self-esteem is the cardinal attribute of an oppressed group member.

It has been stated in many studies that nurses are an oppressed group. There have also been some like Lose Iglesias and de Bengoa Vallejo (2012) to question if nurses are in an oppressed group category. However, there have been few studies that look at the self-esteem of nurses. Bullies have also been noted in studies to have high self-esteem and in others low self-esteem. Looking again at the self-esteem of nurses has merit. Nurses are known to have low self-esteem in general; it could be the reason that such high incidents of bullying are within the nursing profession (Roberts, 1983). Alternatively, it could be that the bullying within the nursing profession causes the lowered self-esteem of its members.

### **Literature Review Related to Key Variables and/or Concepts**

#### **Workplace Bullying and Harassment in Nursing**

In comparison to the general workforce, nurses have the highest rates of workplace violence (Ditmer, 2011). The exact number of bullying and harassment incidents is not known. It is believed that incidents are underreported (Ditmer, 2011; Losa Iglesias & de Bengoa Valljo, 2012). This thought is based on the research review of 136 research articles on violence in the nursing profession by Spector et al. (2014), which claims the rate of bullying among nurses worldwide is 39.7%. It is noted that in several studies wide ranges of prevalence is reported. What needs to be kept in mind is that bullying is subjective. It is also under reported because of fear of retaliation (Ditmer, 2011). It is important to note that many nurses do not realize that bullying and harassment

between peers or lateral violence exists as an actual concept; so they might not even recognize that they are victims. According to Freier (1970), the oppressed usually do not realize they are oppressed.

While peer-to-peer bullying does not have the highest incidence among the sources of bullying and harassment within the profession of nursing, it is thought by many that it should be the type of bullying and harassment that could be the easiest to control or decrease. Woodrow and Guest (2012) compared the consequence of bullying between nursing peers and that of public (patient visitor) violence toward nurses. The former was found to be more detrimental to the health of the RN versus the latter (Woodrow & Guest, 2012). Many contemplate the rationale behind why one nurse would bully or harass another. It is a significant problem within the field of nursing, so much so, that regulating bodies of the healthcare industry felt so inclined to address it.

The Joint Commission, noted that 24% of the reported sentinel events that result in patient death, injury, or permanent loss of function are a result of lack of teamwork and effective communication (TJC, 2009). Bullying and harassment represent a significant portion of these problem behaviors (Ditmer, 2011).

The Joint Commission issued a Sentinel Event Alert on July 8, 2009 that stated, “The safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team” (p. 1). The Joint Commission survey team is focusing more on communication between team members and on teamwork in general according to the



most recent Sentinel Event Alert dated March 1, 2017 from The Joint Commission. In this publication, The Joint Commission recommended that healthcare leaders take action to establish and improve the culture of safety within healthcare organizations (The Joint Commission, 2017). The publication notes that there have been increased reports from healthcare staff to The Joint Commission about encounters of “retaliation, intimidation, hostile actions, subtle passive-aggressive behaviors, negative comments, reluctance and refusal to answer questions, condescending and demeaning language, and lack of collaboration” (The Joint Commission, 2017).

The publication goes on to list eleven actions that The Joint Commission is expecting from healthcare leaders to ensure the hospital is a safe environment for staff and patients alike. Action number 3 states that “all leaders must adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors” (The Joint Commission, 2017, p. 3). This publication is not just referring to nurse to nurse bullying but also the incivility between physicians and nurses and well as other healthcare workers. While there is currently no published evidence of The Joint Commission citing a hospital for nurse to nurse bullying, or for any other type of healthcare worker, this might be changing in the future based on the tone of the latest Joint Commission Sentinel Event Alert publication. They realize that bullying within healthcare is a real problem.

The Joint Commission has learned from their experience of monitoring hospitals across the nation, that patient clinical outcomes are affected by human factors including interrelationships between caregivers. The Joint Commission Standard EC.02.01.01

(Joint Commission Resources, 2010) stated that hospitals are required to maintain a safe environment by creating and maintaining a culture of safety. Hospitals are required to routinely evaluate current practices and procedures to assure caregivers feel free to speak up to each other when an unsafe situation is suspected or observed. This is difficult for leaders to do because 50-80% of horizontal violence goes unreported (Geig, 2010). Establishing a way for hospital leadership to assess if bullying and harassment are prevalent in a particular nursing unit and contributing to a nurse's intent to leave could assist leaders in meeting this Joint Commission Standard.

### **Turnover Intention**

Mobley, Horner, and Hollingsworth (1978) found that intent to leave was a significant predictor of nursing turnover behavior. The theory of planned behavior states that behavioral intentions are key predictors of actual behavior (Ajzen, 1991). Van Breukelen, van der Vlist, and Steensma (2004) conducted a longitudinal study testing the theory of planned behavior. They studied 296 professionals in the Netherlands Navy who completed a survey asking about job satisfaction, years of service, tenure, organizational commitment, attitude towards leaving, behavioral control, intention to leave, and their actual behavior related to turnover. Six months later the same individuals were asked to fill out the same questionnaire again. The turnover of the group was also recorded during this time frame. After two years the group's actual turnover was compared to their reported turnover intention in the previous surveys and it was found to be the best predictor of actual turnover.

In their research Vanderpool and Way (2013) examined work family balance, job anxiety, and turnover intentions as predictors of turnover among health care workers and senior service employees. While Vanderpool and Way's (2013) work was not specifically examining the behavior of nurses, they too found that that turnover intentions were a positive predictor of voluntary turnover as was unmet work life balance and anxiety related to the job. It seems that what was claimed by Mobley, Honer, and Hollingsworth in 1978 holds true today: once nurses develop the intent to leave, the follow-through of leaving an organization is definite.

### **Bullying and Harassment and Turnover Intention**

Researchers have identified the ways in which bullying and harassment physically and mentally affect victims. Some victims find that leaving the organization may be a way to respond and cope with bullying and harassment (McCormack et al., 2009). It is known that bullying and harassment are under reported because of fear of retaliation (Ditmer, 2011). The only way for relief for the victim is to leave the unit or the hospital where the bully is located. With the shortage of nurses, hospital leadership does not want to lose RNs because of its effect on patient safety and the bottom line (Roulin, Mayor, & Bangerter, 2014). Trying to mitigate the turnover prior to it occurring is the desired outcome. According to Griffeth, Hom, and Gaertner (2000), job turnover intention is the best predictor of actual turnover.

Simons and Mawn (2010) reported that the quantitative study conducted by Simons in 2008 examined 511 newly licensed (fewer than three years' experience) RNs from the state of Massachusetts. The participants were mailed a survey that was

distributed using the Tailored Design method to increase the response rate (Simons & Mawn, 2010). Simons and Mawn, explained that the original study design did not aim to use a mixed methods approach; however, when there was such a strong response to the open ended last question on the survey asking the participants to share their experiences with bullying she felt she had a responsibility to analyse their comments.

Simons and Mawn (2010) reported that narratives were written by 184 (36%) of the newly licensed RNs. Personal accounts of being bullied were shared by 139 of the participants with another 14 sharing their accounts of being witnesses to other RNs being bullied (Simons & Mawn, 2010). Using content analysis methodology Simons and Mawn found that four main themes were expressed by these newly licensed RNs. Those themes are described as: bullying from superiors, nurses eating their young, not being part of the clique and intent to leave their current job or the profession of nursing altogether (Simons & Mawn, 2010).

“Nurses eating their young” was directly quoted by 19 of the participants; others described similar experiences without using the actual phrase (Simons & Mawn, 2010). Words used to describe this phenomenon were hostility, barracudas, fearful of ridicule, afraid to ask questions, withholding of crucial patient information, and negativity (Simons & Mawn, 2010). Feeling out of the clique was referred to as being alienated, not part of the group, difficulty fitting in, and perceived they were different because of educational level, ethnicity, or work status (Simons & Mawn, 2010).

One nurse shared that when pregnant she was assigned by the staff nurse in charge of that shift to a human immunodeficiency virus (HIV) infected patient and told to

do her job or leave (Simons & Mawn, 2010). This particular incident could be considered harassment and legal action taken since the nurse was pregnant. Rumors, sarcasm, not helping when asked, and ridiculing someone who had an accent were all reported behaviors associated with not being part of the clique (Simons & Mawn, 2010). Rumors and sarcasm are the type of behavior that most new nurses are not sure how to handle. Providing education to nurses on how to respond to these types of situations is what the nursing literature is starting to focus on (Griffin, 2004). Yet the root of issue or the cause of the problem has not yet been identified.

Lastly, leaving the job was described by the newly licensed RNs as the result of the bullying that they were enduring (Simons & Mawn, 2010). Some even wrote about leaving the profession of nursing altogether. During their orientation period 38 nurses wrote that was the time they considered leaving (Simons & Mawn, 2010). Being the target of gossip was mentioned as a reason they felt they needed to leave one unit for another (Simons & Mawn, 2010).

Nurses felt that during orientation was the time in which they were made to prove themselves worthy to their peers and the time most wanted to leave their jobs (Simons & Mawn, 2010). It was reported that some were purposefully set up by peers to fail even if doing so would negatively affect patient care (Simons & Mawn, 2010). The feeling of powerlessness was an overriding theme (Simons & Mawn, 2010). Einarsen et al. (2011) pointed out that the main attribute of bullying is a power struggle. One comment reflected what most think when reading these accounts—that nurses need to remember that each were new to the profession at one time (Simons & Mawn, 2010).

MacKusick and Minick (2010) contacted RNs who had worked for at least one year, but had not worked in the profession for at least six months. A phenomenological study design was utilized (MacKusick & Minick, 2010). Ten participants were selected by purposive sampling method (MacKusick & Minick, 2010). Current practicing RNs from several hospitals in the southeastern U.S. were asked for names and contact information of RNs who were no longer practicing (MacKusick & Minick, 2010). MacKusick and Minick contacted these RNs and set up face to face interview times. Most of these RNs were female (80%), Caucasian (70%), and had worked for a range of 1-18 years as an RN; all had worked in a hospital inpatient setting (MacKusick & Minick, 2010).

During the conversations, three themes emerged as reasons these RNs had chosen not to return to the field of nursing: (a) unfriendly work environment; (b) emotional distress related to patient care; (c) fatigue and exhaust (MacKusick & Minick, 2010). All RNs reported that an unfriendly work environment was one of the contributing factors they had chosen to leave the profession (MacKusick & Minick, 2010). MacKusick and Minick (2010) attested that the RNs included the follow descriptors of an unfriendly work environment: left alone and ignored by peers, told to toughen up by peers under the auspices of making them better nurses, belittling interactions, sexual harassment, and lack of support in clinical situations; they described the behavior of their peers as being accepted by all as the norm. Many described their experiences as a hazing ritual (MacKusick & Minick, 2010).

Emotional distress was defined by the participants as lack of collaboration between physicians and peers and overly aggressive patient treatment posing an ethical dilemma for them personally (MacKusick & Minick, 2010). The fatigue and exhaustion listed as a causative factor in their decision to leave the profession was related to being constantly exposed to emotional distressing dilemmas and the unfriendly work environment (MacKusick & Minick, 2010).

Collectively, the participants described the work environment as something that no one but another nurse can understand—on off days, nurses in some units need to be on call. They have to remain available to come into work if the unit becomes busy or a peer does not come to work because of illness. Nurses are constantly being asked to work on unscheduled days, always on—both mentally and physically thinking and doing because other people's lives depend on what you do (MacKusick & Minick, 2010). This control of the nurses' work schedule, which also includes clocking in using a time clock for most inpatient nurses is one example of not having autonomy over their own profession.

Raver and Nishii (2010) conducted a research study looking at ethnic harassment, gender harassment, and workplace harassment and their effects on organizational commitment, job satisfaction, and intent to leave. They also looked at the effect all three types of harassment had on depression and physical symptoms. Raver and Nishii used a two item measure of turnover intention that they derived from Hanisch and Hulin (1990). Coefficient alpha was .66, which is lower than the recommended .70 but that is due to the tool only being a two item questionnaire (Raver & Nishii, 2010). The two item tool asked

(a) I am thinking about quitting my job, (b) exploring other job opportunities by checking job listings and want ads.

For the study population, Raver and Nashii (2009) looked at library workers at a university setting in the mid-Atlantic U.S. Of the library's 294 employees, 82% participated in the study. They found that ethnic and gender harassment does not have as high an outcome of turnover intention as does workplace harassment. They make the point, however, that both ethnic and gender harassment are illegal were, as now workplace harassment is not illegal. They believed the reason for the difference is that something more can be done legally to the employee who is harassing someone ethnically or because of gender. When nothing can be done legally, as it is with workplace bullying, the only option is for the harassed employee to leave their position. In their study the coefficient alpha was .75. This same turnover intention tool was used in this study.

The first two studies exhibited that bullying and harassment had an effect on the nurses surveyed wanting to leave their current roles. Withdrawal from bullying is often in the form of turnover (Laschinger & Fida, 2014). There is a known link between bullying and turnover intention. The instruments used to assess turnover intention all were different yet similar. They all asked basic questions such are you planning on leaving your current position. Participants answered these questions using a five point Likert type scale.

Adding to the problem of turnover is the current job availability to nurses. It is not difficult for nurses to leave their roles because they can easily find another one with the



current nursing shortage. This allows nurses to not address the issue straight away but to run from it, which could be reinforcing their low self-esteem.

### **Statistical Analysis**

After reviewing the type of survey data, it was determined that all the data would be ordinal in nature. Ordinal data, as defined by Polit and Beck (2015), is a measurement level that rank orders phenomena along some dimension. The survey tools used for this study all measure subjects' answers using Likert type scales. It was determined from the research questions the number and types of variables being utilized in this study: two independent variables and one dependent. Creswell (2009) listed the type of research to be used based on the number and types of variables. Regression analysis was determined to be the statistical test of choice. After conferring with a Walden University academic support statistics specialist, it was determined that logistic regression would be the statistical analysis of choice for this research project.

### **Summary and Conclusions**

The World Health Organization (2006) identified workplace bullying as a serious public health threat and is reaching epidemic levels worldwide. For the past 30 years, empirical research has been conducted and confirms that workplace bullying is a prevalent social problem that negatively affects not only the individual but the organization and society at large (Nielsen & Einarsen, 2012). It is hard to get a true picture of the prevalence, however, because of underreporting. If nurses are not willing to report the occurrence, the situation cannot improve (Hinchberger, 2009). Many student

nurses accept horizontal violence as a rite of passage, only to mimic the behavior later in their own careers (Hinchberger, 2009).

Bullying and harassment occur in nursing because of oppression of nurses (Roberts, 1983). The oppressed group theory has been used to explain why nurses eat their young or bully and harass peers who are less powerful. Being bullied and harassed leads to nurses wanting to leave their current positions and in some instances, leave the profession (Ditmer, 2011). With the current nursing shortage, this makes safe high quality nursing care more difficult to obtain. Bullying and harassment has been linked to low self-esteem and turnover intention in separate studies but no known studies have yet tried to link all three variable together to date to see how they are related.

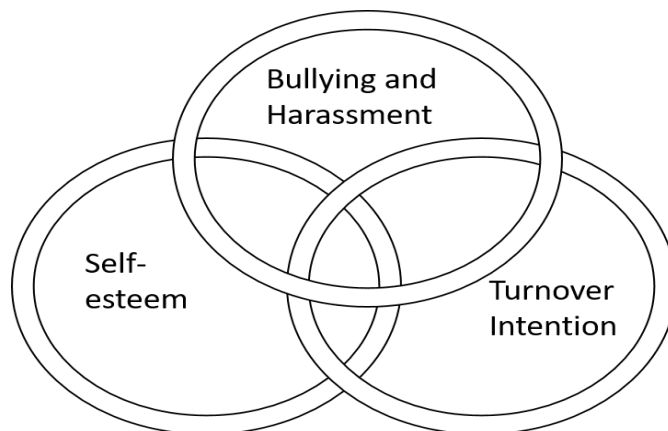
Even though workplace bullying continues to be a serious challenge, no Federal law addressing this issue has been passed (Richardson, Joiner, & Hall, 2016). One state, Tennessee, just passed a law protecting only state government workers from bullying in the workplace (Richardson et al., 2016). The first law to protect those who were bullied at work was passed in Sweden in 1993 (Richardson et al., 2016). Research on the topic of bullying started in the U.S. about 20 years behind the work in Europe. Based on that timeline, maybe federal laws protecting U.S. workers is not in the too distant future.

There is a gap in the literature where the profession of nursing and bullying and harassment are concerned. It is known that there is a high prevalence of bullying and harassment within the nursing profession (Ditmer, 2011). It is known that there is high turnover within the field of nursing (Roulin et al., 2014). Araujo and Sofield (2011) called for more research to be done to link verbal abuse to intent to leave among nurses.

It is also known that nurses have low self-esteem compared to the average individual (Begley & White, 2003; Dimitriadou et al., 2014; Losa Iglesias & de Bengoa Vallejo, 2012). There have not been any studies previously that have looked at the effect that the three following variables have on each other, bullying, harassment, turnover intention, and self-esteem. The relationship these variables have on each other remains unknown and this study hopes to fill that gap. Chapter 3 is an explanation of the research design, instrumentation, data collection methodology, and analysis procedures.

### Chapter 3: Research Method

The primary focus of this study is to examine if there are any relationships between three variables: bullying and harassment, turnover intention, and self-esteem among inpatient RNs (see Figure 2).



*Figure 2.* Visual of study purpose.

The intersecting areas show where these three variables may interact or have a relationship with each other. What that relationship might be is not known. The purpose of this study is to discover if a relationship between these variables exists.

In this chapter, the research design and rationale are reviewed. The population, study setting, and sample group of this study will also be examined. The procedure for conducting the study, the instruments that were used, and the process for data analysis were explored. Finally, threats to validity, ethical considerations, and a final summary conclude this chapter.

A quantitative nonexperimental descriptive comparative study approach was adopted as the research strategy. Three research questions were explored:

*RQ1:* Are there significant relationships among inpatient nurses' reported bullying and harassment experience as assessed by the NAQ and their individual self-esteem as assessed by the RSES with intent to leave the organization as assessed by the Turnover Intentions Measure TIM?

*H<sub>01</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem do not predict their intent to leave the organization.

*H<sub>A1</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem predict their intent to leave the organization.

*RQ2:* Will self-esteem as measured by the RSES of inpatient nurses who report having experienced bullying and harassment as measured by the NAQ be higher or lower than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ?

*H<sub>02</sub>:* Inpatient nurses who report experiencing negative acts as measured by the NAQ will not have a lowered self-esteem score as reported on the RSES.

*H<sub>A2</sub>:* Inpatient nurses who report experiencing bullying and harassment as measured by the NAQ will have a lowered self-esteem score as reported on the RSES.

*RQ3:* Are there higher reports of bullying and harassment as measured by the NAQ among inpatient nurses who report higher intent to leave as measured by the TIM?

*H<sub>03</sub>:* Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will report intent to leave as measured by the TIM.

*H<sub>A3</sub>*: Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will not report intent to leave as measured by the TIM.

The NAQ, RSES, and TIM are the instruments used in this study.

### **Research Design and Rationale**

In this study, three variables were measured or observed. There were two independent variables (self-esteem and bullying and harassment) and one dependent variable (turnover intention). Independent or predictor variables are those variables that affect, influence, or cause outcomes in the dependent variables (Creswell, 2009). Dependent or outcome variables are those that depend on or are influenced by the independent variables (Creswell, 2009). An experimental research design was inappropriate for this work because self-esteem and bullying and harassment cannot be manipulated. A survey research design was used. The survey was cross-sectional, with data collected at one point in time through the use of three different self-administered survey questionnaires. There were no other time or resource constraints with this design choice. Demographic characteristics including age, gender, work unit, and educational level were examined for any relationship patterns with the variables as well.

### **Methodology**

#### **Population**

As of 2016, there were 2,955,200 RNs employed in the U.S. (BLS, 2016). According to the BLS (2016), there are more RNs than any other healthcare occupation. Nationwide, RNs accounted for nearly two of every 100 employed persons (BLS, 2016).

The BLS (2016) reported that inpatient RNs make up the largest portion of RNs in the U.S.; specifically, of the 2,955,200 employed RNs in the U.S., 61% work in inpatient hospital settings. As of October 2017, which was the latest licensure renewal date for RNs in Ohio at that time, 78,889 individuals were noted to be licensed as RNs in Ohio (E. Mays, personal communication, December 15, 2017).

### **Setting and Sample**

A nonprobability sample (specifically a purposeful sample) was used in this study, involving all RNs licensed in the state of Ohio. The state of Ohio maintains a list of all RNs licensed in the state, including their email addresses. This list is updated every 2 years when RNs renew their nursing licenses or new RNs become licensed in Ohio. This list is made available to individuals for research purposes and is considered public domain. The list was received from the state of Ohio's Board of Nursing in January 2018.

Only approximately one third of surveys are returned at best in research studies, so all 78,889 licensed RNs in the state of Ohio were invited to participate (only 208 participants were necessary to meet the requirements of the population sample as indicated by the power analysis). Participants were asked within the demographics section of the survey if they were working full or part time and in a specific inpatient hospital unit. Noting what type of patient care unit nurses work on is important because it is thought that some patient care areas are more prone to bullying and harassment than others. There are higher reported incidents of bullying and harassment in medical surgical and critical care patient care units (Vessey et al., 2011). In this particular study, by asking what unit the RN primary worked in, it could be evaluated if this phenomenon held true.

These types of units are fast paced and nurses in these types of units are caring for either the most critically ill patients or have high nurse to patient ratios. Both scenarios are cause for high stress environments. It would stand to reason then that nurses working in these areas are highly stressed, which is identified in some studies as the type of environment that supports bullying (Vessey et al., 2011).

Study inclusion criteria were as follows: full or part time licensed RN in the state of Ohio who works in an inpatient hospital setting. Exclusion criteria details that the study participants cannot be per diem, travelers, or floating staff members, as these staff members are not fully part of the regular team working on any one unit. They could not be Licensed Practical nurses or nurse's aides. To be considered for inclusion in this study, participants could not be in an educational or administrative role or in any other nursing role, but that of a direct bedside caregiver.

The targeted number of participants was 208 RNs who are licensed in the state of Ohio as a RN and work in an inpatient hospital care unit. To assure that the correct number of appropriate participants were obtained and to add strength to the study by surveying more RNs who met the criteria, all 78,889 licensed RNs in the state of Ohio were asked to participate. It is noted that most participants have good intentions of completing a survey when asked, but only about one third will do so (Baruch & Holtom, 2008; Ziegenfuss et al., 2014). By inviting all licensed RNs in Ohio to participate, it was hoped that there was a better chance of obtaining the minimum number (208) of inpatient direct patient RN caregivers to participate. By inviting all RNs in Ohio, the thought was



more RNs would complete the survey by the deadline and that a greater number of RNs meet the study criteria and would participate giving greater strength to the study.

### **Procedure**

The three survey tools (NAQ-R, RSES, and TIM) along with the demographics were placed into one document, which was then uploaded in to SurveyMonkey. Email addresses of all RNs licensed in the state of Ohio was received in three Excel spread sheets from Ohio Board of Nursing. No RNs on the list had specified that they did not want to receive research questionnaires at the email address they had given to the Ohio Board of Nursing. Once Walden Internal Review Board's permission was obtained, an invitation to participate was sent per email to all RNs licensed in the state of Ohio.

It was made clear to participants that they could drop out at any time without retribution or penalty. They were also informed that their confidentiality would be highly regarded throughout the research process and even upon dissemination of the results.

All potential RN participants were asked for their support in furthering knowledge about the nursing profession by completing the SurveyMonkey online survey. Confidentiality was also explained to participants and was maintained throughout the process. There was no identifying data included in the survey items.

Each invitee who chose to participate agreed to the terms of the implied consent by clicking on the link embedded in the email, which linked them to the SurveyMonkey survey site. The survey was designed that if participants completed the survey they indicated their implied consent. The email invitation to participate notified participants of the procedure, the confidentiality protocol, the voluntary nature of their participation, the

risks of participating, and the benefits of being part of the study. The researchers' contact information was included so the participants could contact the researcher by email with any questions. The return of the survey signified the invited participant's willingness to participate in the study.

Emails needed to be sent out in batches because of the settings on Gmail not allowing mass mailings to discourage marketing scams. Initially emails were sent out to addresses putting their emails in the "to" box on Gmail. Some email comments were received from some invited participants back to the primary investigator that they did not appreciate their personal emails being shared with other invites. (They did not realize that their emails were public domain since they sent them to the Ohio Board of Nursing). Going forward, all invitees' emails were sent with the email addresses in the blind copy box so no one could see other invitees' email address. Reminder emails were sent one week after the initial emails were sent. No incentives to participate were offered. It was not necessary for any extensions of time for completion of the surveys to be given, because eight times the number of needed participants responded within the initial two-week timeframe.

Once the data was obtained, the data was reviewed and participants who gave incomplete responses, did not meet the inclusion criteria (working as a staff nurse at the bedside in an inpatient hospital setting, or working full or part time), were excluded from further evaluation. Using the Statistical Package for Social Science (SPSS) software, the data was analyzed using logistic regression statistical measures and Pearson correlation. Results are further explained in chapter 5. After the results are obtained, documented, and

approved through Walden University, dissemination of the data was attempted via national conferences presentations and peer reviewed journals.

## **Instruments**

### **Demographics**

The participants who volunteer to join the study were asked to complete some demographic data including age stated as a continuous variable, gender dummy coded (female = 0 and male = 1), area of hospital is their primary work area; (critical care, emergency room, medical surgical obstetrics, oncology, pediatrics, perioperative, and psychiatry); Their level of education; (Associate degree, Diploma program, Bachelor's degree, Master's degree, Doctorate of Nursing Practice, [DNP], Doctorate of Philosophy [Ph.D.]).

Participants were also queried if they worked in a hospital as a bedside staff nurse. If they answered "no" to this question, their survey answers were eliminated from the study since the focus of this research is on bedside inpatient staff nurses. Participants were also asked if they worked full time, part time, per diem, or PRN or on occasion, worked as a float nurse, or a traveling nurse. If they answered this question with a response other than "full or part time," all of their survey answers were eliminated from the study. Following data collection the data was exported into an Excel file then entered into SPSS for analysis (see Appendix D).

### **NAQ-R**

The NAQ-R will help determine if the participant has been bullied and harassed at work. The questionnaire describes behaviors that could be perceived as bullying or

harassment but does not use those terms. It is designed to assess perceived exposure to bullying and harassment. Bullying as defined by Einarsen et al. (2009) as it is applied in the NAQ-R in situations where an employee is persistently exposed to negative and aggressive behavior of a psychological nature with the effect of humiliating, intimidating, and frightening or punishing the target. Bullying constitutes evolving and often escalating hostile work relationships over a period of time (Einarsen et al., 2009, p. 25). Harassment is also assessed by the NAQ-R and refers to sexual harassment (Einarsen et al., 2009).

The NAQ-R is a 22-item scale that was developed by Einarsen to overcome the cultural bias noted in the original NAQ that was developed in Norway and showed a Nordic cultural bias tendency. Einarsen developed the NAQ-R that is known to be “reliable, valid, comprehensive yet relatively short and made to be used in a variety of occupational settings and adapted to Anglo-American cultures” (Einarsen et al., 2009, p. 27).

The NAQ-R is a widely used tool to assess bullying, harassment, and incivility (Einarsen et al., 2009). This scale is a forced choice instrument requiring an answer for each question. The NAQ-R is one of the most widely used instruments to measure workplace bullying and harassment (Einarsen et al., 2009). The instrument itself uses a five-point Likert type scale with 1 = *never*, 2 = *now and then*, 3 = *monthly*, 4 = *weekly*, and 5 = *daily*. The score for workplace bullying and harassment is obtained by adding the scores on the 22 items.

Einarsen et al. (2009) used the NAQ-R to investigate the psychometric properties of the tool. In this study of 5,288 workers, the NAQ-R showed to have Cronbach’s alpha

of .90, indicating excellent internal consistency. In Einarsen et al. (2009) study the NAQ-R functioned as expected. It correlated with all measures used in the study, leadership, mental health, and psychosocial work environment which indicated good construct validity of the NAQ-R.

Einarsen was contacted to glean his permission to use this tool, which he granted (see Appendix E). Following data collection, the data was exported into an Excel file then entered into SPSS for analysis (see Appendix F).

## **RSES**

The RSES is one of the most commonly used measures of self-esteem (McMullen & Resnick, 2013; Webster, Smith, Brunell, Paddock, & Nezelek, 2016). The scale was originally designed to measure adolescents' feelings of self-worth. This scale has become the gold standard for several different groups to measure self-esteem (McMullen & Resnick, 2013).

The scale encompasses 10 items in which participants answer on the four-point Likert type scale (Webster et al., 2016). The scale ranges from strongly agree to strongly disagree (McMullen & Resnick, 2013). Scoring ranges from zero to 40 with higher scores indicating higher self-esteem (Rosenberg, 1965). The reliability and validity of this instrument indicates an internal consistency of 0.77 with a minimum coefficient of reproducibility of at least 0.90 (Rosenberg, 1965).

In a recent meta-analysis of 10 research studies using RSES conducted by Webster et al. (2016) the RSES was found to be stable within person variability and convergent validity. Webster et al. also consistently found high test retest reliability.

Scoring for the RSES is as follows: For items 1, 2, 4, 6, and 7 *strongly agree* = 3; *agree* = 2; *disagree* = 1; *strongly disagree* = 0. For items 3, 5, 8, 9, and 10 *strongly agree* = 0, *agree* = 1, *disagree* = 2, *strongly disagree* = 3. The scale ranges from 0-30. Scores ranging from 15 to 25 are within normal range; scores below 15 suggest low self-esteem (Appendix G).

### **TIM**

Turnover intention measure is a two-item scale that was developed by Raver and Nishii (2010). Respondents indicate the frequency on a scale ranging from 0 to 7. The items asked participants to think about quitting their job and if they exploring other jobs by checking job listings or want ads (Appendix H).

### **Data Analysis**

I used SPSS for the regression analysis; this enabled me to test the existence of predictable relationships between data obtained from the three survey tools: NAQ-R, RSE scale, and TIM. There are three components to determining statistical power. They include alpha or significance level, sample size, and the limitations of the effect size (Faul, Erdfelder, Buchner, & Lang, 2009). Alpha levels need to be set to avoid making either a Type I or a Type II error. A Type I error is the probability of rejecting the null hypothesis when it is in fact true. A Type II error is when a researcher accepts the null hypothesis when it is in fact false. In simplistic terms, Type I is when a researcher finds things that are not there and Type II is when a researcher fails to find things that are there (Grimm & Yarnold, 1997). For this particular study, the alpha levels were set at 0.05 and .90 respectively.

For this study, the common alpha level of 0.05 and power level of 0.90 were used. A power analysis using G\*Power (a free online statistical power analysis tool) determined that the number of nurses needed in the study was a minimum of 208 to render statistical power (Faul et al., 2007; Appendix B). To ensure enough responses were obtained, all RNs licensed in the state of Ohio were invited to participate. Since the return rate on surveys is approximately one third, according to Baruch and Holtom (2008), all were invited so as to assure a minimum of 208 respondents so as to render statistical significance. To determine the type of statistical analysis to use, other researchers were questioned as to what their method of choice would be for this type of study and what resources they would use. Two books were recommended and used to review the different types of statistical testing available for the type of data this research study will produce.

Logistic regression analysis analyzes the relationship between multiple independent variables and a dependent variable and yields a predictive equation (Polit & Beck, 2012). Logistic regression is used to predict categorical dependent variables (Polit & Beck, 2012; Tabachnick & Fidell, 2014). As the three survey tools and the demographic questions that were utilized all use a Likert type scale for reporting their answers, all the data received was categorical in nature. Using a logistic regression analysis statistical technique illustrates the cause self-esteem and bullying and harassment have on nurse turnover intention. The relationship and prediction of cause and effect of the independent variables upon the dependent variable is the statistical question being asked (Polit & Beck, 2012).

Pearson correlation coefficient is one of the oldest statistical methods use. Originating in the 1800s, its purpose is to scale the relationship between two variables (Frey, 2016). The range of the Pearson Correlation coefficient is -1.0 to +1.0. An absolute value reflects the strength of the relationship (Frey, 2016). Frey explains that the closer to zero the weaker the association, the farther away from zero the stronger the association. The negative or positive sign indicates the direction of the relationship. Negative correlations can still be high and strong (Frey, 2016).

### **Threats to Validity**

There are two types of threats to validity that a researcher should be concerned about: internal and external (Creswell, 2009). Internal threats “are those experiments, procedures, treatments or experiences of the participants that threaten the researcher’s ability to draw correct inferences” from the data gathered (Creswell, 2009, p. 162). Because this particular study was not a randomized controlled study that introduces a treatment, the survey was sent out to a large group of RNs who all had an equal opportunity to reply within a two-week timeframe thus selection process is not a threat to validity. Maturation may be of concern because nurses range in age from their early 20s to late 70s. Some younger nurses may not realize that what they are experiencing is labeled bullying while older nurses may take for granted that the behavior they are used to is normal. Mortality was being accounted for again with the short timeframe to answer the survey questions one time and by recruiting a larger than needed number helps to assure there are enough participants to meet the power analysis requirements.



Compensation and compensatory rivalry was not an issue since there was no control group in this study.

Threats to external validity arise when researchers draw incorrect conclusions from the data gathered in their study and infer those results upon another group (Creswell, 2009). For example, in this particular study we examined RNs from across the state of Ohio and how they feel about bullying and harassment, self-esteem, and turnover intention. While this study is looking at inpatient RNs in particular, the nurses invited to participate were from a wide variety of settings, inpatient and outpatient, rural and urban. Based on how they answered some of the demographic questions some participants were excluded because they did not work in an inpatient hospital setting. Others were excluded because they were not involved directly with patient care. Therefore nurses who work in education, administration, or in other roles that exclude them from working at the patient's bedside were not included in this study. The researcher cannot make inferences that the results of this study would apply to nurse leaders, educators or nurses in roles other than those at the bedside. Nurses from inpatient hospital units, specifically critical care and medical surgical units, have been reported to have the highest bullying and harassment incidence (Vessey et al., 2011).

### **Ethical Consideration**

This study was reviewed by Walden University IRB prior to commencing. IRB assigned approval number 02-20-18-0150193 to this study. IRB review and approval assures that all ethical and privacy protection standards are in place. However, it was still up to the primary investigator to assure all these standards were met and maintained.

Confidentiality and anonymity as required for any study was maintained throughout the process. Informed invitation letters were used. Participation was voluntary and if invited participants wanted to withdraw their participation at any time, they could do so. All records are stored in a secure password protected electronic file through SurveyMonkey and in SPSS. All tools used have been used in the past without reported problems so no expected risks of high anxiety or stress on the part of the participant were anticipated or realized.

### **Summary**

Araujo and Sofield (2011) have called for more research to be done in the area of nursing turnover intention and bullying and harassment. There is a gap in the literature addressing any kind of actual association between the oppressed group theory whose primary symptom is decreased self-esteem and nursing. Chapter 3 detailed the sampling and methodology of this study. This quantitative comparative descriptive study evaluates the relationships (if any) between bullying and harassment, self-esteem, and turnover intention. Nurses from across the state of Ohio were invited to participate and used as the sample group. A minimum of 208 RNs were needed for this study.

As was stated above, three survey tools were used: the NAQ-R, the RSES, and the TIM. Along with demographic data all the survey items were in Likert type format. SurveyMonkey, the secure research platform, was utilized to contact the sample group and receive response to the survey tool. A logistic regression analysis using SPSS is used to test the proposed relationships. Ethical considerations were outlined. The tools used were examined in detail, as were the demographic data questions that were collected.

This research study is important because it is adding to the knowledge base about the phenomenon of bullying and harassment in nursing. Bullying and harassment are known to be associated with nursing turnover. There is a worsening nursing shortage in the U.S. that affects patients' quality of care, healthcare organizations bottom line, and nurse work satisfaction/turnover intention.

Ultimately, the nursing shortage could affect access to healthcare for all Americans if it continues as it is now, which would negatively affect our whole society. It is imperative that we learn more about the causes and the relationships of what is attributing to this bullying behavior among nursing professionals so we can positively influence society by learning how to mitigate bullying within the ranks of nursing. It is noteworthy that the professionals who are viewed as being the most trusted and ethical of all professionals by the public for the last 15 out of 16 years according to Gallup Poll, which is conducted annually (American Nurses Association, 2016) are so vicious to one another. This research is needed to facilitate a better understand of this phenomenon. It adds to the knowledge base and helps us develop mitigation strategies to help stabilize the U.S. nursing workforce, which in turn will change and benefit society at large positively. In Chapter 4, the results of the study are discussed.

## Chapter 4: Results

The purpose of this quantitative nonexperimental study was to determine if there is a relationship between the variables of self-esteem, bullying and harassment, and RN turnover intention. How these variables related to the collected demographic data regarding gender, age, educational level, employment status, and clinical area within the hospital setting was also examined. This study had three research questions and hypotheses which guided this study:

*RQ1:* Are there significant relationships among inpatient nurses' reported bullying and harassment experience as assessed by the NAQ-R and their individual self-esteem as assessed by the RSES with intent to leave the organization as assessed by the TIM?

*H<sub>01</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem do not predict their intent to leave the organization.

*H<sub>A1</sub>:* Inpatient nurses' reported bullying and harassment experience and individual self-esteem predict their intent to leave the organization.

*RQ2:* Will self-esteem as measured by the RSES of inpatient nurses who report having experienced bullying and harassment as measured by the NAQ be higher or lower than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ?

*H<sub>02</sub>:* Inpatient nurses who report experiencing negative acts as measured by the NAQ will not have a lowered self-esteem score as reported on the RSES.

*H<sub>A2</sub>*: Inpatient nurses who report experiencing bullying and harassment as measured by the NAQ will have a lowered self-esteem score as reported on the RSES.

*RQ3*: Are there higher reports of bullying and harassment as measured by the NAQ among inpatient nurses who report higher intent to leave as measured by the TIM?

*H<sub>03</sub>*: Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will report intent to leave as measured by the TIM.

*H<sub>A3</sub>*: Inpatient nurses who report experiencing higher levels of bullying and harassment as measured by the NAQ will not report intent to leave as measured by the TIM.

The NAQ-R, RSES, and TIM are the instruments used in this study.

The focus of this chapter is to present the results of the qualitative analysis used to test the research questions. The secondary objective of this study was to determine if there was a difference in turnover intention, self-esteem, and bullying and harassment experience, in terms of categorical demographic variables including gender, level of nursing education, employment status, and primary work area, and if there was a relationship between the continuous demographic variable age and turnover intention, self-esteem, and bullying and harassment experience. Study outcomes are also presented in various tables and graphs with narrative discussions and explanations throughout this chapter. First, the demographic data were shared. Second, the results of the statistical analysis of the study variables were reviewed. Lastly, the outcomes of the multiple linear regression analysis and other statistical methods used to address the research questions are presented.

### Statistical Analysis

Data were imported from SurveyMonkey into SPSS version 23 for Windows for data analysis. Data were carefully examined using frequency tables. The RSES erroneously had an answer option of number 5 as an options to choose. The RSES is on a four point Likert type scale. They survey gave an option to select number 5 even though only four choices were available: strongly agree, agree, disagree, and strongly disagree. There were 10 subjects who were excluded from the survey due to selecting number 5 as a choice in the RSES. Additionally, subjects were only included in the analysis if they answered the following questions as indicated below:

*Q4:* Do you work within a hospital as a bedside staff nurse? (Include subjects with responses "Yes")

*Q5:* Do you work full-time or part-time? (Include subjects with responses "Full-time" or "part-time")

*Q6:* What area of the hospital is your primary work area? (Exclude subjects with response: "Non-applicable, I do not work in a hospital.")

After data cleaning, frequency tables and descriptive statistics were used to summarize the demographics and survey responses. Cronbach's alpha coefficients were computed for TIM, RSES, and NAQ-R to determine the reliability of each of the tools. The general guidelines for alpha values are: 0.90 to 1.0 are excellent, 0.80 to 0.89 are good, 0.70 to 0.79 are acceptable, 0.60 to 0.69 are questionable, 0.50 to 0.59 are poor, and below 0.50 are unacceptable (Cronbach, 1951).

Descriptive statistics were used to summarize the three study variables. Normality of the three study variables were assessed via the Shapiro-Wilk tests and the QQ plots. All analyses were performed at the overall level (using the whole sample) and by clinical unit (i.e., primary work area in the hospital). For all analyses, a p-value less than 0.05 indicated significance.

It was found that the data were not normally distributed. Multiple linear regressions justified by the bootstrap technique and non-parametric analyses were conducted by means of the Spearman's rank correlations, Mann-Whitney U tests, and Kruskal-Wallis tests to analyze the three research questions. The bootstrap technique involves repeatedly resampling the sample instead of resampling the population, which enables application of statistical inference without distributional assumptions, such as homoscedasticity and normality (Vogt & Johnson, 2011). The bootstrap technique is recommended for testing of results of parametric statistical tests when model assumptions of the parametric tests are violated (Lavrakas, 2008). The bootstrap technique with 500 resamplings was implemented in SPSS version 23.

To answer RQ1, multiple linear regression was used. The dependent variable was turnover intention as measured by TIM, and the two independent variables were bullying and harassment experience as measured by NAQ and self-esteem as measured by RSES. The bootstrap technique with 1000 resamplings implemented in SPSS version 23 confirmed the robustness of using multiple linear regression as the parametric approach. To answer RQ2 and RQ3, Spearman's rank correlation coefficients were computed between RSES and NAQ-R, and between NAQ-R and TIM.

When looking at the data from the reported unit level the Mann-Whitney U tests (for demographic variables with two levels, including gender and employment status) and Kruskal-Wallis tests (for demographic variables with more than two levels, including highest level of nursing education and primary work area) were used to determine if there was a difference in all three measures, TIM, RSES, and NAQ-R with each reported work area. These were measured according to the categorical demographic variables, including gender, highest level of nursing education, employment status, and primary work area. Spearman's rank correlation coefficients were used to determine if there was a relationship between the continuous demographic variable, age, and TIM, RSES, and NAQ-R.

### **Summaries of Demographic Information**

The survey invitation was sent to 78,889 licensed RNs in the state of Ohio. Of the original 78,889 RNs licensed in the state of Ohio listed on the Board of Nursing list, none opted out of having their email made available to researchers. Invitations to participate in the study were sent to all 78,889 RNs in the state of Ohio. Of those 78,889 surveys emailed, 1,077 were undeliverable because the RNs email address is no longer valid for a variety of reasons (e.g., no longer at that place of business, or they had changed their email address). The total N size minus the rejected emails is a total of 77,812 invited participants. From the 77,812 potential respondents, 1,665 RNs responded to the survey within the two-week timeframe. This is a 2.1% response rate, which is lower than anticipated.



Of the 1,665 respondents, 885 responses needed to be eliminated from consideration in this study because they did not meet the criteria of being an inpatient bedside nurse working in a hospital. Many were administrators and educators, some worked in outpatient settings. There were 10 respondents that erroneously answered the RSES questions by selecting number five on a four-point Likert scale, so their surveys were eliminated. This reduced the final sample size to a total of 770 qualified respondents who participated in the study.

The following demographic questions were posed to participants of this study: What is your gender?; What is your age?; What is your highest level of nursing education?; Do you work within a hospital as a bedside staff nurse?; Do you work full time, part time, PRN Per Diem, or occasionally, as a float nurse, as a traveling nurse?; and What area of the hospital is your primary work area? (See Appendix D). The demographic survey showed that the number of male participants ( $n = 93$ ) was significantly fewer than female participants ( $n = 835$ ). Within the profession of nursing throughout the United States, 11% of RNs are male (U.S. BLS, 2018). Therefore the sample percentage of males versus females in this study adequately reflects the actual U.S. RN population in regard to gender (see Table 3).

Table 3

*Sample Gender*

<i>Answer Choices</i>	<i>Responses</i>
<i>Male</i>	<i>10.1%</i>
<i>Female</i>	<i>89.9%</i>

The age of the survey subjects varied from ages 20-71. The average age of the participants was 39.53 (SD = 12.87) years. Half of RNs are over the age of 50 according to the most recent National Nursing Workforce study completed in 2017 (National Collaboration of State Boards of Nursing [NCSBN], 2017). This is down from 53% of nurses being over 50 years of age in 2013 (NCSBN, 2017).

Table 4

Sample Age			
Age	Mean	Min	Max
	39.53 (12.87)	20	71

The majority of participants worked full-time (87.8%). Over half of the participants (54.2%) had a bachelor's degree in nursing. This is a higher percentage of BSN prepared RNs than the latest report from 2016 from the National Board of Nursing Council of State Boards of Nursing that reported in 2016 that 46.2% of entry level nurses were BSN prepared, and 53.8% were non BSN prepared (NCSBN, 2016).

Primary work areas were included in the demographics of this study because previous studies had found differences in bullying and harassment and turnover intention based on clinical area the RN worked. In this study the top three primary work areas in a hospital reported were: medical surgical (31.3%), critical care (25.2%), and emergency department (13.4%). See all reported primary work areas in Table 5.

Table 5

*Sample's Level of Education, Employment Status, and Primary Work Areas*

		Frequency (%)
Highest Level of Education	Associate Degree	258 (33.5)
	Diploma Program	46 (6.0)
	Bachelor's Degree	417 (54.2)
	Master's Degree	49 (6.4)
Employment Status	Full Time	676 (87.8)
	Part Time	94 (12.2)
Primary Work Area	Critical Care	194 (25.2)
	Emergency Department	103 (13.4)
	Medical-surgical	241 (31.3)
	Obstetrics	66 (8.6)
	Oncology	29 (3.8)
	Pediatrics	46 (6.0)
	Perioperative	61 (7.9)
	Psychiatry	30 (3.9)

Tables 6-8 summarized the survey responses of TIM, RSES, and NAQ-R. For TIM, the mean response scores of the two items were 3.23 and 3.33. For RSES, the mean response scores of the positively-worded items (items 1, 2, 4, 6, and 7) ranged from 3.21

(item 7: On the whole, I am satisfied with myself) to 3.69 (item 2: I feel that I have a number of good qualities); the mean response scores of the negatively-worded items (items 3, 5, 8, 9, and 10) ranged from 1.55 (item 5: I feel I do not have much to be proud of) to 2.26 (item 8: I wish I could have more respect for myself). The mean response scores for the 22 NAQ-R items ranged from 1.28 (item 22: Threats of violence or physical abuse or actual abuse) to 2.67 (item 21: Being exposed to unmanageable workload).

Table 6

*Frequency Count (%) of Responses for the TIM*

Frequency counts (%) of responses and Likert Scale								
	1	1	3	4	5	6	7	Mean (SD)
Items 1	108 (14.0)	222 (28.8)	147 (19.1)	80 (10.4)	89 (11.6)	66 (8.6)	58 (7.5)	3.33 (1.81)
Item 2	110 (14.3)	209 (27.1)	149 (19.4)	93 (12.1)	130 (16.9)	61 (7.9)	18 (2.3)	3.23 (1.64)

Table 7

*Frequency Count (%) of Responses for the RSES*

Frequency counts (%) of responses and Likert Scale					
	1	2	3	4	Mean (SD)
Item 1	10 (1.3)	24 (3.1)	250 (32.5)	486 (63.1)	3.57 (0.62)
Item 2	4 (0.5)	8 (1.0)	213 (27.7)	545 (70.8)	3.69 (0.52)
Item 3*	373 (48.4)	320 (41.6)	65 (8.4)	12 (1.6)	1.63 (0.70)
Item 4	2 (0.3)	24 (3.1)	334 (43.4)	410 (53.2)	3.50 (0.57)
Item 5*	423 (54.9)	277 (36.0)	60 (7.8)	10 (1.3)	1.55 (0.69)

*“table continues”*

Item 6	9 (1.2)	72 (9.4)	389 (40.5)	300 (39.0)	3.27 (0.68)
Item 7	7 (0.9)	83 (10.8)	421 (54.7)	259 (33.6)	3.21 (0.66)
Item 8*	175 (22.7)	269 (34.9)	277 (36.0)	49 (6.4)	2.26 (0.88)
Item 9*	205 (26.6)	277 (36.0)	249 (32.3)	39 (5.1)	2.16 (0.88)
Item 10*	281 (36.5)	270 (35.1)	187 (24.3)	32 (4.2)	1.96 (0.88)

Table 8

*Frequency Count (%) of responses for the NAQ-R*

	Likert Scale					Mean (SD)
	1	2	3	4	5	
Item 1	291 (37.8)	294 (38.2)	47 (6.1)	94 (12.2)	44 (5.7)	2.10 (1.20)
Item 2	295 (38.3)	265 (34.4)	60 (7.8)	88 (11.4)	62 (8.1)	2.17 (1.27)
Item 3	291 (37.8)	227 (29.5)	43 (5.6)	97 (12.6)	112 (14.5)	2.37 (1.45)
Item 4	353 (45.8)	248 (32.2)	61 (7.9)	74 (9.6)	34 (4.4)	1.95 (1.15)
Item 5	274 (26.5)	313 (40.6)	57 (7.4)	76 (9.9)	50 (6.5)	2.11 (1.18)
Item 6	259 (33.6)	288 (37.4)	57 (7.4)	105 (13.6)	61 (7.9)	2.25 (1.27)
Item 7	393 (51.0)	227 (29.5)	49 (6.4)	69 (9.0)	32 (4.2)	1.86 (1.13)
Item 8	362 (47.0)	259 (33.6)	59 (7.7)	62 (8.1)	28 (3.6)	1.88 (1.09)
Item 9	559 (72.6)	132 (17.1)	28 (3.6)	36 (4.7)	15 (1.9)	1.46

*“table continues”*

						(0.91)
Item 10	547 (71.0)	149 (19.4)	20 (2.6)	37 (4.8)	17 (2.2)	1.48 (0.93)
Item 11	403 (52.3)	242 (31.4)	48 (6.2)	50 (6.5)	27 (3.5)	1.77 (1.05)
Item 12	364 (47.3)	249 (32.3)	50 (6.5)	58 (7.5)	49 (6.4)	1.93 (1.19)
Item 13	408 (53.0)	210 (27.3)	49 (6.4)	72 (9.4)	31 (4.0)	1.84 (1.14)
Item 14	197 (25.6)	334 (43.4)	66 (8.6)	105 (13.6)	68 (8.8)	2.37 (1.24)
Item 15	614 (79.7)	114 (14.8)	11 (1.4)	17 (2.2)	14 (1.8)	1.32 (0.77)
Item 16	401 (52.1)	213 (27.7)	47 (6.1)	60 (7.8)	49 (6.4)	1.89 (1.21)
Item 17	519 (67.4)	182 (23.6)	30 (3.9)	25 (3.2)	14 (1.8)	1.48 (0.86)
Item 18	373 (48.4)	220 (28.6)	48 (6.2)	66 (8.6)	63 (8.2)	2.00 (1.28)
Item 19	446 (57.9)	193 (25.1)	64 (8.3)	31 (4.0)	36 (4.7)	1.73 (1.08)
Item 20	520 (67.5)	166 (21.6)	21 (2.7)	37 (4.8)	26 (3.4)	1.55 (1.00)
Item 21	164 (21.3)	288 (37.4)	78 (10.1)	118 (15.3)	122 (15.8)	2.67 (1.38)
Item 22	642 (83.4)	82 (10.6)	19 (2.5)	16 (2.1)	11 (1.4)	1.28 (0.74)
Item 23	397 (51.6)	215 (27.9)	67 (8.7)	57 (7.4)	34 (4.4)	1.85 (1.13)

Table 9 presents the reliability of the constructs in terms of Cronbach's alpha coefficients. Reliability tells us the ability of the instrument(s) to measure what it is meant to measure consistently. The Cronbach's alpha coefficients were 0.86, 0.90, and 0.95 for TIM, RSES, and NAQ-R, respectively, indicating the three instruments had good reliability.

Table 9

*Cronbach's Alpha Analysis*

	Number of items	Cronbach's alpha
TIM	2	0.86
RSES	10	0.90
NAQ-R	22	0.95

Table 10 shows the descriptive statistics of total scores of TIM, RSES, and NAQ-R. The mean total scores of TIM, RSES, and NAQ-R were 3.28 (SD = 1.62), 32.68 (SD = 5.16), and 41.43 (SD = 16.92), respectively. This indicates that participants had a moderate level of turnover intentions, a moderately high level of self-esteem, and moderately low experience of bullying and harassment.

The skewness, kurtosis, and the results of Shapiro-Wilk tests are also displayed in Table 6. The sample skewness measures the tendency of the deviations to be larger in one direction than in the other (Moore et al., 2009). Observations that are normally distributed should have a skewness near zero, as normal distribution is symmetric in a bell shape (Moore et al., 2009). A negative skew indicates that the tail on the left side of the

probability density function is longer than the right side and the bulk of the values lie to the right of the mean (skewed to the left) (Moore et al., 2009). A positive skew indicates that the tail on the right side is longer than the left side and the bulk of the values lie to the left of the mean (skewed to the right) (Moore et al., 2009). From the results of skewness, total score of TIM (skewness = 0.54) was slightly positively skewed; total score of RSES (skewness = -0.45) was slightly negatively skewed; total score of NAQ-R (skewness = 1.31) was moderately positively skewed.

Kurtosis is a measure of whether the data are heavy-tailed or light-tailed relative to a normal distribution (Moore et al., 2009). A distribution with a positive kurtosis value indicates that the distribution has heavier tails and a sharper peak than the normal distribution (Moore et al., 2009), whereas a distribution with a negative kurtosis value indicates that the distribution has lighter tails and a flatter peak than the normal distribution (Moore et al., 2009). From the results of kurtosis, total scores of TIM (kurtosis = -0.73) and NAQ-R (kurtosis = 1.48) had moderate values of kurtosis; total score of RSES (kurtosis = -0.08) had very small kurtosis.

The Shapiro–Wilk test examines the null hypothesis that a sample came from a normally distributed population (Moore et al., 2009). A p-value less than 0.05 indicates that the null hypothesis should be rejected and there is enough evidence to claim that the data tested are not from a normally distributed population, i.e., the data are not normal. On the contrary, if the p-value is greater than 0.05, then the null hypothesis that the data came from a normally distributed population cannot be rejected, and hence there is not enough evidence to claim that the data tested are not from a normally distributed



population, i.e., the data are normal. The results of the Shapiro-Wilk tests suggested that all variables (total score of TIM, total score of RSES, and total score of NAQ-R) were not normally distributed ( $p < 0.05$ ).

The conclusion of non-normal distribution for the three study variables was supported by the QQ plots (Figures 3-5). A quantile-quantile (QQ) plot is a probability plot for comparing two probability distributions by plotting their quantiles against each other (Field, 2013). A point on the plot corresponds to one of the quantiles of the second distribution (y-coordinate, in this study, the normal distribution) plotted against the same quantile of the first distribution (x-coordinate, in this study, the distribution of the observed data). If the two distributions being compared are similar, the points in the QQ plot lie approximately on the line  $y = x$  (the 45-degree line). Figures 3 to 5 indicated that some data points deviated from the 45-degree lines. Thus, the three study variables (total score of TIM, total score of RSES, and total score of NAQ-R) may not be normally distributed.

Table 10

*Descriptive Statistics of Total Scores of TIM, RSES, and NAQ-R*

	Possible range	Mean (SD)	Min	Max	Skewness	Kurtosis	SW
TIM	0-7	3.28 (1.62)	1	7	0.54	-0.73	< 0.001
RSES	10-40	32.68 (5.16)	11	40	-0.45	-0.08	< 0.001
NAQ-R	22-110	41.43 (16.92)	22	110	1.31	1.48	< 0.001

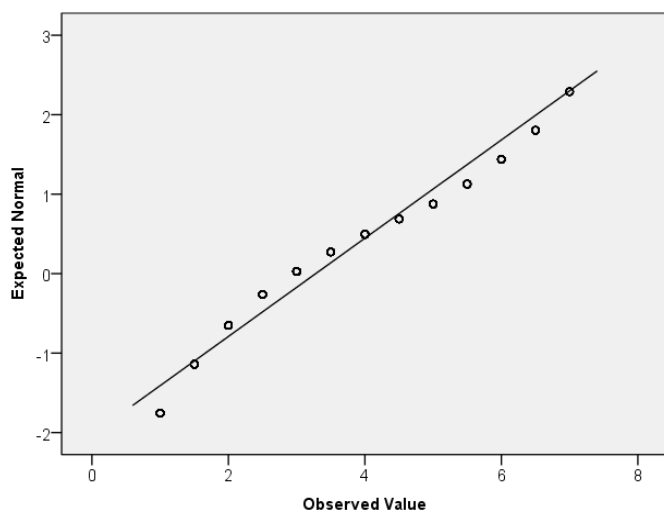


Figure 3. QQ plot of total score of TIM.

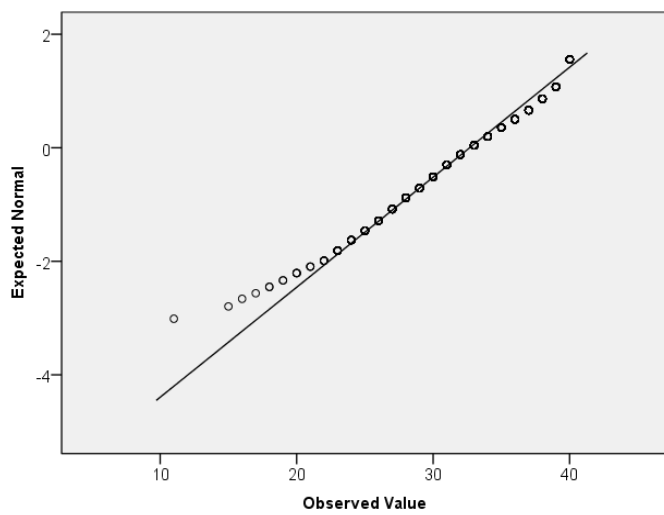
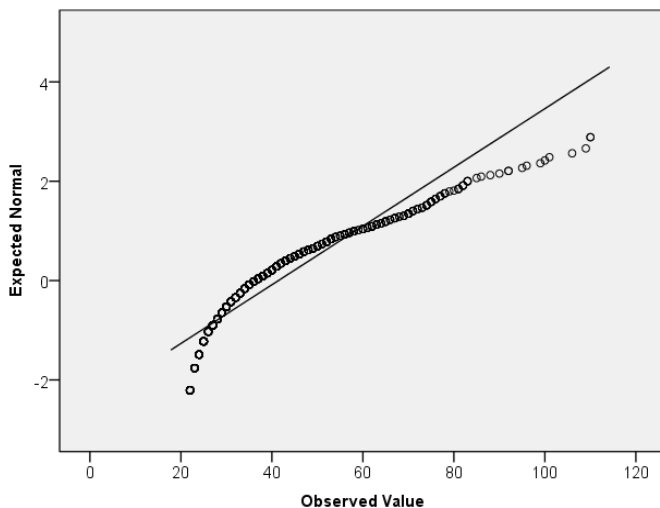


Figure 4. QQ plot of total scores of RSES.



*Figure 5.* QQ plot of total scores of NAQ-R.

### **Analysis Results for Objectives 1 and 2**

As the data (total score of TIM, total score of RSES, and total score of NAQ-R) may not be normally distributed, multiple linear regressions justified by the bootstrap technique and non-parametric analyses (i.e., Spearman's rank correlations, Mann–Whitney U tests, Kruskal–Wallis tests) were utilized in this study to achieve the primary objective (i.e., the three research questions) and the secondary objective which was to determine if there was a difference in the variables (NAQ-R, RSES, and TIM) according to the demographics (gender, highest level of education, employment status, and primary work area).

### **Analysis Results for RQ1**

RQ1 asked: Are there significant relationships among inpatient nurses' reported bullying and harassment experience as assessed by the NAQ-R and their individual self-

esteem as assessed by the RSES with intent to leave the organization as assessed by the TIM? The results of the study supported retaining the null hypotheses. To answer RQ1, multiple linear regression (Field, 2013) was used. The dependent variable was turnover intention as measured by TIM, and the two independent variables were bullying and harassment experience as measured by NAQ-R and self-esteem as measured by RSES. The bootstrap technique with 500 resamplings implemented in SPSS version 23 was used to confirm the robustness of the parametric approach (multiple linear regressions). The analysis was conducted using the entire sample and by primary work area. The analysis results of the multiple linear regressions, using the entire sample and by primary work area are presented in Tables 11-13.

The  $F$ -test of the overall significance (Table 11) indicates that, overall, the regression model statistically significantly predicts the dependent variable, i.e., it is a good fit for the data, for the entire sample and by primary work area ( $F(2, 767) = 261.639, p < 0.001$  for entire sample;  $F(2, 191) = 70.205, p < 0.001$  for clinical care;  $F(2, 100) = 39.269, p < 0.001$  for emergency department;  $F(2, 238) = 76.946, p < 0.001$  for medical surgical;  $F(2, 63) = 29.724, p < 0.001$  for obstetrics;  $F(2, 26) = 4.496, p = 0.021$  for oncology;  $F(2, 43) = 14.039, p < 0.001$  for pediatrics;  $F(2, 58) = 22.161, p < 0.001$  for perioperative;  $F(2, 27) = 3.446, p = 0.046$  for psychiatry).

The  $R^2$  (Table 12) indicated the percentage of the total variation in the dependent variable, turnover intention (total score of TIM), can be explained by the two independent variables, bullying and harassment experience (total score of NAQ-R) and self-esteem (total score of RSES). The  $R^2$  for the regression model using the entire sample was

0.406, indicating 40.6% of the total variation in the dependent variable can be explained by the two independent variables. The  $R^2$  for the regression models by the primary work area ranged from 0.203 (Psychiatry) to 0.485 (Obstetrics).

According to the results of the regression analysis (see Table 12), for the entire sample, there is a statistically significantly negative relationship between turnover intention and self-esteem ( $B = -0.036$ ,  $t(767) = -3.986$ ,  $p < 0.001$ ). Meaning that when self-esteem is high turnover intention is low and vice versa. There is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.057$ ,  $t(767) = 20.633$ ,  $p < 0.001$ ). Meaning that when bullying and harassment are high, turnover intention is high or vice versa. Each primary work area was also evaluated individually. For critical care, there is a statistically significantly negative relationship between turnover intention and self-esteem ( $B = -0.049$ ,  $t(191) = -2.545$ ,  $p = 0.001$ ), and (2) there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.056$ ,  $t(191) = 9.816$ ,  $p < 0.001$ ). For emergency department, there is no statistically significant relationship between turnover intention and self-esteem ( $t(100) = 0.452$ ,  $p = 0.652$ ), and there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.065$ ,  $t(100) = 8.599$ ,  $p < 0.001$ ). For medical surgical, there is a statistically significantly negative relationship between turnover intention and self-esteem ( $B = -0.047$ ,  $t(238) = -3.020$ ,  $p = 0.003$ ), and there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.052$ ,  $t(238) = 11.178$ ,  $p < 0.001$ ). For obstetrics, there

is no statistically significant relationship between turnover intention and self-esteem ( $t(63) = 1.270, p = 0.209$ ), and there was a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.072, t(63) = 7.669, p < 0.001$ ). For oncology, there is no statistically significant relationship between turnover intention and self-esteem ( $t(26) = 0.218, p = 0.829$ ), and there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.082, t(26) = 2.851, p = 0.008$ ). For pediatrics, there is no statistically significant relationship between turnover intention and self-esteem ( $t(43) = -1.171, p = 0.248$ ), and there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.057, t(43) = 4.507, p < 0.001$ ). For perioperative, there is no statistically significant relationship between turnover intention and self-esteem ( $t(58) = -0.562, p = 0.577$ ), and there is a statistically significantly positive relationship between turnover intention and bullying and harassment experience ( $B = 0.059, t(58) = 6.029, p < 0.001$ ). RNs who worked in psychiatry had different results than RNs who worked in other clinical settings. For psychiatry RNs there is no statistically significant relationship between turnover intention and self-esteem ( $t(27) = -1.164, p = 0.118$ ), and there is no statistically significant relationship between turnover intention and bullying and harassment experience ( $t(27) = 2.045, p = 0.051$ ). The results of the bootstrap technique (Table 13) confirmed the results of the regression analysis.

Table 11

*Results of Regressions – The ANOVA Table*

		SS	df	MS	F	P
Entire sample	Regression	815.771	2	407.886	261.639	< 0.001*
	Residual	1195.725	767	1.559		
	Total	2011.496	769			
Critical care	Regression	232.969	2	116.484	70.205	< 0.001*
	Residual	316.907	191	1.659		
	Total	549.876	193			
Emergency department	Regression	111.221	2	55.610	39.269	< 0.001*
	Residual	141.614	100	1.416		
	Total	252.835	102			
Medical surgical	Regression	259.352	2	129.676	76.946	< 0.001*
	Residual	401.098	238	1.685		
	Total	660.450	240			
Obstetrics	Regression	67.118	2	33.559	29.724	< 0.001*
	Residual	71.129	63	1.129		
	Total	138.246	65			
Oncology	Regression	10.997	2	5.498	4.496	0.021*
	Residual	31.796	26	1.223		
	Total	42.793	28			
Pediatrics	Regression	48.488	2	24.244	14.039	< 0.001*
	Residual	74.256	43	1.727		
	Total	122.745	45			
Perioperative	Regression	61.228	2	30.614	22.161	< 0.001*
	Residual	80.124	58	1.381		
	Total	141.352	60			

*“table continues”*

Psychiatry	Regression	11.178	2	5.589	3.446	0.046*
	Residual	43.789	27	1.622		
	Total	54.967	29			

Note: SS = Sum of Squares; df = degrees of freedom; MS = Mean Square; F = F statistic;  $p$  = p-value. \* indicates significance at the 0.05 level.

*Table 12*

*Results of Regressions – Coefficients*

214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)
214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)	214 (31.3)

*“table continues”*





	(31.3)	(31.3)	(31.3)	(31.3)	(31.3)	
214 (31.3)	214	214	214	214	214	214 (31.3)
	(31.3)	(31.3)	(31.3)	(31.3)	(31.3)	
214 (31.3)	214	214	214	214	214	214 (31.3)
	(31.3)	(31.3)	(31.3)	(31.3)	(31.3)	
214 (31.3)	214	214	214	214	214	214 (31.3)
	(31.3)	(31.3)	(31.3)	(31.3)	(31.3)	

Note: B = regression coefficient; SE = standard error;  $t$  = t-statistic;  $p$  = p-value,  $R^2$  = R-squared. \* indicates significance at the 0.05 level.

Table 13

*Results of Regressions – Bootstrap for Coefficients*

		Bootstrap				
		B	Bias	SE	Lower	Upper
Entire sample	Intercept	2.098	-0.006	0.400	1.295	2.825
	RSES	-0.036	0.000	0.010	-0.054	-0.016
	NAQ-R	0.057	0.000	0.003	0.051	0.064
Critical care	Intercept	2.577	0.013	0.762	1.119	4.188
	RSES	-0.049	-0.001	0.019	-0.085	-0.009
	NAQ-R	0.056	0.000	0.005	0.046	www
Emergency department	Intercept	0.064	-0.040	1.184	-2.291	2.584
	RSES	0.012	0.001	0.029	-0.053	0.069
	NAQ-R	0.065	0.000	0.007	0.051	0.081
Medical surgical	Intercept	2.740	-0.032	0.634	1.369	3.891
	RSES	-0.047	0.001	0.016	-0.077	-0.013
	NAQ-R	0.052	0.000	0.006	0.041	0.064
Obstetrics	Intercept	-1.462	0.000	1.378	-3.736	1.412
	RSES	0.045	0.000	0.036	-0.030	0.110
	NAQ-R	0.072	0.000	0.009	0.054	0.091

*“table continues”*

Oncology	Intercept	-0.324	-0.157	1.615	-3.604	2.373
	RSES	0.010	0.006	0.052	-0.079	0.120
	NAQ-R	0.082	-0.001	0.031	0.024	0.138
Pediatrics	Intercept	2.270	0.048	1.872	-1.491	5.859
	RSES	-0.046	-0.002	0.047	-0.139	0.041
	NAQ-R	0.057	0.001	0.015	0.030	0.091
Perioperative	Intercept	1.322	0.031	1.190	-0.979	3.793
	RSES	-0.020	-0.001	0.031	-0.080	0.045
	NAQ-R	0.059	0.001	0.010	0.041	0.081
Psychiatry	Intercept	4.448	-0.406	1.645	-0.022	6.550
	RSES	-0.069	0.012	0.050	-0.137	0.062
	NAQ-R	0.033	0.000	0.017	-0.003	0.066

Note: B = regression coefficient. Bias = bias, SE = standard error for the coefficient, Lower = lower bound of the 95% confidence interval for the coefficient, and Upper = upper bound of the 95% confidence interval for the coefficient, based on the bootstrap procedure. \* indicates significance at the 0.05 level.

### Analysis Results for RQ2

RQ2 asked: Will the self-esteem, as measured by the RSES, of inpatient nurses who report having experienced bullying and harassment, as measured by the NAQ-R, be higher or lower than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ-R? The null hypotheses was retained in regard to RQ2. To answer RQ2, Spearman's rank correlation coefficients were computed between self-esteem (RSES) and bullying and harassment experience (NAQ-R), using the entire sample and by primary work area. The analysis results (Table 11) indicated that there was a statistically significantly negative relationship between self-esteem and bullying and harassment experience, i.e., nurses experiencing more bullying and harassment would

have lower self-esteem, for the entire sample ( $r_s = -0.289$ ,  $p < 0.001$ ), clinical care ( $r_s = -0.375$ ,  $p < 0.001$ ), emergency department ( $r_s = -0.329$ ,  $p = 0.001$ ), medical surgical ( $r_s = -0.261$ ,  $p < 0.001$ ), obstetrics ( $r_s = -0.314$ ,  $p = 0.010$ ), and perioperative ( $r_s = -0.303$ ,  $p = 0.017$ ). There was no statistically significant relationship between self-esteem and bullying and harassment experience for oncology ( $p = 0.192$ ), pediatrics ( $p = 0.059$ ), and psychiatry ( $p = 0.826$ ).

*Table 14*

*Results of Spearman's rho between Self-Esteem (RSES) and Bullying and Harassment Experience (NAQ-R) (RQ2)*

	$r_s$	p
Entire sample	-0.289	< 0.001*
Critical care	-0.375	< 0.001*
Emergency department	-0.329	0.001*
Medical surgical	-0.261	< 0.001*
Obstetrics	-0.314	0.010*
Oncology	-0.249	0.192
Pediatrics	-0.280	0.059
Perioperative	-0.303	0.017*
Psychiatry	-0.042	0.826

Note: \* indicates significance at the 0.05 level.

### **Analysis Results for RQ3**

RQ3 asked: Are there higher reports of bullying and harassment as measured by the NAQ-R among inpatient nurses who report higher intent to leave as measured by the TIM? The null hypothesis for RQ3 was retained. To answer RQ3, Spearman's rank correlation coefficients were computed between bullying and harassment experience

(NAQ-R) and turnover intention (TIM), using the entire sample and by primary work area. The analysis results (Table 12) indicated that there was a statistically significantly positive relationship between bullying and harassment experience and turnover intention, i.e., nurses had higher turnover intention would have more experiencing of bullying and harassment, for the entire sample ( $r_s = 0.634, p < 0.001$ ), clinical care ( $r_s = 0.626, p < 0.001$ ), emergency department ( $r_s = 0.602, p = 0.001$ ), medical surgical ( $r_s = 0.664, p < 0.001$ ), obstetrics ( $r_s = 0.532, p < 0.001$ ), oncology ( $r_s = 0.594, p = 0.001$ ), pediatrics ( $r_s = 0.640, p < 0.001$ ), perioperative ( $r_s = 0.695, p < 0.001$ ), and psychiatry ( $r_s = 0.417, p = 0.022$ ).

*Table 15*

*Results of Spearman's rho between Bullying and Harassment Experience (NAQ-R) and Turnover Intention (TIM) (RQ3)*

	$r_s$	$p$
Entire sample	0.634	< 0.001*
Critical care	0.626	< 0.001*
Emergency department	0.602	< 0.001*
Medical surgical	0.664	< 0.001*
Obstetrics	0.532	< 0.001*

Mann–Whitney U tests (for demographic variables with two levels, including gender and employment status) and Kruskal–Wallis tests (for demographic variables with more than two levels, including highest level of nursing education and primary work area) were used to determine if there was a difference in turnover intention (TIM), self-esteem (RSES), and bullying and harassment experience (NAQ-R), according to the

categorical demographic variables, including gender, highest level of nursing education, employment status, and primary work area. Spearman's rank correlation coefficients were used to determine if there was a relationship between the continuous demographic variable, age, and turnover intention (TIM), self-esteem (RSES), and bullying and harassment experience (NAQ-R).

### **Relationship between TIM, RSES, and NAQ-R**

Table 16 shows the results of Spearman's rho between age and turnover intention, self-esteem, and bullying and harassment experience. It appeared that there was a statistically significantly positive relationship between self-esteem and age, i.e., older nurses would have statistically significantly higher self-esteem, for the entire sample ( $r_s = 0.227, p < 0.001$ ), emergency department ( $r_s = 0.288, p = 0.003$ ), medical surgical ( $r_s = 0.266, p < 0.001$ ), and perioperative ( $r_s = 0.303, p = 0.017$ ).

*Table 16*

*Results of Spearman's rho between Age and TIM, RSES, and NAQ-R*

	TIM	RSES	NAQ-R
Entire sample	0.020 (0.575)	0.227 (< 0.001)*	0.007 (0.848)
Critical care	0.068 (0.345)	0.112 (0.122)	0.078 (0.281)
Emergency department	-0.014 (0.889)	0.288 (0.003)*	-0.078 (0.431)
Medical surgical	0.021 (0.751)	0.266 (< 0.001)*	0.071 (0.271)
Obstetrics	0.091 (0.467)	0.224 (0.071)	-0.124 (0.320)
Oncology	-0.122 (0.527)	0.022 (0.908)	0.013 (0.948)
Pediatrics	0.114 (0.452)	0.039 (0.795)	0.083 (0.585)
Perioperative	0.096 (0.461)	0.303 (0.017)*	-0.035 (0.791)
Psychiatry	0.068 (0.720)	0.355 (0.054)	0.037 (0.845)

Note: Numbers in parentheses are p-values. \* indicates significance at the 0.05 level.

### Relationship between TIM, RSES, and NAQ-R

The analysis results of the Mann–Whitney U tests for determining if there was a difference in turnover intention (TIM), self-esteem (RSES), and bullying and harassment experience (NAQ-R) according to gender are presented in Tables 17-19. Note that analysis was not performed for obstetrics (as all nurses were female) and oncology (as only one nurse was male and the remaining were female). The analysis results indicated that:

This study found that male RNs had statistically significantly higher turnover intention than female RNs for pediatrics (Md = 5.75 for male, Md = 2.50 for female,  $U = 7.0$ ,  $p = 0.039$ , Table 14). Male RNs in this study had statistically significantly more bullying and harassment experience than female RNs for perioperative (Md = 57 for male, Md = 32 for female,  $U = 49.5$ ,  $p = 0.014$ , Table 16). Interestingly female RNs had statistically significantly more bullying and harassment experience than male RNs for psychiatry (Md = 26 for male, Md = 43 for female,  $U = 105.5$ ,  $p = 0.013$ , Table 16).

Table 17

#### *Gender and Turnover Intention*

	Male	Female	U	p
Entire sample	3 (6)	3 (6)	27687.5	0.706
Critical care	2.5 (6)	3 (6)	2355.5	0.060
Emergency department	2.5 (5.5)	3 (6)	809.5	0.697
Medical surgical	3.5 (6)	3 (6)	2622.0	0.812
Obstetrics	NA	NA	NA	NA
Oncology	NA	NA	NA	NA
Pediatrics	5.75 (1.5)	2.50 (5.5)	7.0	0.039*

*“table continues”*

Perioperative	3 (2)	2.5 (5.5)	110.5	0.449
Psychiatry	3 (2)	3.5 (5.5)	89.5	0.136

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

Table 18

*Gender and Self-Esteem (RSES)*

	Male	Female	U	p
Entire sample	33.5 (19)	33 (29)	25721.5	0.495
Critical care	31 (17)	32 (24)	1937.0	0.856
Emergency department	34.5 (14)	34 (17)	734.0	0.787
Medical surgical	35 (15)	32 (29)	2130.5	0.084
Obstetrics	NA	NA	NA	NA
Oncology	NA	NA	NA	NA
Pediatrics	24.5 (7)	32 (20)	76.5	0.081
Perioperative	29 (17)	35 (13)	180.0	0.309
Psychiatry	32 (7)	32 (19)	64.5	0.914

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

Table 19

*Gender and Bullying and Harassment Experience (NAQ-R)*

	Male	Female	U	p
Entire sample	37 (77)	36 (88)	27876.5	0.633
Critical care	36.5 (43)	39 (88)	2207.5	0.203
Emergency department	36.5 (60)	38 (60)	841.0	0.509
Medical surgical	34 (77)	38 (88)	2909.5	0.525
Obstetrics	NA	NA	NA	NA

“table continues”



Oncology	NA	NA	NA	NA
Pediatrics	66.5 (57)	32 (57)	15.0	0.139
Perioperative	57 (37)	32 (63)	49.5	0.014*
Psychiatry	26 (12)	43 (54)	105.5	0.013*

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

### **Relationship between TIM, RSES, and NAQ-R**

The analysis results of the Kruskal–Wallis tests for determining if there was a difference in turnover intention (TIM), self-esteem (RSES), and bullying and harassment experience (NAQ-R) according to education are presented in Tables 17-19. Note that analysis was not performed for psychiatry (as only one nurse had a diploma). The analysis results indicated that:

This study found that in critical care RNs, there was a statistically significant difference in bullying and harassment experience among nurses with different education background ( $\chi^2(3) = 12.940, p = 0.005$ , Table 19). In particular, the results of pairwise comparisons indicated that nurses with a master’s degree had statistically significantly more bullying and harassment experience than nurses with a bachelor’s degree (Md = 65 for master’s, Md = 36 for bachelor’s,  $p = 0.009$ ). There was no difference in bullying and harassment experience among nurses with other education background (bachelor’s vs. associate’s,  $p = 0.313$ ; bachelor’s vs. diploma,  $p = 1.000$ ; associate’s vs. diploma,  $p = 1.000$ ; associate’s vs. master’s,  $p = 0.159$ ; diploma vs. master’s,  $p = 1.000$ ). For medical-surgical RNs, there was a statistically significant difference in bullying and harassment experience among nurses with different education background ( $\chi^2(3) = 8.998, p = 0.029$ ,

Table 19). In particular, the results of pairwise comparisons indicated that nurses with an associate's degree had statistically significantly more bullying and harassment experience than nurses with a bachelor's degree (Md = 41 for associate's, Md = 34 for bachelor's,  $p = 0.046$ ). There was no difference in bullying and harassment experience among nurses with other education background (bachelor's vs. master's,  $p = 0.310$ ; bachelor's vs. diploma,  $p = 1.000$ ; associate's vs. diploma,  $p = 1.000$ ; associate's vs. master's,  $p = 1.000$ ; diploma vs. master's,  $p = 1.000$ ). Note that for the entire sample, the Kruskal–Wallis test indicates that there was a statistically significant difference in turnover intention ( $p = 0.024$ , Table 17) and bullying and harassment experience ( $p = 0.008$ ) for nurses with different education background, the results of all pairwise comparisons indicated insignificance. Therefore, it was concluded that, for the entire sample, there was no statistically significant difference in turnover intention and bullying and harassment experience for nurses with different education background.

*Table 20*

*Education and Turnover Intention (TIM)*

	Associate's	Diploma	Bachelor's	Master's	$\chi^2$	p
Entire sample	3 (6)	3 (5.5)	3 (6)	3 (6)	9.479	0.024 <sup>a</sup>
Critical care	3 (6)	4 (4.5)	3 (6)	4 (5)	4.318	0.229
Emergency department	3.5 (6)	3 (4)	2.5 (5.5)	2.75 (3)	1.613	0.656
Medical surgical	3.5 (6)	3 (5)	3 (6)	3.5 (6)	6.209	0.102
Obstetrics	2 (5)	2.5 (4.5)	2.75 (5.5)	4 (3.5)	3.274	0.351
Oncology	3.25 (5)	2 (1.5)	2.75 (3)	2.25 (2)	3.084	0.379
Pediatrics	3 (2.5)	2.25	2.5 (5.5)	1.5 (3)	2.496	0.476

*“table continues”*

	(4.5)					
Perioperative	3 (5)	2 (4)	2.5 (5.5)	5.75	6.283	0.099
	(0.5)					
Psychiatry	NA	NA	NA	NA	NA	NA

Note: Numbers reported are median (range).  $\chi^2$  = test statistic of the Kruskal–Wallis test.  $p$  = p-value based on Kruskal–Wallis tests. Degrees of freedom (DF) = 3 for the Kruskal–Wallis test. \* indicates significance at the 0.05 level for the Kruskal–Wallis test. NA = not available. <sup>a</sup> indicates significance at the 0.05 level for the Kruskal–Wallis test, but insignificance for all pairwise comparisons.

Table 21

*Education and Self-Esteem (RSES)*

	Associate's	Diploma	Bachelor's	Master's	$\chi^2$	p
Entire sample	32 (29)	32.5 (17)	33 (25)	34 (17)	7.311	0.063
Critical care	31 (24)	32 (9)	33 (22)	32 (13)	5.361	0.147
Emergency department	34.5 (17)	32 (16)	33 (17)	37.5 (7)	2.509	0.474
Medical surgical	31 (29)	34 (10)	32.5 (25)	35 (17)	6.033	0.110
Obstetrics	33 (12)	33 (11)	32.5 (14)	39 (9)	3.098	0.377
Oncology	35 (14)	34 (6)	35 (16)	33.5 (9)	0.147	0.986
Pediatrics	30 (6)	26.5 (17)	32.5 (20)	32 (13)	1.262	0.738
Perioperative	37 (13)	35.5 (12)	33 (17)	36.5 (5)	1.870	0.600
Psychiatry	NA	NA	NA	NA	NA	NA

Note: Numbers reported are median (range).  $\chi^2$  = test statistic of the Kruskal–Wallis test.  $p$  = p-value based on Kruskal–Wallis tests. Degrees of freedom (DF) = 3 for the Kruskal–Wallis test. \* indicates significance at the 0.05 level for the Kruskal–Wallis test. NA = not available. <sup>a</sup> indicates significance at the 0.05 level for the Kruskal–Wallis test, but insignificance for all pairwise comparisons.

Table 22

*Education and Bullying and Harassment Experience (NAQ-R)*

	Associate's	Diploma	Bachelor's	Master's	$\chi^2$	p
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“table continues”

Entire sample	39 (88)	31.5 (60)	35 (87)	40 (88)	11.937	0.008 <sup>a</sup>
Critical care	41 (82)	42 (21)	36 (74)	65 (78)	12.940	0.005*
Emergency department	36 (56)	47 (46)	38.5 (61)	34 (9)	2.159	0.540
Medical surgical	41 (88)	40 (60)	34 (87)	45 (73)	8.998	0.029*
Obstetrics	34.5 (54)	29 (15)	34 (57)	41 (6)	6.670	0.083
Oncology	37 (25)	27 (6)	29 (24)	31.5 (18)	6.105	0.107
Pediatrics	38 (27)	30.5 (44)	32.5 (73)	31 (21)	1.801	0.615
Perioperative	31 (34)	33 (57)	36 (61)	66 (40)	4.414	0.220
Psychiatry	NA	NA	NA	NA	NA	NA

Note: Numbers reported are median (range).  $\chi^2$  = test statistic of the Kruskal–Wallis test.  $p$  = p-value based on Kruskal–Wallis tests. Degrees of freedom (DF) = 3 for the Kruskal–Wallis test. \* indicates significance at the 0.05 level for the Kruskal–Wallis test. NA = not available. <sup>a</sup> indicates significance at the 0.05 level for the Kruskal–Wallis test, but insignificance for all pairwise comparisons.

### Relationship between TIM, RSES, and NAQ-R

The demographic of the employment status of participants was analyzed using the Mann–Whitney U tests for determining if there were any differences in the independent variables and dependent variables. The analysis results indicated that: perioperative, full-time nurses had statistically significantly higher turnover intention than part-time nurses (Md = 2.75 for full-time, Md = 1.5 for part-time,  $U = 228.0$ ,  $p = 0.048$ ). For pediatrics, full-time nurses had statistically significantly lower self-esteem than part-time nurses (Md = 30 for full-time, Md = 37 for part-time,  $U = 202.0$ ,  $p = 0.045$ ). And for pediatrics, full-time nurses had statistically significantly more bullying and harassment experience

than part-time nurses (Md = 36 for full-time, Md = 26 for part-time,  $U = 68.5$ ,  $p = 0.036$ ).

Results are presented in Tables 23-25.

*Table 23*

*Employment Status and Turnover Intention (TIM)*

	Full time	Part time	U	P
Entire sample	3 (6)	3 (6)	30226.5	0.442
Critical care	3 (6)	3.5 (5)	1316.5	0.231
Emergency department	3 (6)	3 (5.5)	510.0	0.966
Medical surgical	3 (6)	3 (6)	2987.0	0.382
Obstetrics	2.5 (5)	2.25 (5.5)	419.5	0.856
Oncology	2.5 (5)	2.5 (1)	24.5	0.833
Pediatrics	2.5 (5.5)	1.5 (3)	79.5	0.081
Perioperative	2.75 (5.5)	1.5 (4.5)	228.0	0.048*
Psychiatry	3.5 (5.5)	3.5 (1)	55.5	0.837

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

*Table 24*

*Employment Status and Self-Esteem (RSES)*

	Full time	Part time	U	P
Entire sample	33 (29)	33 (23)	31528.5	0.904
Critical care	32 (24)	32.5 (15)	993.0	0.598
Emergency department	35 (17)	32 (12)	337.5	0.071
Medical surgical	32 (29)	31 (23)	2319.0	0.247
Obstetrics	33.5 (14)	31.5 (13)	376.5	0.423
Oncology	35 (16)	35.5 (9)	35.0	0.542

*“table continues”*

Pediatrics	30 (20)	37 (14)	202.0	0.045*
Perioperative	35.5 (17)	34 (10)	357.5	0.833
Psychiatry	31.5 (19)	37.5 (8)	81.5	0.071

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

*Table 25*

*Employment Status and Bullying and Harassment Experience (NAQ-R)*

	Full time	Part time	U	P
Entire sample	37 (88)	34 (88)	28797.5	0.141
Critical care	38.5 (88)	41 (48)	1126.0	0.857
Emergency department	37 (61)	43 (50)	562.0	0.550
Medical surgical	37.5 (87)	37 (85)	2815.0	0.727
Obstetrics	34 (58)	32.5 (53)	423.0	0.897
Oncology	33 (25)	28 (12)	17.0	0.443
Pediatrics	36 (73)	26 (20)	68.5	0.036*
Perioperative	36.5 (63)	28 (58)	260.5	0.157
Psychiatry	40.5 (54)	35.5 (30)	43.5	0.617

Note: Numbers reported are median (range). U = statistic of the Mann–Whitney U test.  $p$  = p-value based on Mann–Whitney U test. \* indicates significance at the 0.05 level. NA = not available.

**Relationship between TIM, RSES, and NAQ-R**

The analysis results of the Kruskal–Wallis tests for determining if there was a difference in TIM, RSES, and NAQ-R according to primary work area are presented in Table 23. Note that analysis was performed using the entire sample only. The analysis results indicated that there was a statistically significant difference in self-esteem among

nurses working in different areas ( $\chi^2(7) = 21.507, p = 0.003$ , Table 23). In particular, the results of pairwise comparisons indicated that nurses in critical care had statistically significantly lower self-esteem than nurses in perioperative (Md = 32 for clinical care, Md = 35 for perioperative,  $p = 0.041$ ). There was no difference in self-esteem among nurses working in other areas ( $p > 0.05$ ).

Note that, although the Kruskal–Wallis test indicated that there was a statistically significant difference in turnover intention ( $p = 0.009$ , Table 26) and bullying and harassment experience ( $p = 0.031$ , Table 26) for nurses working in different areas, the results of all pairwise comparisons indicated insignificance. Therefore, it was concluded that there was no statistically significant difference in turnover intention and bullying and harassment experience for nurses working in different areas.

Table 26

*Primary Work Area and Turnover Intention, Self-Esteem, and Bullying and Harassment Experience*

	TIM	RSES	NAQ-R
Critical care	3 (6)	32 (24)	39 (88)
Emergency department	3 (6)	34 (17)	38 (61)
Medical surgical	3 (6)	32 (29)	37 (88)
Obstetrics	2.5 (5)	33 (14)	34 (58)
Oncology	2.5 (5)	35 (16)	33 (25)
Pediatrics	2.5 (5)	31.5 (20)	33 (73)
Perioperative	2.5 (5)	35 (17)	34 (63)
Psychiatry	3.5 (5.5)	32 (19)	40.5 (54)
$\chi^2$	18.845	21.507	15.398

*“table continues”*

p	0.009 <sup>a</sup>	0.003*	0.031 <sup>a</sup>
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Note: Numbers reported are median (range).  $\chi^2$  = test statistic of the Kruskal–Wallis test.  $p$  = p-value based on Kruskal–Wallis tests. Degrees of freedom (DF) = 7 for the Kruskal–Wallis test. \* indicates significance at the 0.05 level for the Kruskal–Wallis test. NA = not available. <sup>a</sup> indicates significance at the 0.05 level for the Kruskal–Wallis test, but insignificance for all pairwise comparisons.

### Summary of Answers to the Research Questions

All three of the research questions in this study were supported by the data. RQ1 was: Are there significant relationships among inpatient nurses' reported bullying and harassment experience as assessed by the NAQ-R and their individual self-esteem as assessed by the RSES with intent to leave the organization as assessed by the TIM? The data results accepted  $H_{A1}$ , which was that inpatient nurse reported bullying and harassment experience and individual self-esteem predict their intent to leave the organization.

RQ2 was: Will self-esteem of inpatient nurses, as measured by the RSES, of inpatient nurses who report having experienced bullying and harassment, as measured by the NAQ-R, be higher or lower than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ-R? The research data supported  $H_{A2}$ . This means that inpatient nurses who report experiencing bullying and harassment as measured by the NAQ-R will have a lowered self-esteem score as reported on the RSES.

RQ3 was: Are there higher reports of bullying and harassment as measured by the NAQ-R among inpatient nurses who report higher intent to leave as measured by the TIM? The research data accepted  $H_{03}$ . Which means that inpatient nurses who report



experiencing bullying and harassment as measured by the NAQ-R will report intent to leave as measured by the TIM.

Chapter 5 summarizes this study, provides an analysis of the findings, and presents limitations of the study. Recommendations for future research are also discussed. The study concludes with a discussion of the implications of the findings for the profession of nursing, researchers, and social change.

## Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine the relationship between inpatient nurses' individual self-esteem and reported bullying and harassment with their intent to leave their organization. There was an identified gap in the literature that more studies need to be conducted on turnover intention and verbal abuse in the field of nursing. The long-term intent of this study is to promote social change by assisting nurse leaders in providing a testing template to help identify nursing units prone to turnover related to bullying and harassment in time to intervene prior to RNs leaving the clinical unit.

This study was conducted by inviting all RNs in the state of Ohio to participate in an online survey via SurveyMonkey using the NAQ-R, RSES, and TIM to assess their experiences with bullying and harassment, self-esteem, and turnover intention. Demographic data related to gender, age, level of nursing education, employment status, and clinical area in which they work were also gathered. A total of 78,889 RNs were invited to participate. Only 1,665 chose to participate, making the response rate 2.1%. After removing erroneous answers and excluding subjects who did not work as an inpatient bedside nurse in a hospital or work full or part-time, there were a total 770 subjects included in the study.

There was no statistically significant difference in terms of turnover intention and bullying and harassment experience for nurses with different educational backgrounds. Participants who held a bachelor's degree numbered 54.2%. The American Association of Colleges of Nursing (AACN) publishes statistics each year on degrees nurses are

obtaining. In the areas of education, the study participants were right in alignment with recent survey data from the AACN. According to the AACN (2018), 55% of U.S. RNs currently hold a baccalaureate degree. The study percentage of male (10.1%) versus female (89.9%) respondents is slightly lower than the current U.S. statistics of male versus female RNs. The percentage of male nurses in the U.S. is somewhere between 11% -14% percent based on two recent reports one from the AACN and one for the U.S. DOL. (AACN, 2018; U.S. DOL, 2018).

Participants were asked to report which primary clinical area they worked within a hospital. Parks, (2015) and Vessey et al., (2011) found differences in reported bullying and harassment and turnover intention based on RN clinical work areas, this study also wanted to examine if clinical work area made any difference in these two variables. The top three clinical areas of work for participants were medical-surgical (31.3%), critical care (25.2%), and emergency department (13.4%). Participants as a whole had a moderate level of turnover intention, a moderately high level of self-esteem, and a moderately low level of bullying and harassment. For the entire sample, there was a statistically significant negative relationship between turnover intention and self-esteem, and there was a statistically significant positive relationship between turnover intention and bullying and harassment.

According to Randle (2003), nurses as a whole historically have low to average self-esteem as rated on the RSES. The participants in this study as a whole had moderately high levels of self-esteem as assessed on the RSES. Dimitriadou et al. (2014) said that formal education individuals go through to become a RN should focus on

enhancing the nursing student's self-esteem. Van Eckert et al. (2012) found that RNs with higher educational levels (bachelor's degree, or master's degree) had statistically significant higher self-esteem than those RNs with an associate degree. In this study, the level of educational preparation of the respondents made no statistical difference in terms of self-esteem levels. Possibly, the current study's group of participants answered the call to take part in the study because they displayed a higher than average self-esteem than most nurses. It is also possible that nursing education's global focus to build up the self-esteem of nurses in the last decade is making a difference. More research in this area is recommended to better understand the self-esteem of nurses as a whole and within various work groups.

### **Interpretation of Findings**











For RQ1, findings indicate that the alternative hypothesis –inpatient nurses reported bullying and harassment experience and individual self-esteem predict their intent to leave the organization was supported. There was a statistically significant relationship between bullying and harassment experiences, self-esteem, and turnover intention of inpatient RNs. Specifically, there was a statistically significant negative relationship between turnover intention and self-esteem; when self-esteem goes up, turnover intention goes down, and vice versa.

There is also a statistically positive relationship between turnover intention and bullying and harassment. When bullying and harassment go up, turnover intention also increases with participants in this study. While there is a relationship between all variables, some of the relationships are positive while others are negative. Table 27

provides a visual summary of the relationships between variables discovered in this research. The arrows indicate desired or undesirable direction with the goal of no more bullying and harassment among RNs.

*Table 27*

*Summary of the Directional Relationship between Variables in this Study*

	Self-Esteem	Bullying and Harassment	Turnover Intention
<b>Variables</b>			
<u>High Self-Esteem</u>	X		
<u>Low Self-Esteem</u>	X		
<u>Victim of</u>			
<u>Bullying and Harassment</u>		X	
<u>Low Turnover Intention</u>			X
<u>High Turnover Intention</u>			X

This is the first study to test for a relationship between all three of these variables in RNs or any other population in the U.S. or Europe. Few studies have looked at bullying and self-esteem among RNs. The direction of the relationship between the two variables was also negative: when bullying and harassment go up, self-esteem goes down.

RNs who experience bullying and harassment from their peers have lower self-esteem than peers who do not experience bullying and harassment from their peers. This study echoes Los Iglesias and de Bengea Vallejo's, (2012) findings. Also like Araujo and Sofield's (2011) study the findings in this study note a relationship between bullying and harassment and low self-esteem among RNs.

There are several studies that have found a relationship between bullying and harassment and turnover intention. Wilson et al. (2011) conducted a research study among RNs from one hospital in the southwest. The response rate was 26%. They found that nurses who experienced lateral violence were significantly more likely to leave their current position. These findings are in alignment with the findings of the current study.

Vessey et al. (2009) found in their descriptive study of 212 RNs that there was a significant negative correlation between bullying and harassment and turnover intention. The results of this study reflect the same findings, that there is a relationship between bullying and harassment and turnover intention of RNs. Simons and Mawn (2010) and Simons (2008) also found a relationship between bullying and harassment and turnover intention of RNs.

More recently, Coetzee and van Dyk (2018) noted in their study that there was a positive relationship between bullying and harassment and turnover intention among 373 South African workers from a variety of industries. These studies reflect the same results as found in this study that there is a positive relationship between the reports of bullying and harassment and higher turnover intention. When bullying and harassment occurs, turnover intention increases.

RQ2 asked: Will the self-esteem, as measured by the RSES, of inpatient nurses who report having experienced bullying and harassment, as measured by the NAQ-R, be higher or lower than those inpatient nurses who report not experiencing bullying and harassment as measured by the NAQ-R? These results of the statistical tests supported the alternative hypothesis -Inpatient nurses who report experiencing bullying and harassment as measured by the NAQ will have a lowered self-esteem score as reported on the RSES. This study's findings are consistent with several previous studies who also found that the self-esteem of nurses experiencing bullying and harassment is lower than those RNs who do not report experiencing bullying and harassment (Begley & White, 2003; Ling et al., 2014; Losa Iglesias & de Bengoa Vallejo, 2012; Unal, 2012).

RQ3 asked: Are there higher reports of bullying and harassment as measured by the NAQ-R among inpatient nurses who report higher intent to leave as measured by the TIM? The results of this research study support the null hypothesis being retained. This means that inpatient nurses who report experiencing bullying and harassment as measured by the NAQ will report intent to leave as measured by the TIM. These results are consistent with results from other studies. RNs who report bullying and harassment have a higher turnover intention. For example, Blackstock et al. (2014) reported that bullying among nurses across all subspecialties and work settings has been shown to be a persistent problem internationally with strong links to turnover.

In summary, all three research questions were supported by the results in this study. What one can surmise from these results is that nurses who are bullied and

harassed have lower self-esteem, and nurses who are bullied and harassed have a higher turnover intention.

This study noted that there are differences noted with age and nurse self-esteem. Nurses who are older have higher self-esteem. This concept has been supported in other studies as well. Vessey et al. (2011) state that newly graduated nurses who are usually young in age are more likely to be victims of bullying and harassment. As suggested by several researchers, this phenomenon could be seen as the source of the well-known adage among nurses that nurses eat their young (Hinchberger, 2009; Park, 2015; Simons & Mawn, 2010).

It was interesting to note that the results of this study found that not only do female nurses suffer bullying and harassment, but in some clinical areas male nurses suffer more from bullying and harassment than female nurses. As the number of males in the field of nursing increases, it will be interesting to learn more about the male nurses' experience with bullying and harassment. Eriksen and Einarsen (2004) found similar results in their study conducted in Norway. They hypothesized that belonging to gender minority group is a risk factor for exposure to bullying and harassment in the work setting. Specifically they found that male nursing assistants are often more exposed to bullying at work than their female counterparts (Eriksen & Einarsen, 2004). Einarsen et al. (2011) noted in their work that men are more likely to be bullied by men, and women more likely to be bullied by women. This study did not explore the reported sex of the bullies of male nurse. This would be an area of interesting area of future research. More recently, Mei-Ling and Yi-Hua (2016) found that in reported bullying incidents, gender



differences exists as well. They found that male gender groups experience more workplace bullying when they are in the minority than when female gender groups do when they are in the minority (Mei-Ling & Yi-Hua, 2016).

This study found that educational preparation does not make a difference in being a victim of bullying and harassment among the participants of this study. This demographic question was posed to find out if there was a difference between nursing preparation and bullying and harassment. There are three educational routes in the U.S. that lead to entry-level licensure for all RNs: diploma programs provided by hospitals, associate degree programs provided by colleges, and baccalaureate degree programs provided by colleges and universities. Nurses from all three programs are qualified to sit for the same NCLEX-RN licensing examination that verifies minimal competency to provide basic safe patient care (Haverkamp, & Ball, 2013). Currently, RNs are encouraged to pursue a bachelor's degree based on the Institute of Medicines (IOM) report *The Future of Nursing leading Change and Advancing Health's* recommendation that 80% of the nursing workforce be baccalaureate prepared by 2020. Their recommendation is based on a Cochrane systematic review showed that staffing nurses with higher levels of educational preparation is linked to better patient outcomes (IOM, 2010). Many nursing positions that are desirable such as educators, team leaders, and managers are now requiring individuals to have a baccalaureate degree.

The rationale was that a potential reason to bully colleagues might be linked to their educational preparation. In this study this proved not to be the case. No other studies

looking at educational preparation and bullying were found in the literature, so more research in this area is encouraged.

This study found that there are differences among clinical areas and the incidence of bullying and harassment with critical care nurses showing low self-esteem and higher experiences of bullying and harassment. The findings in this study correlate to the findings in the Vessey et al. (2009) study showing that the top three reporting areas for bullying and harassment to occur are medical-surgical, critical care, and emergency department. In this study the same three clinical areas reported the most bullying and harassment. The order of incident was slightly different, however, between the two studies. In this study critical care was the highest area for reported bullying and harassment and medical surgical areas were second. In both studies the emergency department nurses ranked their area as third for highest reported bullying and harassment incidents.

One conceivable reason critical care areas have higher reported incidence of bullying and harassment could be because critical care nursing is one of the most stressful specialties in the nursing profession (Race & Skees, 2010). Because of the stress and acuity of their roles, it could be supposed that critical care nurses need to be more assertive because of their role making them speak out and report the bullying and harassment more freely than nurses from other types of clinical units. It could be too that the incidence is indeed higher because of the stressful environment in which critical care nurses work. This finding correlates with what Park (2015) found. According to Park (2015) critical care nurses have the highest incidence of bullying and violence than any

other type of nursing unit. In Park's study violence toward critical care nurses was primarily identified as coming from patients, but "bullying was perpetrated mostly by nursing colleagues (68.1%) across all nursing units" (Park et al., 2015, p. 90).

Some of the same assumptions found in previous research was supported in this study, other assumptions were not upheld. For example, critical care nurses reported having experienced more bullying and harassment than those RNs who worked in other clinical areas. This has been reported in other studies as well (Park, 2015; Vessey et al., 2012). Nurses with BSNs have been reported to be targeted as bullying victims in other studies more than those with other degrees, this was not true in this study for the participants as a whole.

In RQ1 - It was found that all primary work areas had a statistically significant positive relationship between turnover intention and bullying and harassment. All areas accept psychiatry. In the clinical work area of psychiatry, nurses who were bullied and harassed did not have intentions of leaving their positions. This is a unique finding to this study. We need to ask those nurses do not have the intent to leave when they are bullied. Is it because these nurses who specialize in psychiatry have learned a better way through their clinical training to deal with bullying and harassment more effectively? More research needed with psychiatric nurses and their responses to bullying and harassment behaviors. .

The responses to RQ2 showed that all primary work areas had a statistically significant relationship between self-esteem and bullying and harassment, except oncology, pediatrics and psychiatry. Why are these nurses able to disassociate their own

self-esteem from any bullying and harassment they might experience? Possibly oncology nurses more immune because they deal with death on a daily bases and see the larger picture of life and choose not to deal with petty behaviors such as bullying and harassment. We need to learn from them what do they do or say to keep their self-esteem higher than nurses from other clinical areas when faced with bullying and harassment. More research is needed. Pediatric nurses too did not let bullying and harassment behaviors though experienced, affect their self-esteem as much as nurses from other clinical backgrounds were affected. We need to learn why. Possibly because of their work with children they might view and handle relationships differently. We need to learn more.

Psychiatry nurses again were not affected by bullying and harassment as nurses are in other clinical areas. This may be due to their training. Maybe they have they learned to disassociate their own self-esteem and experiences of bullying and harassment. Potentially their clinical training in skilled conversation techniques help them respond differently to those who bully and harass. We need to learn from them and share during their skills within the nursing educational process to help all nurses handle and not to be affected by bullying and harassment. More study is needed around the communication skills needed to deflect bullying and harassment and these techniques need to be taught to all nurses. Eventually the nursing culture will change when bullying and harassment are no longer tolerated within the profession.

When looking at RQ3 by all primary clinical work areas including psychiatry, bullying and harassment was significantly associated with turnover intention. So bullying

and harassment does reportedly occur in psychiatry as well as in all the other clinical work areas. Some nurses in some clinical work areas have the skills needed to deflect the toll bullying and harassment can take on an individual.

### **Limitations of the Study**

Limitations of this study included that the results of this study will not be generalizable to the general nursing populations. The reason being is that this study was conducted in one Midwestern state in the U.S. and would be hard to generalize the results to other nurses within the U.S. that are not from Ohio or the Midwest. Since this study looked at nurses from across the state of Ohio primary work areas like medical surgical nurses were not coming from the same medical surgical unit, but from various medical surgical units. Using the same measurements in primary work areas within a hospital would provide more robust information about the specific work culture.

Only inpatient RNs were asked to participate. It is assumed that bullying and harassment occur in outpatient settings as well, but this study was limited to inpatient nurses only due to time constraints of the researcher.

Historically, surveys have a low response rate and/or are not fully completed by all participants. This phenomena held true with this study. The response rate was only 2.1% (1,665/77,812). Shcherbakova (2016) conducted research on survey methods that yield the best results. The researcher looked at three methods: email surveys, postal surveys, and hybrid surveys (where a postcard is mailed to the participate directing them to go on line to complete a survey). The findings of this study found that traditional

postal mailed surveys yield the highest response rate: 21.0%; emailed surveys response rates were 6.8% and the hybrid method was only 3.2% (Shcherbakova, 2016).

This study's response rate was lower than anticipated. Since the response rate was so low, it might indicate that there was a potential for heavy self-selection bias. For instance, someone might argue that individuals who responded to the survey may have extra drive and dedication to the nursing profession in general. This may correlate with a better personal, professional experience and thereby it would be expected that TIM and RSES to be slightly higher while NAQ-R might be lower among respondents than the general nursing population. Self-selection in this case could have potentially dampened the significance of the results. One could also argue that nurses who have experienced bullying and harassment may have self-selected to participate. In that scenario, the NAQ-R scores would be inflated while the RSES scores would be lower than expected in the general population.

Lastly, when sending out the survey emails, approximately one third of the invited Ohio RNs were sent the emails using the "To" versus the blind copy or "BC" in the email address line. This allowed all recipients to see each other's email addresses. This upset 21 RNs enough to email the researcher asking that their names be taken off the email list. They did not realize that their emails once sent to the Ohio Board of Nursing became public domain. This could have discouraged some individuals from responding to the survey. The timing of the survey was late February through mid-March 2017 which was the time of many Ohio school's spring breaks which could have been a deterrent to completing an online survey due to being on vacation.

### **Recommendations for Further Research**

Future research is needed on the topics of bullying and harassment, self-esteem and turnover intention among RNs. This study has found that there are differences among RNs who work in various clinical settings and levels of self-esteem and bullying and harassment experiences. Questions that warrant further investigation include: Is self-esteem among RNs from same unit types, but from different hospital systems similar? Is there consistency among RNs from, for example critical care, across the country in experiences with bullying and harassment and turnover intention? What, if anything, does personality type and individual attraction to an inpatient subspecialty have to do with bullying and harassment? With the increase of males entering the nursing profession, what is their experience with bullying and harassment? How does the enculturation process of RNs into the profession effect self-esteem and ultimately bullying and harassment among peers? What is the self-esteem of nurses across the country or internationally compared to the general public? Does bullying and harassment occur between RN peers in leadership, academia, or outpatient settings? Finally what techniques can be learned from psychiatry nurses in how to handle bullying and harassment effectively?

This study and other studies have indicated critical care seems to be an area of nursing that continues to have a high incidence of bullying and harassment. This study also indicated that there is low self-esteem among critical care nurses, which is surprising given the academic rigor and clinical achievement it takes an individual to become a critical care RN. It would be interesting to look at personality types of nurses attracted to

various clinical areas and how that might correlate to incidence of bullying and harassment.

Further research needs to be done to determine the cause of bullying and harassment among RNs. Many have attributed the cause of bullying and harassment among RNs to the oppressed group theory. This study tried to look at one attribute of oppression: self-esteem. In this study it was found that all the RNs surveyed had a moderately-high level of self-esteem as determined by the RSES. This assessment would render one to believe that oppression is not a common theme among Ohio nurses, but bullying and harassment still was reported as being experienced.

Since Roberts (1983) first shared her concept that bullying and harassment between RNs has its roots in the oppression of the nursing profession, many have taken for granted that is the cause for lateral violence between nursing peers. One of the cardinal symptoms of oppression is low self-esteem (Roberts, 1983). This study found among that the Ohio RNs who participated in this study self-esteem would not be categorized as low, yet bullying and harassment were reported by the participants. This makes the case that more research around oppression in nursing is needed. Most likely, lateral or horizontal violence between RN peers is learned behavior passed down from generation to generation in the professional acclimation process. More research needs to be conducted to determine what the root cause of bullying and harassment between nursing professional is so that strategies can be developed to mitigate the issue before it causes nurses to leave their work units or the profession altogether.



One of the strategies is that much has been done to encourage the nursing profession to become just that, a profession. Magnet certification is a recognition of requirements for nursing shared governance structures, peer review expectations, and nurses to have a seat at the highest levels of leadership within the hospital system. The IOM report (2010) asked nurses to become bachelor degree holders prepared at least 80% of RNs to have a BSN by 2020, and the focus on RNs working to the full scope of their licensure have all helped to allow for greater autonomy, professionalism, job satisfaction.

### **Implications for Social Change**

This research study has brought to light that there may be an easier way for nursing leaders or organizational psychologist to test a particular nursing unit to determine if bullying and harassment exist. Since a high percentage of bullying and harassment go unreported and individuals fear retaliation for reporting bullying and harassment, conducting TIM and RSES might help leadership assess if further inquiry regarding bullying and harassment activities is indicated. If self-esteem is low and turnover intention is high, bullying and harassment may be taking place within the ranks of the unit. Once it is identified then education of the team would be necessary to mitigate the bullying and harassment. Ideally education for all nurses about bullying and harassment behaviors and how to deflect them starting in nursing school and within hospitals and other entities where nurse's work would also assist in changing this ongoing enculturated behavior among nurses. By learning to identify when a work group is experiencing bullying and harassment and teaching all RNs how to better handle the situation when faced with bullying and harassment, RN turnover may be reduced thus

allowing for safer quality care to be given by skilled professionals that are happy in their work environment. This would also lead to decreased health care cost.

### **Conclusion**

The purpose of this quantitative study was to explore the relationship between self-esteem, bullying and harassment, and turnover intention of inpatient RNs. Demographic data (age, gender, level of nursing education, work area, and work status) were also examined in regard to these variables. This study found that there is a relationship between self-esteem, experienced bullying and harassment, and turnover intention. Specifically when bullying and harassment is experienced, self-esteem is lower and turnover intention is higher. Bullying and harassment among RNs is most likely multifactorial, however this study did not support that the Oppressed Group theory for the nursing profession as a whole as one of those causes based on the moderately-high self-esteem scores among all the participants. The results of this study might generate greater awareness of bullying and harassment among RNs, its effect on turnover intention and how self-esteem is related to experiencing bullying and harassment. Bullying and harassment is not done in secret. It is witnessed by many and its effects are felt throughout the organization even to the level of the patient. Coworkers, units, teams, and health care organizations all are impacted negatively by bullying and harassment between nursing professionals. Almost half of all U.S. RNs are direct targets of bullying and harassment from their peers; finding a solution is monetarily and morally essential.

Andrea Adams, the late British author of *Bullying at Work; How to Confront and Overcome*, shared at a Manufacturing, Science, and Finance Union conference in

England just prior to her untimely death that bullying is a destruction of the victims self-esteem (Adams, 1995). Adams went on to foretell that bullying at work leads to high sickness rates, absenteeism, low morale, reduced productivity, staff turnover, potential litigation, and a poor corporate image. Adams (1995) shared that Sweden passed a law in 1994 entitled Offensive Discrimination at Work Act that serves to protect employees from bullying. The law helps employers identify bullying and offers a framework for protection of all employees. The U.S. in 2018 does not yet have such a law.

Adams (1995) proclaimed that it is essential for business to complete risk assessments. This study has shown how three highly reliable tools could be used to assess a hospital nursing unit for signs of bullying and harassment, prior to nurse turnover taking place. Using these tools as part of a risk assessment formula can give psychologists and nurse leaders' time to mitigate the issue on individual units prior to turnover becoming a problem.

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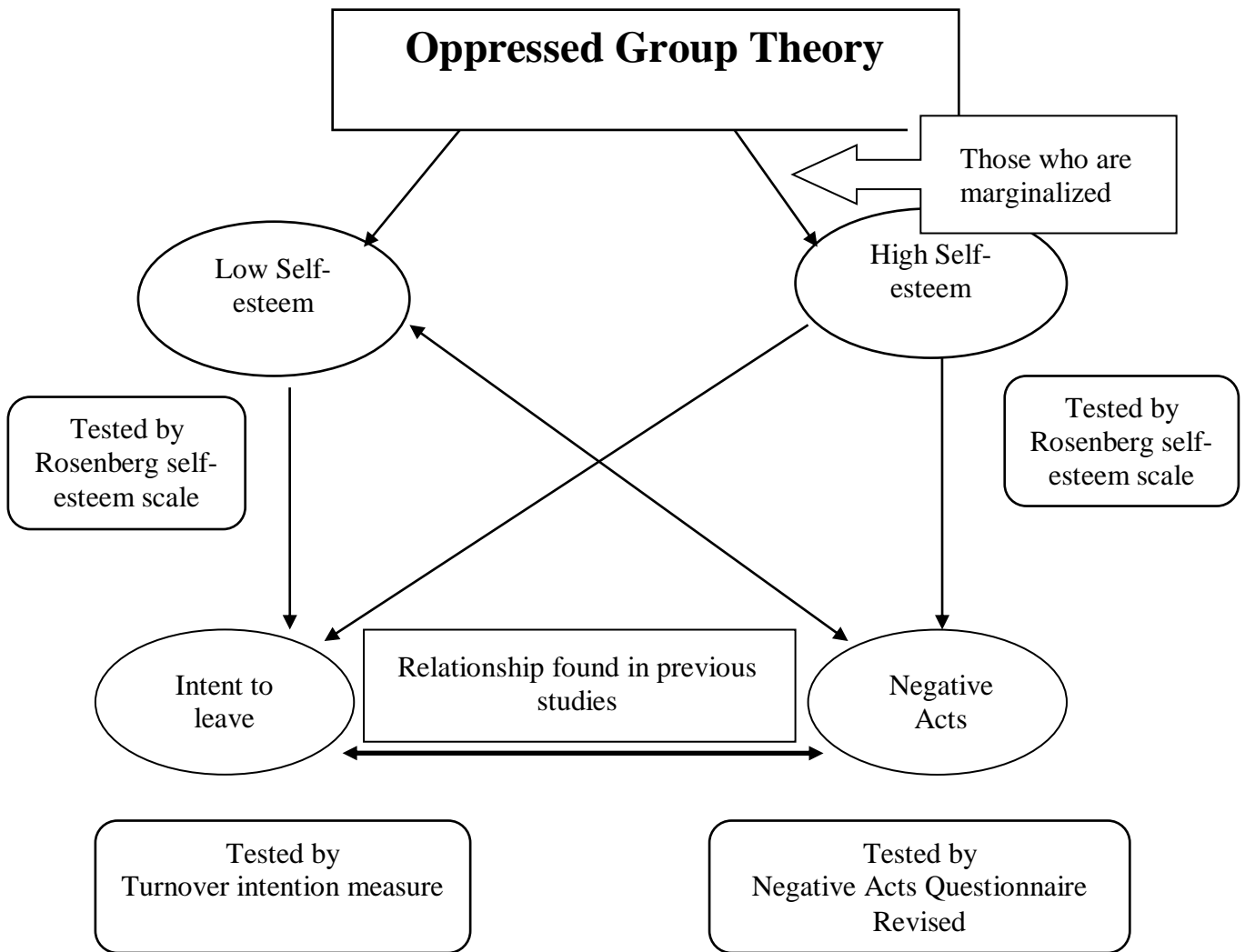
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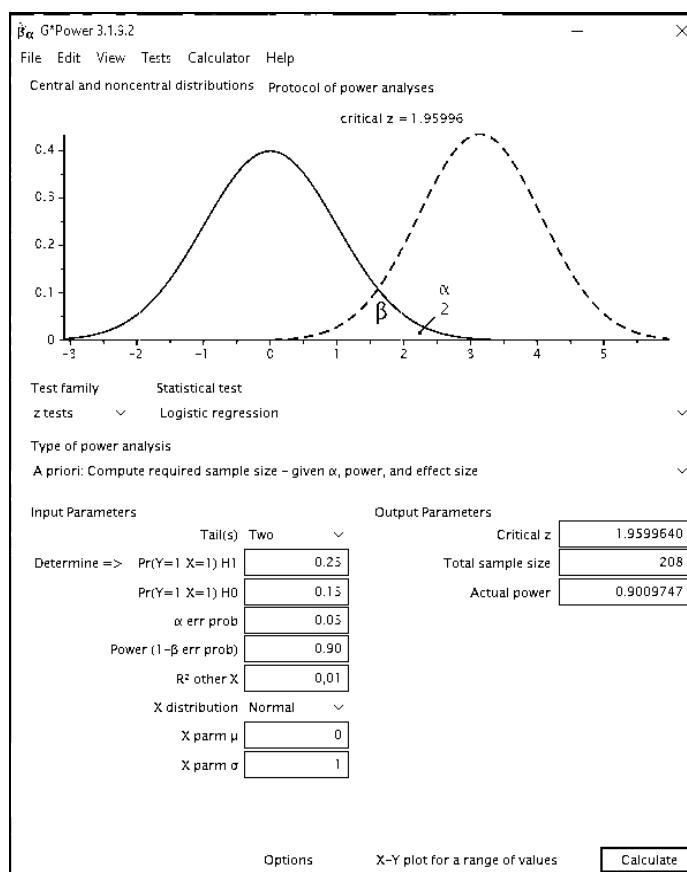
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Appendix A1:  
Conceptual Model



## Appendix B1: G-Power Power Analysis



## Appendix C: Invitation Letter

Dear RN in the state of Ohio,

Study Title:

### **The Effect of Self-Esteem, Bullying and Harassment, on Nurse Turnover Intention.**

You are being invited to participate in a research study so new information can be learned about the relationship between self-esteem, bullying and harassment, and registered nurse (RN) turnover intention. The researcher is asking you to participate because you are an RN in a staff nurse role, working full or part time in a hospital in an inpatient setting anywhere within the State of Ohio.

This study is voluntary. You are free to turn down or accept the invitation. There are 35 survey questions. All answers will be given using a five point Likert type scale. There are also six demographic questions. Completion time is estimated to be less than or equal to 12 minutes.

Your confidentiality will be respected. This study is anonymous. There will not be any identifying information on the questionnaire. The researcher will not have any access to any personal identifiers that might link your responses to your name. All responses are stored electronically in a password protected computer program, accessible only by the researcher. The secure data will be kept for a minimum of five years as required by Walden University.

There will be no reporting of any individual data. Reported data will only pertain to collective responses. You will not be able to receive any personal survey results. Any learnings will be through reported group findings in the form of presentations or study publications.

There will be no payment for your participation in this study. You will, however, have the satisfaction knowing the benefit of this study is to help discover new knowledge about the self-esteem, bullying and harassment patterns and turnover intention of Registered Nurses in Ohio.

This study should not impose any risk to your safety or well-being. It is possible that some questions asked may make you uncomfortable or cause you to remember situations that may have been upsetting to you. You do not need to answer any questions that you do not wish to answer. You may stop participating at any time.

Joyce Arand who is a Ph.D. doctoral student in the Industrial Organizational Psychology program at Walden University is the primary investigator. For questions or concerns about this research study, you can contact the researcher, Joyce Arand via email at Joyce.Arand@Waldenu.edu. Or you may contact Dr. Stacy Sprague the Walden University professor who is advising the researcher in this study via email at Stacy.sprague.mail@waldenu.edu. If you have questions about your rights as a participant, you may contact Walden IRB at IRB@mail.waldenu.edu.

Walden IRB approval number is 2-20-18-0150193 and it expires 2/19/2019.

If you feel you understand the study well enough to make a decision about participating, please indicate your consent by clicking on the survey link below and returning a completed survey. To protect your privacy, no consent signature is needed. Please keep a copy of this invitation letter/consent form for your records.

Thank you for your help in expanding the knowledge about the nursing profession.

Survey link here

<https://www.surveymonkey.com/r/SH6CKXT>

## Appendix D: Demographic Data

What is your gender? Male Female

What is your age?

What is your highest level of nursing education?

Associate degree      Master's degree

Diploma program      Doctorate of nursing practice

Bachelor's degree      Ph.D.

Do you work within a hospital as a bedside staff nurse?

Yes      No

Do you work full time, part time, PRN Per Diem, or occasionally, as a float nurse, as a traveling nurse?

What area of the hospital is your primary work area?

Critical care

Emergency department

Medical surgical

Obstetrics

Oncology

Pediatrics

Periopertative

Psychiatry

Nonapplicable, I do not work in a hospital

## Appendix E: Permission Letter

Permission Letter to Use NAQ-R From Staale Einarsen

January 8, 2017

To Whom It May Concern, **If you are interested in using the Negative Acts Questionnaire in your research you are welcome to use this scale in your research as long as you agree with the following terms:**

**1. That you give us a short description of your research project, and some information about yourself (workplace/institution, education/title).**

**Please provide the following information;**

**Dissertation Title/working title:** The Effect of Self-Esteem, Bullying and Harassment on Inpatient Registered Nurse Turnover Intention

**Purpose:** In partial fulfillment for PhD in organizational psychology

**Personal information:** Joyce Arand MS CNS RNC NEA-BC PhD student in organizational psychology at Walden University

**University Information:** Walden University

For 45 years, Walden University, an accredited institution, has been serving the higher education needs of adult learners. Today, more than 47,800 students from all 50 U.S. states and more than 150 countries are pursuing bachelor's, master's, and doctoral degrees and certificates online in a broad range of disciplines including health sciences, counseling, criminal justice, human services, management, psychology, education, public health, nursing, social work, public administration, and information technology.

**Supervisor information and contact details:**

Stacy Orr-Sprague PhD organizational psychology, Chair of my dissertation committee at Walden University

**2. That you provide us with the NAQ data (only the NAQ data, not any other data you collect) after you have finished your study, including demographic data and response rate. These data must be compatible with SPSS.**

Please state; I will provide you with the NAQ data once the research and subsequent review of the data is complete. I will include demographic data and response rate. I will be using SPSS to analyse the data.

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**3. That the use of the NAQ is for research purposes only (non-profit).**

I will be using the NAQ for non-profit research work only.

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**4. That each permission is for one project only.** I am asking permission for my dissertation research study only. **5. That you provide us with any translation of the questionnaire you may do, and that such translation must be done in a professional sound manner with back translation.** I am planning on using the NAQ and will be happy to provide you with a copy of the format. I will use in the NAQ in English.

### Appendix F: Negative Acts Questionnaire Revised

Over the last six months, how often have you been subjected to the following negative acts at work? Please indicate the number that best corresponds with your experience over the last six months: 1 Never; 2 Now and then; 3 Monthly; 4 Weekly; 5 Daily Someone withholding information, which affects your performance.

Being humiliated or ridiculed in connection with your work.

Being ordered to do work below your level of competence.

Having key areas of responsibility removed replace with more trivial or unpleasant task.

Spreading of gossip and rumors about you.

Being ignored, excluded or being isolated from others.

Having insulting or offensive remarks made about your person (i.e., habits or background) your attitudes or your private life.

Being shouted at or being the target of spontaneous anger or rage.

Intimidating behavior such as finger pointing, invasion of personal space, shoving, locking/barring the way.

Hints or signals from others that you should quit your job.

Repeated reminders of your errors or mistakes.

Being ignored or facing a hostile reaction when you approach.

Persistent criticism of your work and efforts.

Having your opinions and views ignored.

Practical jokes carried out by people you do not get along with.

Being given tasks with unreasonable or impossible targets or deadlines.

Having allegations made against you.

Excessive monitoring of your work.

Pressure not to claim something which by right you are entitled to (e.g., sick leave, holiday entitlement, travel expenses).

Being subject of excessive teasing and sarcasm.

Being exposed to unmanageable workload

Threats of violence or physical abuse or actual abuse.

Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will not refer to a one time incident as bullying

Using the above definition please state whether you have been bullied at work over the last six months?

No \_\_, Yes \_\_, Now and Then \_\_\_\_, Yes several times per week \_\_\_\_, Yes almost daily.

(Einarsen et al., 2009)



## Appendix G: Rosenberg Self-Esteem Scale

Statements	Strongly agree	Agree	Disagree	Strongly Disagree
1.I feel that I am a person of worth, at least on an equal plane with others.				
2.I fell that I have a number of good qualities.				
3.All in all, I am inclined to feel that I am a failure				
4.I am able to do things as well as most other people				
5 I feel I do not have much to be proud of.				
6 I take a positive attitude toward myself				
7 On the whole, I am satisfied with myself.				
8 I wish I could have more resepect for myself				
9 I certainly feel useless at times				
10 At times I think I am not good at all.				

## Appendix H: Turnover Intention Measure

Indicated how often you have done the following:  
(using 0 as never to 7 indicating more than once a week).

Thinking about quitting your job? 0 1 2 3 4 5 6 7

Explore other job opportunities by checking job listings or job advertisement (print or internet) 0 1 2 3 4 5 6 7