AN ABSTRACT OF THE THESIS OF

Amy Miller for the Master of Science in Psychology presented on May 2019.

Title: The Effects of a Toxic Work Environment for Registered Nurses

Thesis Chair: Dr. Persinger

Abstract approved:

This study investigated the environment of registered nurses in hopes of gaining an understanding of turnover intentions. Registered nurses from Eastern Kansas were surveyed to gain perspective on perceptions of workplace bullying, abusive supervision, and workplace autonomy in an attempt to understand what may be contributing to turnover. Variables were selected and explored with the oppression theory framework. The goal is to create solutions that will help retain talent in the Nursing field. There were 33 registered nurses who participated in this study. Nurses were surveyed on peer to peer hostility, physician support, abusive supervision, job characteristics, turnover intentions, and burnout. The results indicate that abusive supervision had the strongest relationship with the turn over intentions ($\beta = .67$, $p < .001$). Generalization of the results should be cautioned as the sample size was low and convenience sampling was used.

Keywords: nurses, turnover, burnout, abusive supervision, horizontal hostility

THE EFFECTS OF A TOXIC ENVIRONMENT FOR REGISTERED NURSES

A Thesis

Presented to the Department of Psychology

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

---

by

Amy M. Miller

May 2019

Approved for the Department of Psychology

Approved by the Dean of the Graduate
School and Distance Education

ACKNOWLEDGMENTS

My deepest thanks to my thesis committee members: George Yancey and Christopher Stone. Dr. Yancey has inspired and shaped my learning experience throughout my undergraduate and graduate studies. I am grateful to have had Dr. Yancey as a professor during the majority of my thesis. Dr. Yancey is someone I will always look up to. Dr. Yancey's teaching style and passion for Industrial and Organizational Psychology have influenced the way I approach the world. I want to thank Dr. Stone for being there for the graduate students at ESU when we needed him the most. The support and the knowledge shared from Dr. Stone and Dr. Yancey will be something I am always appreciative of. I would also like to express gratitude to my parents for continuously checking in and supporting me through the progress of this project. The support I received from my friends and family will be remembered.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Literature Review

With the nursing shortage still predicted to be an epidemic until 2022, retaining talent is vital for the Healthcare industry's bottom line (Nursing Solutions, 2016). Burnout is a common variable identified in helping professions. Burnout affects more than just profit margins and turnover rates. Burnout in nurses has been cited to effect nurse performance, mental health, and patient recovery (Cho, Sung-Hyun, Mark, Barbara, Knafl, Chang, Hyoung., & Yoon, 2017; Oh, Uhm, & Yoon, 2016). Nurse-to-nurse hostility and burnout are linked, leading to hostile work environments that further aid in toxic behaviors (Bouckenoogh, Raja, & Butt, 2013; Brotheridge, Grandey, 2002; Maslach, 1982 Oh, Uhm, & Yoon, 2016). To understand burnout in nurses, one needs to examine the profession. Understanding the origins of nursing can help understand the connection between burnout and nursing. This section briefly describes the history of nursing and how the supposed oppressive state could be rooted in the origin of the profession.

The beginning of the nursing profession is often credited to Florence Nightingale. Florence Nightingale is recognized as a significant figure in reforming the nursing profession and commonly referred to as the founder of modern nursing. Nightingale was well educated and known for her heavy reliance on statistics to provide evidence for her reforms (Selanders & Crane, 2012). During the American Civil War, Florence collected data and provided physicians with compelling evidence that changing the temperature and location of the healing center would make drastic improvements in patients' recovery (Selanders & Crane, 2012). Nightingale was a big contender for providing quality care to patients. The passion for care shaped Florence's values, empowered her staff, and set standards for nurses. Much time has passed since Nightingale's reform of the

nursing program in 1860; however, the core of the nursing profession stays true to this principle of creating a caring environment for patients. The National League for Nursing (2017) has caring as the first core value a nurse must embody. Caring is virtually synonymous with nursing and remains the profession's core. Although the core of nursing has remained a constant to the virtue of caring, some silent standards and values have emerged from others over the past 150 years.

Nurses Expectations and Oppression Theory

Kathleen Bartholomew is a former registered nurse who has written and studied nurse-to-nurse hostility through the oppression theory framework. Bartholomew has identified expectation in the nursing profession that facilitates an oppressive state. These expectations could have potentially formed from the profession being predominately women. According to social roles, gender stereotyping, and sexism, women are socialized in childhood to be nurturers, swallow or suppress anger, and deny or minimize hurt feelings (Clow, Ricciardelli, & Bartfay, 2014; Sheridan-Leos, 2008). Reverby (1987) observed that once nursing was seen as a "calling from God," appropriate characteristics were attributed to accompany the paradigm. Being viewed as "Angels of Mercy" only exemplified the expectation that nurses must care unconditionally (Reverby, 1987). Once values were established, social structures causally cast women as nurses. Accompanying expectations were that nurses reject their own needs and work long hours for little reward, nurses do not complain, and nurses are subordinate and speak only when spoken to (Bartholomew, 2006; Reverby, 1987). These characteristics are expectations of nurses and what nurses try to live up to, often implicitly. The expectations could be hindering the nursing profession.

The expectation of being subordinate reveals that nurses are not the dominant group in the work environment. The dominant group is stereotypically established as physicians. If you take

into account the context of the nursing origin, prescription to these roles was a seemingly inevitable event. The nursing profession was founded in a patriarchal society, where most of the nurses were women working for men, the physicians, and caring for strangers who were most commonly male soldiers. Using the oppression theory as a framework can reveal a few behaviors that are expected to occur once the power is unevenly distributed.

According to Paulo Freire's Pedagogy of the Oppressed, there is an inevitable prescription that happens between the oppressor and the oppressed (Freire, 1972). A basic relationship between the subordinate group and the oppressor is established, and the behavior of the oppressor is prescribed to the subordinate. The oppressed group internalizes the guidelines and image of the oppressor (Freire, 1972). Meaning that the subordinate group also takes on the values of the dominant group, and the subordinate group stops espousing their own value. Once the subordinate group stops espousing their value, their value becomes suppressed. The subordinate group feels inferior because they have to reject their values and characteristics to maintain the status quo for the dominant group (Freire, 1972). The separation creates internal conflict and self-hatred of the subordinate group that manifests itself through aggressive actions toward one another (Freire, 1972). So, although the nurses want to care and help other people, being oppressed implicitly builds aggression for their fellow nurses who are in the subordinate group (Bartholomew, 2006). When the subordinate group denies its own value, the consequence is a feeling of powerless and weakened sense of self (Freire, 1972).

Freire first coined horizontal violence when examining the oppression theory while observing a tribe in Africa. After the African tribe was colonized, there was a subordinate group and a dominant group. The values once respected and cherished in the subordinate group were lost. Losing a sense of values could be what happens once nursing students start practicing.

Somers, Finch, and Bimbaum (2010) interviewed 31 first-year nursing students to understand why they decided to choose to nurse as a profession. The results indicated that there were two distinct groups among nursing students: traditionals and instrumentals. Traditionals were attracted to nursing as a helping profession, while instrumentals were interested in career-related rewards such as variety and mobility. Although the values that the nursing students identified do exist within the profession, it is rare to perceive the values as existing due to the oppressive state, or they are not fully cherished like the nursing students expect, which could contribute to a large amount of turnover in first-year nurses (Guerrero, Chénervet, & Kilroy, 2017; Somers et al., 2010).

Through the oppression theory, the values that were hoped for and taught to the nursing students do not transfer into the working conditions because the nurses must adopt the values of the physicians. One of the most powerful forms of organizational socialization is the education system endorsed by profession (Malloy et al., 2009). Physicians' schooling historically has not centered on the same definition of "caring for patients" as the nurses' schooling is. Surveys showed that physicians tend to identify more with the organization as to where nurses identify more with patient care. Results indicated differences in decision-making and attitudes, where the nurses' identified with a caring, ethical orientation more than the physicians (Malloy et al., 2009). The physicians' subtle behaviors could be maintaining dominance and subsequently, impairing nurses' autonomy and self-worth. Sandra Roberts, who earned her Ph.D. in Nursing, applied the oppression theory to nursing and noted that physicians engage in certain behaviors that maintain dominance: not making eye contact with nurses, not learning the nurses' names, and short interactions (1983). These behaviors, although they might not have the intention of maliciousness, can be a direct link to characteristics of an oppressed group: low self-esteem, self-hatred, and feelings of powerlessness (Freire, 1972; Malloy et al., 2009; Roberts, 1983).

Work Place Bullying and Horizontal Hostility

Defining workplace bullying within the context of the nursing profession has proven to be difficult, as research still has yet to unite on a single definition. This section will explain the unique phenomenon that is common within workplace bullying for the nursing profession. Bullying, in its simplest form, is the inability to defend one's self (Trépanier, Feret, & Austin, 2013). Workplace bullying defined as the occurrence of a persistent pattern of mistreatment from others in the workplace (Ma, Wang, Chien, 2017). The Task Force on the Prevention of Workplace Bullying (2001) has defined bullying as:

Repeated inappropriate behavior, direct or indirect, whether verbal physical or otherwise, conducted by one or more persons against another or others, at the place of work or in the course of employment, which could reasonably be regarded as undermining the individual's right to dignity at work.

The Task Force Prevention of Workplace Bullying (2001) used this definition in a survey capturing workplace bullying. Based on 5,252 respondents, 48% reported bullying from a supervisor and 42% from a peer on the same power level. These results illustrate that a group with more power (supervisors) is more likely to bully. While this might be true for the majority of professions, workplace bullying for Nursing is acknowledged more frequently by peers on the same power level. Nurses tend to bully each other, theoretically putting their peer-to-peer bullying percentage higher than being bullied by a supervisor (Bartholomew, 2006).

The common saying, "Why nurses eat their young and each other," alludes to the hostility that clouds the air in the nursing culture and were first coined in 1986 (Rege, 2017). Higher reports

of witnessing bullying come from nurse to nurse reports. In 2017, Pittsburgh-based Select International Healthcare conducted a survey, and 85% of the nurses reported being abused by a fellow nurse. One in three of the nurses in that survey had also considered quitting the profession entirely due to bullying (Rege, 2017). The same statistic found in 1995 in an international survey where one in three nurses plan to leave their position because of horizontal hostility (McMillan, 1995). It is true that some climates host a higher hostility level than others, and scores will vary due to this influence, but this seems to be a ubiquitous problem in the profession.

What exactly categorizes nurse-to-nurse bullying? What is counted as an act of mistreatment to a peer? The lack of a universal term for nurse-to-nurse bullying has made it a challenging idea to study. Being bullied by a peer on the same power level goes by many names: lateral violence, horizontal violence, horizontal hostility, harassment, and nurse-to-nurse bullying. Harassment is differentiated from other bullying techniques through understanding motives. Harassment is characterized by racial or sexual motives (Simons & Mawn, 2010). There are also distinctions that differentiate horizontal hostility, horizontal violence, and lateral violence. Time distinctions are the most prominent differentiator between horizontal hostility, violence, or lateral violence and bullying (Sheridan-Leos, 2008; Bartholomew, 2006). For a behavior to be considered bullying, it must be repeated and consistent for at least six months, whereas horizontal or lateral violence can be an isolated event (Simons & Mawn, 2010). Other research breaks bullying into four components: frequency (at least once a week), persistence (six-month duration), intensity (hostile in nature), and power imbalance (Samnani & Singh, 2015). In an attempt to unify research and get an accurate understanding of workplace behavior, this cross-sectional study will define peer level bullying as horizontal hostility in an attempt to account for isolated events.

A further defined understanding of horizontal hostility can put behaviors into a dichotomy: overt and covert (Bartholomew, 2006). Overt behaviors will be displayed openly with name-calling, bickering, faultfinding, backstabbing, criticism, intimidation, gossip, shouting, blaming, using put-downs, and raising eyebrows (Bartholomew, 2006). Below is an example of overt bullying behaviors from a qualitative study documented by Bartholomew (2006):

> I am used to being in a charge nurse position and am now working on recovering patients from the cath lab. The hostility is thickly veiled. I come into work and say something like, "Nice day today," and the charge replies, "What's that supposed to mean?"…. When the charge nurse came back from break I told her all that had happened in her absence-for example that I taped down the IV in 214. Coldly, she responded, "What did you do that for?" It's a constant, negative, put-you-down undercurrent that never ends.

That passage is a shortened version of an interview Bartholomew held with a practicing registered nurse. The bullying behaviors in the above recollection were faultfinding and intimidation (Bartholomew, 2006). There was no sense of camaraderie from the head nurse, and the text suggests that the head nurse was defensive.

While behaviors are common among nurses, covert bullying is the nurses' favored weapon of perpetration with covert behaviors reported at higher incidents than overt behaviors (Bartholomew, 2006; Simons, 2008; Etienne, 2014; Simons & Mawn, 2010). Through the lens of oppression theory, covert behavior is easier and more comfortable for a suppressed group to execute (Freire, 1972). Covert behaviors are mental and not as openly displayed. Covert behaviors are illustrated through unfair assignments, sarcasm, eye rolling, ignoring, making faces behind someone's back, refusing to help, sighing, whining, refusing to work with someone, sabotage, isolation, exclusion, and fabrication (Bartholomew, 2006).

Simons and Mawn (2010) conducted a qualitative research study on newly licensed registered nurses to explore horizontal hostility. Simons and Mawn mailed open-ended questionnaires to 184 newly licensed nurses in the United States to gain insight on the perceived causes of bullying and the impact of bullying behaviors. The results revealed four themes the nurses identified in reporting their bullying stories: structural bullying, nurses eating their young, feeling out of the clique, and leaving their job. The themes of being "out of the clique" and "structural bullying" were reported from nurses reporting alienation and unfair assignment, behaviors that align with covert bullying. Here is an illustration of a nurse reporting her experience of unfair assignment and alienation (Simon & Mawn, 2010):

> During my first pregnancy, because the charge nurse did not like me, I was assigned the most infectious patients (HIV, tuberculosis, and hepatitis). When I complained, I was ridiculed and told, "Sorry, this is your assignment." When pregnancy complications developed, I was put on light duty but nobody would help me. I was told, "Do your job or leave."

The above depicts a supervisor giving an unfair assignment, but head nurses can also feel the wrath of isolation from their unit. Bartholomew (2006) interviewed a manager who was isolated from her unit:

> It had taken me almost 6 months to quit because of something I just couldn't quite put my finger on was holding me back…Then one day, when I was getting onto the elevator, I simply "got it." I looked at another manager who was already in the elevator and, as we said our perfunctory hellos, a sickening feeling punched me in the gut. As always, her eyes were riveted to the floor in order to avoid any chance of conversation… I was dying of loneliness. Despite having a good relationship with my staff, physicians, and

> administration, I had been banned by my peers, but I hadn't the faintest idea why. The years of being ignored were taking their toll.

It seems that verbal aggression and covert behaviors, such as ignoring or isolating a peer, emerge most commonly in nurses retelling of bullying experiences. A quantitative study had similar results. Etienne (2014) administered an online version of the Negative Acts Questionnaire-Revised (NAQ-R) to 10,000 registered nurses in the Pacific Northwest states (only 95 surveys were completed). Forty-eight percent of the 95 respondents reported being bullied in the workplace during the last six months. The results indicated that covert behaviors were the most prominent tactic with nurses. Being ignored or feeling left out was the number one reported negative act experienced at work (Etienne, 2014).

Hypothesis 1 (H1): Nurses will experience horizontal hostility from their peers more than occasionally, "now and then." On average, they will experience it on a monthly or weekly basis.

Dispositional Variables in Horizontal Hostility

Dispositional variables such as gender, years in the profession, and personality should be considered when looking at the horizontal hostility. These variables could add considerable insight into the differences in coping and the dynamics of workplace bullying.

Gender. The social structures of gender carry multiple expectations that can guide behavior and interactions. Because the attributes that coincide with gender exist in society, it is important to explore the relationship gender plays in horizontal hostility. Some theories explain how female stereotypes could relate to horizontal hostility. Sheridan-Leos (2008) cited lateral violence as a consequence of the female nurses not appropriately displaying frustration. Stereotypically, women are more likely to deny or minimize when their feelings are hurt, leading to a misappropriation of anger that is often toward someone on the same power level or a lower

power level (Sheridan-Leos, 2008; Bartholomew, 2006). These findings could help explain why the profession of nurses sees a higher prevalence of horizontal hostility.

Male nurses are the minority gender in the nursing profession. Gaining insight into the minority within a subordinate group will help understand the complexity of horizontal hostility. When examining the dilemma of nurse gender through the frame of oppression, male nurses should align closer to the dominant group. Following oppression guidelines, men would prescribe easier to the values of the dominant groups; therefore, experience less self-criticism and espouse less microaggression to their peers and subordinates (Freire, 1972). Thus, they will have less hostility to express than their female peers will.

According to gender role theory, men and women internalize expectations that guide behaviors according to gender. Under this theory, men are more likely to be dominant and women to be submissive, therefore, gaining men immunity to being suppressed or bullied. However, the oppression theory would suggest that the natural alignment that men inherently fulfill with the dominant group through gender could hinder the male nurses. The female nurses could be more likely to bully their fellow male counterparts because the male nurses are now a minority group. Being part of a minority group puts that group at higher risk of being bullied (Wang & Hsieh, 2016). Wang and Hsieh (2016) found that employees in minority groups carried a higher risk of social exclusion from the primary group. Within an oppressive state, female nurses are the subordinate group, however, the female gender is the dominant gender within the oppressive group so that male gender would be the minority. The female nurses could potentially use their minority counterparts as a scapegoat and displace their frustration more often on the male minority.

Bartholomew (2006) recognized that male nurses might be at high risk for horizontal hostility due to their minority status. Bartholomew's data showed that the male nurses took part in

disparaging remarks about their colleagues and reported verbal attacks from co-workers as well. Bartholomew (2006) did not report significantly higher levels of bullying from or toward male nurses. Male nurses are susceptible to horizontal hostility, but maybe not any more than the female nurses are.

Occasionally labor is divided along gender lines, and when this occurs, there are inevitable gender stereotypes (Clow, Bartfay, & Ricciarell, 2014). The idea of a female nurse is found on an international level. People expect the nurse to be a woman and that male nurse are attributed to be more feminine than other men (Clow et al., 2014). Because of this, men who study nursing can be cast into the minority and must overcome social isolation, sexism, and inaccurate portrayals of male nurses. The strong, positive, social constructs often attributed to the male gender might buffer the vulnerable-minority status that male nurses hold in the profession, or the misattributions might lead to more bullying.

A study by Clow, Bartfay, and Ricciarelli in 2014 explored attitudes toward male nurses. The results seemed to indicate no severity toward male nurses compared to the female nurses. There were 145 students surveyed on their attitudes toward male and female nurses and their attitude toward social roles and sexism. There were 90 non-nursing students surveyed and 55 nursing students, who were in their third year. It is important to note that the nursing students were in their third year because the students would have completed two years of internship with a hospital, inferring more exposure to male nurses. According to the researchers, the more exposure to a male nurse, the more normal it becomes, therefore, eliminating the hostile sexism that often is attributed to the minority gender (Clow et al., 2014). Results indicated that female nurses had higher positive attitudes for male and female nurses compared to non-nursing students. Non-nursing students only had high positive attitudes toward male nurses if they scored low in hostile

sexism, which could give insight into patient perceptions of male nurses (Clow et al., 2014). Because of mixed findings, the following research question is posed.

Research Question (RQ): Will the male nurses experience more or less horizontal hostility than the female nurses?

Newly practicing registered nurses. It is no coincidence that a registered nurse coined the term, "nurses eat their young." Research indicates a higher risk of experiencing horizontal hostility in first-year nurses (Bartholomew, 2006; Guerrero, Chénervet, & Kilroy, 2017; Sheridan-Leos, 2008). Lack of years in the profession can single out a nurse for higher risk of being bullied. Bartholomew (2006) recognized that any new hire or transfer was at a higher risk of experiencing horizontal hostility. New graduates or new transfers are easy prey as the new nurse is in the "out group" and has not earned his or her right as "one of us" (Bartholomew, 2006). In the United States, Bartholomew found that nurse turnover in hospitals was 8.4%, but the annual voluntary turnover rate for first-year nurses was 27.1% (2006).

Simons (2008) conducted a study that demonstrated a relationship between workplace bullying and turnover intentions in newly registered nurses working in Massachusetts. After receiving 511 mailed in responses of the NAQ-R from newly registered nurses (practicing for less than three years), 31% indicated being bullied at least two times weekly or daily from another nurse during a six-month period. Correlation analysis also revealed that the higher the bullying exposure, the higher the intention to turnover.

The nature of the quantitative study did not indicate what aspects of bullying were relating highest to turnover. To gain more insight on what bullying aspects related highest to turnover, Simon and Mawn (2010) contacted the same population of registered nurses from the Simon 2008 study. All participants received an open-ended questionnaire in the mail, allowing the nurses to

share their experiences in-depth in hopes of identifying a common theme. As mentioned earlier, the four themes that emerged from the content analyses were: structural bullying, nurses eating their young, feeling out of the clique, and leaving the job. Out of 184 respondents, 19 explicitly wrote, “nurses eat their young.” The nurses mentioned their own early experiences and indicated that newly licensed nurses are at a higher risk of horizontal hostility (Simons and Mawn, 2010).

Hypothesis 2 (H2): There will be a negative relationship between years in service and peer-to-peer horizontal hostility. In other words, newly registered nurses (practicing for less than three years) will report higher amounts of horizontal hostility.

The personality of victims and bullies. Personality will also guide perceptions of bullying in the workplace. Characteristics that the victim and bully possess are important to consider when looking at interactions. Some characteristics elicited through situations, and others can be part of the individual’s disposition. Research has looked at both perpetrator personality and target personality to see if there were such a thing as general personality profiles for either category.

Personality and behaviors can emanate, even unconsciously, contribute to the likelihood of being a victim of bullying. Samnani and Singh (2015) created a conceptual framework that looked at influences on workplace bullying. The researchers focused on organizational influence as well as victim and perpetrator personality. When considering the personal disposition and situational context, the researchers cited literature that supported the victim precipitation theory. The victim precipitation theory states that individuals possess or exhibit characteristics that elicit negative behaviors from others.

An example would be an individual who feels vulnerable and helpless and feels he or she has low levels of support (Samnan & Singh, 2015; Tepper, 2000)

Ménrd, Brunet, and Savoie (2011) attempted to examine personality variables in interpersonal workplace deviance. Interpersonal workplace deviance in this study was defined similarity to workplace bullying. Interpersonal deviance is captured through psychological aggression (mocking a co-worker, verbal aggression) and physical aggression (shoving a co-worker) in relation to a six-month time period, similar to the time-frequency requirements of workplace bullying. The sample consisted of 284 workers from an array of fields from office workers, technicians, managers, to workmen/workwoman (nonmanager staff). Participants responded to a survey that measured their interpersonal deviance. The researchers used the Interpersonal Deviant Workplace Behaviours Scale that measured physical (hitting, shoving) and psychological violence (refusing to talk to a coworker). Each item asked the participants to answer how often they perpetuate the deviant behavior. For example, an item will say, "Teasing coworker in front of other employees" and the scale was a 10-point Likert scale ranging from 1(every day) to 10 (0 times per 6 months). Personality traits accounted for 7.6% of the variance in interpersonal deviance; however, agreeableness was the only significant relationship ($\beta = -.251$, $p < .001$). Participants who scored high in agreeableness scored low in partaking in interpersonal deviance (Ménard, Brunet, & Savoie, 2011).

Support for the trait agreeableness and predicting bullying behavior is reported in Wilson and Nagy's (2017) study. Wilson and Nagy (2017) were interested in instigator's personality traits and used the Big 5 to examine engagement in bullying behavior. The study consisted of 129 American employees who were at their company for at least six months. Wilson and Nagy had participants answer the International Personality item pool to assess the Big 5 personality and used the Negative Acts Questionnaire-Revised (NAQ-R) to assess bullying behavior. The wording of the NAQ-R was modified to gauge the engagement of negative acts instead of looking at how often

exposed to negative acts. To determine whether a participant may have purposely answered in a pleasant manner, researchers also used the Social Desirability Scale-17 (SDS-17). After controlling for social desirability, conscientiousness, agreeableness, and neuroticism yielded significant results. Perpetrators were more likely to demonstrate low agreeableness (r (124) = -.37, $p < .001$) and low conscientiousness (r (124) = -.33, $p < .001$). Perpetrators were also more likely to report high neurotic tendencies (r (124) = .21, $p = .02$). Interestingly there was not a buffering effect for conscientiousness and neuroticism in relation to bullying behavior. Participants who reported high conscientiousness and high neuroticism were still likely to engage in bullying behavior at a higher rate ($\Delta R^2 = .00$). Wilson and Nagy's (2017) study provide the support that personality assessments might be a viable part of the screening procedure for organizations in the future, especially if the environment is struggling with workplace bullying.

Personality is an important dispositional variable to acknowledge when studying human behavior; however, there will be no research questions or hypothesis over personality and horizontal hostility in nurses for this research due to the complexity of personality and relatively low validity, that comes with testing personality variables.

Abusive Supervision

Abusive supervision is a more specific form of workplace bullying. Tepper (2000) operationally defined abusive supervision as subordinates' perceptions of the extent to which supervisors engage in the sustained display of hostile verbal and nonverbal behaviors, excluding physical contact. Tepper's emphasis on perception is largely supported by research that includes rumored supervision as part of the definition. Tepper's research suggests that even when abuse is rumored, there have been psychological effects on the employees due to the environment being alleged as more negative (Harris, Harvey, & Cast, 2013; Tepper, 2000).

Characteristics of supervisors can shape and form social norms (Malloy et al., 2009; Nielson, 2013; Wang & Hsieh, 2016). Leaders have a pervasive presence over their subordinates and inherently influence the environment and their subordinates. Differing leadership styles have different relationships with workplace bullying, finding Laissez-fare linked to the highest prevalence of workplace bullying (Nielson, 2013). Negative psychological symptoms can crossover from leader to followers. Crossover of burnout symptoms identified from the transfer of emotions due to inadequate social support (Li, Wang, Yang, & Liu, 2016). It would make casual sense to assume that leaders who feel psychologically stressed will display abusive behaviors to subordinates. If nursing supervisors or physicians are feeling distressed, it could be transferred through emotional interactions and displayed through the environment. In turn, abusive supervision may drain subordinates' resource and cause them to be psychologically distressed.

Tepper (2000) found that subordinates who reported high perceptions of abusive supervision also reported low morale, higher absenteeism, high turnover intention, and job dissatisfaction. Similar results were found from a separate study. The study surveyed 148 registered nurses to gain insight on perceptions of supervisor bullying. The study looked at first and second hand perceptions and concluded that both perceptions of abusive supervision created a vulnerable environment that threatened first-year nurses, especially (Simons & Mawn, 2010). Tepper (2000) found that supervisors who reported feelings of depression were more likely to abuse their subordinates.

Because many abusers do not recognize they are abusive, a toxic environment continues because there are no changes in abuse (Tepper, 2000). Because there are no changes in the environment and a hostile environment prevails, the subordinates must repair the damaged justice. To repair the feeling of injustice, the employee might withhold organizational citizenship behavior

and perform anti-organizational citizenship behavior, like revenge and retaliation (Ménard, Brunet, & Savoi, 2011; Tepper, 2000). Nurses in the United States who indicated experiencing verbal abuse from a physician also indicated horizontal hostility (Bartholomew, 2006). This behavior supports the notion that nurses misappropriate anger with the physician onto their peers at the same power level.

Gender of the supervisor could also play a role in perceived abuse. Wang and Hsieh (2016) studied men in a minority position at the Ministry of Finance in Taiwan. Less than 22% of the participants were men. The participants answered a shortened version of the NAQ-R to assess exposure to workplace bullying and were asked to identify demographic information and gender of their supervisors. The researchers eliminated the items that measured physical bullying because covert behaviors are more prevalent in workplace bullying. Results indicated that the men were more likely to be targets of bullying. However, both male and female subordinates reported being subjected to more bullying behaviors when assigned male supervisors.

Work Environment and Workplace Bullying

Contextual variables, such as organizational culture, team, and individual autonomy, are essential to keep in mind when considering workplace bullying. Supervision or leaders in the workplace play a huge role in defining the work environment (Malloy et al., 2009). Wang, Li, Chen, Liang, Yang, and Lee (2015) examined how stress experienced by one individual affects the level of stressors experienced by another person who is in the same environment. Lack of social support from medical staff directly linked to depression symptoms in patients (Wang et al., 2015). This could be because the psychological and interpersonal stressors that come with stress can play into the environment that everyone is a part of (Li et al., 2016). If the organization allows hostility as a norm, it will emphasize toughness and survival of the fittest for the employees (Wang & Hsieh,

2016). If the environment is highly competitive, and employees receive reinforcement for aggressive or bullying behavior, it will strengthen the normalcy of the bullying behavior. Rewards are not always explicitly acknowledged. An example of rewarding covert bullying behavior is captured from Kathleen Bartholomew's interview with a registered nurse (2006):

Five years of being ignored went by, and then one day, I finally heard the gossip about me. "Who does she think she is, having a three-day retreat for her charge nurses? Where did she get the money?" Then one day a peer stopped me in the hall after I had obtained a much-needed .5 support position and caught me totally off-guard. "You better be quiet now, missy. Now that you got what you wanted, you had better keep that mouth of yours shut."

The nurse partaking in covert behaviors, such as eye rolling, and overt behavior, such as using hostile language, strengthened the nurses' relationship with the other nurses who were angry with the nurse who was allowed vacation and support. Using hostile behavior toward someone allotted vacation time can also lead to structural bullying (Simon & Mawn, 2010). The bullying behavior strengthened the relationships between the other nurses who did not receive extended time off. There was no reported repercussion for the nurse, who bullied the other nurse, or the nurses who were gossiping. Instead, the victim was further ostracized, and the bullies were allied.

A fundamental factor in predicting workplace bullying hinges on the organizational contexts and the tolerance for bullying behaviors (Sloan, 2012; Samnani & Singh, 2015). Studies show that social support for nurses can provide nurses with profound benefits in work engagement (Vera, Martînez, Lorente, & Chambel, 2015). Social support can buffer intentions to leave an organization (Van der Heijden, Kummerling, Van der Van Dam, Schoot, Estryn-Behar, & Hasselhorn, 2010). A study done to analyze the effects of social support and job autonomy to predict work engagement found that social support from the supervisor was the only social support

that was positively related to work (Vera et al., 2015). Illustrating the notion that, in the end, the supervisor is the one who can influence autonomy.

Job Autonomy

Job autonomy is the degree to which the job allows for the employee's discretion, freedom, and independence in determining how he or she wants to carry it out (Hackman & Oldham, 1975). Job autonomy has been found to be the most important job resource among nurses (Velez & Neves, 2016). The restriction of job autonomy can lower satisfaction and work engagement and has been shown to add to the psychological symptoms of burnout (Li et al., 2016; Vera et al., 2015).

Velez and Neves (2016) conducted a study where they surveyed subordinates and supervisors at various industries on their perception of autonomy. The individuals were also surveyed over psychosomatic symptoms and deviant behaviors. The results indicate that when subordinate autonomy was low, psychosomatic symptoms were high, and so were deviant behaviors. This could be because autonomy is an innate desire for humans, and when there is a position lacking control of the outcome, psychosomatic symptoms develop to cope (Velez & Neves, 2016). When autonomy is lacking, there is evidence of individual and group consequences such as lower teamwork and turnover intentions (Simons & Mawn, 2010).

If nursing supervisors are experiencing burnout, it is likely that he or she would not have the resources to exhibit a supportive environment and would result in bullying behavior and lower perception of autonomy. When employees feel as though they do not have autonomy in the workplace, a huge void of satisfaction occurs (Li et al., 2016). A study surveying 89 psychiatric nurses showed a high level of exhaustion, depersonalization, and depression symptoms when work role autonomy and perception of the work environment were negative (Madathil, Heck, &

Schuldber, 2014). The perception of lack of autonomy due to a poor work environment was also related to burnout in the nurses (Madathil et al., 2014).

Trépanier et al. (2013) found a need for autonomy to be the strongest correlation to burnout. When job autonomy was low, the organization was more susceptible to abusive supervision, workplace deviance, and targets of abuse were less likely to leave (Tepper, 2000; Velez & Neves, 2016). Sheridan-Leos (2008) found that a lack of autonomy would increase bullying behavior because it thwarts the innate satisfaction that comes with autonomy at work. Because of this finding, this hypothesis was created.

Hypothesis 3 (H3): The relationship between autonomy and physician support at the nurses' organizations will be negatively related to peer-to-peer horizontal hostility.

Burnout

The Cost of Caring is one of the first published works to define burnout. Maslach (1982) wrote about first-hand examples of burnout after interviewing caring professionals. The book shows how to recognize, cure, and prevent burnout in nurses, teachers, counselors, doctors, police officers, social workers, and other professions where the main objective is caring for others. Maslach defined burnout as, "a syndrome of emotional exhaustion, depersonalization, and feelings of reduced personal accomplishment." Burnout can be factor analyzed into three dimensions: emotional exhaustion, cynicism, and reduced efficacy.

There has been evidence to support that burnout can be identified in medical personnel with only two of the dimensions: emotional exhaustion and depersonalization (West, Dyrbye, Satele, Sloan, & Shanafelt, 2012). Dichotomizing burnout through factor loading also identified an opportunity for single item responses. The study used physicians, surgeons, and medical students. Results indicated high Spearman correlation for emotional exhaustion (.76, .83) and for

depersonalization (.61, .72). Interestingly, these surveys did not include nurses as participants. According to the Oppression theory, the Oppressors, which would theoretically be the physicians, would be more able to identify with their feelings. Answering outright to a question like, "I feel burned out from my work," would be a lot more likely for the dominant group. The oppressed group, like the nurses, are not able to identify with their own emotions as easily (Freire, 1972). For this study, burnout is explored with all three dimensions of burnout.

The dimension of emotional exhaustion and burnout are often coupled because burnout is commonly found in helping professions where emotional labor is required (Brotheridge & Grandey, 2002; Maslach & Jackson, 1984; Raja, Javed, & Abbas, 2017). In a time-lagged study of burnout mediating workplace bullying and work-family conflict, a positive significant relationship was found with the dimension of emotional exhaustion of burnout and workplace bullying (Raja et al., 2017). There were 151 government employees surveyed with a shortened version of the NAQ, emotional exhaustion, and work-family conflict. The individuals were surveyed over a six-week period. Every two weeks, the individuals would get a new survey. The results indicated that the individuals who reported a high level of workplace bullying during week one reported a high level of burnout at week two. There was not a clear relationship between burnout and work-family conflict (Raja et al., 2017). The results support the idea that workplace bullying appears to leave victims emotionally and physically drained. Workplace bullying can deplete social resources and coincide with burnout symptoms (Raja et al., 2017).

Brotheridge and Grandey (2002) explored emotional labor to understand aspects of job demands that relate to burnout. In their study, emotional labor was broken into "job-focused emotional labor" and "employee-focused emotional labor." The job-focused emotional labor was defined by frequent interactions with customers, "people work," and the employee-focused

emotional labor was defined by the employees' ability to manage emotions to meet job demands. Brotheridge and Grandey (2002) captured the behavior of the emotional labor in two dimensions: surface level acting, or faking, and deep acting. The researchers surveyed 238 employees in five different people-oriented industries and found that when individuals worked employee-focused jobs, their ability to deep act was related to their burnout symptoms. In other words, when employees took part in surface level acting or faking, they also reported higher levels of burnout symptoms. Results for deep acting are not as clear. Deep acting is the ability to control internal thoughts and feelings. The ability to compartmentalize emotions and gain control over emotions during work situations has had mixed results (Brotheridge & Grandey, 2002; Hocschild, 1983; Gross & Levenson, 1997). Deep acting techniques can decrease emotional dissonance and allow the individual to feel a greater sense of accomplishment, buffering burnout, or the physiological effort of suppressing true feelings can lead to emotional exhaustion. Alluding to the idea that if nurses possess deep acting techniques, there will not be burnout symptoms in regard to patient care.

There is evidence that burnout symptoms can stem from situational factors that may not originate at work but rather at home or in personal life (Nohe, Meier, Sonntag, & Michel, 2015). Personality factors and disposition can make individuals more susceptible to burnout (Ghorpade, Lackritz, & Singh, 2001). However, for this study, burnout will be only be assessed through nurses' self-reported symptoms in regards to their profession and their patients without surveying for insight into personality or personal life.

Hypothesis 4 (H4): There will be a positive relationship between peer-to-peer horizontal hostility and nurse burnout.

Turnover Intention, Organizational Commitment, and Professional Commitment

Voluntary turnover is a problem for any employer, but voluntary turnover is especially serious when there is a projected shortage for a field like there is for nurses. Turnover intention is widely accepted as an outcome related to employee burnout and low levels of job satisfaction (Carsten & Spector, 1987). The complexity of turnover intentions cannot be limited to the study of burnout as a moderator. Personality, organizational commitment, and situational variables are essential to keep in context.

There have been efforts to examine the relationship between positive and negative affectivity and job satisfaction (Bouckenooghe, Raja, & Butt, 2013). After surveying 321 participants from eight different organizations in Pakistan, researchers also examined the relationship of affectivity to job performance and turnover intentions. The organizations ranged from hospitals to manufacturing companies, and the individuals ranged from nurses to electrical engineers. Results indicated only partial support in predicting turnover intention with negative and positive affectivity (Bouckenooghe, Raja, & Butt, 2013). In another attempt to study personal disposition and how it affects burnout and organizational commitment, 445 female nurses in Beijing, China, were surveyed on core self-evaluations (Zhou, Lu, Liu, Zhang, & Chen, 2014). The nurses were also surveyed on organizational commitment. Results indicated that if nurses had a strong self-evaluation and high affective commitment to their organization, they were less likely to report burnout symptoms.

Turnover intention is typically defined as the desire to leave an organization. The commitment an employee has to an organization has been shown to influence behaviors such as turnover, absenteeism, and performance effectiveness (Ménard, Brunet, & Savoie, 2011). Zhou et al. (2014) found that organizational commitment can buffer burnout symptoms. The importance

that organizational commitment can have on job satisfaction is reported in Bateman's (1984) longitudinal study on 128 nurses. Results indicated that organizational commitment is an antecedent to job satisfaction rather than an outcome.

Hypothesis 5 (H5): There will be a positive relationship between peer-to-peer horizontal hostility and nurse turnover intentions.

Organizational commitment can be defined as an employees' loyalty to the organization, willingness to exert effort on behalf of the organization, and desire to maintain membership (Bateman, 1984). The relationship between employees and their organization is often examined through three different commitment styles: affective, continuance, and normative. Meyer and Allen (1991) defined affective commitment as an employee's emotional attachment, identification, and desire to be in the organization. Continuance commitment is commitment based on costs that an employee associates with leaving the organization, while normative commitment represents an employee's feeling of obligation to stay within the organization. Affective commitment to an organization has been linked to psychological benefits, increased job performance, job satisfaction, and work engagement (Batemean, 1984; Gill, Meyer, Lee, Shin, & Yoon, 2011; Ohana, 2014). Continuance commitment to an organization has been linked to workplace deviance and has been shown to be the most detrimental to organizations (Gill et al., 2011).

Ohana (2014) researched predictors of company commitment. Data on 20,936 employees from 1,496 companies showed that for employees to be effectively committed to a company, individuals must perceive organizational justice. Nurses who are in a climate where bullying is tolerated probably have lower perceptions of organizational justice; therefore, they are probably less effectively committed to their organization.

Leaving the profession completely has been reported by nurses who have experienced hostile environments (Bartholomew, 2006). In an attempt to understand what variables predict professional commitment in nursing, Guerrero, Chénevert, & Kilroy (2017) ran a longitudinal study on nurses living in Canada. Pre-entry perceptions of nursing showed a large amount of variance in commitment to the nursing profession. Experiencing a reality shock when transferring from University to Hospital work can deter newly graduated nurses from staying in the field (Guerrero et al., 2017). Thus, painting a realistic pre-entry perception during nursing school with a realistic job preview might better prepare nurses.

On the other hand, research also shows that when student nurses had positive experiences, they were more likely to have positive experiences when practicing the profession, and if student nurses had negative experiences, they were more likely to have negative experiences when practicing the profession, therefore, hindering commitment to the profession (Guerrero et al., 2017). The other variables that predicted professional commitment came down to providing a positive work environment and excellent work characteristics, such as bonuses, job security, and opportunity for career advancement (Guerreroro et al., 2017). Examining nurses' commitment to the profession could be beneficial in reversing the nursing shortage.

Hypothesis 6 (H6): There will be a positive relationship between abusive supervision and nurse turnover intentions.

Chapter 2
METHODS

Before collecting any data, I obtained approval of my University's IRB (see Appendix H). Each participant received a cover letter (see Appendix I). The cover letter indicated that the study is concerned with the perceptions of the nurses' work environment, that nurses were not required to participate, and that they were allowed to withdrawal at any time. Confidentiality was promised.

After IRB approval, times were established with each Hospital's HR in determining best availability of the Nursing staff. All four HR departments declined my proposal. Participants were volunteers that contacted me digitally. The consent form and survey were mailed to the nurses. Nurses mailed the signed consent form and survey back to me. My decision to do paper and pencil surveys was rooted in two motivators. Online surveys typically have a lower rate return than paper (Etienne, 2014). The second motivator was rooted in the silent culture that is valued within healthcare (Bartholomew, 2006). I thought a direct approach of individually asking nurses to complete a paper and pencil survey might allow for more security (Bartholomew, 2006).

Methods

Registered nurses from the Midwest were asked to participate in this study. In hopes of getting a higher response rate and more honest results guidelines Bartholomew's (2006) suggest were implemented and demographic questions were kept to a minimum. Thus, participants were not asked to identify their race, ethnicity, or age.

The final sample included 33 registered nurses. The average number of years of practice in their occupation was 6.69 years with a standard deviation of 8.12 years. The average number of years tenure with their hospital was 4.15 years with a standard deviation of 6.70. Participants were predominately women (84%). Participants' supervisors were 81% women and average supervisor age was reported between 36-40,41-45 years of age.

Instruments

Each survey was selected from previous research. Modifications were made to the Likert-scales of all of the surveys so that each survey followed the same scale. Some of the instruments were shortened. Below are the modifications and decisions for instrument selection.

Horizontal hostility. Perceptions of bullying behaviors will be assessed using a shortened, 10 item version of the Negative Acts Questionnaire Revised (NAQ-R) (Einarsen, Hoel & Notelaers, 2009) (see Appendix A). The full NAQ-R has a Cronbach's alpha of .90, indicating excellent consistency and potential reliability if the instrument was shortened (Einarsen, Hoel, & Notelaers, 2009). The decision to shorten the scale was after the statistical backing and recognizing that many of the items are redundant and the scale was still valid under single factors (Einarsen, Hoel, & Notelaers, 2009). The NAQ-R is a 22 objective questionnaire referring to bullying behaviors in the context of work. The behaviors in the NAQ-R have been identified as three categories: personal bullying, work-related bullying, and physically intimidating forms of bullying. The acts vary from indirect (being ignored or excluded) to direct negative acts (finger pointing). Work related bullying can be found in items 1, 3, 14, 16, 18, 19. Person-related bullying items are 2, 4, 5, 6, 7, 10, 11, 12, 13, 15, 17, 20. Physically intimidating bullying are items 8, 9, 22. The NAQ-R can be used as a single factor measure with high correlations between the full NAQ-R and the three factors with the three dimensions exceeding .70 (Einarsen, Hoel, Notelaers, 2009). The ten items I will use measure the frequency of exposure to hostile behaviors on a five-point Likert scale (1 No, 2 yes, now and then, 3 yes, several times per month, 4 yes, several times per week, 5 yes, almost daily). An example of an item: Someone withholding information, which affects your performance (α = .71) (Einarsen, Hoel, & Notelaers, 2009). Because I did select 10

items, I thought were most related to the acts nurses would be exposed to, I did run a Cronbach alpha for my version of the NAQ-R (α =.79).

Abusive supervision. To assess abusive supervision, Tepper's (2000) Abusive Supervision Measure will be used. Tepper's original 15-item measure assessed nonphysical abusive supervision, perceived mobility, and organizational justice. However, Mitchell, Maureen, and Ambrose (2007) performed exploratory and confirmatory factor analyses on two separate data sets that used the original 15-item measure and found evidence for only two factors, passive abuse and active abuse. The first factor, passive abuse, explained 48% of the variance and included statements like my supervisor "doesn't give me credit for jobs requiring a lot of effort." The second factor, active abuse, explained 9% of the variance and included statements like my supervisor "ridicules me" and "tells me my thoughts and feelings are stupid." Five of the items failed to load conclusively on either factor. Thus, I will use these ten items to measure the two types of supervisor abuse (Appendix B). In addition, I added one of the items that dealt with receiving the silent treatment from one's boss. I added this item because qualitative studies reported silent treatment or being ignored as the number one concern, or major reported incident, for Registered Nurses (Etienne, 2014; Sheridan-Leos, 2008; Simon & Mawn, 2010) The nurses indicated their agreement with each item using the same five-point Likert scale as the NAQ-R (1, "No" to 5, "Yes, almost daily"). A high score indicated the prevalence of abusive supervision. The 11-item measure used appears in Appendix B.

Job autonomy. Job autonomy is assessed with a 4-item survey (Appendix C). The survey items were inspired by the Control and Complexity survey created by Frese, Kring, Soose, and Zempel (1996). The coefficient alpha was .78 for the control items. Items in the original scale are measured on a five-point Likert scale (1, very little to 5, very much). The scale has been changed

to match the rest of the surveys and will be a five-point Likert scale (1, "No" to 5, "Yes, almost daily"). The items in the original survey are posed as questions ("If you look at your job as a whole: how many decisions does it allow you to make?"), these have been changed to statements (My job allows me to make decisions). This is to better match with the scale.

Physician support. To assess the perception of physician support, a new scale was created (Appendix D). The survey is 4 items and is on a 1-6 Likert scale (1, strongly disagree to 6, strongly agree). An example of an item from the survey would be, "In general, the physicians go out of their way to make my work life easier."

Burnout. To measure burnout, I will be using a version of the Bernhard's (2007) College Student Survey (CSS) (Appendix E). This survey examines how frequently students experience certain events. The original CSS consists of 22 items and is divided into 3 subscales: Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). Xi Lu (2010) created a 15 items survey from the Bernhard's (2005) CSS. Where the word "school" was exchanged with by "work," and "friends and classmates" exchanged with "colleagues and supervisors." Items 1 to 6 measure EE; items 7 to 11 measure DP, and items 12 to 15 measures PA. Item 11 on the DP scale was reverse scored. Higher scores on EE and DP, and low scores on PA indicate higher levels of burnout. Xi Lu (2010) found internal consistency for EE, DP, and PA with coefficients of .87, .65, and .78. In an attempt to understand nurses' perception of patients, I have added 3 additional items to the survey. The added items and their dimension of burnout are: DP ("I feel like I sometimes treat patients as impersonal objects."), ("I don't really care what happens to some patients"), and PA ("I can easily create a relaxed atmosphere with my patients"). Nurses will be instructed to use the same five- point Likert-Scale (1, "Never" to 5, "Almost daily")

used in obtaining information on horizontal hostility and abusive supervision. See Appendix D for survey.

Turnover intention. Intention to quit was measured with Colarelli's (1984) three-item scale (Appendix F). This scale was used in Sak's (2006) study of employee engagement and found high levels of internal consistency (.84). A sample item is, "I am planning to search for a new job during the next twelve months." (α=.82). Participants responded to the items with a five-point Likert-type scale (1, "Never" to 5, "Almost daily")

Demographics. Demographics will be listed last in an attempt to create a safe and anonymous environment (Schutt, 2017). Nurses identified their gender, how long they have been practicing the profession, how long they have been at that hospital, the age of their supervisor, and the gender of their supervisor. These questions appear in Appendix G.

Statistical Analyses

H1: Nurses will experience horizontal hostility from their peers more than occasionally, "now and then." On average, they will experience it on a monthly or weekly basis.

To examine the first hypothesis, I ran a one-sample t-test to compare the nurses' mean score on the NAQ-R against a score of 2 which equates to experiencing hostility only now and then.

RQ: Will the male nurses experience more or less horizontal hostility than the female nurses?

To examine my research question, I compared the means of female and male nurses in the entire population study. Because I have two groups, I conducted an independent samples t-test where the male and female hostility averages from the shortened NAQ-R will be compared.

H2: There will be a negative relationship between years in service and peer-to-peer horizontal hostility. In other words, newly registered nurses (practicing for less than three years) will report higher amounts of horizontal hostility.

For my second hypothesis, I ran a Pearson correlation to examine the relationship between years of tenure and horizontal hostility reported from the NAQ-R. To examine whether or not newly registered nurses will report higher amounts of horizontal hostility, I ran a regression.

H3: Both autonomy and physician support will be negatively related to peer-to-peer horizontal hostility.

For my third hypothesis, I ran a Pearson correlation to examine the relationship between autonomy and physician support and horizontal hostility reported from the NAQ-R.

H4: There will be a positive relationship between peer-to-peer horizontal hostility and nurse burnout.

For my fourth hypothesis, I ran a Pearson correlation to examine the relationship between horizontal hostility reported from the NAQ-R and nurse burnout.

H5: There will be a positive relationship between peer-to-peer horizontal hostility and nurse turnover intentions.

For my fifth hypothesis, I ran a Pearson correlation to examine the relationship between horizontal hostility reported from the NAQ-R and nurse turnover intentions.

H6: There will be a positive relationship between abusive supervision and nurse turnover intentions.

For my sixth hypothesis, I ran a Pearson correlation to examine the relationship between abusive supervision, using Tepper's (2000) Abusive Supervision Measure and nurse turnover intentions.

CHAPTER 3

RESULTS

Data was obtained via paper and pencil surveys. Responses were entered into an Excel file and stored on a personal hard drive. The variables examining work environment with the NAQ-R can be found on Table 1. Critical value of *r* was calculated by using formula from Dunaetz (2017). Internal consistency of each survey was derived from the Cronbach alpha and is displayed in the diagonal on Table 1.

A table with the descriptive demographic data can be found on Table 2. A total of 33 registered nurses completed the survey. There are 5 male and 28 females. The average years worked as a registered nurse is 6 and the average amount of time working at their current hospital is 4.15. There are 6 nurses who reported being supervised by a male nurse and 27 nurses who reported having a female supervisor. The average age of the supervisor fell in the category of '41-45' years old.

Hypothesis Testing

Statistical analysis was conducted on Excel. All six of the hypotheses are tested at a significance level of .05. The research question is also tested at a significance level of .05. Tables are from Excel. The following are the results from hypothesis analyses and research question.

Hypothesis 1

To assess whether or not nurses will experience horizontal hostility more than occasionally a one sample *t*-test was performed. The results for the H1 can be found on Table 3. The one-sample t-test was associated with a non-significant effect, $t\ (31) = -.30$, $p > .05$. Thus, H1 was not supported. On average the nurses did not report higher than 2 on the NAQ-R ($M = 1.97$, $SD = .58$), inferring that nurses experience peer to peer hostility less than "now and then."

Table 1

Table of Correlation for Main Variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. Respondent	--											
2. Gender	0.19	--										
3. Gender Supervisor	0.38*	0.02	--									
4. Years as RN	-0.24	-0.23	-0.01	--								
5. Years in Hospital	-0.09	0.13	0.20	0.4*	--							
6. Supervisor Age	0.21	-0.03	0.04	0.28	0.23	--						
7. NAQR Average	0.21	-0.01	-0.17	-0.16	-0.18	0.13	0.79					
8. Autonomy	-0.14	0.07	0.33*	0.24	0.36*	0.13	-0.02	0.55				
9. Physician	-0.29	0.12	0.30	0.12	0.39*	-0.18	-0.15	0.30	0.78			
10. Burnout	0.40*	0.20	0.11	-0.21	-0.11	0.19	0.27	0.02	-0.27	0.79		
11. Turn - Over Intention	0.31	0.25	-0.20	-0.36	-0.42*	-0.13	0.33	-0.47**	-0.49**	0.41*	0.83	
12. Abusive Supervision	-0.03	0.01	-0.21	-0.03	-0.07	0.11	0.12	-0.01	-0.13	0.17	0.03	0.93

Note: *$p < .05$, **$p < .01$, *two-tailed.* $N = 33$. For gender, 1 = female, 2 = male.

Table 2

Descriptive Statistics of Demographic Variables

Measures	M	SD	Range
Years as RN	6.70	8.13	31.00
Years in Hospital	4.15	6.71	32.00
Supervisor Age	4.53	1.78	6.00

Note: $N = 33$.

Table 3

t-Test: NAQ-R

	NAQ-R Average
Mean	1.97
Variance	0.34
Observations	33.00
df	32.00
t Stat	-0.30
P(T<=t) one-tail	0.38
t Critical one-tail	1.69

Research Question

An independent-samples *t*-test was calculated to determine whether or not there is significant difference between the NAQ-R scores between male and female nurses. Results for the independent – samples *t* test is displayed on Table 4. When the sample is broken into gender, the sample size is less than 30. Because this lowers the sample size, equal variances were assumed. Results indicated non-significant results, for male **(***M* = 1.96, *SD* = .25) and female (*M* = 1.98, *SD* = .37), *t* (31) = -.051, $p < .05$. These results suggest that there is no difference between male and female nurses when it comes to peer to peer horizontal hostility.

Hypothesis 2

I ran a Pearson correlation to compare years of tenure to horizontal hostility reported from the NAQ-R. There is a negative relationship between years worked as an RN and reported NAQ-R scores (r = -.16), which provides partial support for H2. To analyze the relationship of newly registered nurses and reported negative acts, I ran a regression with the NAQ-R scores as the independent variable and years of tenure for newly registered nurse as the dependent variable. The results for the regression are displayed on Table 5. Results yielded no significance of NAQ-R scores on the years in the profession (β = -.12, p = .58). Indicating that a nurse working less than 3 years in the profession, reported -.12 points less on the NAQ-R, not supporting H2. No statistically significant support was found for H2.

Table 4

t-Test: NAQ-R Gender Means

	Male	Female
Mean	1.96	1.98
Variance	0.25	0.37
Observations	5.00	28.00
Pooled Variance	0.36	
df	31.00	
t Stat	-0.05	
P(T<=t) one-tail	0.48	
t Critical one-tail	1.70	
P(T<=t) two-tail	0.96	
t Critical two-tail	2.04	

Hypothesis 3

I ran a Pearson correlation to examine the relationship between autonomy (M = 4.02, SD = .50) and physician support (M = 2.97, SD = .83). Results indicated a positive relationship between autonomy and physician support; however, the results are not significant (p > .05). I examined the dependency each variable had on the NAQ-R by running a regression. Results indicated no dependency for autonomy (β = .03, p > .05) or physician support

(β = -.11, $p > .05$).) The regression (Table 6) indicates that when nurses reported NAQ-R scores around 2.18 they reported autonomy at a .03 increase and physician support was negatively related with how nurses reported to NAQ-R.

Table 5

Regression of NAQ-R score on years of tenure

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	2.03	0.14	14.08	0.00	1.74	2.32
Years of Tenure (less than 3 Years)	-0.12	0.21	-0.56	**0.58**	-0.54	0.31

Table 6

Regression for Autonomy and physician support

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	2.18	0.86	2.53	0.02	0.42	3.94
Autonomy	0.03	0.22	0.14	**0.89**	-0.42	0.48
Physician Support	-0.11	0.13	-0.83	**0.41**	-0.39	0.16

Hypothesis 4

I ran a Pearson correlation to examine the relationship between self-reported burnout scores and self-reported NAQR. The average response to burnout was surprisingly low ($M = 2.89$, $SD = .55$). A regression (Table 7) was used to test if burnout scores predicted NAQ-R scores, the results indicated that it was not significant (β = .30, $p > .05$).

Hypothesis 5

I ran a Pearson correlation to examine the relationship between turnover intentions (M = 3.07, SD = 1.15) and the NAQ-R. A positive relationship between turnover intention and NAQ-R (r = 0.31). This provides partial support for H5; however, the regression analysis (Table 8) revealed the relationship was not significant (β = .30, p = .08).

Hypothesis 6

A Pearson correlation revealed a positive and significant relationship between self-reported abusive supervision (M = 1.89, SD = 1.15) and turnover intentions. A simple regression (Table 9) was calculated to predict participants intention to turn over based on their report of abusive supervision behavior. A significant regression equation was found (F (1, 32) = 11.81, p < .001), with an R^2 of .28. Nurses were more likely by nearly a full point, or .67, to report turnover intention if reporting abusive supervision. These findings result in statistically significant model (β = .67, p <.001).

Table 7

Regression of NAQ-R scores on burnout scores

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	1.09	0.54	2.02	0.05	-0.01	2.20
Burnout	0.30	0.18	1.65	**0.11**	-0.07	0.68

Table 8

Regression of NAQ-R and Turnover Intention

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	1.86	0.69	2.70	0.01	0.46	3.26
Turnover Intention	0.61	0.33	1.83	**0.08**	-0.07	1.30

Table 9

Regression for Abusive Supervision and Turnover Intention

Regression Statistics	
Multiple R	0.53
R Square	0.28
Adjusted R Square	0.25
Standard Error	1.00
Observations	33.00

ANOVA

	df	SS	MS	F	Significance F
Regression	1.00	11.76	11.76	11.81	0.00
Residual	31.00	30.86	1.00		
Total	32.00	42.61			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%
Intercept	1.80	0.41	4.39	0.00	0.96	2.63
Abusive Supervision	0.67	0.20	3.44	**0.00**	0.27	1.07

CHAPTER 4

DISCUSSION

Exploring environmental variables that could potentially account for workplace bullying behavior deserve investigation. The purpose of this paper was to explore work place bullying in registered nurses in hopes of identifying a significant relationship to theoretically help with the nursing shortage. The variables in this study were derived from the oppression theory framework. Overarchingly, it was predicted that the structure of the environment in hospitals was contributing to environmental variables that could potentially be linked to burnout or turnover intentions in nurses.

Results indicated no significant findings with the variables selected with the exception of abusive supervision and turn over intentions. Abusive supervision was linked to turn over intentions; therefore, it could be argued that a main proponent of the oppression theory was supported. Perhaps indicating that hospital environments do function under an oppressive state. There are several things to keep in mind when interpreting all hypothesis.

The most obvious factor that could be contributing to results is the sample size. The minimum acceptable N size for research is 30 and this study had 33 participants. Having a low sample size can contribute to the nonsignificant results and the strength of the supported results in H6.

There was not statistical support for H1, which examined the nurses' self-reported observation of being subjected to bullying behavior by their fellow nurses. The average response was below a 2 indicating that on average nurses in this study claimed, "Never" being a victim of bullying. At first, this can seem surprising, however, understanding an oppressive state can explain the variance. It is important to note that the oppressed do not always realize they are

being oppressed (Freire, 1972). In fact, for the oppressed to become liberated they must first acknowledge the act of being oppressed, which due to the prescribed values of the dominate group, the veil of oppression blinds their ability to acknowledge the dehumanizing behaviors that are oppressing them (Freire, 1972). If the nurses are being oppressed or implicitly complying to the expectation of a silent culture (Bartholomew, 2006; Reverby, 1987), a Likert scaled quantitative response might be too simple of an approach. The construct and types of the questionnaires will be discussed in the limitation section.

When interpreting the results from the research question and H2, it's important to remember that the sample was categorized into binary groups, therefore lowering the sample from 33. The research question broke the group into male and female and H2 broke the group down from newly practicing nurses to more seasoned nurses. I think having a larger sample size or running a meta-analysis of past research asking these questions might have led to different results.

There was a positive relationship between autonomy and physician support, H3. The regression showed a nonsignificant relationship with these two variables and the NAQ-R. Indicating that autonomy and physician support did not change whether or not a nurse reported being a target of peer to peer hostility. Because there is a positive relationship between perceived autonomy and perceived physician support, it would make sense that nurses reporting a high level of these would not feel like they were being targets of work place bullying.

The results for H4 could indicate that peer to peer bullying might not be related to burnout. The average response for both surveys were relatively low. The average response for burnout was 2.98 and the average response for the NAQ-R was 1.97. This scale ranged from 1 =

never and 2 = very rarely, indicating that the nurses in this study did not identify strongly with burnout symptoms or NAQ-R.

There was a positive relationship between turnover intentions and NAQ-R. The regression indicated that the relationship was non-significant, (p = .08), however, support for the nurses wanting to leave the position due to peer to peer bullying is something that could potentially be looked into with different surveying tools. Burnout might be correlated stronger to something related to a job characteristic, the emotional labor of the position, and wanting to leave the company could be related to coworker interaction.

Hypothesis 6 was statistically significant. The positive relationship between turnover intentions and abusive supervision suggests the idea coworker interaction might have a role on retaining nurses than burnout symptoms.

Limitations and Future Research Directions

This study has several limitations. First, a major assumption that was the base of this study could have led to some of the insignificant results. For future research, surveying each hospital's specific culture would be beneficial. If oppression theory is in fact the framework in which hospitals function, there would be a veil of silence due to the underlining assumption in the oppression theory. Grasping a better foundation of the culture in which hospitals operate in would allow for better variable selection, allow for unifying definitions, and potentially allow for creation of more effective surveying tools.

The lack of unifying definitions for this body of research is a second limitation that should be noted. The lack of operant definitions for 'bully,' 'target,' and 'victim,' has logically created a difficulty in creating assessments that are consistent. Hershcovis (2011) saw this in the examination of workplace bullying. Hershcovis ran a meta-analysis to look at how targets of

bullying responded to various attempts of capturing workplace aggression. There was significant overlap between constructs identified as aggression in the workplace. Hershcovis' showed distinctions between constructs and support that the collection of data through current assessments are not allowing for targets to make distinctions. For future research definitions along with the survey could be added or allowing a space for qualitative feedback.

Due to the complicated concepts and potential veil of oppression, this study limited results by using only quantitative data. Previous research that had results that found significant bullying behavior between nurses were largely identified through the qualitative analysis. This could be perhaps due to the nature of the nurses not being able to identify as a 'victim' or 'target' when simply given a Likert scale. Behaviors they are exposed to might be so normal they no longer see it as bullying behavior but will want to share distinct incidences they want to share.

Nurses identifying distinct incidences fall within the definition of bullying for researchers who recognize distinct incidences and isolated events as a form of bullying (Simons & Mawn, 2010). The duration of bullying behavior typically has to last for 6 months (Bartholomew, 2006, Samnani & Singh, 2015, Sheridan-Leos, 2008). Supporting the notion that definitions are important for research that require self-identification with undesirable characteristics. Providing a context or unifying on a relevant definition to examine the behavior could allow for consistent results. When looking at peer to peer hostility an operant definition specialized for bullying in environments speculated to be in an oppressed state might be beneficial for research. Simply due to the fact that oppression becomes normal and "light bulb moments" might be the only way oppressed individuals will be able to recognize their environment.

Surveying to understand that concept would be beneficial to interpreting and crafting more revealing surveying tools for the future. If there is a veil of oppression limiting the nurse's

perception to process bullying behavior, looking at the frequency and impact of extrinsic variables might be something that could expose a relationship with turnover intention or burnout. The mental and emotional state of a nurse is a human factor that needs to be assessed and might be more complicated to capture than a Likert point survey. Consider extrinsic variables that also shape environment for nurses.

For hospitals who are interested in retention or the environmental health of their organization I would recommend surveying nurses on their perspective of the company culture. Because this study revealed a significant relationship between the intention to leave and their perception of their supervisor, I would recommend looking into that relationship with the nurses and allowing qualitative feedback. If there is oppression happening in hospitals the only way to break free is liberation, which takes effort from the oppressors. Therefore, I think a beneficial training would be with the physicians. If medical staff could unify values, there would be a relief of oppressed symptoms. Unifying values could be done from a strong positive culture being espoused from the hospital's mission or starting the unification during the physicians' schooling. Curriculum changes to emphasize more caring and empathetic cultures is something that educational systems have begun to move toward (Malhorta, 2016; Smith, 2016). Because of the change in educational curriculum, the next few years might reveal a supportive relationship between nurse supervisors and nurses.

This study allows for a some understanding between the nurses' perceptions of environmental variables, coworker relations, and their intention to stay with their hospital. The findings allow for interpretation and brainstorming on different ways to approach the nursing retention. I encourage future research to investigate variables related more toward nurse and nurse supervisor relationships and to allow the nurses to provide qualitative feedback.

References

Bartholomew, K. (2006). *Ending nurse-to-nurse hostility: Why nurses eat their young and each other*. HC Pro, Inc..

Bateman, T. (1984). A longitudinal analysis of the antecedents of organizational commitment. *Academy of Management Journal, 27*(1), 95-112.

Bernhard, H. I. (2007). A survey of burnout among college music majors. *College Student Journal. 41*(2). 392-401.

Bouckenoogh, D., Raja, U., & Butt, A. N. (2013). Combined effects of positive and negative affectivity and job satisfaction on job performance and turnover intentions. *The Journal Of Psychology: Interdisciplinary And Applied, 147*(2), 105-123.

Brotheridge, C. M., & Grandey, A. A. (2002). Emotional labor and burnout: Comparing two perspectives of "people work." *Journal of Vocational Behavior, 60*, 17-39.

Carsten, J., Spector, P. (1987). Unemployment, job satisfaction, and employee turnover: A meta-analytic test of the Muchinsky model. *Journal of Applied Psychology, 72*(3), 374-381.

Colarelli, S. M. (1984). Methods of communication and mediating processes in realistic job previews. *Journal of Applied Psychology, 69*(4), 633-642.

Cho, Sung-Hyun, Mark, Barbara A., Knafl, G., Chang, Hyoung., & Yoon, H., (2017). Relationships between nurse staffing and patients' experiences, and the mediating effects of missed nursing care. *Journal of Nursing Scholarship, 49*(3), 347-355.

Clow, K. A., Ricciardelli, R., & Bartfay, W. J. (2014). Attitudes and stereotypes of male and female nurses: The influence of social roles and ambivalent sexism. *Canadian Journal of Behavioural Science/ Revue Canadienne Des Sciences Du Comportment, 46*(3), 446-455.

Core Values (2017). Retrieved from: http://www.nln.org/about/core-values.

Dunaetz, David. (2017). Critical Value of r Calculator (Excel). 10.13140/RG.2.2.12146.81607.

Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. *Work & Stress, 23*(1), 24-44.

Etienne, E. (2014). Exploring workplace bullying in nursing. *Workplace Health & Safety, 62*(1), 6-11.

Freire, P. (1972). *Pedagogy of the oppressed*. New York: Herder and Herder.

Frese, M., Kring, W., Soose, A., & Zempel, J. (1996). Personal initiative at work: Differences between East and West Germany. *Academy of Management Journal, 39(*1), 37-64.

Ghorpade, J., Lackritz, J., & Singh, G. (2001). Personality as a moderator of the relationship between role conflict, role ambiguity, and burnout. *Journal Of Applied Social Psychology, 41*(6). 1275-1290.

Gill, H., Meyer, J. P., Lee, K., Shin, K., Yoon, C. (2011). Affective and continuance commitment and their relations with deviant workplace behavior in Korea. *Asia Pacific Journal of Management, 28*(3).

Gross, J., & Levenson, R. (1997). Hiding feelings: The acute effects of inhibiting negative and positive emotions. *Journal of Abnormal Psychology. 106*(1), 95-103.

Guerrero, S., Chénervet, D., & Kilroy, S. (2017). New graduate nurses' professional commitment: Antecedents and outcomes. *Journal of Nursing Scholarship,49*(5), 572-599.

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: test of a theory. *Organizational Behavior and Human Performance. 16*, 250-279.

Harris, K., Harvey P., Cast M. (2013): An Investigation of abusive supervision, vicarious abusive supervision, and their joint impacts, *The Journal of Social Psychology,*153(1), 38-50.

Hershcovis, M. S. (2011). "Incivility, social undermining, bullying…oh my!": A call to reconcile constructs within workplace aggression research. *Journal of Organizational Behavior*, *32*, 499-519.

Hochschild, A. R. (1983). *The managed heart: The commercialization of human feeling.* Berkeley: University of California Press.

Li, Y., Wang, Z., Yang, L., & Liu, S. (2016). The crossover of psychological distress from leaders to subordinates in teams: The role of abusive supervision, psychological capital, and team performance. *Journal of Occupational Health Psychology, 21*(2), 142-13.

Ma, S-C., Wang H-H., Chien, T-W. (2017). Hospital nurses' attitudes, negative perceptions, and negative acts regarding workplace bullying. *Annals of General Psychiatry 16*:33.

Madathil, R., Heck, N.C., & Schuldber, D. (2014). Burnout in psychiatric nursing: Examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of Psychiatric Nursing, 28(*3), 160-166.

Malhotra, J. (2016). Charting a New Course for Future Physicians. Retrieved from https://alumin.georgetown.edu/alumni-stories/gume/magazine/2015/charting-new-course.

Malloy, D. C., Hadjistavropoulos, T., McCarthy, E. F., Evans, R. J., Zakus, D. H., Park, I., Williams, J. (2009). Culture and organizational climate: nurses' insights into their relationship with physicians. *Nursing Ethics*, *16*(6), 719-733.

Maslach, C. (1982). *Burnout: The cost of caring.* Englewood Cliffs, NJ: Prentice Hall.

Maslach, C., & Jackson, S. E. (1984). Burnout in organizational settings. *Applied Social Psychology Annual, 5,* 133-153.

McMillan, I. (1995). Losing control. *Nursing Times* 91(15), 40-43.

Ménard, J., Brunet, L., & Savoie, A. (2011). Interpersonal workplace deviance: Why do

offenders act out? A comparative look on personality and organizational variables. *Canadian Journal of Behavioural Science/ Revue. Canadienne Des Sciences Du Comportement, 43*(4). 309-317. doi:10.1037a0024741.

Meyer, J.P., & Allen, N.J. (1991). A three-component conceptualization of organizational commitment. *Human Resource Management Review, 1,* 61-89.

Mitchell, M. S., & Ambrose, M. L. (2007). Abusive supervision and workplace deviance and the moderating effects of negative reciprocity beliefs. *Journal of Applied Psychology, 92*(4), 1159-1168.

Nielsen, M. B. (2013). Bullying in work groups: The impact of leadership. *Scandinavian Journal of Psychology*, *54*(2), 127-136.

Nohe, C., Meire, L. L., Sonntag, K., & Michel, A. (2015). The chicken or the egg? A meta-analysis of panel studies of the relationship between work family conflict and strain. *Journal of Applied Psychology 100,* (2): 522-36.

Nursing Solutions, Inc. National Healthcare Retention & RN Staffing Report. (2016).

Oh, H., Uhm, D., & Yoon, Y. J. (2016). Workplace bullying, job stress, intent to leave, and nurses' perceptions of patient safety in South Korean hospitals. *Nursing Research, 65*(5), 380-388.

Ohana, M., (2014). A multilevel study of the relationship between organizational justice and affective commitment. The moderating role of organizational size and tenure. *Personnel Review*, *43*(5), 654-671.

Raja, U., Javed, Y., & Abbas, M. (2017). A time lagged study of burnout as a mediator in the relationship between workplace bullying and work-family conflict. *International Journal of Stress Management.* Advance online publication.

Rege, A (2017). *8 things to know about nurse bullying.* Retrieved from https://www.beckershospitalreview.com/human-capital-and-risk/8-things-to-know-about-nurse-bullying.html.

Reverby, S. (1987). *Ordered to care: The dilemma of American nursing 1850-1945.* New York: Cambridge University Press.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. *Advances In Nursing* Science *5*(4), 21-30.

Sak, A. M. (2006). Antecedents and consequences of employee engagement. *Journal of Managerial Psychology, 21*, 600-619.

Samnani, AK., Singh, P. (2015). Workplace bullying: Considering the interaction between individual and work environment. *Journal of Business Ethics 139*(3): 537-549.

Schutt, R. K., (2017). *Investigating the social world: The process and practice of research*. Sage Publications.

Selanders, L., Crane, P., (2012). The voice of Florence Nightingale on advocacy. *OJIN: The Online Journal of Issues in Nursing 17*(1).

Self Determination Theory (2018). Retrieved from: http://selfdeterminationtheory.org/questionnaires.

Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal Of Oncology Nursing*, *12*(3), 399-403.

Simons, S., & Mawn B. (2010). Bullying in the workplace a qualitative study of newly licensed registered nurses. *AAOHN Journal, 58*(7), 11-30.

Simons R., (2008). Workplace bullying experienced by Massachusetts Registered Nurses and the relationship intention to leave the organization. *Advances in Nursing Science 31*(2), 48-59.

Sloan, M. M. (2012). Unfair treatment in the workplace and worker well-being: The role of coworker support in a service work environment. *Work and Occupations, 39,* 3-34.

Smith, T. (2016). Value-based card, an elusive concept, enters the curriculum. Retrieved from https://www.ama-assn.org/education/accelerating-change-medical-education/value-based-care-elusive-concept-enters-curriculum.

Somers, M.J., Finch, L., & Birnbaum, D. (2010). Marketing nursing as a profession: Integrated marketing strategies to address the nursing shortage. *Health Marketing Quarterly, 27*(3), 291-306.

Task Force on the Prevention of Workplace Bullying. (2001). Report of the task force on the prevention of workplace bullying: *Dignity at work-the challenge of workplace bullying.* Dublin: Health and Safety Authority.

Tepper, B.J., (2000). Consequences of abusive supervision. *Academy of Management Journal. 43*(2),178-190.

Trépanier, S., Fernet, C., & Austin, S. (2013). Workplace bullying and psychological health at work: The mediating role of satisfaction of needs for autonomy, competence, and relatedness. *Work & Stress*, 27(2), 123-140.

Van der Heijden, B. I. J. M., Kummerling, A., Van der Van Dam, K., Schoot, E., Estryn-Behar, M., & Hasselhorn, H. M. (2010). The impact of social support upon intention to leave among female nurses in Europe: Secondary analysis of data from the NEXT survey. *International Journal of Nursing Studies, 47*, 434-445.

Velez, M.J., & Neves, P. (2016). Abusive supervision, psychosomatic symptoms, and deviance: Can job autonomy make a difference? *Journal of Occupational Health Psychology*, *21*(3), 322-333.

Vera, M., Martînez, I., Lorente, L., Chambel, J. (2015). The role of co-worker and supervisor support in the relationship between job autonomy and work engagement among Portuguese nurses: A multilevel study. *Social Indicators Research, 126*(3), 1143-1156.

Wang, M., Hsieh, Y. (2016). Do gender differences matter to workplace bullying? *Work: Journal of Prevention, Assessment and Rehabilitation, 53*(3), 631-638.

Wang, J-Y., Li Y-S., Chen J-D., Liang W-M., Yang T-C., Lee Y-C., et al (2015). Investigating the relationships among stressors, stress level, and mental symptoms for infertile patients: A structural equation modeling approach. *PLoS ONE 10(*10).

West, C. P., Dyrbye, L. N., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2012). Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *Journal of General Internal Medicine*, *27*(11), 1445–1452.

Wilson, J., Nagy, M. (2017). The effects of personality on workplace bullying. The Psychologist-Manager Journal, *20* (*3*), 123-147.

Xi, Lu (2010). *The Impact of a Wellness Program on Burnout, Commitment, Turnover and Life Satisfaction* (Thesis).

Zhou, Y., Lu, J., Liu, X., Zhang, P., & Chen, W. (2014). Effects of core self-evaluations on the job burnout of nurses: The mediator of organizational commitment. *Plos ONE, 9*(4).

Appendices

Appendix A

Horizontal Hostility

Instructions: Listed below are 10 behaviors. How often do you experience each type of behavior from your peers at the hospital? For each behavior, circle a number between 1 (never) and 5 (almost daily) that best represents how often you experience that behavior from your peers.

	NEVER	YES, VERY RARELY	YES, NOW AND THEN	YES, SEVERAL TIMES PER WEEK	ALMOST DAILY
1. Someone withholding information that affects your performance.	**1**	**2**	**3**	**4**	**5**
2. Being ordered to do work below your level of competence.	1	2	3	4	5
3. Having your opinions ignored.	**1**	**2**	**3**	**4**	**5**
4. Pressure to not claim something to which by right you are entitled (e.g. sick leave, holiday).	1	2	3	4	5
5. Having insulting or offensive remarks made about your person, or your private life.	**1**	**2**	**3**	**4**	**5**
6. Hints or signals that you should quit your job.	1	2	3	4	5
7. Being shouted at or being the target of spontaneous anger.	**1**	**2**	**3**	**4**	**5**
8. Repeated reminders of your errors or mistakes.	1	2	3	4	5
9. Practical jokes carried out by people you don't get along with.	**1**	**2**	**3**	**4**	**5**
10. Being given tasks with unreasonable deadlines.	1	2	3	4	5

Appendix B

Supervisory Abuse

Instructions: Listed below are 11 behaviors. How often do you experience each type of behavior from your main supervisor at the hospital? For each behavior, circle a number between 1 (never) and 5 (almost daily) that best represents how often you experience that behavior from your main supervisor.

My supervisor …	NEVER	YES, VERY RARELY	YES, NOW AND THEN	YES, SEVERAL TIMES PER WEEK	ALMOST DAILY
1. Ridicules me.	**1**	**2**	**3**	**4**	**5**
2. Tells me my thoughts or feelings are invalid.	1	2	3	4	5
3. Gives me the silent treatment.	**1**	**2**	**3**	**4**	**5**
4. Puts me down in front of others	1	2	3	4	5
5. Invades my privacy.	**1**	**2**	**3**	**4**	**5**
6. Doesn't give me credit for jobs requiring a lot of effort.	1	2	3	4	5
7. Blames me to save himself/herself embarrassment.	**1**	**2**	**3**	**4**	**5**
8. Breaks promises he/she makes.	1	2	3	4	5
9. Makes negative comments about me to others.	**1**	**2**	**3**	**4**	**5**
10. Tells me I am incompetent.	1	2	3	4	5
11. **Lies to me.**	**1**	**2**	**3**	**4**	**5**

Appendix C

Autonomy

Instructions: Listed below are 4 job characteristics. How often do you experience each type of characteristics present themselves in your work environment? For each statement, circle a number between 1 (never) and 5 (almost daily) that best represents how often you experience opportunities at work

	NEVER	YES, VERY RARELY	YES, NOW AND THEN	YES, SEVERAL TIMES PER WEEK	ALMOST DAILY
1. My job allows me to make decisions.	**1**	**2**	**3**	**4**	**5**
2. I determine how I do my work	1	2	3	4	5
3. I plan and arrange my work on my own (calculate, decide on materials/tools)	**1**	**2**	**3**	**4**	**5**
4. I participate in decisions made by the Charge Nurse or the supervisor. (They ask for opinions and suggestions)	1	2	3	4	5

Appendix D
Physician Support

Instructions: Listed below are 4 statements regarding the physicians you most often work with at your hospital. Please indicate the extent to which you agree or disagree with the following four statements by circling the appropriate number between 1 (strongly disagree) and 6 (strongly agree).

	Strongly Disagree	Disagree	Neither disagree or agree	Agree	Strongly Agree
1. In general, the physicians go out of their way to make my work life easier.	**1**	**2**	**3**	**4**	**5**
2. In general, the physicians are easy to talk to	1	2	3	4	5
3. In general, I can rely on the physicians when things get tough.	**1**	**2**	**3**	**4**	**5**
4. In general, I can talk to the physicians about work place problems.	1	2	3	4	5

Appendix E

Burnout

Instructions: Listed below are 18 statements about your work behaviors. Please indicate how often you experience each of these by circling one of the numbers between 1 (never) and 5 (almost daily).

	NEVER	YES, VERY RARELY	YES, NOW AND THEN	YES, SEVERAL TIMES PER	ALMOST DAILY
1. I feel emotionally drained from my work.	**1**	**2**	**3**	**4**	**5**
2. I feel used up at the end of the week.	1	2	3	4	5
3. Working with people all day is really a strain for me.	**1**	**2**	**3**	**4**	**5**
4. Working with people puts too much stress on me.	1	2	3	4	5
5. I feel like I am at the end of my rope.	**1**	**2**	**3**	**4**	**5**
6. I feel frustrated by work.	1	2	3	4	5
7. I feel I treat some colleagues and supervisors as if they were impersonal objects.	**1**	**2**	**3**	**4**	**5**
8. I feel I treat some patients as if they were impersonal objects.	1	2	3	4	5
9. I worry that work is hardening me emotionally.	**1**	**2**	**3**	**4**	**5**
10. I don't really care what happens to some colleagues and supervisors.	1	2	3	4	5
11. I don't really care what happens to some patients.	**1**	**2**	**3**	**4**	**5**
12. I feel colleagues and supervisors blame me for some of their problems.	1	2	3	4	5
13. I deal very effectively with the problems of my colleagues and supervisors.	**1**	**2**	**3**	**4**	**5**
14. I feel I am positively influencing other people's lives through my work.	1	2	3	4	5
15. I can easily create a relaxed atmosphere with my colleagues and supervisors.	**1**	**2**	**3**	**4**	**5**
16. I have accomplished many worthwhile things at work.	1	2	3	4	5
17. I feel exhilarated after working close with my colleagues and supervisors.	**1**	**2**	**3**	**4**	**5**
18. I can easily create a relaxed atmosphere with my patients.	1	2	3	4	5

Appendix F

Turnover Intention

Instructions: Please indicate how often you experience the thoughts presented below by circling one number for each item between 1 (never) and 5 (almost daily).

	NEVER	YES, VERY RARELY	YES, NOW AND THEN	YES, SEVERAL TIMES PER WEEK	ALMOST DAILY
1. I frequently think of quitting my job.	**1**	**2**	**3**	**4**	**5**
2. I am planning to search for a new job during the next 12 months.	1	2	3	4	5
3. Right now, my decision to remain with my organization is based more on necessity than desire.	**1**	**2**	**3**	**4**	**5**

Appendix G

Demographics

Instructions: Please complete the four questions below.

Please circle to indicate your gender: Male Female Other

Please circle to indicate the gender of your direct supervisor: Male Female Other

Please indicate (in years) how long you have been a Registered Nurse: _____ years

Please indicate (in years) how long you have been working at this Hospital: _____years

Please circle the age category you think your direct supervisor best fits:

25 & younger	26-30	31-35	36-40	41-45	46-50	51-55	56 & older

Appendix H

IRB Application

EMPORIA STATE
UNIVERSITY

GRADUATE SCHOOL AND DISTANCE EDUCATION

Amy Miller Psychology
1240 Highland Street Emporia, KS 66801

Dear Ms. Miller:

March 30, 2018

Research and Grants Center

Campus Box 4003 1 Kellogg Circle Emporia, Kansas 66801-5415 620-341-5351 620-341-5909 fax
www.emporia.edu/reseach

Your application for approval to use human subjects has been reviewed. I am pleased to inform you that your application was approved and you may begin your research as outlined in your application materials. Please reference the protocol number below when corresponding about this research study.

If it is necessary to conduct research with subjects past this expiration date, it will be necessary to submit a request for a time extension. If the time period is longer than one year, you must submit an annual update. If there are any modifications to the original approved protocol, such as changes in survey instruments, changes in procedures, or changes to possible risks to subjects, you must submit a request for approval for modifications. The above requests should be submitted on the form Request for Time Extension, Annual Update, or Modification to Research Protocol. This form is available at www.emporia.edu/research/irb.html.

Requests for extensions should be submitted at least 30 days before the expiration date. Annual updates should be submitted within 30 days after each 12-month period. Modifications should be submitted as soon as it becomes evident that changes have occurred or will need to be made.

On behalf of the Institutional Review Board, I wish you success with your research project. If I can help you in any way, do not hesitate to contact me.

Sincerely,

Dr. John Barnett
Chair, Institutional Review Board

Title: Effects of a Toxic Work Environment for Registered Nurses

Protocol ID Number: Type of Review: Time Period:

18081
Expedited
March 2018 to March 2019

An Equal Opportunity Employer

Appendix I

Cover Letter

Dear Participant,

My name is Amy Miller and I am a graduate student at Emporia State University. For my final project, I am looking at how hospital environments play a role in the retention of Registered Nurses.

In order to better understand the hospital environment for Nurses, you are being invited to participate in research study by completing a one-page survey. The surveys will ask you about your peers, supervisors, physicians, and personal feelings. The survey will take around 10 minutes to complete. If at any time you no longer want to participate in this study, please stop filling out the survey and return it back to me. If you do not feel comfortable filling out some of the survey questions or statements feel free to not answer.

The survey was constructed by Amy Miller of Emporia State University. Copies of the data obtained from this study will be provided to my thesis advisor. Your responses are completely confidential and no one at your organization, or outside of my thesis chair and I, will see individual results.

Thank you for taking the time to assist me in my final project to complete my graduate degree. The data collected will provide useful information to help retain talent and insight into creating a healthy work environment. If you would like a summary copy of this study, please email me your information following the completion of your survey. If you have additional information or questions, please contact me, or my thesis chair, at the email below.

Please provide your signature indicating that you understand the purpose of the study, the potential benefits, the confidentiality of your responses, and your ability to participate and end continuation of participation at any moment.

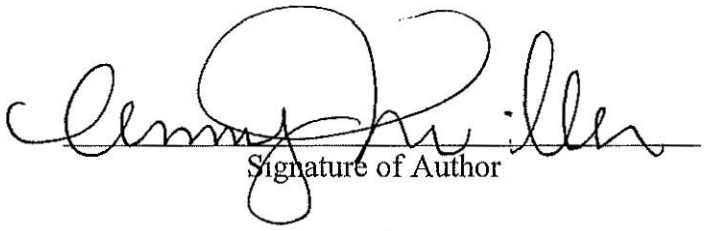
Signature of participation: _____

Thank you,

Amy Miller
Amille28@g.emporia.edu

Dr. George Yancey
gyancey@emporia.edu

I, Amy Miller, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.



Signature of Author

06/03/19

Effects of a Toxic Work Environment for Registered Nurses
Title of Thesis

_____
Signature of Graduate Office Staff Member

_____
Date Received