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Meanings of workplace bullying: Labelling versus experiencing and the belief in a just world.

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MEANINGS OF WORKPLACE BULLYING:

LABELLING VERSUS EXPERIENCING AND THE BELIEF IN A JUST WORLD

by

Jennifer W. Out

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ABSTRACT

Workplace bullying has been identified as a growing occupational stressor among health care professionals (Mayhew & Chappell, 2001; Quine, 1999, 2002). However, estimates of the prevalence rates of workplace bullying have been found to vary considerably. Studies relying on self-labelling consistently report lower prevalence rates than do those that present participants with lists of predefined negative acts (e.g., Mikkelsen & Einarsen, 2001; Salin, 2001). The purpose the present study was to explore the process of self-labelling among nurses experiencing workplace abuse.

A total of 385 nurses registered as members of the College of Nurses of Ontario completed surveys containing scales that measured their frequency of exposure to negative behaviours in the workplace, job satisfaction, turnover, intentions, burnout, and psychological distress. A scale assessing fundamental beliefs about the world, others, and one's self was also included. Although 47.2% of the sample indicated having experienced at least one negative behaviour on a weekly basis for the past six months, only 18.6% of respondents labelled their experiences as bullying. Nurses who were bullied reported significantly lower levels of job satisfaction, higher levels of burnout, greater intentions to leave their current jobs, and more psychological distress than did their non-bullied colleagues. Bullied nurses also reported having more negative beliefs about the benevolence of world and people than did nurses who were not bullied. Bullied nurses who labelled their experiences as bullying reported significantly lower levels of job satisfaction, higher levels of burnout, and greater psychological distress than did nurses who were bullied but did not label their experiences as such. Bullied nurses who labelled their experiences as bullying also perceived other people as less benevolent than bullied nurses who did not label their experiences as bullying. Finally, verbal abuse (e.g.,

ridicule or insulting teasing, gossip or rumours) was found to be more strongly associated with self-labelling than behaviours that were physical and overt in nature.

Results of the study are discussed with reference to Janoff-Bulman's (1989, 1992) Cognitive Theory of Trauma and Lerner's (1980) Just World Theory. Implications for the treatment of bullied workers are presented and directions for further research are suggested.

DEDICATION

This research is dedicated to the nurses of Ontario who, through their dedication, skill, and compassion, form the backbone of our health care system.

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Thanks,

JWO.

Words differently arranged have a different meaning,
and meanings differently arranged have different effects.

Blaise Pascal

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CHAPTER I

INTRODUCTION

In the mid 1970s, Dr. Carroll Brodsky reviewed more than a thousand claims filed with the California Workers' Compensation Appeals Board and the Nevada Industrial Commission by workers who had been injured in the workplace. Although many of these workers had been maimed or crippled as a result of violations of safety standards, Dr. Brodsky encountered a substantial number of workers who reported that they were ill and unable to work because of victimization and harassment by employers, coworkers, and consumers. This latter group of workers, in particular, interested him because he believed that they represented the most preventable of all workplace injuries. In 1976, Dr. Brodsky published *The Harassed Worker*, the first book to document the pervasive effects of workplace harassment on emotional well-being, physical health, and worker productivity.

Bullying and harassment by supervisors and/or colleagues constitutes one of the most rapidly growing health and safety concerns in today's workplace. Since the beginning of the 1990s, well over 100 articles and more than a dozen books (e.g., Adams, 1992; Cooper, Hoel, & Einarsen, 2002; Davenport, Schwartz, Elliott, & Vidali, 1999; Fox & Spector, 2005; Rayner, Hoel, & Cooper, 2002) have been written about bullying and harassment among coworkers. In 1999, The International Journal of Manpower devoted an entire issue to a discussion of the theoretical and applied issues involved in workplace bullying. More recently, the British Journal of Guidance and Counselling devoted their August 2004 issue to a discussion of bullying at work. Some of the papers published in this issue explored the psychological impact of bullying in the workplace while others described preliminary research related to organizational responses to

allegations of workplace harassment.

Issues of bullying and harassment in the workplace have also been highlighted by international websites such as the Workplace Bullying and Trauma Institute (http://bullyinginstitute.org) and the American based Campaign Against Workplace Bullying (http://bullybusters.org). These sites provide factual information related to workplace bullying, as well as links to online support for workers who have been subjected to such behaviours. In November of 2003, the Work Trauma Foundation, a South African based organization, hosted an international conference on the management of psychosocial problems in the workplace that included presentations and discussions of issues related to workplace bullying and harassment.

International reviews of bullying in the workplace published in recent years not only emphasize the increasing frequency and severity of these behaviours but also confirm Dr. Brodsky's initial observations of the substantial toll that they exact on the physical and emotional well-being of employees (Einarsen, Raknes, & Matthiesen, 1994; Keashly, 1998; Mikkelsen & Einarsen, 2002a; Zapf, 1999). Much of the early research concerning workplace harassment has occurred in Scandinavian countries (Sweden, Norway, Finland, and Denmark) where strong government legislation has been instituted to support and protect the rights of workers (Bjorkqvist, Osterman, & Hjelt-back, 1994; Einarsen & Raknes, 1997; Einarsen & Skogstad, 1996; Hogh, & Dofradottir, 2001; Leymann, 1996; Mikkelsen & Einarsen, 2001, 2002b; Vartia, 1996, 2001). This legislation recognizes sexual harassment as one form of abusive behaviour in the workplace but also notes that several other forms of harassing behaviour may occur and delineates specific prohibitions against such behaviours in order to ensure the health and well-being of all workers. Einarsen (2000) suggests that by broadening the definition of

workplace harassment, Scandinavian researchers were given more latitude to study the problem of workplace abuse as it extends beyond sexual harassment and that this may be one reason why accounts of workplace bullying have predominated in Northern European countries, with some notable exceptions (e.g., Bukspan, 2004; Cortina, Magley, Williams, & Langhout, 2001; Hoel, Cooper, & Farahger, 2001; Jennifer, Cowie, & Ananiadou, 2003; Keashly, 2001; Lee, 2000; Lewis, Coursol, & Wahl, 2001; Mayhew & Chappell, 2001; Neuman & Baron, 1998; Niedl, 1996; O'Moore, Seigne, McGuire, & Smith, 1998; Quine, 1999, 2002; Rayner, 1997; Zapf & Gross, 2001).

Researchers from Scandinavian countries have typically reported lower rates of bullying and harassment than those found by researchers in Great Britain, Australia, and the United States (Einarsen, 2000). It is likely that these differences in prevalence rates may be largely due to international differences in the way in which workplace bullying is defined and measured. Scandinavian researchers have generally used more stringent definitions of bullying that emphasize repeated abuse over an extended period of time (i.e., at least six months), and also involve an imbalance of power between the victim and the bully (e.g., see Bjorkqvist et al., 1994; Einarsen, 2000). This strict emphasis on frequency and duration has resulted in reports of lower prevalence rates of bullying in Scandinavian countries.

Salin (2001) noted that, in addition to variations in international definitions of bullying, differences in strategies for gathering data also make it quite difficult to compare prevalence rates reported by different researchers. In particular, she notes that strategies relying on the use of self-judgement or self-labelling (i.e., asking participants to indicate whether they have been bullied) typically report lower prevalence rates of bullying than do studies that use lists of predefined negative behaviours to identify

victims of bullying. For example, in her study of 377 Danish business professionals, Salin (2001) found that the prevalence rate of bullying varied depending on the method used to measure it. When participants were asked to complete a behavioural questionnaire, 24.1% reported that they had been subjected to at least one negative behaviour on a weekly basis for the past six months. However, when participants were provided with a description or definition of bullying, only 8.8% labelled themselves as victims of bullying.

In their survey of 236 Danish hospital employees, Mikkelsen and Einarsen (2001) reported results similar to those obtained by Salin (2001). Approximately 16% of the hospital employees surveyed, reported that they had been exposed to various bullying behaviours on a weekly basis for the past six months; however, when provided with an operational definition of bullying, only 3% of the sample identified themselves as having been bullied at their workplace. Similarly, in their study of 186 blue-collar employees from a Danish manufacturing company, Agervold and Mikkelsen (2004) found that when subjective criteria were used to define bullying, only 1.6% of their sample identified themselves as victims or targets of bullying. In contrast, when victims of bullying were identified through the use of operational criteria, the prevalence rate rose to 13%.

In the sexual harassment literature, a similar discrepancy has been noted (e.g., Magley, Hulin, Fitzgerald, & DeNardo, 1999). Studies that require women to label themselves as victims or targets of sexual harassment typically report lower rates of prevalence than do studies that rely on the use of questionnaires with behaviourally based items. Magley et al. suggest that one possible reason for this difference may be related to the negative connotations associated with the word 'victim' and refer to Lerner's (1980) theory of a just world (i.e., the belief that people get what they deserve and deserve what

they get) as a paradigm to help in understanding this phenomenon. Based on this line of reasoning, women who have been sexually harassed may be less likely to self-label themselves as victims of sexual harassment because of the negative schemas people typically hold of victims and the concomitant views that victims must somehow deserve the lot they have been given.

In a qualitative study of children's views of bullying, Hantler (1994) found that children typically characterized victims of bullying as being "different" in some way. When children were asked "who gets bullied?" they most often cited examples of children who deviated from the "norm" (e.g., children with physical attributes that do not fit in with the Westernized ideal of beauty, isolated and lonely children, children representative of visible minorities, and children who dressed or spoke differently).

Magley et al. (1999) sought to address the "discrepancy between experiencing unwanted sex-related behaviors on the one hand, and labelling them as sexual harassment on the other, to learn what this discrepancy can tell us about the psychological experience of sexual harassment" (p. 390). The authors found that the perceptual process of labelling experiences as sexual harassment had no effect on the level of psychological distress reported by the women in their study. They argued that the experience itself, and not the subsequent labelling of such experiences, was most strongly tied to negative emotional outcomes.

Magley et al.'s (1999) results are important given that they highlight the methodological difficulties inherent in using single-item self-labelling questions to assess sexual harassment. Historically, two approaches have been used to assess prevalence rates of sexual harassment: (a) behavioral assessments of sexual harassment that use lists of predefined behaviours, and (b) responses to single-item self-labelling questions.

Magley et al. acknowledged the arguments of critics who suggest that the prevalence rates of sexual harassment are inflated when participants are asked behavioural questions without specifically using the term sexual harassment. Still, her findings suggest that the process of labelling an experience as harassment is complex and that responses to single-item self-labelling questions may underestimate the prevalence of such behaviours.

The same types of methodology described above have been applied to the study of workplace bullying and similar arguments about the limitations of both methods of measurement have been discussed (Liefooghe & Olafsson, 1999; Rayner, Sheehan, & Barker, 1999; Salin, 2001). Disagreement continues to exist about how bullying should be best operationalized and measured. In her review of the interpersonal and systemic aspects of emotional abuse at work, Keashly (2001) noted that much of the research to date has relied on survey research that is based on researchers' definitions and theories of what constitutes emotional abuse rather than on the meaning given to these experiences by the victims of these behaviours. Little attention has been given to the process of self-labelling as it applies to bullying in the workplace.

The purpose of the present study was to explore the process of self-labelling and how women, and nurses in particular, come to attach meaning and significance to bullying that they may experience in the workplace. Research suggests that, within the health care system, nurses may be at a heightened risk for bullying and horizontal aggression (e.g., Farrell, 1997, 1999; Mayhew & Chappell, 2001). Some authors have argued that workplace gender segregation, such as that found in nursing, increases the likelihood of same-sex bullying, especially among women (e.g., Bray, 2001). Others have suggested that inequitable power relations between men and women in society are amplified within a patriarchal health care system (e.g., Duffy, 1995; Farrell, 2001;

McCall, 1996; Roberts, 1983) and that it is these imbalances in power which lay the foundation for the bullying and harassment of nurses. Although men comprise a relatively small percentage of the total number of nurses in Canada and the United States, on average, they tend to earn more pay than their female nursing colleagues and tend to be overrepresented in administrative positions (e.g., Glover & Radcliffe, 1998; Kalist, 2002; Williams, 1995).

Despite the differing theories as to why nurses appear to have a greater likelihood of being bullied or harassed within the health care system, there is little disagreement about the effects of such victimization on the job satisfaction, emotional well-being, and retention of nurses in the profession. According to the results of a recent survey of 6,000 British nurses about their experiences in the workplace, one in six nurses or 17% of those surveyed reported that they had been bullied by a staff member at some point during the past year (RCN, 2002). Bullying was assessed with a single self-labelling item (i.e., "Have you been bullied or harassed by a staff member in the last 12 months?"). Being bullied or harassed at work was found to be associated with higher levels of psychological distress and more absenteeism, and at least a third of those nurses who were bullied indicated that they intended to leave their profession within the next year (compared with 16% of those who had not been bullied or harassed).

To date, there have been no published accounts of research describing the relationship between self-labelling and psychological outcomes in the area of workplace bullying. Although Magley et al. (1999) found that labelling unwanted sex-related experiences as sexual harassment had no effect on psychological and job related outcomes, no attempts have been made to determine whether these findings can also be extended to employees experiencing other types of abusive behaviours in the workplace.

Do employees who label negative behaviours in the workplace as bullying differ from employees who do not? Is it necessary to label negative behaviours as "bullying" in order to experience adverse psychological and job related outcomes or is the mere experience of such behaviours enough to result in harmful effects? This study was designed to address these questions and to explore additional factors that may be associated with the process of self-labelling.

CHAPTER II

REVIEW OF THE LITERATURE

Definitions of Workplace Bullying and Harassment

Keashly (1998) wrote: "An important step in understanding any phenomenon is identifying the specific aspects or features of the construct" (p. 89). An inherent difficulty, thus far, in the study of workplace bullying has been related to the lack of consensus among operational definitions proposed by different researchers. Brodsky (1976) provided the first cited definition of workplace harassment and described it as:

> ... repeated and persistent attempts by one person to torment, wear down, frustrate, or get a reaction from another person. It is treatment that persistently provokes, pressures, frightens, intimidates, or otherwise discomforts another person. This behavior may go on for a week or many years ... Repeated harassment behavior is not necessarily from the same person ... continued harassment behavior is felt by the target to place him in a cornered position. He is teased, badgered, and insulted and feels he has little recourse to retaliation in kind. (p. 2)

Since the publication of Brodsky's book, the terms and descriptions used to define workplace bullying have evolved and consist of a number of dimensions including: (a) the types of behaviours involved, (b) frequency and duration, (c) power imbalances, and (d) resulting harm to the victim or target (See Table 1 for a comparison of some definitions commonly used to describe workplace bullying and harassment).

Forms of Harassing Behaviours. In their summary of literature relating to workplace bullying, Rayner and Hoel (1997) suggested that evaluating bullying among adults in the workplace is much more difficult than measuring bullying among children

Table 1

Terms and Definitions Used to Describe Workplace Bullying

Reference	Term	Definition
Adams (1992)	Bullying	Bullying at work is about persistent criticism and personal abuse, both in public and in private, which humiliates and demeans the individual, gradually eroding their sense of self. In its hidden forms, bullying is designed to undermine a person's ability and convince them they are no longer good at anything. (p. 50)
Leymann (1996)	Psychological Terror / Mobbing	Psychological terror or mobbing in working life involves hostile and unethical communication, which is directed in a systematic way by one or a few individuals mainly towards one individual who, due to mobbing is pushed into a helpless and defenceless position ... These actions occur on a very frequent basis of at least once per week and over a long period of time, at least six months. Because of the high frequency and long duration of hostile behaviour, this maltreatment results in considerable psychological, psychosomatic, and social misery. (p. 168)
Keashly (1998)	Emotional Abuse	Emotional abuse is a term coined ... to capture the hostile verbal and nonverbal behaviors that are not explicitly tied to sexual or racial content yet are directed at gaining compliance from others. Examples of these behaviors include yelling or screaming, use of derogatory names, the 'silent treatment,' withholding of necessary information, aggressive eye contact, negative rumour, explosive outbursts of anger, and ridiculing someone in front of others. (p. 85)

(continued)

Table 1 (continued).

Terms and Definitions Used to Describe Workplace Bullying

Reference	Term	Definition
Einarsen (2000)	Bullying / Harassment	... bullying and harassment occurs when one or more individuals, repeatedly over a over a period of time are exposed to negative acts (be it sexual harassment, tormenting, social exclusions, offensive remarks, physical abuse, or the like) conducted by one or more other individuals. In addition, there must exist an imbalance in the power-relationships between parties. The person confronted has to have difficulties defending himself/herself in this situation. It is not bullying if two parties of equal 'strength' are in conflict or if the incident is an isolated event. (pp. 383-384)
Zapf & Gross (2001)	Bullying	Bullying occurs, if somebody is harassed, offended, socially excluded, or has to carry out humiliating tasks and if the person concerned is in an inferior position. To call something bullying, it must occur repeatedly (e.g., at least once a week) and for a long time (e.g., at least six months). It is not bullying if it is a single event. It is also not bullying if two equally strong parties are in conflict. (p. 498)

(continued)

Table 1 (continued).

Terms and Definitions Used to Describe Workplace Bullying

Reference	Term	Definition
Aquino & Lamertz (2004)	Workplace Victimization	We define workplace victimization as an employee's perception of having been the target, either momentarily or over time, of emotionally, psychologically, or physically injurious actions by another organizational member with whom the target has an ongoing relationship. . . there are many different interpersonal behaviours that can lead a person to be victimized, so our definition subsumes many of the constructs that scholars have used to describe such acts (e.g., petty tyranny, workplace aggression, or bullying). . . our definition assumes that victimization is highly subjective because it depends on a person's experience of a particular injurious event, which may not be shared, validated, or observed by others. (p. 1023)
Rospenda & Richman (2004)	Generalized Workplace Harassment	... Generalized Workplace Harassment (GWH) represents any negative workplace interpersonal interaction that affects the terms, conditions, or employment decisions related to an individual's job, or creates an intimidating, hostile, or offensive working environment, but is not based on any legally protected characteristic. As such, GWH constitutes interpersonally hostile interactions such as being sworn at, subjected to humiliating or demeaning behaviour, threatened, or otherwise mistreated in the workplace. We define this construct broadly, without reference to length of time over which the experiences occur, whether perpetrators intended to harm the targets, or whether perpetrators are supervisors, coworkers, or clients. (pp. 221-222)

in the schoolyard, because adults are less likely to engage in overt acts of physical aggression and are more likely to engage in a wide range of verbal and indirect bullying that may be more ambiguous and difficult to detect. Verbal and passive forms of aggression (e.g., the 'silent treatment', failing to return phone calls, failing to provide information needed by the victim) are reported as being more frequent by victims than physical and active forms of aggression (Baron & Neuman, 1996; Baron, Neuman, & Geddes, 1999; Richman et al., 1999).

Baron and Neuman (1998) surveyed 452 public and private sector employees (250 females, 202 males) about the frequency with which they experienced 40 different forms of aggressive behaviour at work. Participants were more likely to report having been subjected to covert and passive forms of aggression that impeded their ability to perform their jobs (e.g., failure to transmit needed information, failure to return phone calls or respond to memos) rather than experiencing overt behaviours typically associated with workplace violence (e.g., physical attack, theft, threats of physical violence).

Rayner and Hoel (1997) proposed that bullying behaviours can be grouped into the following five categories: threat to professional status (e.g., includes behaviours such as public professional humiliation, accusations regarding lack of effort, belittling of opinions, etc.); threat to personal standing (e.g., name-calling insults, intimidation, devaluing with respect to age); isolation (e.g., physical and/or social isolation, the withholding of information); overwork (e.g., the imposition of impossible deadlines, undue pressure to complete tasks); and destabilization (e.g., failure to give credit when credit is due, removal of responsibility, assignment of meaningless tasks, repeated reminders of mistakes, and setting the worker up to fail).

Questionnaires and surveys of workplace bullying typically include items that

assess each of the categories proposed by Rayner and Hoel (1997), with some minor modifications to fit the particular sample being studied (Cowie, Naylor, Rivers, Smith, & Pereira, 2002). For example, the Negative Acts Questionnaire (NAQ; Einarsen & Raknes, 1997), one of the most commonly used measures of workplace bullying, contains items assessing each of the categories described above. The measure also includes several items related to physical aggression and threats of violence in the workplace. In their sample of 460 Norwegian industrial workers, Einarsen and Raknes found that 7% of the sample reported being subjected to one or more of the following bullying behaviours from coworkers or supervisors on a weekly basis: ridicule and insulting teasing, verbal abuse, rumours and gossip spread about themselves, offending remarks, recurring reminders about mistakes or blunders, hostility or silence when entering a conversation, and the devaluing of one's effort and work. Approximately 22% of the sample reported being subjected to one or more of the above behaviours on a monthly basis.

Quine (1999) designed a 20-item inventory to assess bullying behaviours based on the five categories of bullying behaviours proposed by Rayner and Hoel (1997). She surveyed 396 British nurses and found that overall, 44% of the sample reported that they had experienced one or more types of bullying behaviours in the past 12 months, and 50% reported that they had witnessed the bullying of others. Approximately 33% of the nurses experienced destabilizing behaviours (as described by Rayner and Hoel); 27% had experienced behaviours designed to isolate them; 22% reported threats to personal standing; 19% of nurses surveyed indicated that they had experienced threats to professional status and 19% reported that they had been pressured to "overwork."

More recently, Rospenda and Richman (2004) developed the 29-item Generalized Workplace Harassment Questionnaire (GWHQ) to assess harassing experiences at work.

The authors administered the questionnaire to 1700 current and former employees of an American university at three points in time. Using factor analysis, the authors suggested that the GWHQ tapped into four factors: covert hostility (e.g., ignored you, excluded you, treated unfairly), verbal hostility (yelled, humiliated, gossiped, rumours), manipulation (left notes, turned against, threatened), and physical hostility (e.g., hit physically, pushed, grabbed, threw something). Rospenda and Richman found that covert hostility was the most frequently experienced type of harassment, followed by verbal hostility, manipulation, and physical hostility. Verbal hostility was found to be the strongest predictor of distress resulting from generalized workplace harassment.

Frequency and Duration. Cowie et al. (2002) discussed the difficulties related to defining bullying in the workplace and noted that "while some degree of repetition is usually thought to characterize bullying, there is no agreement on the intent and nature of the frequency needed to define it" (p. 35). Einarsen and Skogstad (1996) have suggested that behaviours that have occurred on an occasional or weekly basis within the last 6 months may be considered bullying. In contrast, Leymann (1990) proposed more stringent criteria and defined bullying as the experience of at least one negative incident per week for at least six months.

It is not surprising that higher prevalence rates of bullying result when researchers use less rigorous definitions of duration and frequency; however, even when Leymann's (1990) more extreme definition is used, a significant number of workers can still be classified as being bullied in the workplace. Using Leymann's definition, Mikkelsen and Einarsen (2001) found that 16% of their sample of hospital employees (N=236) reported weekly exposure to one or more negative acts (as measured by the NAQ) for at least 6 months. Niedl (1996) sampled 368 Danish hospital employees and found that 26.6% of

the sample could be classified as victims of bullying or "mobbing" using Leymann's definition.

Power Imbalances. Some researchers (Bjorkqvist et al., 1994; Niedl, 1995 as cited in Einarsen, 2000; Zapf & Gross, 2001) have argued that conflict between persons of relatively equal power or strength should not be considered bullying. Keashly (1998) noted that in the workplace literature, power has traditionally been defined in terms of occupational status. When a worker is harassed by a superior, the imbalance in power is obvious. However, when a worker is harassed by colleagues, it is much more difficult to determine whether a power imbalance exists. It should not be assumed that colleagues are of equal power just because they share the same job status within the workplace. Power within an organization can be derived from several sources including informal social relationships with colleagues and supervisors, and inter-reliance of job tasks. Cowie et al. (2002) noted that the power imbalances between the bully and the victim need not be objective and have suggested that it is important to find some way of assessing the victim's subjective experience in helping to define whether he or she has been bullied.

Coworkers and subordinates have been frequently identified as sources of workplace bullying and aggression, especially in the nursing literature. Although verbal abuse of nurses by physicians has been commonly reported (e.g., Cook, Green & Topp, 2001; Diaz & McMillin, 1991; Manderino & Berkey, 1997), aggression or bullying among nurses has also received increasing attention in recent years (e.g., Einarsen, Matthiesen, & Skogstad, 1998; Farrell, 1997, 1999; Glass, 1997; Hamlin, 2000; Hampshire, 2000; Lee & Saeed, 2001; McCall, 1996; Rowe, & Sherlock, 2005; Wilson, 2000). Mayhew and Chappell (2001) suggested that within the health care system, nurses may be at a heightened risk for bullying because they may perceive themselves as being

relatively powerless. As noted previously, power relations between men and women in society are amplified in nursing. Duffy (1995) wrote: "the subordinate status of nursing, and its stereotypical female images, are so deeply embedded that nurses are unable to see that their position in the health care system reflects, above all, inequitable power relations" (p. 6). Duffy argues that bullying among nurses is a manifestation of horizontal violence (i.e., aggression directed between members of an oppressed group) and suggests that it is due to feelings of frustration and powerlessness in relation to the dominant group.

Several authors, most notably Roberts (1983) and Skillings (1992), have used Freire's (1970) theory of oppressed group behaviour to help explain this phenomenon. According to Freire's theory, members of the dominant group identify their norms and values as the 'right' ones in society. The characteristics of the subordinate group become negatively viewed and devalued over time. Members of the subordinate group eventually come to believe that internalizing the norms and values of the dominant group will lead to power, status, and control. In trying to be more like the dominant group, members of the subordinate group give up their own identity and try to adopt characteristics associated with the dominant group. Freire suggests that within individual members of the oppressed group, this results in feelings of low self-esteem and dislike for members of one's own group. Frustration and aggression build and then are directed horizontally towards members of the same group rather than vertically towards the oppressor.

Resulting Harm to the Victim or Target. Most definitions of workplace bullying and harassment assume that such behaviours are associated with negative effects on the physical and emotional well being of workers, as well as worker productivity. When compared to their nonbullied colleagues, victims of workplace bullying consistently

report higher levels of depression, anxiety and psychosomatic complaints (Cortina et al., 2001; Einarsen et al., 1998; Einarsen & Raknes, 1997; Hoel, Faragher, & Cooper, 2004; Mikkelsen & Einarsen, 2001, 2002b; Niedl, 1996; O'Moore, Seigne, McGuire, & Smith, 1998; Quine, 1999, 2001). They also report higher levels of hostility (Bjorkqvist et al., 1994; Richman et al., 1999) and cynicism (Matthiesen & Einarsen, 2001). Workplace bullying has also been found to be significantly associated with lower levels of job satisfaction and higher rates of both absenteeism and burnout (Agervold & Mikkelsen, 2004; Cortina et al., 2001; Einarsen & Raknes, 1997; Einarsen & Skogstad, 1996; Einarsen, Matthiesen, & Skogstad, 1998; Quine, 2001; Varhama & Bjorkqvist, 2004; Vartia, 2001).

Several authors have reported significant associations between workplace bullying and substance abuse. Exposure to abusive and harassing behaviour in the workplace has been shown to be significantly associated with the frequency of drinking, heavy episodic drinking, and prescription drug use (Richman et al., 1999; Richman Shinsako, Rospenda, Flaherty, & Freels, 2002; Rospenda, Richman, Wislar, & Flaherty, 2000; Wislar, Richman, Frendrich, & Flaherty, 2002).

Richman, Flaherty, and Rospenda (1996) surveyed 108 medical students during their internship year of a residency training program about their experiences with sexual harassment and generalized workplace abuse. Approximately two thirds of the sample was male. Roughly 40.5% of the female interns and 5.6% of male interns participating in the study reported experiencing discriminatory treatment based upon their gender. More than 50% of male and female interns reported being "yelled at", and roughly 43.7% of male interns and 35.1% of female interns reported being "humiliated in front of others." In addition to responding to questions about sexual harassment and generalized

workplace abuse, the interns also completed measures assessing problem drinking and narcissism, as well as those related to experiences with the specific occupational stressors of "overwork" and "lack of control."

Richman et al. (1996) found that, although stressors such as overwork and lack of control did not significantly relate to drinking outcomes for the participants in their study, experiences with sexual harassment and generalized workplace harassment were predictive of drinking outcomes in male and female interns. The authors also reported that narcissism influenced the reporting of abusive events by males but not females. Male interns were also significantly more likely than female interns to report using alcohol as an escape. The authors suggested that "individuals with a fragile sense of self are most likely to experience psychological damage from abusive experiences and to use alcohol to mask the painful feelings resulting from those experiences" (p. 401).

Rospenda (2002) sampled 2,038 employees (1,098 women, 940 men) of an urban American university at two points in time about their experiences with sexual harassment, generalized workplace harassment, alcohol use, and help-seeking behaviours. Approximately 33% of the sample reported experiencing behaviours consistent with sexual harassment on more than one occasion; 64% of the sample reported experiencing indicators of generalized workplace harassment on more than one occasion. Even after statistically controlling for job stress and prior use of health services, employees experiencing sexual harassment or generalized workplace harassment were more likely than their non-harassed colleagues to report having sought health or mental health services to deal with occupational issues. Women experiencing generalized workplace harassment were more likely to report having used health or mental health services than men. Generalized workplace harassment was associated with increased odds of problem

drinking.

Some victims of prolonged and severe workplace bullying may show signs of Post Traumatic Stress Disorder (e.g., Bjorkqvist et al., 1994; Leymann & Gustafson, 1996). Mikkelsen & Einarsen (2002a) interviewed 118 victims of bullying at work and found that 29% of the sample met the all the DSM-IV diagnostic criteria for Post Traumatic Stress Disorder. The authors reported a significant positive relationship between the level of bullying as measured by the Negative Acts Questionnaire (NAQ) and the severity of reported post-traumatic stress symptoms experienced by participants.

Prevalence and Cross-Cultural Variations

To date, there are few large scale studies that report prevalence rates of workplace bullying and abuse using North American samples. Studies involving greater than 1000 participants typically report a high frequency of exposure to bullying behaviours with prevalence rates ranging from 54% (Richman et al., 1999; Rospenda, 2002; Wislar et al., 2002) to approximately 71% (Cortina et al., 2001; Cortina & Magley, 2003).

As discussed previously, prevalence rates of bullying appear to be lowest in Scandinavian countries; however, whether this is a true indication of a lower rate of occurrence or whether this is an artefact of methodological differences in the definition and measurement of bullying remains to be seen. In general, large scale studies report the prevalence rates of bullying among the general working population in Scandinavian countries to be approximately 7-8% (Einarsen et al., 1994; Einarsen & Skogstad, 1996; Mikkelsen & Einarsen, 2002). In a 1992 survey of 2,400 employees, Leymann (1996) estimated the prevalence of mobbing to be approximately 3.5%.

In contrast, Rayner (1997) suggested that workplace bullying has been estimated to affect up to 50% of the United Kingdom's workforce at some point in their working

lives. Quine (1999) surveyed 1,100 British health care workers and found that 38% of the sample reported being subjected to bullying in the workplace during the previous year while 42% indicated that they had witnessed the bullying of others. Smith, Singer, Hoel and Cooper (2003) sampled 5,288 adults employed in various occupations in Great Britain and found that when provided with a definition of bullying, 10.6% of the sample reported that they had been bullied at work over the last six months.

Einarsen (2000) noted that power inequalities vary across countries and argued that the lower prevalence rates of bullying obtained from studies in Scandinavian countries reflect lower frequencies of harassment due to lower "power distance" (Hofstede, 1980). Power distance concerns the extent to which inequalities in status and power are accepted in society. In high power distance countries, employees tend to believe that subordinates should be submissive to superiors and generally prefer more autocratic or paternalistic styles of decision-making. In contrast, employees of low power distance countries tend to prefer a consultative style of decision-making in which there is some mutual dependence between the superior and the subordinate. Hofstede also suggested that power distance varies across occupations and found that employees of low-education, low-status occupations were more likely to have high power distance orientations than those working in high-education, high-status occupations.

Einarsen (2000) argued that the Scandinavian countries have been identified as having low power distances and, as such, a lower frequency of harassment compared to countries with higher power distances (e.g., France, Spain). He did not make any reference to the power distance value estimated for Great Britain and how it compares with those estimated for the Scandinavian countries. According to Hofstede (1980) the power distance value calculated for Great Britain is only slightly higher than the values

calculated for Switzerland, Norway, and Sweden. Although the differences in power distance between these nations is minimal, discrepancies in the reported prevalence rates of bullying are significant. This would seem to suggest that power distance orientations can only account for a small proportion of the variance in prevalence rates of bullying reported by British and Scandinavian researchers.

When reported prevalence rates are seen to vary so dramatically within a country (as in the case of Great Britain), it leads one to question the methodology used to obtain these rates rather than differences that may be ascribed to culture. As noted previously, studies that rely on the use of self-labelling typically report lower prevalence rates than do those that use objective criteria to identify victims. For example, when Quine (1999) surveyed 1,100 British health care workers about their experiences with bullying using a questionnaire of 20 behaviourally oriented items, she found that 38% of the sample had been bullied. In contrast, when Smith et al. (2003) used a single item self-labelling technique to identify victims of bullying in Great Britain, they reported a prevalence rate of 10.6%. These results suggest that differences in international prevalence rates may be due to methodological differences in the measurement of bullying rather than differences in incidence due to cultural factors such as power distance.

Canadian Perspectives

In 2001, the Legislative Assembly of Ontario proposed Bill 70, an act to amend the Occupational Health and Safety Act with respect to incidents of workplace violence. Workplace violence was defined as "physical or psychological violence, including bullying, mobbing, teasing, ridicule and any other acts or use of words that can be interpreted as designed to hurt or isolate a person in the workplace" (Legislative Assembly of Ontario, 2004, ¶ 1). In accordance with the act, workplace employers are

required to maintain records of workplace violence and to establish strategies to deal with such behaviour. Employers are required to develop written policies of progressive disciplinary measures that the employer will take to deal with workers whom it finds to have committed acts of workplace violence. Written codes of conduct with respect to workplace violence are to be posted in plain view within the workplace. Under the amendments made to the Occupational Health and Safety Act, workers who are deemed to be at risk of committing acts of workplace violence may be requested by their employer to undergo a psychological assessment.

Changes to Ontario's Occupational Health and Safety Act resulted, in part, from recommendations made by a coroner's inquest into the 1999 shooting rampage by a former employee of OC Transpo in Ottawa (Canada Safety Council, 2004). On April 6, 1999, the former employee killed four of his coworkers and then committed suicide. He had reportedly been a victim of workplace harassment. Among the recommendations from the coroner's inquest was that the definition of workplace violence should include not only physical violence but also psychological harassment. The OC Transpo jury recommended that federal and provincial legislation be enacted to prevent workplace violence and that employers develop policies to address this issue.

A search of the literature produced few references to research on workplace bullying using Canadian samples. Less than a handful of citations for quantitative research studies were found. The largest study was conducted by Duncan et al. in 2001. The authors surveyed 6,526 registered nurses from Alberta and 2,661 registered nurses from British Columbia about their experiences with 5 types of violence in the workplace (e.g., physical assault, threat of assault, emotional abuse, verbal sexual harassment, sexual assault). Specifically, nurses were asked to indicate whether they had experienced

any of the five types of violence over the last five shifts that they worked. The authors found that 30% of the sample reported having experienced at least one of the violent behaviours listed above. Patients were found to be the main source of all types of abuse; however physicians and nursing colleagues were listed as being the perpetrators for more than one quarter of the incidents of emotional abuse reported by the nurses in the survey. Younger nurses were found to be significantly more likely to experience emotional abuse than older nurses. Earlier studies of abusive behaviour directed at Canadian nurses (e.g., Graydon, Kasta, & Khan, 1994; Pekrul, 1993) have reported similar findings.

Schat and Kelloway (2003) surveyed 225 health care employees working in Ontario about their experiences with workplace aggression. The authors also investigated whether two types of organizational support (i.e., instrumental and informational) buffered the effects of workplace aggression and violence on health and job-related outcomes. Eighty-seven percent of their sample were women and participants ranged in age from 21 to 65 years. Although several occupations were represented in the sample, approximately 44.5% of participants were employed as nurses and health care aides. The authors used a questionnaire with behaviourally oriented items to assess participants' experiences with bullying. Schat and Kelloway found that approximately 89% of their sample reported at least some exposure to aggression in the workplace during the past year. They also found that both instrumental and information support provided by the organization buffered the adverse effects of workplace aggression on physical and emotional well-being.

The only other major study of workplace bullying utilizing a Canadian sample was published by Keashly, Trott, and MacLean in 1994. The authors surveyed 59 undergraduate students (30 females, 29 males) about their experiences with nonsexual

non-physical abusive behaviour in the context of their employment as resident assistants (RAs). The authors found that experience with abusive behaviours was relatively common with nearly 45% of the sample reporting having experienced at least one abusive event during the course of their work. At least 20% of the sample reported having experienced the following abusive behaviours: being belittled intellectually, put down in public, talked to in a sarcastic manner, glared at, sworn at, the target of temper tantrums, and intimidated by unreasonable work demands. Approximately 7% of the sample reported being grabbed or pushed. The men and women in the sample did not differ significantly in their reporting of the number, impact, and frequency of abusive events. Frequency of abusive events was found to be negatively associated with job satisfaction ($r = -.51, p < .01$). Keashly et al. reported that the 13.6% of their sample resigned as a result of their negative experiences and roughly 33% of the sample ignored the abusive behaviour or did nothing.

Generalizations about the prevalence rates of workplace bullying in Canada cannot be made based on the studies cited above. Although Duncan et al. (2001) surveyed a large sample of nurses, they did not provide data concerning specific types of bullying behaviours. Keashly et al. (1994) provided more details about the abusive behaviours experienced by the students in their study; however, the ability to generalize their findings is limited by their small sample size. Schat and Kelloway (2003) used an appropriate sized sample but noted limitations (e.g., low power) associated with their use of moderated multiple regression analyses to explore the effects of organizational support on the outcomes of workplace violence and aggression.

More in-depth research with Canadian samples in applied settings is needed in order to determine whether rates of workplace bullying in Canada are comparable to

those reported by other nations. Measurement strategies that combine the use of objective criteria (e.g., use of behaviourally oriented items) with subjective criteria (e.g., self-labelling) would be appropriate. The use of behavioural checklists may provide valuable information about the types of behaviours that victims experience while the use of a single self-labelling item would taken into the victim's subjective perceptions of being bullied. The latter may shed some light on labelling process and tap into aspects of various definitions of bullying that are more difficult to measure (e.g., perceived power imbalances between the victim and the bully).

Characteristics of Risk-Groups

Several authors have suggested that the prevalence rates of bullying may be influenced by a number of factors including gender, age, personality characteristics of the victim, a history of previous victimization, and characteristics specific to particular organizations and work settings. Research findings related to each of these areas are briefly reviewed in the following sections.

Age and Gender. Relatively few studies have made specific mention of the variables of age or gender of the target when reporting rates of bullying. Research findings regarding the association between age of the target and risk of being harassed or victimized are mixed. In some instances, older workers have been reported to encounter more harassment and bullying than younger workers (Einarsen & Skogstad, 1996) while in other instances the reverse has been found (Cole, Grubb, Sauter, Swanson, & Lawless, 1997; Einarsen & Raknes, 1997; Rospenda, 2002).

Research findings regarding gender appear to be more consistent. With a few exceptions (e.g., Erikson & Einarsen, 2004; Einarsen & Skogstad, 1996; Keashly et al., 1994), researchers have generally found that women report having been bullied more

often than men (e.g., Bjorkqvist et al., 1994; Rospenda, 2002; Salin, 2001; Smith et al., 2003; Wislar et al., 2002). Cortina et al. (2001) reviewed literature on social power theory and hypothesized that employees with lower social power (i.e., women, members of minority groups) may be more vulnerable to workplace harassment. The authors surveyed 1,180 public-sector employees in the United States and although they found no support for their supposition that minority group members would be more likely to be victims of bullying, they did find that women reported greater exposure to instances of incivility or harassment in the workplace than did men.

Erikson and Einarsen (2004) surveyed 6485 Norwegian assistant nurses (246 males, 6203 females) to test the hypothesis that male assistant nurses, representing a small gender minority in that particular profession and workplace, would report being subjected to more bullying at work than their female colleagues. Using odds ratios and Chi-square tests, the authors found that the association between gender and bullying at work was significant such that male assistant nurses were found to be twice as likely as their female colleagues to report having experienced bullying at work.

Personality Characteristics. The issue of whether to assume that some personality factors predispose individuals to victimization and harassment remains a contentious one, given that the characteristics in question may be the result, rather than the cause, of the bullying process itself. Although several researchers have reported personality differences between victims and nonvictims (e.g., Brodsky, 1976; Coyne, Seigne, & Randall, 2000; O'Moore et al., 1998; Vartia, 1996; Zapf, 1999), these results are limited by their correlational designs. At best, these and other authors can only suggest that some personality characteristics may be related to some instances of bullying and victimization.

Wislar et al. (2002) sought to determine the extent to which certain personality characteristics differentially affected the likelihood that the work environment would be perceived as sexually harassing and/or interpersonally abusive. The authors surveyed 1,880 participants working at an American university at two separate points in time and found that respondents with high scores on scales measuring neuroticism and narcissism were significantly more likely to report abusive and/or harassing work environments at both times they were surveyed than were workers who scored low on these scales.

Aquino and Bradfield (2000) surveyed 350 government office employees and found that workers who were high in aggressiveness and negative affectivity perceived higher levels of victimization than those who were low in these traits. Coyne, Seigne, and Randall (2000) reported that victimized workers in their study tended to be less independent and extroverted, less stable, and more conscientious than non-victims.

Previous Victimization. O'Moore et al. (1998) surveyed 30 self-identified victims of bullying in Ireland and found that 17 (56.6%) reported that they had been bullied as children and that of this number, four (23.5%) also claimed to have bullied other children. The authors also reported that of the thirty victims in their sample, seven (23.3%) had been bullied in their previous jobs. Smith et al. (2003) surveyed 5,288 adults employed in various occupations in Great Britain and found that respondents who were victimized as children at school were also more likely to be victimized as adults in the workplace. Smith et al. found that the highest risk of workplace victimization was for those who had been both bullies and victims at school.

Recent research suggests that children who are both bullies and victims (i.e., bully-victims) tend to respond aggressively to ambiguous situations and are less liked by peers (e.g., Haynie et al., 2001; Pellegrini, 1998; Salmivalli & Nieminen, 2002; Warden

& Mackinnon, 2003). Smith et al. (2003) made reference to similar findings by earlier researchers (e.g., Olweus, 1993; Schwartz, Dodge, Pettit, & Bates, 1997) and suggested that it would not be surprising if adults who were both bullies and victims as children continued to be victimized in the workplace "since they might take forward characteristics such as a distrust of others and an aggressive response to ambiguous situations, which could appear to justify or in part provoke an aggressive response" (p. 186). Although this is an interesting and plausible suggestion as to the aetiology of bullying in the workplace, it should be noted, however, that the correlations between school and workplace bullying reported by Smith et al (2003) are modest and that most of their respondents who were victimized as children were not victimized as adults in the workplace. This suggests the need to consider additional organizational and environmental factors that may be implicated in the development of bullying in the workplace.

Organizations and Work-Settings. A number of researchers have sought to identify work-related variables that could create environments in which bullying and harassment are more likely to occur. Einarsen et al. (1994) surveyed 2215 members of six different Norwegian labour unions and found that low satisfaction with leadership, low perceived control over one's work, and role conflict correlated most strongly with experiences of bullying. In their survey of 186 blue-collar employees from a Danish manufacturing company, Agervold and Mikkelsen (2004) found that bullied employees experienced their work as less meaningful and were less likely to report having work that encouraged their personal development than did non-bullied employees.

In general, bullying is more common in private organizations, in male dominated organizations, and in industrial organizations (Einarsen, 2000; Einarsen & Skogstad,

1996). Bullying has been found to be more likely to occur in work environments characterized by authoritarian leadership and a lack of communication between supervisors and subordinates (Vartia, 1996). Baron and Neuman (1996, 1998) found that cost cutting (e.g., lay-offs, pay cuts, downsizing) and a higher frequency of changes within an organization (e.g., restructuring, increased diversity) was related to greater instances of workplace aggression. Lack of work group harmony, low levels of co-worker support and fears of impending lay-offs have all been found to be associated with a higher prevalence rate of harassment (Cole et al., 1997).

Meanings of Workplace Bullying

In her chapter concerning the psychological impact of sexual harassment, Koss (1997) wrote: "Experiencing sexual harassment transforms women into victims and changes their lives. It is inevitable that once victimized, at minimum, one can never again feel quite as invulnerable" (p. 4). Although she was writing about sexual harassment, Koss' statements also seem to reflect the experiences that some victims of workplace abuse have reported. Consider the following excerpt cited from an interview that Keashly (2001) conducted with an employee who had been victimized in the workplace:

> . . . if the guy was to physically assault me, it would be clear in my mind what course of action to take too. And that would be it. But here it's sort of picking away at your mind, and you don't feel pain in that sense . . . you just feel self-doubt and you feel humiliation. You feel unsure about things and it just kind of builds up. So it's abusive in a way that destabilizes or depletes the very resources it takes to do well . . . you don't feel like a man anymore, a grown man who can take care of himself (p. 248).

Self-labelling as a victim or target of bullying has also been found to be associated with feelings of shame which may last even after the bullying has ended. In his interviews with 15 British university lecturers, Lewis (2004) suggested that "exposing one's experiences of bullying within an organization with a bullying culture might lead to feelings of inadequacy, deviance or even social exclusion." Lewis cites the following quote from one male participant to illustrate the shame associated with being bullied or victimized in the workplace:

> Well, I didn't think of it as bullying. It's still a word I have problems with, because I come from the valleys [synonymous with heavy industry and tough working conditions] where bullying in school was commonplace and you just got on with it. But bullying in work is something else, isn't it? I mean, I'm a manager. What will my staff think of me if I say I'm being bullied? They'd probably tell me to "pull myself together and get on with it." As for going home and telling my family I was being bullied, well, what would my sons think? (p. 290)

Lewis further suggests that bullied workers may not report their experiences to administration because to do so could lead to additional exposure and humiliation.

With the exception of the work by Keashly (2001) and Lewis (2004), there are few studies that explore the victim's personal appraisal of being bullied, yet much of the research, to date, has relied upon self-labelling – a process that intrinsically involves some subjective appraisal of experience. The following sections present theory and research related to how people come to interpret, label, and make meaning of their victimization.

Labelling vs. Experiencing: Contributions of Labelling Research. To date, there are no published studies that examine the process of self-labelling as it applies to bullying

in the workplace. However, there are a number of studies that explore the process of self-labelling as it applies to sexual harassment. Stockdale, Vaux, and Cashin (1995) surveyed 1,147 male and female students, faculty and staff of an American university and found that respondents who experienced unwanted sexual attention were more likely to acknowledge being sexually harassed if they had a strong emotional reaction to the experience and if the perpetrator was a superior. Women are more likely to acknowledge being sexually harassed if they are exposed to behaviours that are more severe (i.e., sexual coercion) and more frequent (Barak, Fisher, & Houston, 1992; Ellis, Barak, & Pinto, 1991).

Sommers (1994, as cited in Magley et al., 1999) argued that the process of self-labelling is complex and that research "should move beyond simple predictive-descriptive approaches to examine the effects of labelling on the outcomes associated with sexual harassment, specifically, between women who label unwanted sex-related experiences as harassment and those who do not" (p. 391). In an attempt to understand this phenomenon, Magley et al. surveyed 969 women employed in three different organizations about their sexual harassment experiences, work attitudes and behaviours, and psychological well-being. Women in the study completed the Sexual Experiences Questionnaire (SEQ; Fitzgerald et al., 1988; Fitzgerald, Gelfand, & Drasgow, 1995; Gelfand, Fitzgerald, & Drasgow, 1995). The SEQ is a behavioural measure of sexual harassment that also includes a single self-labelling question as its final item (i.e., "have you been sexually harassed?"). This allows for comparisons to be made between rates of behaviours endorsed and the labelling of such behaviours as sexual harassment. Women were classified into seven groups based both on their frequency of exposure to harassing behaviours (i.e., none, low frequency, moderate frequency, high frequency) and their

subsequent self-labelling of their experiences (i.e., women categorically indicated whether they had been victims of sexual harassment).

With the use of multiple group discriminant function analyses, Magley et al (1999) found no significant differences on any of the outcome measures (i.e., work attitudes and behaviours, psychological well-being) between those who labelled their experiences as sexual harassment and those who did not. The authors found that experiences with sexually harassing behaviours at work were consistently associated with psychological distress but that labelling these experiences as sexual harassment had no effect on the degree of distress reported. These results would seem to suggest that behavioural measures of sexual harassment might be superior to those that rely on self-labelling, given that frequency of exposure to harassing behaviours was more predictive of psychological distress than the subjective process of self-labelling.

Munson, Miner, and Hulin (2001) replicated the work of Magley et al. (1999) using a sample of 28,000 American military personnel. The authors extended the research of Magley et al. by including both men and women in their sample, and by also exploring whether certain antecedent variables (e.g., attitudes toward sexual harassment, perceived organizational climate) could be shown to be reliably associated with the self-labelling process. Munson et al. found that frequency of sexual harassment, rather than labelling, was more strongly associated with negative job and psychological outcomes. Munson et al. concluded that their findings were similar to those reported by Magley et al.

More recently, Harned (2004) used cross-sectional data from two samples of undergraduate women ($N = 1,395$) attending an American university to assess the relationship among women's labelling of their unwanted sexual experiences with dating partners and a variety of psychological and school related outcomes. Using a behavioural

measurement approach, 34.3% of the women in the sample indicated that they had experienced some type of sexual victimization by a dating partner during their time at university. In contrast, only 5.2% of the sample labelled themselves as having experienced sexual abuse or assault. This discrepancy in prevalence rates is similar to that reported by Magley et al. (1999). Hared used path analysis to compare competing models of the relationships among unwanted sexual experiences, labelling, and negative outcomes. She concluded that the distress associated with sexual victimization stems from the unwanted sexual experience itself rather than a women's self-definition as a victim. Harned argued that her results serve as evidence that labelling cannot be considered a valid criterion for determining who ahs experienced sexual victimization.

If the process of self-labelling is not associated with increased emotional distress, why are so many women reluctant to label their experiences as sexual harassment? Similarly, why are so many workers reluctant to label themselves as victims of bullying (e.g., Salin, 2001; Quine, 2002)? Theory and research related to the process of victimization and the psychological impact of trauma may be useful in helping us to provide answers to these questions and are presented in the following sections.

Janoff-Bulman's (1989, 1992) Cognitive Theory of Trauma. Koss (1990) proposed that women may be reluctant to label themselves as victims because of the negative connotations associated with the word victim:

> . . . there are many reasons why victims of sexual harassment cannot or will not reveal their experience. . . Among these reasons is the traditional view of a victim as a loser (Taylor, Wood, and Licthman, 1983). . . When people acknowledge their status as victims, some degree of devaluation and social stigma is inevitably incurred (Goffman, 1963). Thus, there is considerable motivation to reject the

role of "victim" both to oneself and to others. (pp. 73-74).

Koss further suggests that to acknowledge one's victim status is to also acknowledge loss and vulnerability, and to question one's basic assumptions about fairness and justice.

In her cognitive theory of trauma, Janoff-Bulman (1989, 1992) proposed that the distress and anxiety experienced by people who are victimized results from threats to their fundamental assumptions about the world and themselves. There are three fundamental assumptions related to our perceptions of invulnerability. These are the assumptions that: (1) the world is benevolent; (2) the world is a meaningful place, and (3) the self is worthy (Janoff-Bulman & Frieze, 1983). In the absence of trauma, these fundamental assumptions often go unchallenged; however, when traumatic events occur, these basic beliefs are questioned and this, in turn, results in a heightened sense of vulnerability and distress.

The first fundamental assumption concerns beliefs about the benevolence of the world and refers to the extent to which people view the world in positive or negative terms. This assumption is based on two highly correlated beliefs: (1) the belief that the world itself is a place where good things happen, and (2) the belief that people are basically good, kind, helpful and caring.

The second fundamental assumption concerns perceptions about the meaningfulness of the world. It involves beliefs about the distribution of positive and negative outcomes according to the principles of justice, control, and chance (Janoff-Bulman, 1989). Janoff-Bulman suggests that one way for us to make sense of our world is to believe that events are distributed in a fair and just manner. According to Lerner's (1980) theory of a just world, people have a very basic need to believe in world in which people get what they deserve and deserve what they get. Negative events are believed to

happen to those who are immoral or unjust. The world does not appear meaningful to people who feel that they were victimized without due cause (Janoff-Bulman & Frieze, 1983).

Janoff-Bulman (1992) also suggests that we try to understand the distribution of positive and negative outcomes through our consideration of an individual's behaviour and refers to Rotter's (1996) writings concerning locus of control. Rotter proposed that people attribute their outcomes to internal or external forces. People with an internal locus of control believe that events generally result from their own behaviour or their own control. They are likely to believe that they can minimize their vulnerability to victimization through their own actions and behaviours. Conversely, people with an external locus of control believe that events in their lives are determined by forces beyond their control such as powerful others, fate, chance, or luck. According to Janoff-Bulman (1989): "a person who believes strongly in randomness will not regard justice or controllability as powerful determinants of outcomes and will argue that there is nothing one can do or be that will serve to protect an individual from negative outcomes" (p. 119).

The third fundamental assumption involves beliefs about our own self-worth (Janoff-Bulman, 1989). According to this assumption, people generally perceive themselves as good, capable and moral individuals. Janoff-Bulman suggested that if the world is seen as largely being malevolent and unjust, individuals could still maintain a sense of invulnerability if they believe themselves to be worthy, lucky and capable of avoiding harm or misfortune.

Mikkelsen and Einarsen (2002) interviewed 118 self-identified victims of bullying at work to assess the prevalence and severity of Post-Traumatic Stress Disorder

(PTSD) symptomology. The authors also used an adapted version of Janoff-Bulman's (1989) World Assumptions Scale (WAS) to investigate whether victims of workplace bullying differed in their fundamental assumptions about themselves, others and the world, when compared to a non-bullied control group. The WAS contains eight subscales measuring the following dimensions: benevolence of the world, benevolence of people, randomness, justice, controllability, self-work, luck, self-controllability. The authors found significant group differences on all of the eight subscales except for randomness and self-controllability. Compared to non-bullied controls, victims of bullying perceived the world as less benevolent and people as less caring. They considered themselves less worthy, less capable, and unluckier. They also perceived the world as less controllable. Group differences were greatest on the assumption of justice such that victims of bullying scored significantly lower on the justice subscale than did members of the non-bullied control group.

Lerner's (1980) Belief in a Just World. Although Janoff-Bulman (1989; 1992) made cursory mention of Melvin Lerner's just world theory, Mikkelsen and Einarsen's (2002) findings suggest that justice, or rather perceived injustice, is perhaps the most relevant factor in differentiating the fundamental assumptions of victims from those of non-victims. Lerner and Miller (1978) described the concept of the just world hypothesis as follows:

> Individuals have a need to believe that they live in a world where people generally get what they deserve. The belief that the world is just enables the individual to confront his physical and social environment as though they were stable and orderly. Without such a belief it would be difficult for the individual to commit himself to the pursuit of long-range goals or even to the socially regulated

> behavior of day-to-day life. Since the belief that the world is just serves such an important adaptive function for the individual, people are very reluctant to give up this belief, and they can be greatly troubled if they encounter evidence that suggests that the world is not really just or orderly after all. (pp. 1030-1031).

Lerner (1980) suggested that although people have a need to believe in a just world, they nonetheless do acknowledge that injustices exist; however, he also suggested that people employ strategies or "tactics" to eliminate threats to their belief in a just world. He argued that some of these strategies are rational and involve direct means of addressing and coping with the reality of injustice. Lerner listed prevention and restitution programs for victims of crime, as an example of a rational strategy. In addition to rational strategies of coping with threats to our belief in a just world, Lerner suggested that people also use irrational tactics to reduce the distress associated with witnessing an injustice such as: (a) denial, (b) reinterpretation of the event in terms of its outcome (i.e., the idea that the injustice resulted in making the victim a better person), (c) reinterpretation of the event in terms of its cause (the idea that the misfortune or injustice is attributable to something the victims did or failed to do), and (d) reinterpretation of the character of the victim (the idea that misfortune or injustice is attributable to deficiencies in the personal character of the victim).

Reviews of just world research (e.g., Furnham, 2003; Hafer & Olson, 1998) suggest that Lerner's theory has been popular in explaining why people engage in victim blaming, yet more recently, the theory has been applied to help explain how victims cope or respond to personal misfortune. Lipkus and Siegler (1993) sampled 221 American adults to examine how individual beliefs in a just world would influence the frequency of self-reported instances of personal discrimination in various domains such as age, race,

gender, and religion. They suggested that the acknowledgement of personal discrimination runs counter to beliefs or assumptions that we live in a just and orderly society. The authors found that respondents with a strong belief in a just world reported fewer acts of discrimination against themselves than those with a weak belief in a just world.

With the exception of the study by Lipkus and Siegler (1993), Furnham (2003) suggests that most of the just world research has focused on observers' responses to the misfortunes of others and that relatively few studies have focused on victims' perceptions of their own misfortune. Research exploring the belief in a just world and personal deprivation has typically involved university students participating in laboratory settings in which feelings of deprivation were induced by the experimenters (e.g., Hafer & Correy, 1999; Hafer & Olson, 1989). Such studies tell us little about the personal experiences of victimized individuals and the strength of their beliefs in a just world. More research is needed to explore how beliefs in a just world may be influenced by bullying and other types of victimization.

Putting It All Together: Rationale and Purpose of the Present Study

A recent survey of 6000 nurses conducted by the Royal College of Nursing in Great Britain (RCN, 2002) provides evidence detailing the harmful effects of bullying on the psychological well-being, physical health, and the long-term retention of nurses. Results of the *Working Well Survey* completed in 2000 revealed that one in six nurses (17%) reported that they had been bullied by a staff member at sometime within the last 12 months. At least 10% of this number reported being bullied on a weekly basis and 4% reported being bullied on a daily basis. Bullying was assessed with a single self-labelling item (i.e., "Have you been bullied or harassed by a staff member in the last 12 months?").

Nurses working in community settings were equally as likely as their colleagues working in hospital settings to report that they had been bullied. Bullying was more frequent among certain groups of nurses, particularly those with disabilities (41%) and those from ethnic minority backgrounds (29%). Full-time staff (21%) were more likely to report being bullied than part-time staff (12%). Immediate supervisors or managers were most commonly identified as the person responsible for bullying (41%); a further third identified a nursing colleague as the main source of harassment. Approximately 38% of the nurses being bullied cited personality clashes as the cause of bullying and harassment; however, more than half of the ethnic minority nurses in the study said that their race was the focus of bullying.

Many victimized nurses often take no action against workplace bullies because of fears of retaliation (e.g., loss of employment, increased harassment), intimidation, and a perceived lack of organizational support (e.g., Rosenstein, 2002). Approximately 45% of the bullied nurses in the RCN study either reported the problem to a senior colleague or made an informal or formal complaint; however, 25% of those who were victimized took no action (RCN, 2002). Most of the nurses who were bullied indicated that they were not satisfied with their employer's handling of the situation. Being bullied or harassed at work was found to be associated with higher levels of psychological distress and more absenteeism, and at least a third of those who were bullied indicated that they intended to leave their profession within the next year (compared with 16% of those who had not been bullied or harassed).

According to the Canadian Institute for Health Information (CIHI), there are approximately 300,000 RNs, LPNs, and Psychiatric RNs presently working in the Canadian health care system (CIHI, 2001). A study commissioned by the Canadian

Nurses Association (CNA) in 1997 reported a projected shortage of 78,000 RNs by 2011 and 113,000 RNs by 2016 (Ryten, 1997). Although researchers (e.g., Cameron, Armstrong-Stassen, Bergeron, & Out, 2004) have explored the effects of various organizational factors (e.g., organizational support, supervisor support, work-group cohesiveness, etc.) and job related factors (e.g., autonomy, salary, working conditions, etc) on job satisfaction, few studies have explored the effects of bullying and horizontal violence on Canadian nurses' job satisfaction and turnover intentions. Given the nursing shortages that have been projected, research regarding additional features of the workplace (e.g., bullying, horizontal violence) that may affect the job satisfaction, retention, and recruitment of nurses is needed.

The purpose of the present study was to explore the process of self-labelling and how women, and nurses in particular, come to attach meaning and significance to bullying that they experience in the workplace. To date, there have been no published accounts of research describing the relationship between self-labelling and psychological outcomes in the area of workplace bullying. Although Magley et al. (1999) found that labelling unwanted sex-related experiences as sexual harassment had no effect on psychological or job related outcomes, no attempts have been made to determine whether these findings can be extended to employees experiencing other types of abusive and bullying behaviours in the workplace. Is it necessary to label negative behaviours as "bullying" in order to feel distressed or is the mere experience of such behaviours enough to result in adverse emotional outcomes? Do bullied nurses who label abusive experiences in the workplace as bullying report lower levels of job satisfaction than bullied nurses who don't label their experiences as bullying? Is there any significant relationship between bullying and nurses' intentions to leave their current jobs? This

study was designed to address these questions and to explore additional factors that may be associated with the process of self-labelling.

Primary Hypotheses: Bullying and Outcomes of Self-Labelling

If the findings by Magley et al. (1999) can be extended to the study of workplace bullying, one would expect that the process of labelling is unrelated to the experience of negative outcomes associated with workplace harassment and abuse. According to this line of reasoning, exposure to negative acts in the workplace will result in adverse psychological and job related outcomes regardless of whether nurses label these experiences as bullying. Such a proposition runs counter to established models of stress and coping (e.g., Lazarus & Folkman, 1984). According to the transactional model of stress and coping proposed by Lazarus and Folkman, an individual's subjective appraisal of a situation as being threatening is often more strongly associated with psychological distress than the objective experience of the event itself.

Several recent studies exploring the relationship between neuroendocrine responses to stress and the cognitive appraisal of stressors have reported findings to support Lazarus and Folkman's (1984) model. Researchers have found that the perception or interpretation of events, rather than mere exposure to the event itself, is significantly associated with differential profiles of endocrine and sympathetic arousal (see Olff, Langeland, & Gersons, 2005 amd Gaab, Rohleder, Nater, & Ehlert, 2005, for reviews of the relationship between the cortisol stress response and the cognitive appraisal of events). The appraisal of potential stressors as "threats" rather than "challenges" has been found to be associated with greater cortisol reactivity. Olff et al. argue that the appraisal process is an important determinant of psychological and physiological stress responses.

Based on this line of reasoning, it was argued that self-labelling (i.e., cognitive appraisal) is intrinsically linked to the psychological consequences of bullying and that nurses who self-label as having been bullied will report greater psychological distress than nurses who do not label similar experiences as bullying.

A. Relationships Among Bullying, Self-Labelling, and Job-Related Variables. Research on workplace bullying has consistently demonstrated a significant negative relationship between experiences with bullying and job satisfaction and organizational commitment. In particular, workers who are bullied report lower levels of job satisfaction and higher rates of job turnover than their nonbullied coworkers (e.g., Cortina et al., 2001; Einarsen & Raknes, 1997; Einarsen & Skogstad, 1996; Einarsen et al., 1998; Quine, 2001; Varhama & Bjorkqvist, 2004; Vartia, 2001). Based on these findings, it was expected that nurses who reported being subjected to negative behaviours in the workplace would report less job satisfaction and a greater propensity to leave nursing, than their non-bullied colleagues. It was also predicted that nurses who labelled their experiences as bullying would report lower levels of job satisfaction and a greater propensity to leave nursing than their coworkers who experienced similar behaviours but who did not label them as instances of bullying.

B. Victimization, Self-Labelling and Burnout. Based on examples from the literature, it was expected that nurses who are bullied would report higher levels of burnout than their non-bullied colleagues. In particular, it was expected that nurses who are bullied would report higher levels of emotional exhaustion and depersonalization than nurses who were not bullied. It was also expected that the labelling process would magnify this trend such that nurses who labelled their experiences as bullying would report higher levels of emotional exhaustion and depersonalization than nurses who

experienced similar behaviours but who do did not label them as bullying.

C. Victimization, Self-Labelling and the Assumptive World. Based on findings reported by Mikkelsen and Einarsen (2002) and Janoff-Bulman's (1989, 1992) Cognitive Theory of Trauma, it was expected that the assumptive worlds of nurses who were bullied would be more negative than those of their non-bullied colleagues. In particular, it was hypothesized that:

- nurses who were bullied would view the world as less benevolent and people as less caring than their non-bullied colleagues
- nurses who were bullied would perceive themselves as less worthy, less capable, and unluckier than their non-bullied coworkers; and
- nurses who were bullied would perceive the world as less controllable and less just than their non-bullied coworkers.

In each instance, it was expected that these trends would be more salient for nurses who labelled their experiences as bullying, than it would for nurses who shared similar experiences but did not engage in the self-labelling process.

D. Victimization, Self-Labelling and Psychological Distress. Based on research describing the psychological effects of bullying, it was hypothesized that nurses who were bullied would report greater levels of psychological distress (i.e., more depression, anxiety, hostility, interpersonal sensitivity, and somatization) than nurses who were not bullied in the workplace. Again, it was expected labelling experiences as bullying would be more strongly associated with negative emotional outcomes such that victimized nurses who labelled their experiences as bullying would report greater levels of depression, anxiety, hostility, interpersonal sensitivity, and somatization, than their bullied colleagues who did not label their experiences as bullying.

Supplementary Analyses

A. NAQ Items and Self-Labelling. As noted previously, an inherent difficulty, thus far, in studying the domain of workplace bullying has been related to the lack of consensus among operational definitions proposed by different researchers. Prevalence rates of bullying appear to vary depending upon the methods used to identify victims of workplace abuse. Prevalence rates based on single self-labelling items appear to underestimate the prevalence of bullying while prevalence rates based on patterns of responses to behavioural check-lists may inflate rates of occurrence. The Negative Acts Questionnaire, developed by Einarsen and Raknes (NAQ, 1997) continues to be the most popular measure of workplace bullying. This scale is comprised of 22 items written in behavioural terms with no reference to the words harassment or bullying. The scale yields a total score based on how frequently respondents have indicated exposure to each of the behaviours listed. Each item on the NAQ is equally weighted. There is some question as to whether this may be appropriate. Theoretically, it is possible for two individuals to achieve the same overall score but to report being subjected to very different patterns of negative behaviours.

Keashly (1996) noted that some behaviours may need to occur only once in order to be labelled physical violence (e.g., being stabbed or shot) while others may need to occur repeatedly before they are labelled the same way (e.g., pushing or banging into someone while walking down a hallway). Keashly also suggested that the same can be said to be true of emotional abuse. For example, being put down in public may only need to happen once to be considered emotional abuse while glaring or social exclusion may need to occur repeatedly before they are considered to be abusive. The NAQ weights each item equally and does not account for such differences in perceptions.

A secondary aim of this study was to explore whether some items on the NAQ would be more strongly associated with self-labelling than others. Knowing whether certain behaviours are more likely to result in labels of bullying could provide some insight into how people form judgements about the negative experiences that they may encounter in the workplace and could aid in the refinement of existing scales used to assess workplace bullying.

B. Job Experience and Victimization. McKenna, Smith, Poole, and Coverdale (2003) surveyed 551 registered nurses in their first year of practice in New Zealand about their experiences with horizontal violence. The authors suggested that new graduate nurses may be at a particular risk for horizontal violence because of their "junior status and high levels of stress associated with role adjustment" (p. 91). Over half of the new RNs in the study reported feeling undervalued by nursing colleagues and over one third of respondents experienced behaviours that have typically been considered as forms of workplace harassment.

Although the study by McKenna et al. (2003) provides an estimate of the prevalence of horizontal violence or workplace bullying among new graduate nurses, it provides no information as to how rates might differ between new grads and more experienced nursing staff. An additional purpose of this study was to explore whether there might be significant relationship between bullying (i.e., scores on the NAQ) and age or job experience (i.e., years employed as a nurse). As noted previously, research regarding age as a risk factor for bullying has produced mixed findings. As a result, no specific hypothesis regarding workplace bullying and age or job experience was suggested. Rather, this was viewed as an area of exploration for the present study.

CHAPTER III

METHODOLOGY

Participants

A total of 1,200 packages (representing approximately 4% of the total number of nurses employed full-time in hospital settings in Ontario) were mailed to a random sample of nurses registered with the College of Nursing of Ontario (CNO). Place of employment (i.e., general hospital), gender (i.e., females) and geographic location (i.e., hospitals located in cities and regions with populations greater than or equal to 250,000 inhabitants) were used as selection criteria from the CNO database. Women constitute the majority of the nursing workforce in Ontario. Only 3.8% of all nurses working in Ontario are male (Bartfay & Davis, 2001). Given the disparity between the numbers of male and female nurses, it was decided to limit the sample to female nurses. The sample size would need to be increased dramatically in order to obtain a comparative sample of males. This was deemed unfeasible both in terms of cost and practicality.

The inter- and intra-professional relationships of nurses and other medical staff is a prime focus of the study. Nurses employed in settings in which they have little to no contact with peers would be unable to comment about their relationships with colleagues in a manner comparable to that of nurses working in hospital wards and clinics. Nurses working in rural settings are much more likely to work in isolation and their experiences with colleagues would likely differ substantially from those of nurses employed in the wards of an academic teaching hospital. As a result, nurses working in rural or urban areas with less than 250,000 residents were excluded from participation in this study. This limit was placed on sample selection to ensure that nurses participating in the study would be employed in settings in which they would be working with a

number of nursing colleagues, as well as medical and administrative staff.

Materials and Measures

Negative Acts Questionnaire (NAQ; Einarsen & Raknes, 1997). The Negative Acts Questionnaire (NAQ) was developed to measure how often respondents have been subjected to a range of negative acts and potentially harassing behaviours in the workplace. The questionnaire contains 22 items based on literature reviews and interviews with victims of harassment in the workplace. A copy of the entire questionnaire can be found in Appendix A. All of the items comprising the NAQ are written in behavioural terms with no reference to the words *harassment* or *bullying.* Respondents are asked to indicate how often they have experienced each act or event during the last six months on a scale with the following response categories: "never", "now and then", "about weekly", "about daily." The NAQ yields a single score with higher scores representing more frequent exposure to negative and potentially harassing behaviours in the workplace.

The operational criterion for classifying women as victims of bullying is based on Leymann's (1996) definition and would require that nurses indicate that they have experienced at least one negative behaviour on a weekly basis for the past six months. Frequency of harassment was broken down into three categories: low frequency (i.e., nurses scoring at least one standard deviation below the mean on the NAQ); moderate frequency (i.e., nurses scoring between one standard deviation below and one standard deviation above the mean on the NAQ), and high frequency (i.e., nurses scoring at least one standard deviation above the mean on the NAQ).

Studies employing the NAQ have reported high internal consistencies with Cronbach's alphas ranging from .84 to .93 (Matthiesen & Einarsen, 2001; Mikkelsen &

Einarsen, 2001, 2002). Mikkelsen and Einarsen (2001) reported significant positive correlations between scores on the NAQ and scores on the Hopkins Symptom Checklist (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Participants who reported being subjected to a greater number of harassing behaviours were more likely than their non-bullied colleagues to report higher levels of anxiety, depression, and somatization, as measured by the HSCL-25. Mikkelsen and Einarsen (2002) also reported a significant positive relationship between scores on the NAQ and the severity of reported post-traumatic stress symptoms as measured by the Post-traumatic Diagnostic Scale (PDS; Foa, 1995; Foa, Cashman, Jaycox, & Perry, 1997). The more bullying acts reported by the victims, the more post-traumatic stress symptoms they displayed.

A slightly modified version of the NAQ was devised for use in the current study. Two items that were considered to be vague and ambiguous were deleted from the inventory (i.e., "funny" surprises; reactions from others because you work too hard). Response categories were also modified and expanded to allow respondents to be more precise in their reports of their exposure to the negative acts listed in the questionnaire. The modified inventory contained the following response categories: "never", "less than monthly", "monthly", "weekly", and "daily." Response categories were based on a 5-point Likert type scale with values ranging from 0 (never) to 4 (daily). Cronbach's alpha was used to examine the reliability and internal consistency of this modified version of the NAQ and is reported in the results section.

Single Self-Labelling Item. The following single item self-labelling question was also added to the inventory: "Have you been bullied in the work place?" The response category for this item was kept consistent with the response category that was used with the NAQ. This was done to avoid unduly attracting respondents' attention to the single

self-labelling item. The addition of this single self-labelling item at the end of the NAQ allowed for comparisons to be made between the number and types of behaviours endorsed in the NAQ and the subsequent labelling of those behaviours as bullying.

Specific Events in the Workplace (Keashly, Trott, & MacLean, 1994). This questionnaire contains items describing 48 events that may occur between people in the workplace. The measure consists of 18 positive and 30 abusive interpersonal events. The authors of the scale reported that items were primarily generated from scales used by researchers in the area of family violence to assess the presence and intensity of nonphysical abusive behaviours (e.g., Abusive Behaviors Inventory, Shepard & Campbell, 1992; Psychological Maltreatment of Women Inventory, Tolman, 1989; Conflict Tactics Scale, Strauss, 1979). The authors also noted that additional items were also generated from reviews of organizational and health care literature.

Respondents were presented with a list of positive events and were asked to indicate whether they had experienced each event in the workplace during the previous 12-month period. Respondents were also asked to indicate the frequency (1 = rarely to 5 = always) and impact (-3 = extremely negative to +3 extremely positive) of each event that they have experienced and to identify who engaged in the behaviour (boss, co-worker, and/or subordinate). Based on these items, Keashly et al. (1994) developed six indices. Three of these indices measured the number, impact, and frequency of abusive events. The remaining three indices measured the number, impact, and frequency of positive events. Internal consistencies were found to be good with Cronbach's alphas ranging from .87 to .92 for the abuse indices and from .78 to .84 for the positive event indices.

Keashly et al. (1994) reported significant positive correlations between level of

job satisfaction as measured by the Job Descriptive Index (JDI; Smith, Kendall, & Hulin, 1969) and scores on the positive event index. Both the number and frequency of abusive events were found to have significant negative correlations with scores on the JDI such that lower levels of job satisfaction were associated with greater exposure to a number of abusive events in the workplace.

For the present study, a subset of 9 items was selected from the 18 positive events described in the inventory to counterbalance the negative behaviours listed in the NAQ. A copy of these items can be found in Appendix A. Response categories were changed to match those used for the modified NAQ and participants were asked to indicate how often they have experienced each event in the workplace during the previous six months. Cronbach's alpha was used to examine the reliability and internal consistency of this modified version of the positive events subscale and is reported in the results section. High scores on this subset of items indicated greater experience of positive events in the workplace

Job Satisfaction Subscale of the Ward Organisational Features Scales (WOFS; Adams, Bond & Arber, 1995). The Ward Organisational Features Scales is a multidimensional measure designed to assess hospital nurses' perceptions of the physical and social aspects of their work environment. The WOFS includes six sets of measures comprising 14 subscales. Each subscale contains items rated on a four point Likert-type scale with values ranging from 1 (strongly disagree) to 4 (strongly agree). The job satisfaction subscale contains seven items that assess global perceptions of working relationships with others, as well as the propensity to resign. High scores on this subscale represent greater levels of job satisfaction. Internal consistency of the Job Satisfaction Subscale was found to be good with Cronbach's alpha reported by the authors as .77.

Test-retest reliability of the job satisfaction subscale was also adequate with a reported Pearson correlation coefficient of .77. Subsequent research with the WOFS has reported significant positive correlations between the job satisfaction subscale and subscales measuring cohesion of the ward nursing team, collaboration with medical staff, the level of professional practice achieved within the ward, and staff organization – which includes items about the relationship between staffing and workload (Adams & Bond, 2000). A copy of the Job Satisfaction Subscale of the WOFS can be found in Appendix A.

Turnover Cognitions Scale (Bozeman & Perrewé, 2001). The Turnover Cognitions Scale was developed to assess thoughts related to quitting one's job and intentions to search for another job with a different organization. Bozeman and Perrewé reported that items from their scale were based on work by Mowday, Koberg and MacArthur (1984) and Mobley, Horner, and Hollingsworth (1978). The scale contains 5 items rated on a five point Likert-type scale with values ranging from 1 (strongly disagree) to 5 (strongly agree). In the present study, items were rated using a four point scale from 1 (strongly disagree) to 4 (strongly agree) so that these items could be appended to the job satisfaction subscale of the WOFS (described above). Internal consistency of the scale was found to be good with Cronbach's alpha reported as .92 and .94 in two separate samples. No information related to test-retest reliability was reported. Bozeman and Perrewé found that scores on the Turnover Cognitions Scale were significantly and negatively correlated to a measure of organizational commitment. A copy of the Turnover Cognitions Scale can be found in Appendix A. High scores on the Turnover Cognitions Scale reflect a greater propensity to leave one's current job.

Maslach Burnout Inventory - Second Edition (MBI; Maslach & Jackson, 1986). Since its introduction in the early 1980s, the MBI has become the most widely used

instrument in burnout research (Densten, 2001). The inventory contains 22 statements of job related feelings and was developed to assess three interrelated aspects of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. For each item, respondents were asked to indicate how often they have experienced that feeling using the following response categories: "never", " a few times a year or less", "once a month or less", "a few times a month", "once a week", "a few times a week", and "every day." Response categories are based on a 7-point Likert type scale with values ranging from 0 (never) to 6 (every day).

The Emotional Exhaustion (EE) subscale contained nine items that assess feelings of being emotionally overextended and drained by one's work. The Depersonalization (DP) subscale contains five items that measure "an unfeeling and impersonal response towards recipients of one's service, care, treatment, or instruction" (p. 2, Maslach & Jackson, 1986). The Personal Accomplishment (PA) subscale contains eight items that assess feelings of competence and achievement with respect to one's work. Scores for each subscale are summed separately and are not combined into a single, total score. Higher scores on the EE and DP subscales and lower scores on the PA subscale indicate greater burnout. Internal consistency of the MBI is good with Cronbach's alphas for the three subscales reported as follows: .90 for EE; .79 for DP; and .71 for PA.

Convergent validity of the MBI is reflected in its correlation with scales measuring turnover intentions and organizational commitment. In an American sample of 262 nurses, Kalliath, O'Driscoll, Gillespie, and Bluedorn (2000) reported that scores on both the EE and DP subscales were significantly correlated with greater turnover intentions, as measured by the 8-item Staying or Leaving Index (Bluedorn, 1982), and lower levels of organizational commitment, as measured by the Organizational

Commitment Scale (Mowday, Steers, & Porter, 1979). A copy of the MBI can be found in Appendix A.

World Assumptions Scale (WAS; Janoff-Bulman, 1989). The World Assumptions Scale (WAS) is a 32 item self-report measure designed to assess the basic assumptions proposed by Janoff-Bulman. The measure contains 8 subscales. Two subscales include items about the benevolence of the world and people in general. Three subscales include items that assess beliefs about justice, control, and randomness and reflect the fundamental assumption of the meaningfulness of the world. The final three subscales relate to the fundamental assumption of self-worth and contain items related to perceived controllability, personal luck, and self-worth. Respondents were asked to indicate the extent of their agreement with each statement using a six-point Likert-type scale with values ranging from 1 (strongly disagree) to 6 (strongly agree). High scores reflect stronger beliefs of each of the three basic assumptions outlined by Janoff-Bulman: benevolence of the world, meaningfulness of the world, and worthiness of the self. Janoff-Bulman reported that each of the subscales had reliabilities ranging between .67 and .78. Mikkelsen and Einarsen (2002) reported Cronbach's alpha values being .82 for benevolence of the world, .60 for benevolence of people, .73 for randomness, .86 for justice, .75 for controllability, .80 for self-worth, .75 for self-controllability, and .71 for luck. Lerner's (1980) just world theory was measured by the justice subscale of the WAS. A copy of the WAS can be found in Appendix A.

Symptom Assessment – 45 Questionnaire (SA-45; Strategic Advantage, Inc., 2000). The Symptom Assessment – 45 Questionnaire is a brief, multidimensional, symptom checklist used to assess general psychiatric symptomatology. Respondents were asked to rate how often (during the past seven days) they have been bothered or

distressed by each of the 45 symptoms listed using a 5 point Likert type scale with responses ranging from 1 (not at all) to 5 (extremely). The SA-45 consists of nine symptom domain scales; five of these scales were used in the present study: Anxiety (ANX); Depression (DEP); Hostility (HOS); Interpersonal Sensitivity (INT); and Somatization (SOM). Each scale contained 5 items. Scale scores were obtained by summing individual items. To aid in interpretation, raw scores were converted to T-scores and percentiles for each of the SA-45's domain scales and indices. In nonpatient samples, a T-score of 65 or greater suggests a likely problem area.

The SA-45 was derived from the Symptom Checklist – 90 (SCL-90; Derogatis, Lipman, & Covi, 1973) using cluster analytic techniques. Separate gender based norms were developed for both inpatient and nonpatient groups of adults and adolescents. The internal consistency for each of each of the SA-45's nine scales is reported to be good, with Cronbach's alpha coefficients of 0.71 or greater obtained for adult and adolescent inpatient and nonpatient samples. Convergent validity of the SA-45 is reflected in its correlation with the SCL-90. The correlations between the scales and indices of the two measures are .95 or greater. Due to copyright restrictions, SA-45 items used in the present study cannot be listed in Appendix A. The reader is directed to contact the test publisher (see References) for further information about this measure.

Demographics. The questionnaire also contained a number of items inquiring about personal demographics (e.g., age, ethnicity, education, marital status, etc.) and items related to the work environment such as the number of years employed as a nurse, number of years employed at current work setting, type of unit or work setting (e.g., medical-surgical, psychiatry, labour-delivery, surgical, etc), and work status (e.g., full-time, part-time). The back page of the questionnaire was left blank so that nurses could

add additional comments if they chose to do so. A copy of the items contained in the demographics section is presented in Appendix A.

Token Incentive. A small token incentive (herbal tea bag) was included in the questionnaire packages along with a brief note thanking nurses for their participation in the study. Dillman (2000) suggests that the inclusion of small material incentives such as ball point pens may increase response rates by at least 8% to 10%. Church (1993) found that the average response rate of studies with material incentives was approximately 9% higher than those without such incentives.

Procedure

A modified version of the Tailored Design Method (TDM; Dillman, 2000) was used as a model for data collection for the current study. The TDM is "based upon considerations of social exchange, that is, how to increase perceived rewards for responding, decrease perceived costs, and promote trust in beneficial outcomes from the survey" (p. 5, Dillman, 2000). The model describes detailed procedures for questionnaire construction and emphasizes the need for timed mailings, personalized contact, and the provision of tangible incentives to maximize response rates.

Packages were mailed to a random sample of 1,200 nurses registered as members of the College of Nurses of Ontario. Each package contained six components: cover letter (Appendix B); consent form (Appendix C); questionnaire; token incentive; return envelope; and information regarding occupational stress (Appendix D).The questionnaires contained items based on the following scales: Negative Acts Questionnaire (NAQ; Einarsen & Raknes, 1997); Specific Events in the Workplace (Keashly et al., 1994); Organizational Job Satisfaction Scale (Sauter et al., 1997); Turnover Cognitions Scale (Bozeman & Perrewé, 2001); Maslach Burnout Inventory

(MBI; Maslach, Jackson & Leiter, 1986); World Assumptions Scale (WAS, Janoff-Bulman, 1989); and Symptom Assessment – 45 Questionnaire (SA-45; Strategic Advantage, Inc., 2000). Items related to demographics and characteristics of nurses' work settings were also included in the questionnaires.

The cover letter was personalized and provided general information about the study. The consent form contained information outlining the rationale for the study, techniques for data collection, and methods to ensure confidentiality of respondents' data. Participants were informed that their involvement in the study was voluntary and that return of completed questionnaires constituted implied consent to participate in the research.

Individual identification numbers were printed in clear view on the front page of each questionnaire. This was done to ensure that follow-up mailings were sent only to non-respondents. Information about the presence and purpose of the identification number was provided in the information form. Follow-up mailings are an essential part of the TDM design. Without follow-up contacts, response rates may "fall as much as 20% to 40% below those normally obtained through mail surveys" (Dillman, 2000; p. 177).

Participants were allowed 4 weeks to return the questionnaires. After that time, follow up letters (see Appendix E) and replacement questionnaires were sent to a random subset of 200 non-responders. Postage-paid business reply envelopes were provided for the return of questionnaires. Participants were informed that feedback regarding the results of the study would be posted on the faculty supervisor's webpage upon completion of the study.

CHAPTER IV

RESULTS

Preliminary Analyses

Statistical analyses were performed with the Statistical Package for Social Sciences (SPSS), version 10.0.

Data Screening. The objective criterion for classifying women as victims or targets of bullying was based on Leymann's (1996) definition of bullying. According to Leymann, workers are classified as victims of bullying if they have experienced at least one negative behaviour on a weekly basis for the past six months. In the present study, nurses were to be classified into groups based on their responses to the NAQ and their response to a single self-labelling item. The mean and standard deviation of the Negative Acts Questionnaire were intended to be used to determine the frequency of harassment and this was to be broken down into three categories: low frequency (i.e., nurses scoring at least one standard deviation below the mean on the NAQ); moderate frequency (i.e., nurses scoring between one standard deviation below and one standard deviation above the mean on the NAQ), and high frequency (i.e., nurses scoring at least one standard deviation above the mean on the NAQ).

Prior to classifying the nurses into groups, scores on the NAQ were assessed to determine whether they represented a normal distribution. Descriptive analysis showed that the scores on the NAQ were positively skewed with the mean of 10.84 (SD = 9.25) being greater than the median of 8.00 (kurtosis = 3.95, skewness = 1.64). Scores on the NAQ ranged from 0 to 59. Salin (personal communication, August 6, 2003) reported that the NAQ did not follow a normal distribution in her research and that scores on the measure tend to be positively skewed.

Given the pattern of NAQ distribution, the strategy for classifying women into groups based on frequency of experience with bullying behaviours was abandoned. Instead, scores on the NAQ were calculated by dichotomizing the response to each item (i.e., participants either reported that they had experienced a negative behaviour on a weekly basis or they did not) and women were classified as victims of bullying if they indicated that they had experienced at least one negative behaviour on a weekly basis for the past six months. Responses to the single self-labelling item were also dichotomized and participants were categorized as either 'self-labellers' or 'non-labellers.' This method of classification resulted in the creation of four groups: (1) bullied, self-labellers, (2) bullied, non-labellers, (3) non-bullied, non-labellers, and (4) non-bullied, self-labellers.

Sample Description. Of the 1,200 packages that were mailed out, a total of 417 questionnaires were returned for a response rate of 34.75%. Of this number, 385 questionnaires were usable. The remaining 32 questionnaires were removed from subsequent analyses because participants indicated that they were on permanent disability, extended sick leave, maternity leave, or were retired. Only questionnaires completed by nurses who had been working for at least the past six months were retained for statistical analysis.

Based on the system of categorization described above, the following groups resulted:

- bullied, self-labellers (n = 64)
- bullied, non-labellers (n = 99);
- on-bullied, non-labellers (n = 182)
- and non-bullied, self-labellers (n = 40)

Because it is unclear what the nurses in the non-bullied, self-labelling group were labelling (i.e., they had not reported being subjected to at least one negative behaviour on a weekly basis for the past six months), they were not included in the main analyses with the other three groups. Mean scores for nurses in the "non-bullied, self-labelling" group are analyzed with respect to the rest of the sample in the supplementary analyses section. Demographic characteristics, means and standard deviations for this group on all dependent variables can be found in Appendix F.

A breakdown of the sample by hospital location is presented in Table 2. Participants ranged in age from 22 years to 65 years, with a mean age of 44.35 years (*SD* = 9.80 years). On average, participants indicated that they had been employed as nurses for 21.13 years (*SD* = 10.54 years) and had worked at their current place of employment for 15.34 years (*SD* = 10.05 years). Hospital restructuring or amalgamation was cited as the most frequent cause for change of work setting. Nurses reported working an average of approximately 39.52 hours per week (*SD* = 6.12 hours) and were employed in a wide variety of units within the hospital. The majority of nurses were distributed across the following hospital units: emergency room/ critical coronary (30.4%); medical-surgical floors (23.2%); and operating room/ recovery (17.4%).

Approximately 69% of the sample indicated that they were married or involved in common-law relationships; 17.4% stated that they were single; and 13.6% reported that they were separated, divorced, or widowed. Overall, the sample was predominantly Caucasian; only 38 nurses or 10% of the sample identified themselves as visible minorities. With respect to education the majority of the sample (67.8%) reported having obtained an R.N. diploma from a hospital or college based school of nursing; 26.1% indicated that they had a Baccalaureate degree in nursing or a non-nursing areas.

Table 2

Breakdown of Sample (N = 345) by Hospital Location

City	*n* (percent)
Hamilton	82 (23.8%)
Kitchener	19 (5.5%)
London	55 (15.9%)
Mississauga	22 (6.4%)
Ottawa	46 (13.3%)
St. Catharines / Niagara	11 (3.2%)
Toronto	74 (21.4%)
Windsor	36 (10.4%)

Approximately 47.2% (n = 163) of participants indicated that they had experienced at least one negative behaviour on a weekly basis for the past six months. These nurses met the criteria for Leymann's (1996) operational definition of bullying. Based on responses to the single self-labelling item, roughly 18.6% (n = 64) of respondents reported that they had been bullied at their workplaces within the last six months.

Demographic characteristics were analyzed by group using one-way between-subjects analysis of variance (ANOVA) and Chi –square analyses. Demographic characteristics for each group are presented in Table 3 and Table 4. Significant differences between groups were found for age, F (2, 342) = 5.64, $p < .01$, and the number of years employed as a nurse, F (2, 342) = 4.11, $p < .05$. Nurses in the bullied, self-labelling group were more likely to be younger than their non-bullied colleagues (M = 41.18 yrs, SD = 9.82 yrs; and M = 45.79 yrs, SD = 9.38 yrs, respectively). Nurses in the bullied, self-labelling group were also more likely to be less experienced than their non-bullied colleagues (M = 18.09 yrs, SD = 10.39 yrs; and M = 22.40, SD = 10.29 yrs, respectively). No significant differences in age or number of years employed as a nurse were found between nurses in the bullied, self-labelling group and nurses in the bullied, non-labelling group. No other significant differences among the groups were found for any of the remaining demographic variables.

Reliability of Measures. Alpha reliability coefficients were computed for all scales and subscales and are presented in Table 5. Each of the measures demonstrated adequate reliability, with Cronbach's alpha reliability coefficients ranging from .62 to 91. The mean, standard deviation, and range of each scale and subscale are also provided in Table 5.

Table 3

Selected Demographic Characteristics by Group (N = 345)

	Bullied						
	Self-Labellers (n = 64)		Non-Labellers (n = 99)		Non-Bullied (n = 182)		
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	ANOVA $F(2, 342)$
Age (in years)	41.18_a	9.82	43.76	10.09	45.79_a	9.38	5.64**
Years Employed as a Nurse	18.09_a	10.39	20.78	10.75	22.40_a	10.29	4.11*
Years Employed in Current Workplace	12.88	9.08	15.87	10.92	15.91	9.80	2.36
Years Employed in Current Position	9.42	8.23	9.95	8.61	10.02	8.99	0.12
Average Hours Worked per Week	38.86	6.50	39.99	5.87	39.50	6.16	0.59
No. of Days of Sick Leave	7.10	10.91	6.21	10.66	6.84	13.30	0.13
No. of Days of Sick Leave due to Stress	1.22	3.06	1.12	3.56	1.29	5.35	0.05

Note. Means in a row sharing subscripts are significantly different. *$p < .05$. **$p < .01$.

Table 4

Selected Demographic Characteristics by Group (N = 345)

Variable	Bullied		Non-Bullied	χ^2	*p*
	Self-Labellers (*n* = 64)	Non-Labellers (*n* = 99)	(*n* = 182)		
Cultural / Ethnic Group				0.69	0.71
Caucasian	58 (90.6%)	86 (86.9%)	163 (89.6%)		
Visible Minority	6 (9.4%)	13 (13.1%)	19 (10.4%)		
Marital Status				2.98	0.56
Single	14 (21.9%)	19 (19.2%)	27 (14.8%)		
Married/Common Law	43 (67.2%)	64 (64.6%)	131 (72.0%)		
Other	7 (10.9%)	16 (16.2%)	24 (13.2%)		
Level of Education				4.73	0.58
R.N. (college or hospital – based school of nursing)	47 (73.4%)	68 (68.7%)	119 (65.4%)		
Baccalaureate degree in nursing or non-nursing	15 (23.4%)	25 (25.3%)	50 (27.5%)		
Masters degree in nursing or non-nursing	2 (3.1%)	5 (5.1%)	13 (7.1%)		
Doctorate degree in nursing or non-nursing	0 (0.0%)	1 (1.0%)	0 (0.0%)		

(continued)

Table 4 (continued)

Selected Demographic Characteristics by Group (N = 345)

Variable	Bullied		Non-Bullied	χ^2	*p*
	Self-Labellers (*n* = 64)	Non-Labellers (*n* = 99)	(*n* = 182)		
Work Unit / Setting				11.95	0.85
Medical/Surgical	14 (21.9%)	23 (23.2%)	43 (23.6%)		
ER; Critical Coronary; Special	19 (29.7%)	31 (31.3%)	55 (30.2%)		
Psychiatry; Mental Health	5 (7.8%)	4 (4.0%)	8 (4.4%)		
Pediatrics; NICU	5 (7.8%)	6 (6.1%)	18 (9.9%)		
OR/Recovery	13 (20.3%)	17 (17.2%)	30 (16.5%)		
Labour and Delivery	3 (4.7%)	8 (8.1%)	15 (8.2%)		
Complex Continuing Care//LTC	2 (3.1%)	2 (2.0%)	1 (0.5%)		
Education; Development; Administration	0 (0.0%)	3 (3.0%)	2 (1.1%)		
Research	0 (0.0%)	3 (3.0%)	5 (2.7%)		
Other	3 (4.7%)	2 (2.0%)	5 (2.7%)		
Shift Worked				5.69	0.22
Days	18 (28.1%)	37 (37.4%)	78 (42.9%)		
Evenings	2 (3.1%)	6 (6.1%)	9 (4.9%)		
More than one shift	44 (68.8%)	56 (56.6%)	95 (52.2%)		

Note. Group *n*s may vary slightly by demographic variable as not all participants responded to each item.

Table 5

Alpha Reliability Coefficients, Scale Means, and Scale Standard Deviations for All Dependent Measures (N = 385)

Measure	Alpha	Mean	Standard Deviation	Possible Range	Actual Range
NAQ	.88	10.84	9.25	0 - 80	0 - 59
Positive Events	.84	14.81	6.23	0 - 36	0 - 32
Job Satisfaction	.76	21.26	4.04	7 - 28	11 - 28
Turnover Cognitions	.87	8.61	4.00	5 - 20	5 - 20
Maslach Burnout Inventory					
Emotional Exhaustion	.91	24.80	11.10	0 - 54	0 - 53
Depersonalization	.78	6.13	5.55	0 - 30	0 - 27
Personal Accomplishment	.78	37.22	6.77	0 - 30	16 - 28
World Assumptions Scale					
Benevolence of the World	.82	18.32	3.65	4 - 24	6 - 24
Benevolence of People	.68	19.35	3.08	4 - 24	9 - 24
Justice	.70	10.98	3.68	4 - 24	4 - 23
Controllability	.70	12.66	3.47	4 - 24	4 - 24
Randomness	.62	13.90	3.76	4 - 24	4 - 24
Self-Worth	.70	19.97	3.44	4 - 24	7 - 24
Self-Controllability	.68	17.70	3.05	4 - 24	7 - 24
Luck	.82	15.92	4.22	4 - 24	4 - 24

(continued)

Table 5 (continued)

Alpha Reliability Coefficients, Scale Means, and Scale Standard Deviations for All Dependent Measures (N = 385)

Measure	Alpha	Mean	Standard Deviation	Possible Range	Actual Range
SA-45					
Depression	.86	55.72	6.84	47 - 83	47 - 83
Anxiety	.75	56.47	7.96	46 - 84	46 - 82
Hostility	.78	57.95	5.22	54 - 88	54 - 78
Interpersonal Sensitivity	.80	56.95	6.61	48 - 84	48 - 74
Somatization	.81	59.08	8.69	46 - 87	46 - 83

Note. Prior to statistical analysis, raw scores on the SA-45 subscales were converted to T-scores for comparison with the standardization sample of the SA-45. The means, standard deviations, and ranges for each subscale's T-scores are reported above.

Primary Analyses

A. Relationships Among Experiences with Bullying, Self-Labelling, and Job Related Variables. Intercorrelations between the Negative Acts Questionnaire (NAQ) and several job related variables are presented in Table 6. Scores on the NAQ were found to be significantly and negatively associated with scores on measures of job satisfaction and experience with positive events in the workplace. Scores on the NAQ were found to be significantly and positively associated with scores on the Turnover Cognitions Scale. Nurses who reported greater experiences with negative acts in the workplace also reported a greater propensity to leave their current jobs.

A series of one-way ANOVAs was performed to determine if differences existed among the three groups of nurses (i.e., bullied self-labellers; bullied non-labellers; and non-bullied nurses) on measures related to bullying, positive experiences in the work place, job satisfaction, and turnover intentions (see Table 7). Levene's test for equality of variances revealed that the assumption for homogeneity of variance was rejected for scores on the NAQ, $F(2, 342) = 30.18$, $p < .001$, Positive Events subscale, $F(2, 342) = 5.18$, $p < .01$, and Turnover Cognitions scale, $F(2, 342) = 12.08$, $p < .001$. Due to unequal variances, Games-Howell post hoc analyses were used to identify which groups differed from each other on the NAQ, Positive Events subscale, and Turnover Cognitions scale. The assumption for homogeneity of variance was supported for scores on the Job Satisfaction subscale of the WOFS, $F(2, 342) = 1.90$, $p > .05$. As a result, Bonferroni post hoc analyses were used to identify which groups differed from each other on this subscale.

Significant differences in mean scores were found among the three groups of nurses on the NAQ, $F(2, 342) = 204.14$, $p < .001$. Given that the NAQ was used to

Table 6

Intercorrelations Between the Negative Acts Questionnaire (NAQ) and Selected Job Related Variables (N = 345)

Scale	1	2	3	4
1. NAQ	--			
2. Positive Events	-.28**	--		
3. Job Satisfaction	-.55**	.40**	--	
4. Turnover Cognitions	.36**	-.24**	-.61**	--

**$p < .01$

Table 7

Means, Standard Deviations, and One-Way Analyses of Variance (ANOVA) for Scores on the Negative Acts Questionnaire (NAQ), and Selected Job Related Variables by Group (N = 345)

	Bullied							
	Self-Labellers (n = 64)		Non-Labellers (n = 99)		Non-Bullied (n = 182)		ANOVA	
Selected Scales	*M*	*SD*	*M*	*SD*	*M*	*SD*	$F(2, 342)$	η^2
Negative Acts Questionnaire (NAQ)	23.21_a	10.50	12.08_a	6.07	4.95_a	4.08	204.14***	0.54
Positive Events	$11.58_{a,b}$	5.12	15.07_b	6.83	15.77_a	6.07	11.20***	0.06
Job Satisfaction	17.64_a	3.93	20.58_a	3.77	22.83_a	3.38	51.25***	0.23
Turnover Cognitions	10.52_a	4.04	9.51_b	4.57	$7.52_{a,b}$	3.24	18.14***	0.10

Note. Means in a row sharing subscripts are significantly different. ***$p < .001$.

categorize nurses into groups, one would expect the means and standard deviations of each of the groups to differ significantly from one another on this scale. Nurses in the bullied, non-labelling group scored significantly higher on the NAQ than did their non-bullied colleagues. Figure 1 depicts means for each group of nurses on the NAQ. Nurses who were bullied and labelled their experiences as bullying scored significantly higher on the NAQ than did nurses in the other two groups (i.e., bullied, non-labellers, and non-bullied, non-labellers).

Significant differences were found among the three groups of nurses on a measure assessing the frequency of exposure to positive events in the workplace, F (2, 342) = 11.20, $p < .001$ (See Figure 2). Nurses who labelled their experiences as bullying reported significantly fewer instances of positive events in the workplace than did their non-bullied colleagues. Nurses who were bullied and labelled their experiences as bullying also reported fewer instances of positive experiences in the workplace than did nurses in the bullied, non-labelling group. No significant differences were found on this scale between nurses in the bullied, non-labelling group and those in the non-bullied group.

Significant differences were found among the three groups of nurses on a measure of job satisfaction, F (2, 342) = 51.25, $p < .001$ (Figure 3). Nurses who were bullied and labelled their experiences as bullying reported significantly lower levels of job satisfaction than nurses who were not bullied. Nurses in the bullied, self-labelling group reported significantly lower levels of job satisfaction than nurses in the bullied, non-labelling group. Nurses in the bullied, non-labelling group reported significantly lower levels of job satisfaction than nurses who were not bullied.

Significant differences were also found among the three groups of nurses on a

Figure 1. Mean scores on the Negative Acts Questionnaire (NAQ) by Group (N = 345)

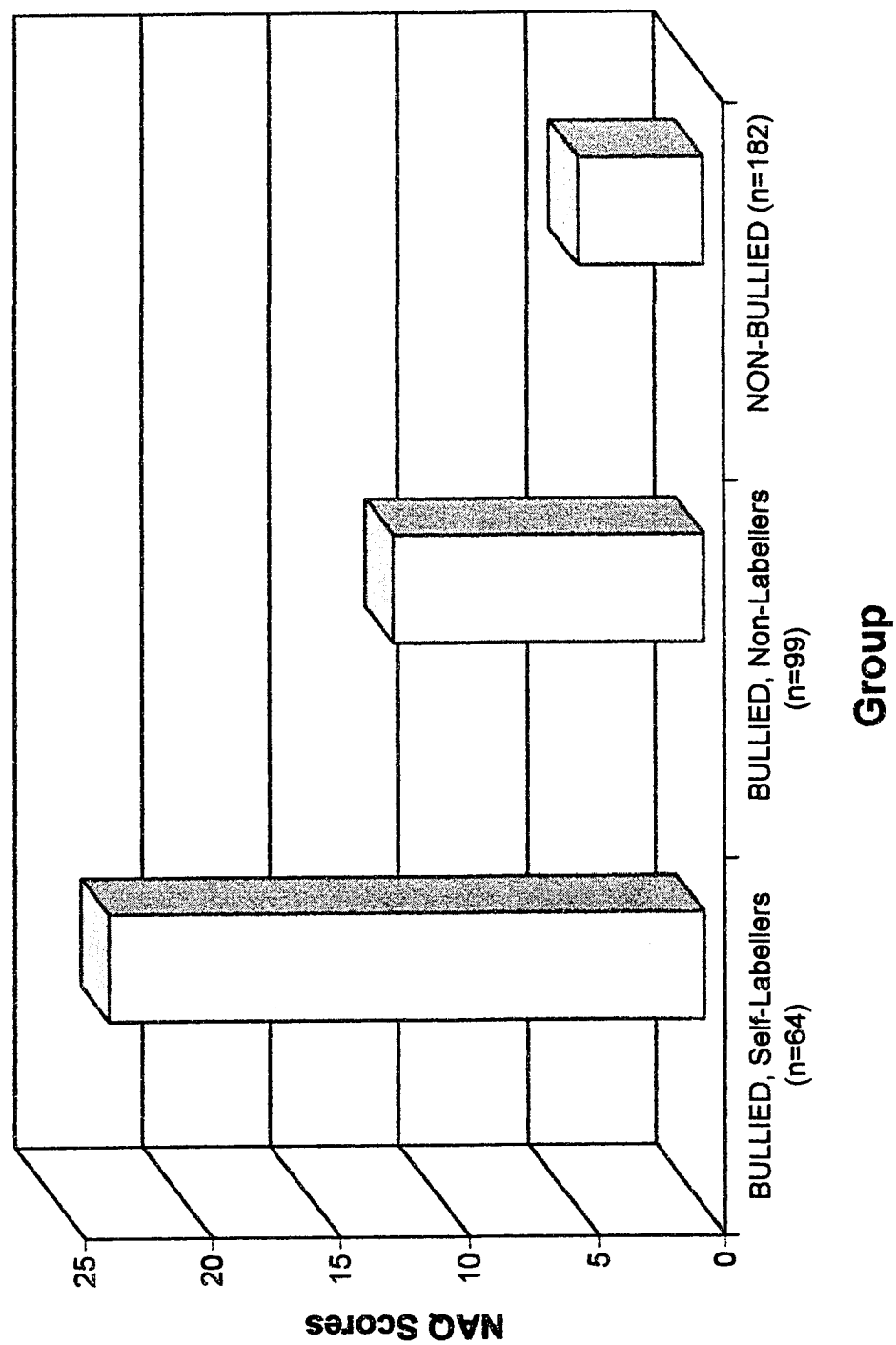


Figure 2. Mean scores on the Positive Events Subscale by Group (N = 345)

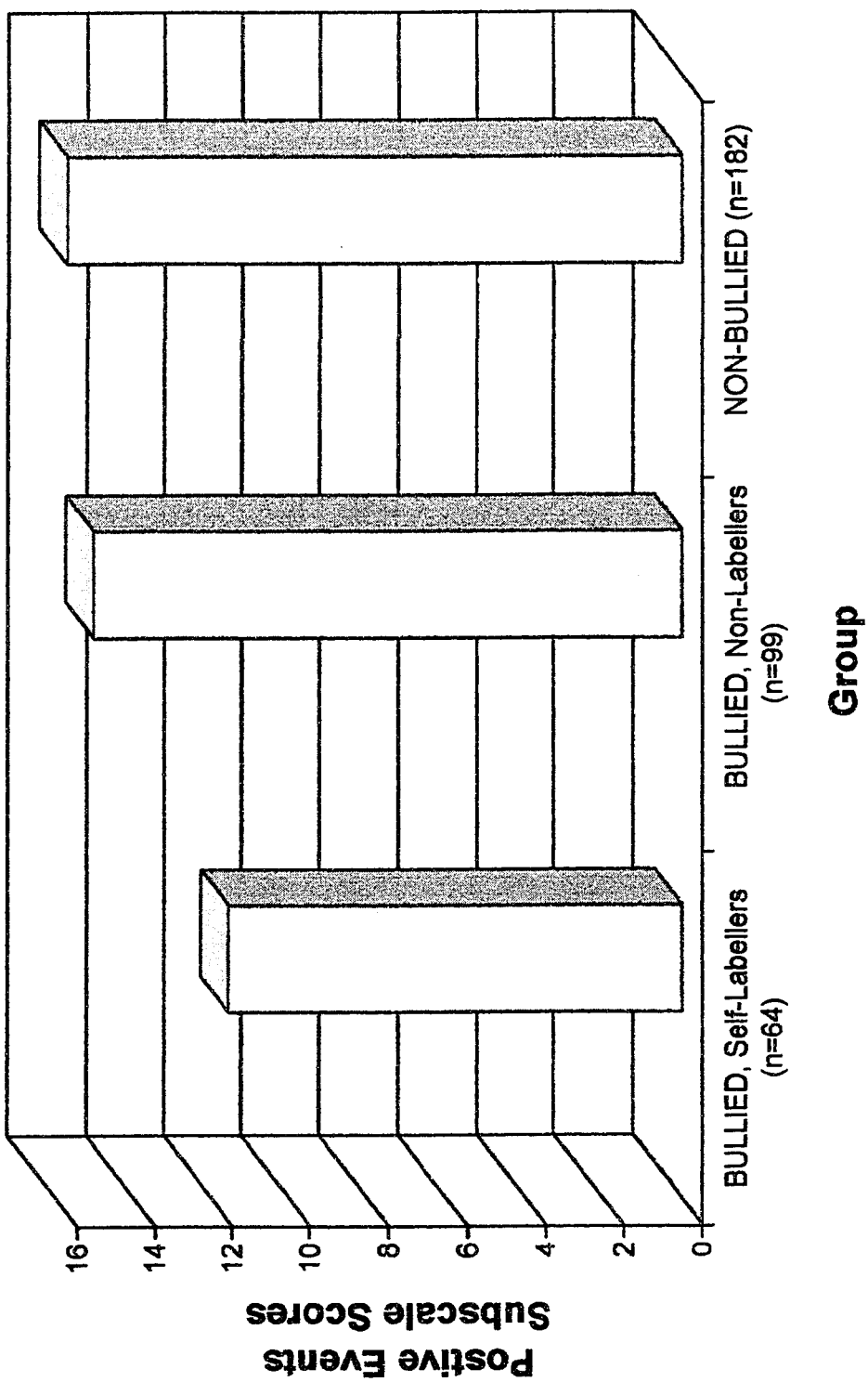
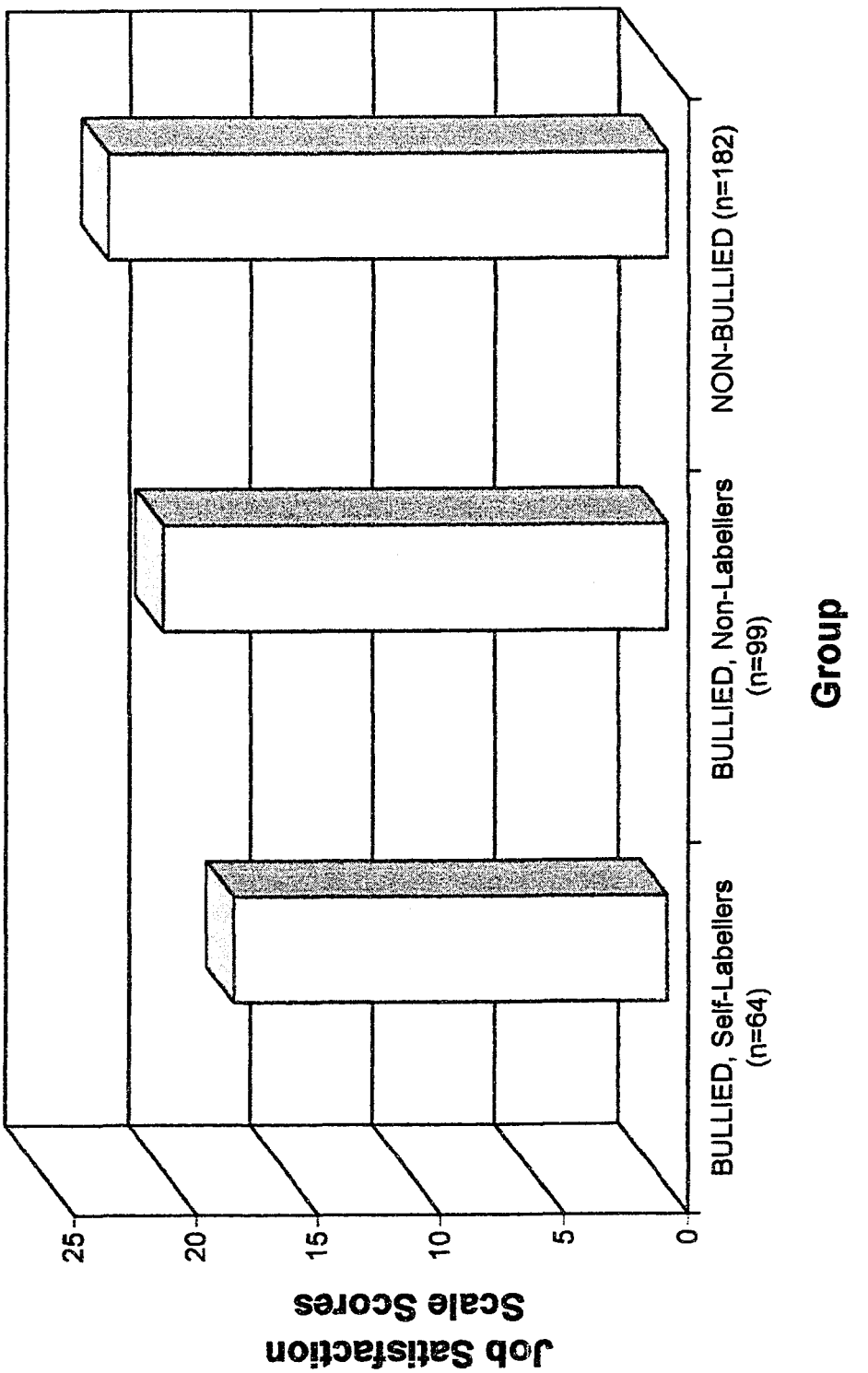


Figure 3. Mean scores on the Job Satisfaction Scale by Group (N = 345)



measure of turnover cognitions, $F(2, 342) = 18.14, p < .001$ (See Figure 4). High scores on this scale indicate a greater propensity to leave one's job. Nurses who were bullied and labelled their experiences as bullying reported significantly higher scores on the Turnover Cognitions scale than did nurses who were not bullied. Nurses in the bullied, non-labelling group reported significantly higher scores on this scale than did nurses who were not bullied. No significant differences in scores on this scale were found between nurses in the bullied, self-labelling group and those in the bullied, non-labelling group.

B. Victimization, Self-Labelling, and Burnout. A multivariate analysis of variance (MANOVA) was used to determine if the groups differed on the three subscales of the Maslach Burnout Inventory (MBI). MANOVA is used to determine the statistical significance of one or more independent variables on a set of two or more dependent variables. With respect to the MBI, Emotional Exhaustion, Depersonalization, and Personal Accomplishment were treated as dependent variables and group (based on NAQ scores and responses to the single self-labelling item) served as the independent variable. Intercorrelations between subscales of the MBI are presented in Table 8. Group means, standard deviations, and stepdown *F*s are presented in Table 9.

The Bonferroni inequality was used to define the maximum value of alpha (.05) for the MANOVA and subsequent univariate tests. Whenever multiple statistical tests are carried out, there is a possibility of committing a Type I error (i.e., falsely rejecting the null hypothesis) because the overall alpha level becomes inflated. For example, if an ANOVA was performed for each of the three subscales of the MBI, the overall alpha level would be 3 (.05) = .15. This would result in a 15% chance of committing at least one Type I error across the three ANOVAs. The Bonferroni inequality conservatively sets the alpha level for each dependent variable by taking the total alpha level and

Figure 4. Mean scores on the Turnover Cognitions Scale by Group (N = 345)

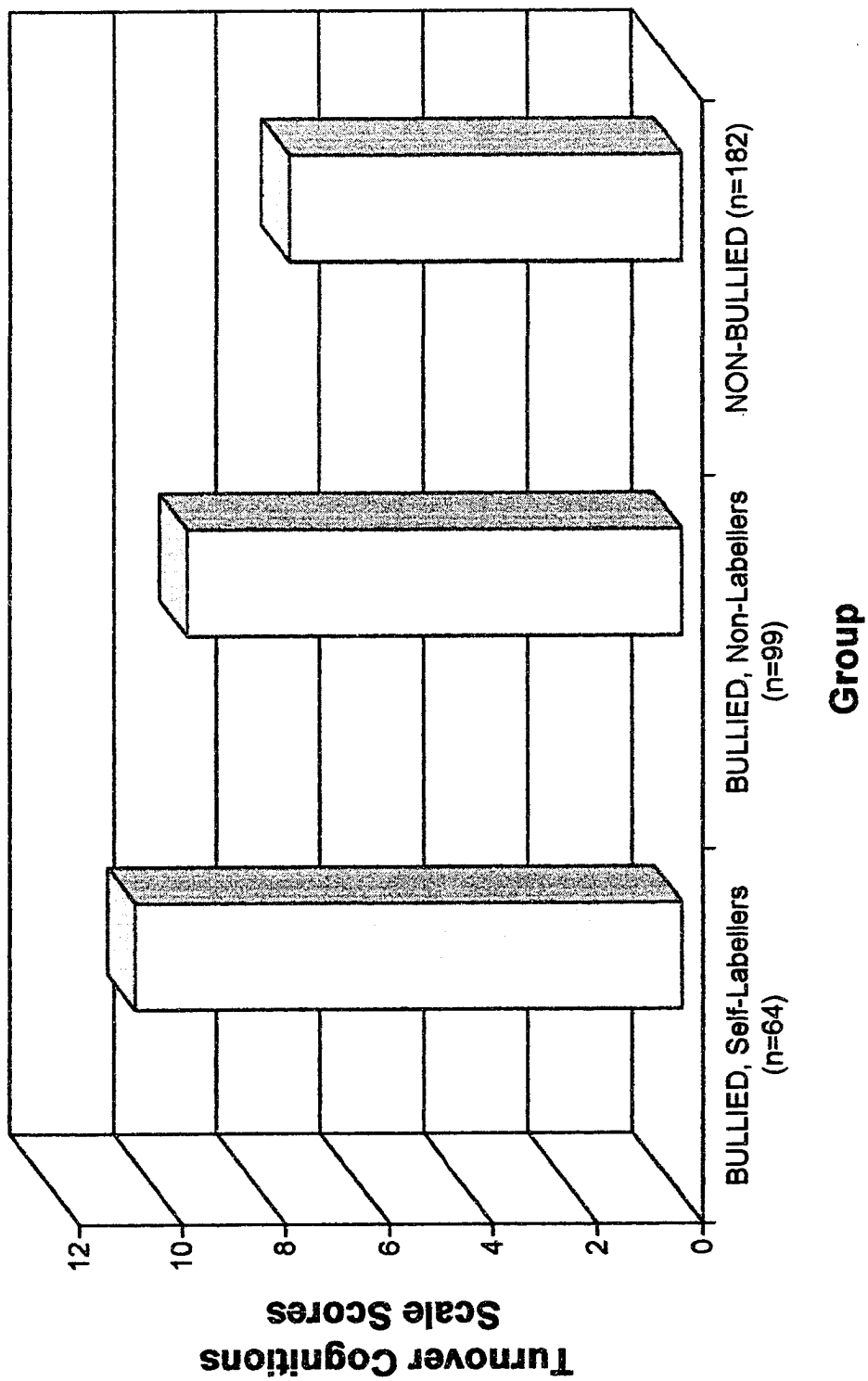


Table 8

Intercorrelations Between Subscales of the Maslach Burnout Inventory (N = 345)

Scale	1	2	3
1. Emotional Exhaustion	--		
2. Depersonalization	.61**	--	
3. Personal Accomplishment	-.35**	-.38**	--

**$p < .01$

Table 9

Means, Standard Deviations and One-Way Analyses of Variance (ANOVA) for Scores on the Subscales of the Maslach Burnout Inventory (MBI) by Group (N = 345)

	Bullied							
	Self-Labellers (n = 64)		Non-Labellers (n = 99)		Non-Bullied (n = 182)		ANOVA	
MBI Subscale	*M*	*SD*	*M*	*SD*	*M*	*SD*	$F(2, 341)$	η^2
Emotional Exhaustion	33.05_a	10.10	27.25_a	10.75	20.99_a	9.97	15.92***	.09
Depersonalization	9.09_a	6.32	7.82_b	6.11	4.55_{ab}	4.50	3.25*	.02
Personal Accomplishment	35.22	6.92	36.45	7.49	38.44	6.21	0.13	.00

Note. Means in a row sharing subscripts are significantly different. F statistics for Depersonalization and Personal Accomplishment are derived from Analyses of Covariance (ANCOVA) as per the Roy-Bargmann stepdown analysis method.

*$p < .05$. **$p < .01$. ***$p < .001$.

dividing it by the number of tests so that the alpha level for the set of dependent variables tested in the MANOVA does not exceed an acceptable value. In this case, the Bonferroni inequality was used to set the overall alpha level at .05.

Preliminary analyses showed that missing data was not problematic. The test of the assumption of homogeneity of covariance matrices in the three groups was rejected [Box's $M = 26.71$, $F\,(12,\ 189857) = 2.19$, $p < .05$]. Based on this result and the unequal number of participants per cell, Pillai's Trace was used to calculate multivariate significance. Pillai's Trace is more robust to violations of the homogeneity of variance assumption and is well-suited to research in which there are unequal numbers of participants per cell (Tabachnick & Fidell, 1996). The multivariate null hypothesis of equality of the means over all groups for all variables was rejected at the .05 level [Pillai's Trace = .19, $F\,(10,\ 678) = 12.11$, $p < .001$].

Although this finding suggests that there are significant differences between the groups of nurses on the composite of the three MBI subscales, the multivariate F statistic alone does not provide information about the magnitude of the differences between the groups on the dependent variables. In contrast, the calculation of an effect size provides an indication of the amount of variability in the dependent variables that can be accounted for by the independent variable. It is a measure of the degree to which the independent variables and dependent variables are related. One measure of effect size in MANOVA is eta-squared (η^2). Eta-squared is typically expressed as a number ranging between zero and one. In his discussion of the classification of effect sizes, Weinfurt (2000) suggested that .01 represents a small effect size; .09 represents a medium effect size; and .25 or greater represents a large effect size. Weinfurt further noted that the majority of social research produces small to medium effect sizes. With respect to the

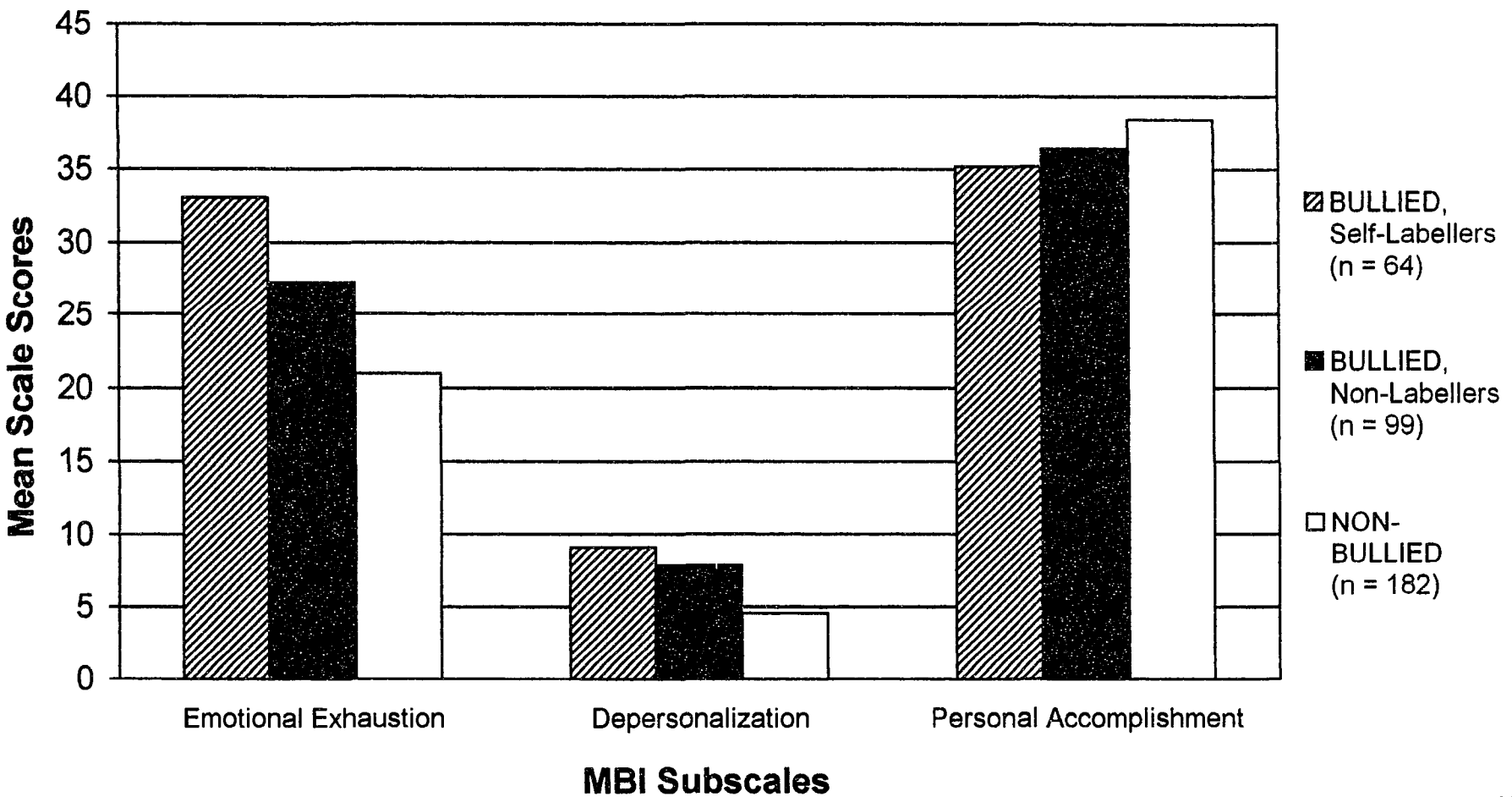
Maslach Burnout Inventory, the Pillai's multivariate effect size was medium at .10. Figure 5 illustrates differences among the three groups of nurses (bullied, self-labellers; bullied, non-labellers; and non-bullied, non-labellers) in their mean scores on the subscales of the MBI.

To identify the dependent variables that contributed to the rejection of the multivariate null hypothesis, the Roy-Bargmann stepdown analysis was used. If there is a logical a priori causal ordering of variables, a stepdown analysis may be appropriate (Weinfurt, 2000). Priorities are assigned to dependent variables according to theoretical or practical considerations. In stepdown analysis, each dependent variable is analyzed, in turn, with higher-priority dependent variables treated as covariates and with the highest-priority dependent variable tested in a univariate ANOVA.

In the case of the Maslach Burnout Inventory (MBI), prior research has supported a two-factor model of burnout consisting of emotional exhaustion and depersonalization, with emotional exhaustion being the stronger of the two factors (Kalliath et al., 2000). Based on this conceptualization, the subscales of the MBI were entered in the Roy-Bargmann stepdown analysis in the following order: emotional exhaustion, depersonalization, and personal accomplishment.

Emotional exhaustion was found to differ significantly among the groups at the .001 level. Nurses who were bullied reported significantly higher levels of emotional exhaustion than did nurses who were not bullied. Nurses who were bullied and labelled their experiences as bullying reported significantly higher levels of emotional exhaustion than nurses in the bullied, non-labelling group. Nurses in the bullied, non-labelling group reported significantly higher levels of emotional exhaustion than did nurses who were not bullied. The strength of association (eta-squared) for emotional exhaustion was .18, and

Figure 5. Means scores on the Maslach Burnout Inventory (MBI) subscales by Group (*N* = 345)



suggested a moderate effect size.

Depersonalization was also found to differ significantly among the groups at the .05 level. Nurses who were bullied and labelled their experiences as bullying reported significantly higher levels of depersonalization than did nurses who were not bullied. Nurses who were bullied but did not label their experiences as bullying reported significantly higher levels of depersonalization than did nurses who were not bullied. No significant differences in reported levels of depersonalization were found between nurses who were bullied and labelled their experiences as bullying and nurses who were bullied but did not label their experiences as such. The strength of association for depersonalization was .02, suggesting a small effect size for this variable.

After controlling for the effects for emotional exhaustion and depersonalization, there were no significant differences between the groups on the personal accomplishment subscale.

C. Victimization, Self-Labelling, and the Assumptive World. Intercorrelations between the subscales of the World Assumptions Scale (WAS) are presented in Table 10. MANOVA works best with moderately correlated dependent variables (Tabachnick & Fidell, 1996). Although it was initially planned to use a MANOVA to test for group differences on the subscales of the WAS, preliminary analysis showed that some of the subscales of the WAS did not correlate well with one another. Based on these findings, a series of one-way ANOVAs was performed to determine if differences existed among the three groups of nurses (i.e., bullied self-labellers; bullied non-labellers; and non-bullied nurses) on the subscales of the WAS. Again, the Bonferroni inequality was used to protect against the likelihood of making a Type I error. Levene's test revealed that the assumptions of homogeneity of variance were supported for all of the WAS subscales.

Table 10

Intercorrelations Between Subscales of the World Assumptions Scale (WAS) (N = 345)

Scale	1	2	3	4	5	6	7	8
1. Benevolence of the World	--							
2. Benevolence of People	.67**	--						
3. Justice	.13*	.01	--					
4. Controllability	.12*	-.02	.53**	--				
5. Randomness	.05	.01	.04	-.06	--			
6. Self-Worth	.40**	.35**	.01	.02	-.10	--		
7. Self-Controllability	.29**	.19**	.25**	.34**	.05	.20*	--	
8. Luck	.38**	.32**	.20**	.18**	.05	.29**	.33**	--

*$p < .05$; **$p < .01$.

Bonferroni post hoc analyses were used to identify which groups significantly differed from one another with respect to their mean scores on the subscales of the WAS. Group means, standard deviations, and univariate *F*s are presented in Table 11.

Significant differences were found among the three groups of nurses on a subscale of the WAS that assessed their perceptions of the benevolence of the world, $F(2, 342) = 3.10, p < .05$. High scores on this subscale reflect greater beliefs in the world as being a just and fair place. Nurses who were bullied and labelled their experiences as bullying reported significantly lower scores on this subscale than did nurses who were not bullied. No significant differences in scores on this subscale were found between nurses in the bullied, self-labelling group and those in the bullied, non-labelling group. No significant differences in scores were found between nurses in the bullied, non-labelling group and nurses who were not bullied.

Significant differences were found among the three groups of nurses on a subscale of the WAS that assessed their perceptions of the benevolence of people, $F(2, 342) = 11.23, p < .001$ (See Figure 6). Higher scores on this subscale reflect greater beliefs that people are supportive and caring. Bullied nurses who labelled their experiences as bullying perceived other people as less supportive and caring than did nurses who were not bulled. Bullied nurses who labelled their experiences as bullying also perceived other people as less benevolent than nurses in the bullied, non-labelling group. No significant differences in perceptions of the benevolence of people were found between nurses in the bullied, non-labelling group and nurses who were not bullied. No significant differences were found among the three groups of nurses on the six remaining subscales of the WAS: Justice, Controllability, Randomness, Self-Worth, Self-Controllability, and Luck.

D. Victimization, Self-Labelling, and Psychological Distress. A multivariate

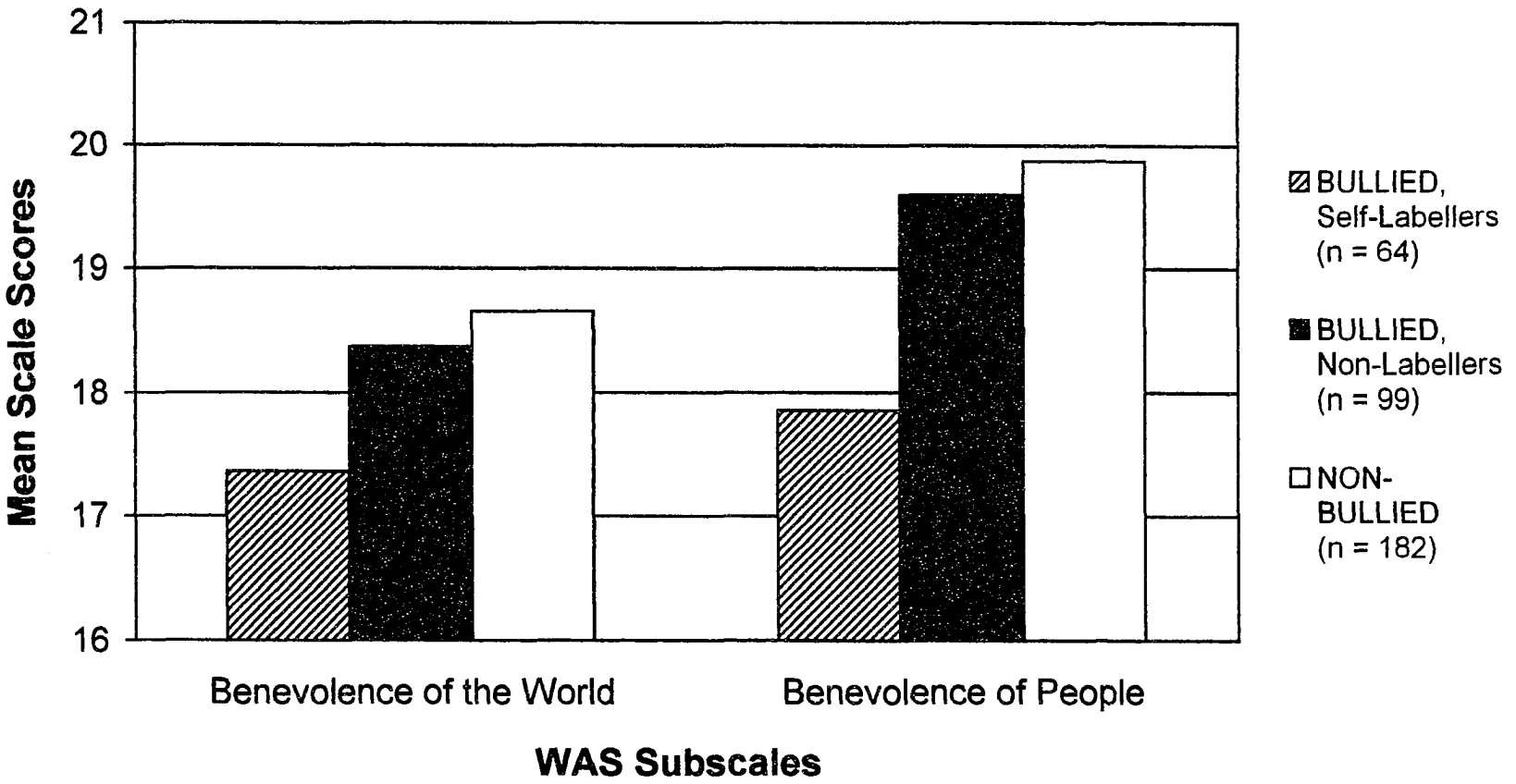
Table 11

Means, Standard Deviations, and One-Way Analyses of Variance (ANOVA) for Subscales of the World Assumption Scale (WAS) by Group (N = 345)

	Bullied							
	Self-Labellers (n = 64)		Non-Labellers (n = 99)		Non-Bullied (n = 182)		ANOVA	
WAS Subscale	*M*	*SD*	*M*	*SD*	*M*	*SD*	$F(2, 342)$	η^2
Benevolence of the World	17.36_a	3.62	18.37	3.54	18.66_a	3.62	3.10*	.02
Benevolence of People	$17.86_{a,b}$	3.38	19.59_a	2.84	19.87_b	2.85	11.23***	.06
Justice	10.44	3.81	11.01	3.44	11.21	3.66	1.07	.01
Controllability	12.17	3.10	12.91	3.39	12.92	3.53	1.25	.01
Randomness	14.06	3.80	14.37	3.68	13.62	3.63	1.40	.01
Self-Worth	19.19	3.43	20.07	3.32	20.06	3.55	1.67	.01
Self-Controllability	17.34	2.81	17.77	3.06	17.69	2.98	0.45	.00
Luck	15.31	4.04	15.58	3.98	16.24	4.31	1.52	.01

Note. Means in a row sharing subscripts are significantly different. *$p < .05$. ***$p < .001$.

Figure 6. Mean scores on selected subscales of the World Assumptions Scale (WAS) by Group (*N* = 345)



analysis of variance (MANOVA) was used to determine if the groups differed on the five subscales of the SA-45. Depression, Anxiety, Hostility, Interpersonal Sensitivity, and Somatization were treated as dependent variables and group (based on NAQ scores and responses to the single self-labelling item) served as the independent variable. Intercorrelations between subscales of the SA-45 are presented in Table 12. Group means, standard deviations, and univariate Fs are presented in Table 13 and each group's pattern of responses to the five subscales is presented in Figure 7. Again, the Bonferroni inequality was used to protect against the probability of committing a Type I error and was set conservatively at .05 level.

The test of the assumption of homogeneity of covariance matrices in the three groups was rejected [Box's $M = 46.00$, $F\,(30,\ 137754) = 1.49$, $p < .05$]. Based on this result and the unequal number of participants per cell, Pillai's Trace was used to calculate multivariate significance and Games-Howell post hoc analyses were used to identify which groups differed significantly from one another. The multivariate null hypothesis of equality of the means over all groups for all variables was rejected at the .05 level [Pillai's Trace = .11, $F\,(10,\ 678) = 4.11$, $p < .001$]. The very small p value resulting from the overall test supported confidence in the presence of true mean differences between the groups. The Pillai's multivariate effect size was small at .06.

To identify the dependent variables that contributed to the rejection of the multivariate null hypothesis, Wilkinson's (1975) successive MANOVAs method was used. If there is no logical a priori causal ordering of variables, Weinfurt (2000) suggests that alternative methods, such as the one described by Wilkinson may be more appropriate. This technique differs from a stepdown analysis in that the contribution of a dependent variable is derived by examining the decrease in multivariate effect as a

Table 12

Intercorrelations Between Selected Subscales of the SA-45 (N = 345)

Scale	1	2	3	4	5
1. Depression	--				
2. Anxiety	.67**	--			
3. Hostility	.52**	.54**	--		
4. Interpersonal Sensitivity	.66**	.61**	.52**	--	
5. Somatization	.33**	.44**	.31**	.32**	--

**$p < .01$

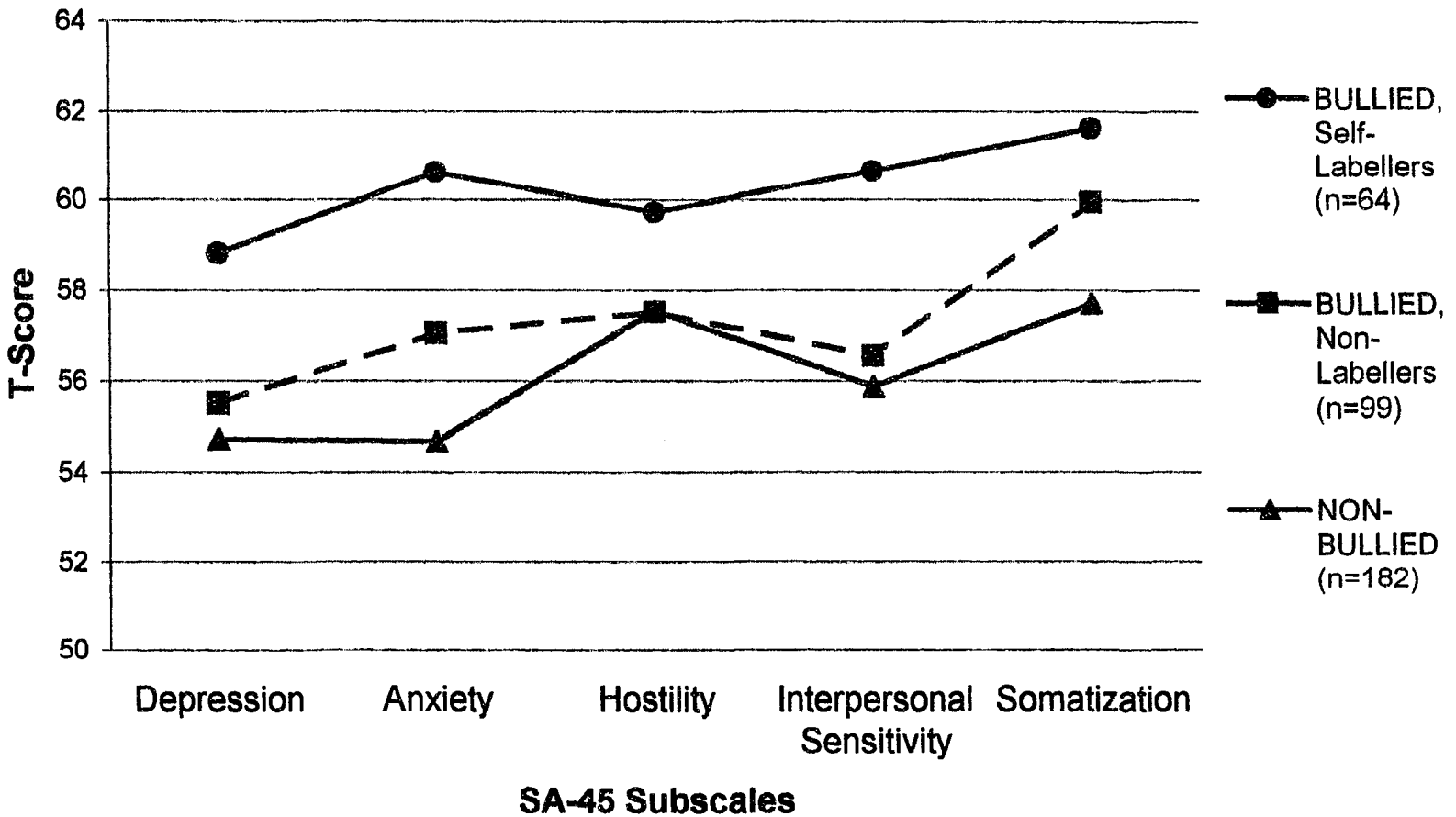
Table 13

Means, Standard Deviations, and One-Way Analyses of Variance (ANOVA) for Subscales of the SA-45 by Group (N = 345)

	Bullied							
	Self-Labellers (n = 64)		Non-Labellers (n = 99)		Non-Bullied (n = 182)		ANOVA	
SA-45 Subscale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(2, 342)	η^2
Depression	$58.81_{a,b}$	6.38	55.51_{a}	6.61	54.74_{b}	6.84	8.83***	.05
Anxiety	60.63_{a}	8.49	57.05_{a}	7.75	54.69_{a}	7.31	14.61***	.08
Hostility	$59.73_{a,b}$	5.96	57.52_{a}	5.32	57.55_{b}	4.76	4.71*	.03
Interpersonal Sensitivity	$60.66_{a,b}$	6.21	56.55_{a}	6.02	55.87_{b}	6.62	13.63***	.07
Somatization	61.64_{a}	8.73	59.94_{b}	8.35	$57.71_{a,b}$	8.63	5.69**	.03

Note. Means in a row sharing subscripts are significantly different. *p < . 05. **p < .01. ***p < .001.

Figure 7. Mean scores on selected SA-45 Subscales by Group (*N* = 345)



function of removing that particular variable from the MANOVA. Based on this method, anxiety and interpersonal sensitivity were found to result in the greatest change in effect size when removed from the model (change in eta-squared equal to -.11, and -.08, respectively).

Level of anxiety was found to differ significantly among the groups, $F(2, 342) = 8.83, p < .001$. Items on this scale inquire about symptoms related to fearfulness, panic, tension, and restlessness. Nurses who were bullied and labelled their experiences as bullying reported significantly higher levels of anxiety than did nurses who were not bullied. Nurses in the bullied, self-labelling group also reported significantly higher levels of anxiety than did nurses in the bullied, non-labelling group. Nurses in the bullied, non-labelling group reported significantly higher levels of anxiety than did nurses who were not bullied.

Interpersonal sensitivity was found to differ significantly among the groups, $F(2, 342) = 13.63, p < .001$. High scores on this scale reflect feelings of insecurity and inferiority around others. People who score high on this scale may also feel that others are unsympathetic or unfriendly. Bullied nurses who labelled their experiences as bullying reported significantly higher levels of interpersonal sensitivity than did nurses who were not bullied. Nurses in the bullied, self-labelling group also reported significantly higher levels of interpersonal sensitivity than did nurses in the bullied, non-labelling group. There was no significant difference in interpersonal sensitivity between nurses in the bullied, non-labelling group and nurses who were not bullied.

Level of depression was found to vary significantly among the groups, $F(2, 342) = 8.83, p < .001$. High scores on this scale reflect feelings of loneliness, sadness, and hopelessness. Bullied nurses who labelled their experiences as bullying reported

significantly higher levels of depression than did nurses who were not bullied. Nurses in the bullied, self-labelling group also reported significantly higher levels of depression than nurses in the bullied, non-labelling group. There was no significant difference in level of depression reported by nurses in the bullied, non-labelling group and that reported by nurses who were not bullied.

Scores on the somatization subscale were found to differ significantly among the groups, $F(2, 342) = 5.69, p < .01$. People who score high on this scale tend to report a number of vague physical symptoms such as feelings of numbness, hot or cold spells, soreness, tingling, and heaviness in various parts of the body. Bullied nurses who labelled their experiences as bullying scored significantly higher on the somatization subscale than did their nonbullied colleagues. Nurses in the bullied, non-labelling group scored significantly higher on the somatization subscale than did nurses who were not bullied. There was no significant difference in somatization scores between bullied nurses who labelled their experiences as bullying and nurses in the bullied, non-labelling group.

Level of hostility was found to vary significantly among the three groups of nurses, $F(2, 342) = 4.71, p < .05$. People who score high on this scale may report having temper outbursts, getting into frequent arguments, shouting, and having urges to harm others or break things. Bullied nurses who labelled their experiences as bullying reported significantly greater levels of hostility than did nurses who were not bullied in the workplace. Nurses in the bullied, self-labelling group also reported significantly higher levels of hostility than did nurses in the bullied, non-labelling group. There was no significant difference in hostility scores between nurses in the bullied, non-labelling group and nurses who were not bullied.

Supplementary Analyses

A. NAQ Items and Self-Labelling. A secondary aim of this study was to determine whether some items on the NAQ would be more strongly associated with self-labelling than others. To identify the most discriminating items on the NAQ, point biserial correlations between individual NAQ items and the single self-labelling item were computed and are presented in Table 14. The two groups of bullied nurses (i.e., labellers versus non-labellers, $N = 163$) were used to compute these correlations. Of the 20 NAQ items used in this study, 15 were found to be significantly correlated with self-labelling at the .01 level and 3 were found to be significant at the .05 level. Verbal behaviours that were direct (overt) in nature (e.g., ridicule or insulting teasing, gossip or rumours about you, repeated offensive remarks about you or your personal life) were most strongly correlated with self-labelling.

B. Job Experience and Victimization. As noted previously, nurses in the bullied, self-labelling group were found to be significantly younger than their non-bullied colleagues by approximately four years. Although this difference is statistically significant, a span of only 4 years is not qualitatively meaningful and does not provide substantial support for the proposition that younger nurses may be at a higher risk for bullying and victimization than older nurses. Another way of looking at the correlation between age and bullying is to explore the correlation between work experience, as measured by the number of years employed as a nurse, and bullying.

On average, participants indicated that they had been employed as nurses for 21.13 years ($SD = 10.54$ years). Using the mean and standard deviation, nurses in the sample were categorized into two groups: (a) participants working as nurses for ten years or less; and (b) participants working for as nurses for thirty years or more. Eighty-four

Table 14

Point Biserial Correlations Between Items of The Negative Acts Questionnaire (NAQ) and Self-Labelling (N = 163)

NAQ Item	r_{ph}
Ridicule or insulting teasing	.41**
Gossip or rumours about you	.40**
Repeated offensive remarks about you or your personal life	.40**
Social exclusion from co-workers or work-group activities	.38**
Repeated reminders about your blunders	.37**
Silence or hostility as a response to your questions or attempts at conversations	.37**
Neglect of your opinions or views	.33**
Hints or signals from others that you should quit your job	.31**
Devaluing of your "rights" and opinions with reference to your age	.29**
Devaluing of your work and efforts	.29**
Devaluing of your "rights" and opinions with reference to your gender	.28**
Verbal abuse	.27**
Exploitation at work, such as private errands	.26**
Physical abuse or threats of physical abuse	.22**
Unwanted sexual attention	.22**
Being deprived of responsibility or work tasks	.19**
Unwanted sexual advances	.19*
Offending telephone calls or written messages	.18*
Ordered to do work below your level of competence	.15
Someone withholding necessary information so that your work gets complicated	.14

*$p < .01$. **$p < .05$.

nurses or 21.8% of the sample reported having been employed as a nurse for 10 years or less; 98 nurses or 25.5% of the sample reported having been employed as a nurse for 30 years or more. These two groups are important because they represent two very different generations of nurses: those just entering the profession, and those who are embarking on retirement.

A series of one-way ANOVAs was performed to determine if differences existed between the two groups on measures related to bullying, positive experiences in the workplace, and job satisfaction (see Table 15). Differences in Turnover Intentions were not explored given that nurses who have been employed for 30 years or more are more likely to indicate that they will retire than they are to seek new employment. Any differences between the two groups with respect to their scores on the Turnover Cognitions Scale would be artificial.

Significant differences in mean scores were found between the two groups of nurses on the NAQ, $F(1, 180) = 6.72, p < .05$; Positive Events Scale, $F(1, 180) = 4.70$, $p < .05$; and Job Satisfaction Subscale, $F(1, 180) = 6.01, p < .05$. Participants employed for 10 years or less as nurses reported significantly greater levels of bullying and harassment in the workplace than nurses working for 30 or more years. Women working for ten years or less as nurses reported experiencing significantly fewer positive events in the workplace and less job satisfaction than women who had been working as nurses for 30 years or more.

Nurses in the two groups were also compared with respect to their scores on the scales assessing their beliefs about the "goodness" of world and people, in general (see Table 15). No significant differences between the two groups were found in their scores on a scale measuring their beliefs about the benevolence of the world. In contrast,

Table 15

Means, Standard Deviations, and One-Way Analyses of Variance (ANOVA) for Selected Scales and Subscales by Group as a Function of Years Employed as a Nurse (N = 182)

	Years Employed as a Nurse					
	≤ 10 years (n = 84)		30+ years (n = 98)			
Variable	*M*	*SD*	*M*	*SD*	ANOVA $F(1, 180)$	η^2
NAQ	12.21	8.93	8.83	8.67	6.72*	.04
Positive Events Scale	13.16	5.54	15.65	6.84	4.70*	.03
Job Satisfaction Subscale	20.65	3.89	22.10	4.04	6.01*	.03
World Assumptions Scale						
Benevolence of the World	17.61	3.82	18.69	3.87	3.61	.02
Benevolence of People	18.81	3.19	20.27	2.96	10.17**	.05

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

women who had been employed as nurses for 30 years or more were significantly more likely to report viewing people as being benevolent than women who had been working as nurses for 10 years or less, $F(1, 180) = 10.17, p < .01$.

A multivariate analysis of variance (MANOVA) was used to determine whether the two groups differed significantly in their scores on the subscales of the Maslach Burnout Inventory (MBI). Emotional Exhaustion, Depersonalization, and Personal Accomplishment were treated as dependent variables and group (based on years employed as a nurse) served as the independent variable. Group means, standard deviations and stepdown *F*s are presented in Table 16. The Bonferroni inequality was used to protect against the probability of committing a Type I error and was set at the .05 level. The test of the assumption of the homogeneity of covariance matrices in the two groups was rejected [Box's $M = 21.03, F(6, 220318) = 3.44, p < .01$]. Based on this result, Pillai's Trace was used to calculate multivariate significance. The multivariate null hypothesis of equality of the means between the two groups for all variables was rejected at the .05 level [Pillai's Trace = .13, $F(3, 178) = 9.21, p < .001$].

The Roy-Bargmann stepdown analysis method was used to identify the dependent variables that contributed to the rejection of the multivariate null hypothesis. The subscales of the MBI were entered in the Roy-Bargmann stepdown analysis in the following order: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Emotional exhaustion was found to differ between the two groups at the .05 level. Women who were employed as nurses for 10 years or less reported significantly higher levels of emotional exhaustion than did women who had been working as nurses for 30 years or more. The strength of association (eta-squared) for emotional exhaustion was .03, suggesting a small effect size for this variable.

Table 16

Means, Standard Deviations and One-Way Analyses of Variance (ANOVA) for Scores on the Subscales of the Maslach Burnout Inventory (MBI) by Group as a Function of Years Employed as a Nurse (N = 182).

	Years Employed as a Nurse					
	≤ 10 years (n = 84)		30+ years (n = 98)			
MBI Subscale	*M*	*SD*	*M*	*SD*	ANOVA $F(1, 180)$	η^2
Emotional Exhaustion	26.89	11.63	22.92	10.25	6.00*	.03
Depersonalization	8.40	6.55	4.70	4.20	14.80***	.08
Personal Accomplishment	35.17	7.40	39.20	6.16	5.80*	.03

Note. F statistics for Depersonalization and Personal Accomplishment are derived from Analyses of Covariance (ANCOVA) as per the Roy-Bargmann stepdown analysis method. *$p < .05$. **$p < .01$. ***$p < .001$.

After controlling for the effects of emotional exhaustion, depersonalization was found to differ significantly between the two groups of nurses at the .001 level. Women who were employed as nurses for 10 years or less reported significantly higher levels of depersonalization than women who had been working as nurses for 30 years or more. The strength of association for depersonalization was .08, suggesting a small effect size for this variable.

After controlling for the effects of emotional exhaustion and depersonalization, personal accomplishment was found to differ significantly between the two groups of nurses at the .05 level. Women who had been employed as nurses for 30 or more years reported significantly higher levels of personal accomplishment than women who had been employed as nurses for 10 years or less.

A MANOVA was also used to determine if the two groups of nurses differed significantly on the five subscales of the Symptom Assessment – 45 (SA-45). Depression, Anxiety, Hostility, Interpersonal Sensitivity, and Somatization were treated as dependent variables and group (based on number of years employed as a nurse) served as the independent variable. Group means, standard deviations, and univariate *F*s are presented in Table 17. The Bonferroni inequality was used to protect against the probability of committing a Type I error and was set at the .05 level.

The test of the assumption of homogeneity of covariance matrices in the two groups was rejected [Box's $M = 26.60$, $F(15,\ 123967) = 1.72$, $p < .05$]. Based on this result, Pillai's Trace was used to calculate multivariate significance. The multivariate null hypothesis of equality of means between the groups for all variables was rejected at the .01 level [Pillai's Trace = .10, $F(5,\ 176) = 3.88$, $p < .01$]. The small p value resulting from the overall test supported confidence in the presence of true mean

Table 17

Means, Standard Deviations and One-Way Analyses of Variance (ANOVA) for Subscales of the Symptom Assessment – 45 (SA-45) by Group as a Function of Years Employed as a Nurse (N =182)

	Years Employed as a Nurse					
	≤ 10 years (n = 84)		30+ years (n = 98)			
SA-45 Subscale	*M*	*SD*	*M*	*SD*	ANOVA $F(1, 180)$	η^2
Depression	57.21	6.67	54.38	6.67	8.18**	.04
Anxiety	59.06	7.59	55.27	8.03	10.61**	.06
Hostility	59.86	5.60	57.26	4.28	12.60***	.07
Interpersonal Sensitivity	59.31	6.30	55.78	6.45	13.87***	.07
Somatization	60.61	9.27	60.46	7.77	0.01	.00

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

differences between the groups. The Pillai's multivariate effect size was moderate at .10.

To identify the dependent variables that contributed to the rejection of the multivariate null hypothesis, Wilkinson's (1975) successive MANOVAs method was used. Each variable was found to result in little change (i.e., <.01) in effect size when removed from the MANOVA. Thus each variable appears to have contributed about equally to the rejection of the multivariate null hypothesis.

Significant differences in mean scores between the two groups were obtained on measures of depression, $F(1, 180) = 8.18, p < .01$; anxiety, $F(1, 180) = 10.61, p < .01$; hostility, $F(1, 180) = 12.60, p < .001$; and interpersonal sensitivity, $F(1, 180) = 13.87$, $p < .001$. Women who had been employed as nurses for 10 years or less reported significantly higher levels of depression, anxiety, hostility, and interpersonal sensitivity than did women who had been employed as nurses for 30 years or more. There was no significant difference between the two groups of nurses on the somatization subscale.

C. Non-Bullied, Self-Labellers. In the studies by Magley et al. (1999) and Munson et al. (2001) women who labelled themselves as victims of sexual harassment but who endorsed no behavioural items on the Sexual Experiences Questionnaire (SEQ) were dropped from subsequent statistical analyses. Both groups of authors suggests that the women in these groups were labelling themselves based on experiences that they may have had over their lifetimes rather than on incidences of such behaviour over the past 12 months.

Forty women in the present study labelled themselves as having been bullied in the workplace even though they did not meet the criteria outlined in Leymann's (1996) definition of bullying. Recall that Leymann's definition of bullying requires that victims experience as least one negative or harassing behaviour on a weekly basis for at least six

months in order to be identified as victims of workplace bullying. Nurses in this non-bullied, self-labelling group endorsed some items on the NAQ but indicated having experienced them on a monthly basis or less during the past six months

Rather than dismissing the experiences of these women, univariate and multivariate statistical analyses were used to compare their scores on selected dependent variables with those of the other groups of nurses in this study. Means and standard deviations on selected scales and subscales for each of the four groups of nurses are presented in Table 18. Only post hoc analyses relevant to the nurses in the non-bullied, self-labelling group will be discussed in the following sections. For a more in-depth discussion of the statistical differences between nurses in each of the other three groups (i.e., bullied, self-labellers; bullied, non-labellers; and non-bullied, non-labellers) please refer to previous analyses.

A series of one-way ANOVAs was performed to determine if differences existed among the four groups of nurses on measures related to bullying, positive experiences in the workplace, job satisfaction, and turnover intentions. Levene's test for equality of variances revealed that the assumption for homogeneity of variance was rejected for scores on the NAQ, $F(3, 381) = 21.48, p < .001$; Positive Events Subscale, $F(3, 381) = 3.89, p < .01$; and Turnover Cognitions Scale, $F(3, 380) = 8.06, p < .001$. Due to unequal variances, Games-Howell post hoc analyses were used to identify which groups differed from each other on each of these dependent variables. The assumption for homogeneity of variance was supported for scores on the Job Satisfaction Subscale of the WOFS, $F(3, 380) = 1.28, p > .05$. As a result, Bonferroni post hoc analyses were used to identify which groups differed from one another on this variable.

Significant differences in mean scores were found among the four groups of

Table 18

Means and Standard Deviations on Selected Scales and Subscales by Group (N = 385)

Scale	Non-Bullied, Non-Labellers (n = 182)		Non-Bullied, Self-Labellers (n = 40)		Bullied, Non-Labellers (n = 99)		Bullied, Self-Labellers (n = 64)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
NAQ	4.95_{abc}	4.08	9.33_{b}	4.98	12.08_{c}	6.07	23.22_{abc}	10.50
Positive Events Scale	15.77_{a}	6.07	14.90_{b}	5.46	15.07_{c}	6.83	11.58_{abc}	5.12
Job Satisfaction Subscale	22.83_{ac}	3.38	21.68_{b}	3.59	20.58_{c}	3.77	17.64_{abc}	3.93
Turnover Cognitions Scale	7.52_{ac}	3.24	8.33_{b}	4.09	9.51_{c}	4.57	10.52_{ab}	4.04
Maslach Burnout Inventory								
Emotional Exhaustion	20.98_{ac}	9.97	22.90_{b}	9.92	27.25_{c}	10.75	33.05_{abc}	10.10
Depersonalization	4.55_{ac}	4.50	4.38_{b}	3.81	7.82_{bc}	6.11	9.09_{ab}	6.33
Personal Accomplishment	38.44_{a}	6.21	36.75	6.21	36.45	7.49	35.22_{a}	6.92

Note. Means in a row sharing subscripts are significantly different.

(continued)

Table 18 (cont.)

Means and Standard Deviations on Selected Scales and Subscales by Group (N = 385)

Scale	Non-Bullied, Non-Labellers (n = 182)		Non-Bullied, Self-Labellers (n = 40)		Bullied, Non-Labellers (n = 99)		Bullied, Self-Labellers (n = 64)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
World Assumptions Scale								
Benevolence of the World	18.66	3.62	18.18	3.95	18.37	3.54	17.36	3.62
Benevolence of People	19.87_{a}	2.85	18.75	3.36	19.59_{c}	2.84	17.85_{ac}	3.38
Symptom Assessment – 45								
Depression	54.74_{a}	6.84	55.77_{b}	6.49	55.51_{c}	6.61	58.81_{abc}	6.38
Anxiety	54.69_{ac}	7.31	56.05_{b}	6.92	57.05_{c}	7.75	60.63_{abc}	8.49
Hostility	57.55_{a}	4.76	58.75	5.03	57.52	5.32	59.73_{a}	5.96
Interpersonal Sensitivity	55.87_{a}	6.62	57.50_{b}	5.56	56.55_{c}	6.02	60.66_{abc}	6.21
Somatization	57.71_{abc}	8.63	62.60_{b}	8.35	59.94_{c}	8.35	61.64_{a}	8.73

Note. Means in a row sharing subscripts are significantly different.

nurses on the NAQ, $F(3, 381) = 141.86, p < .001$. Given that the NAQ was used to categorize nurses into groups, one would expect the means and standard deviations of each group to differ significantly from one another on this scale. Nurses in the bullied, self-labelling group scored the highest on the NAQ followed by nurses in the bullied, non-labeller group. Nurses in the non-bullied, self-labelling group scored significantly lower than those in the bullied, non-labelling group, but significantly higher than nurses in the non-bullied, non-labelling group.

The items that were most frequently endorsed on the NAQ by women in the non-bullied, self-labelling group are presented in Table 19. These items reflect behaviours that are hostile but covert in nature (e.g., neglect of your opinions of views, gossip or rumours about you) as opposed to items that are hostile and direct (e.g., repeated offensive remarks about you or your personal life, repeated reminders about your blunders).

Significant differences were also found among the four groups of nurses on a measure assessing their frequency of experience with positive events in their workplaces, $F(3, 381) = 7.63, p < .001$. Nurses in the non-bullied, self-labelling group scored significantly higher on the Positive Events Subscale than did nurses in the bullied, self-labelling group. No significant differences in scores on this variable were found between nurses in the non-bullied, self-labelling group and those in the other two groups (i.e., bullied, non-labellers and non-bullied, non-labellers).

Significant differences were found among the four groups of nurses on a measure of job satisfaction, $F(3, 380) = 34.39, p < .001$. With respect to their scores on the job satisfaction scale, nurses in the non-bullied, self-labelling group were found to differ significantly only from nurses in the bullied, self-labelling group. Nurses in the non-

Table 19

Negative Acts Questionnaire (NAQ) Items and Frequency of Endorsement by Nurses in the Non-Bullied, Self-Labelling Group (N = 40)

NAQ Item	**Frequency *n* (%)**
Neglect of your opinions or views	31 (77.5%)
Gossip or rumours about you	30 (75.0%)
Someone withholding necessary information so that your work gets complicated	29 (72.5%)
Silence or hostility as a response to your questions or attempts at conversation	28 (70.0%)
Ridicule or insulting teasing	26 (65.0%)
Devaluing of your work and efforts	24 (60.0%)
Ordered to do work below your level of competence	24 (60.0%)
Verbal abuse	24 (60.0%)
Social exclusion from co-workers or work group activities	17 (42.5%)
Repeated reminders about your blunders	16 (40.0%)
Devaluing of your "rights" and opinions with respect to your age	14 (35.0%)
Being deprived of responsibility or work tasks	13 (32.5%)
Offending telephone calls or written messages	10 (25.0%)
Repeated offensive remarks about you or your personal life	10 (25.0%)
Physical abuse or threats of physical abuse	9 (22.5%)
Devaluing of your "rights" and opinions with respect to your gender	9 (22.5%)
Unwanted sexual advances	8 (20.0%)
Unwanted sexual attention	8 (20.0%)
Hints or signals from others that you should quit your job	6 (15.0%)
Exploitation at work, such as private errands	4 (10.0%)

bullied, self-labelling group reported significantly higher levels of job satisfaction than nurses in the bullied, self-labelling group.

Significant differences were also found among the four groups of nurses on a scale measuring their propensity to leave their current jobs, $F(3, 380) = 11.99, p < .001$. Nurses in the non-bullied, self-labelling group scored significantly lower on a measure of turnover cognitions than nurses in the bullied, self-labelling group. No significant different differences in turnover cognitions were found between nurses in the non-bullied, self-labelling group and nurses the other two groups (i.e., bullied, non-labellers and non-bullied, non-labellers).

A multivariate analysis of variance (MANOVA) was used to determine whether the four groups of nurses differed significantly from one another on the subscales of the Maslach Burnout Inventory (MBI). The test of homogeneity of covariance matrices in the four groups was rejected [Box's $M = 39.13$, $F(18, 106838) = 2.13, p < .01$]. Based on this result and the unequal number of participants per cell, Pillai's Trace was used to calculate multivariate significance and Games-Howell post hoc analyses were used to identify which groups differed from one another. The multivariate null hypothesis of equality of the means over all groups for all variables was rejected at the .001 level [Pillai's Trace = .20, $F(9, 1143) = 8.86, p < .001$]. The resulting multivariate effect size (.07) was small.

Roy-Bargmann stepdown analysis was used to identify the dependent variables that contributed to the rejection of the multivariate null hypothesis. The subscales of the MBI were entered in the Roy-Bargmann stepdown analysis in the following order: Emotional Exhaustion, Depersonalization, Personal Accomplishment. Emotional exhaustion was found to differ significantly among the four groups, $F(3, 381) = 24.88, p$

< .001. Nurses in the non-bullied, self-labelling group reported significantly lower levels of emotional exhaustion than nurses in the bullied, self-labelling group. Nurses in the non-bullied, self-labelling group did not differ significantly from nurses in the other two groups (i.e., bullied, non-labellers and non-bullied, non-labellers). The strength of association (eta-squared) for emotional exhaustion was .16 and suggested a medium effect size for this variable.

After controlling for the effects of emotional exhaustion, nurses in the four groups were also found to differ significantly in their reported levels of depersonalization, F (3, 380) = 3.77, $p < .05$. Nurses in the non-bullied, self-labelling group reported significantly lower levels of depersonalization than nurses in the bullied, self-labelling group and nurses in the bullied, non-labelling group. No significant differences in depersonalization were found between nurses in the non-bullied, self-labelling group and those in the non-bullied, non-labelling group. The strength of association (eta-squared) for depersonalization was .03 and suggested a small effect size for this variable.

After controlling for the effects of emotional exhaustion and depersonalization there were no significant differences between groups on the personal accomplishment subscale, F (3, 379) = .73, $p > .05$.

One-way ANOVAs were performed to determine if differences existed between the four groups of nurses on two subscales of the World Assumptions Scale (WAS): (1) benevolence of the world, and (2) benevolence of people. Levene's test of homogeneity of variance was support for both subscales. Bonferroni post hoc analyses were used to identify which groups differed significantly from one another with respect to their mean scores on these two subscales.

No significant differences were found between the four groups of nurses in their

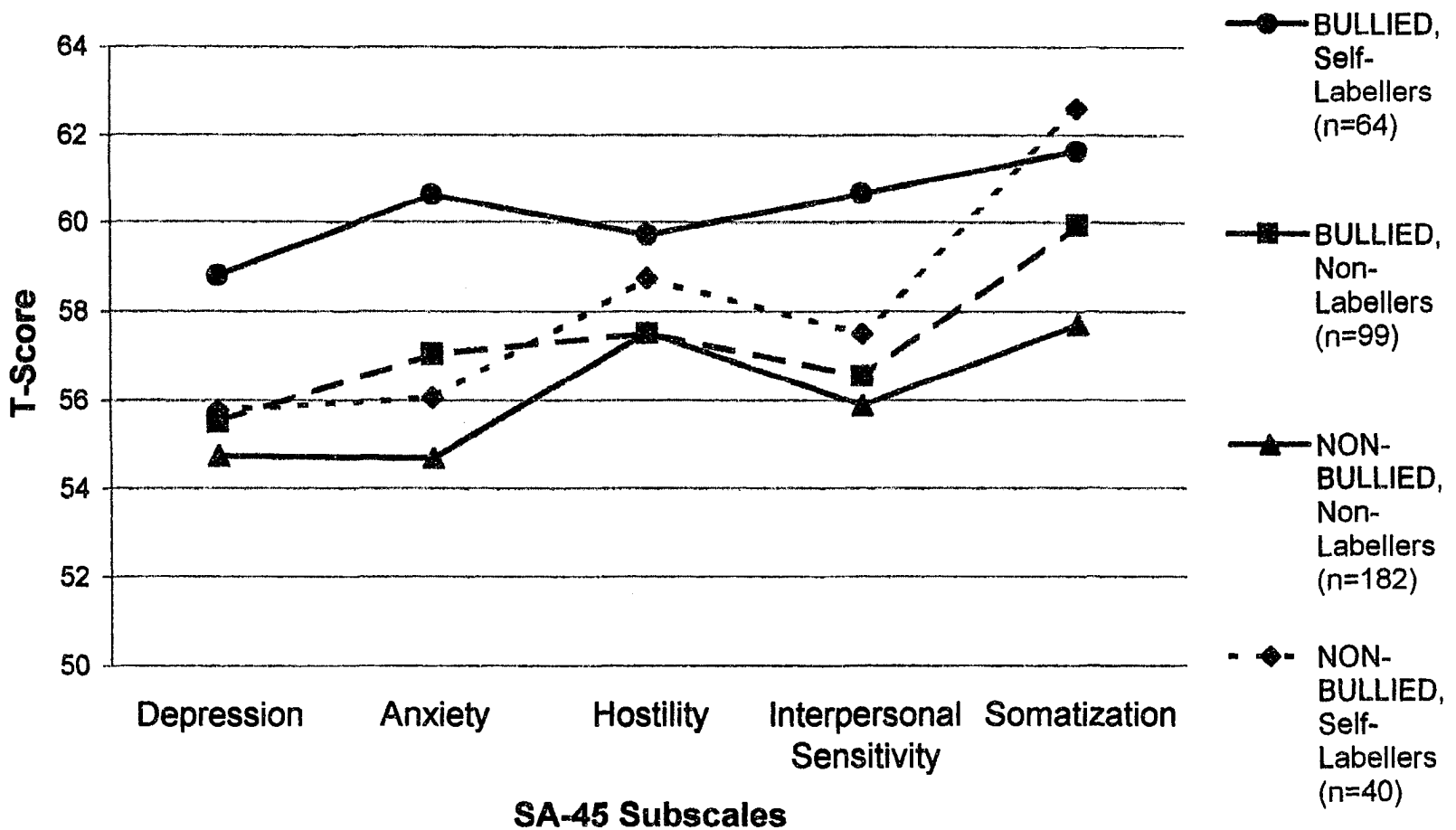
mean scores on a subscale of the WAS that assessed their perceptions of the benevolence of the world, $F(3, 381) = 2.05, p > .05$. Although significant differences were found among the groups on a subscale of the WAS that assessed their perceptions of the benevolence of people, $F(3, 381) = 7.86, p < .001$, nurses in the non-bullied, self-labelling group were not found to differ from nurses in any of the other three groups.

A multivariate analysis of variance (MANOVA) was used to determine if the groups differed in their scores on the five subscales of the Symptom Assessment – 45 (SA-45). Depression, Anxiety, Hostility, Interpersonal Sensitivity, and Somatization were treated as dependent variables and group (based on NAQ scores and responses to the single self-labelling item) served as the independent variable. Each group's pattern of responses on the subscales of the SA-45 are presented in Figure 8.

Although the test of the assumption of homogeneity of covariance matrices in the four groups was supported, unequal cell sizes indicated the use of Pillai's Trace to calculate multivariate significance. The multivariate null hypothesis of equality of the means of all groups for all variables was rejected at the .001 level [Pillai's Trace = .13, $F(15, 1137) = 3.45, p < .001$]. The very small p value resulting from the overall test supported confidence in the presence of true mean differences between the groups. The Pillai's multivariate effect size was small at .04. Since equal variances between the groups were assumed, Bonferroni post hoc analyses were used to identify which groups differed from one another. The Bonferroni inequality was used to protect against the likelihood of committing a Type I error.

To identify the dependent variables that contributed to the rejection of the multivariate null hypothesis, Wilkinson's (1975) successive MANOVAs method was used. As variables were removed from the model, in turn, changes in effect size were

Figure 8. Mean scores on selected SA-45 Subscales by Group (*N* = 385)



found to be negligible (i.e., less than -.01). All five variables were identified as having contributed approximately equally to the rejection of the multivariate null hypothesis.

Level of depression was found to vary significantly among the groups, F (3, 381) = 5.92, $p < .01$. Nurses in the non-bullied, self-labelling group reported significantly lower levels of depression than nurses in the bullied, self-labelling group. No significant differences in levels of depression were noted between nurses in the non-bullied, self-labelling group and nurses in the other two groups (i.e., bullied, non-labelling group, non-bullied, non-labelling group). The effect size for depression was small at .05.

Level of anxiety was also found to vary significantly among the groups, F (3, 381) = 9.96, $p < .001$. In line with the findings regarding levels of depression, nurses in the non-bullied, self-labelling group reported significantly lower levels of anxiety than nurses in the bullied, self-labelling group. Again, no significant differences in level of anxiety were noted between nurses in the non-bullied, self-labelling group, and nurses in the other two groups (i.e., bullied, non labelling group, non-bullied, non-labelling group). The effect size for anxiety was small at .07.

Although the level of hostility was found to vary significantly among the groups, F (3, 381) = 3.44, $p < .05$, the level of hostility reported by nurses in the non-bullied, self-labelling group did not differ significantly from the levels reported by nurses in the other three groups. The effect size for hostility was small at .03.

Levels of interpersonal hostility were found to vary significantly among the four groups of nurses, F (3, 381) = 9.42, $p < .001$. Nurses in the non-bullied, self-labelling group reported significantly lower levels of interpersonal hostility than did nurses in the bullied, self-labelling group. No significant differences in level of interpersonal hostility were found among nurses in the non-bullied, self-labelling group and those in the bullied,

non-labelling group, and non-bullied, non-labelling group. The effect size for interpersonal sensitivity was small at .07.

Finally, scores on the SA-45 subscale assessing for symptoms of somatization were found to vary significantly among the four groups of nurses, $F(3, 381) = 5.84, p < .01$. Nurses in the non-bullied, self-labelling group scored significantly higher on the somatization subscale than nurses in the bullied, self-labelling group and nurses in the non-bullied, non-labelling group. No significant differences in level of somatization were found between nurses in the non-bullied, self-labelling group and nurses in the bullied, non-labelling group. The effect size for somatization was small at .05.

Summary of Quantitative Findings

1. Nurses who were bullied in the workplace were expected to report less job satisfaction and a greater propensity to leave their current jobs than their non-bullied colleagues. This hypothesis was fully supported in that both groups of bullied nurses (labellers and non-labellers) reported significantly lower levels of job satisfaction (as measured by the Job Satisfaction subscale of the WOFS) and significantly greater intentions to leave their current jobs (as measured by the Turnover Cognitions Scale) than did their non-bullied colleagues.

2. Nurses in the bullied, self-labelling group were hypothesized to report lower levels of job satisfaction than nurses in the bullied, non-labelling group. This hypothesis was fully supported. Bullied nurses who labelled their experiences as bullying reported significantly lower levels of job satisfaction than bullied nurses who did not label their experiences as bullying.

3. It was also hypothesized that nurses in the bullied, self-labelling group would demonstrate greater propensities to leave their present jobs (as measured by scores on the

Turnover Cognitions Scale) than nurses in the bullied, non-labelling group. This hypothesis was not supported. There were no significant differences between nurses in the bullied, self-labelling group and those in the bullied, non-labelling group with respect to their scores on the Turnover Cognitions Scale.

4. Nurses who were bullied in the workplace were expected to report higher levels of burnout (as measured by the Maslach Burnout Inventory) than nurses who were not bullied. This hypothesis was fully supported in that nurses who were bullied reported greater levels of emotional exhaustion and depersonalization than did nurses who were not bullied.

5. Nurses in the bullied, self-labelling group were expected to report higher levels of burnout than nurses in the bullied, non-labelling group. This hypothesis was partially supported. Nurses who were bullied and labelled their experiences of bullying reported significantly higher levels of emotional exhaustion than nurses in the bullied, non-labelling group. However, there was no significant difference between the two groups of nurses on the Maslach Burnout Inventory (MBI) subscale of depersonalization.

6. Based on Janoff-Bulman's (1989, 1992) Cognitive Theory of Trauma, it was expected that nurses who were bullied would hold more negative assumptions about the world. This hypothesis was partially supported: nurses in the bullied, self-labelling group were found to have more negative views about the benevolence of the world than their non-bullied colleagues, however nurses in the bullied, non-labelling group were not found to differ significantly from their colleagues with respect to their scores on this subscale.

7. It was also expected that bullied nurses would hold more negative views about people than nurses who were not bullied. This hypothesis was fully supported. Both

groups of bullied nurses (i.e., self-labellers and non-labellers) held more negative beliefs about the benevolence of people than did nurses who were not bullied.

8. It was also expected that bullied nurses would perceive the world as less controllable and less just than non-bullied nurses. This hypothesis was not supported. No significant differences were found between the groups on the WAS subscales that measured beliefs about controllability and justice.

9. Bullied nurse were also hypothesized to perceive themselves as less worthy, less capable, and unluckier than non-bullied nurses. This hypothesis was also not supported. Again, there was no significant differences between the groups on WAS subscales that assessed nurses perceptions about themselves as being worthy, capable, and lucky.

10. Based on the research describing the psychological effects of bullying, it was expected that bullied nurses would report greater levels of psychological distress (i.e., more depression, anxiety, hostility, interpersonal sensitivity, and somatization) than nurses who were not bullied in the workplace. This hypothesis was supported. Bullied nurses reported significantly higher levels of depression, anxiety, and somatization than their non-bullied colleagues. Notably, self-labelling was found to be significantly associated with scores on measures of interpersonal sensitivity and hostility. Bullied nurses who labelled their experiences as bullying reported significantly greater levels of interpersonal sensitivity and hostility than their non-bullied colleagues. Nurses in the bullied, non-labelling group did not differ significantly from their non-bullied colleagues with respect to their scores on measures of interpersonal sensitivity and hostility.

11. It was also hypothesized that self-labelling would be intrinsically associated with nurses' experiences of psychological distress such that nurses in the bullied, self-

labelling group were expected to report greater levels of depression, anxiety, hostility, interpersonal sensitivity, and somatization than nurses in the bullied, non-labelling group. This hypothesis was fully supported for measures of depression, anxiety, hostility, and interpersonal sensitivity. No significant differences were found between the two groups of bullied nurses (labellers and non-labellers) on a measure of somatization.

12. Fifteen of the 20 NAQ items used in this study were found to correlate with self-labelling at the .01 level and 3 NAQ items were found to be significant at the .05 level. The magnitude of the point biserial correlations between the individual NAQ items and self-labelling was found to range from .18 to .41. Verbal behaviours that were overt in nature (e.g., ridicule or insulting teasing, gossip or rumours about you, and repeated and offensive remarks about you or your personal life) were most strongly correlated with self-labelling ($r = .41, p < .01$; $r = .40, p < .01$; and $r = .40, p < .01$, respectively).

13. Participants who had been employed as nurses for 10 years or less scored significantly higher on the NAQ (i.e., reported being subjected to more bullying behaviours) than participants who had been employed as nurses for 30 years or more. Women who had been employed as nurses for 10 years or less also reported significantly lower levels of job satisfaction and less exposure to positive events in the workplace than women who had been employed as nurses for 30 years or more. Nurses with less experience also reported greater levels of burnout and psychological distress than nurses who were close to retirement.

14. Forty nurses labelled themselves as victims of bullying even though they did not meet the criteria outlined by Leymann's (1996) operational definition of bullying. Although nurses in this group reported having experienced some of the behaviours listed by the NAQ, the frequency with which they experienced such behaviours was on a

monthly basis or less. Items on the NAQ that were most frequently endorsed by nurses in this group represented behaviours that were aggressive but covert or indirect in nature (e.g., neglect of your views or opinions, someone withholding necessary information so that your work) as opposed to those that are direct and more blatantly hostile (e.g., repeated offensive remarks about you or your personal life, repeated reminders about your blunders).

In general, nurses in non-bullied, self-labelling group did not differ significantly from nurses in the non-bullied, non-labelling group and those in the bullied, non-labelling group with respect to their scores on scales measuring work-related variables (e.g., job satisfaction, experiences of positive events in the workplace, turnover intentions, and burnout). Conversely, nurses in the non-bullied, self-labelling group reported significantly higher levels of job satisfaction and experienced with more positive events in the workplace than nurses in the bullied, self-labelling group. Nurses in the non-bullied, self-labelling group also scored lower on measures of turnover intentions, emotional exhaustion, and depersonalization than nurses who met Leymann's (1996) criteria for bullying and who also labelled their experiences as bullying (i.e., nurses in the bullied, self-labelling group).

Nurses in the non-bullied, self-labelling group did not differ significantly from nurses in any of the other three groups on measures assessing their beliefs about the benevolence of the world and the benevolence of people. In general, nurses in the non-bullied, self-labelling group also did not differ significantly from nurses in the non-bullied, non-labelling group and those in the bullied, non-labelling group with respect to their scores on scales measuring psychological distress (i.e.., depression, anxiety, hostility, and interpersonal sensitivity). Nurses in the non-bullied, self-labelling group

scored significantly higher than nurses in the non-bullied, non-labelling group on a scale measuring tendencies toward somatization. Nurses in the non-bullied, self-labelling group did not differ significantly from those in the bullied, non-labelling and bullied, self-labelling groups with respect to their scores on this scale.

Qualitative Findings

Many of the nurses who participated in the study provided written comments about their perceptions of their profession, which included their perceptions of their working relationships with others as well as characteristics of the job itself (e.g., work load, shift work, vacation time, etc). Bullied nurses who labelled their experiences as bullying, frequently commented about the quality of their interpersonal relationships with other nurses. One ER nurse in her forties summarized her views as follows:

> Nursing as a profession should be ashamed – we fail to stand behind and beside each other and instead tear each other down. At every opportunity there is negative talk, criticism, gossiping, defaming others' character and calling into question colleagues' competency instead of supporting and encouraging each other. The lack of professionalism has reached epic proportions – on a daily basis, I have witnessed and also have been the victim of nurses yelling at other nurses in front of patients and family, gossiping about other nurses in front of patients, not working as a team because a coworker has a grudge against another and therefore patient care suffers.

Some of the nurses in the study described stress that resulted from working long hours with few resources while others zeroed in on the stress that results from adverse relationships with colleagues. One nurse in her fifties, working in a complex continuing care unit, commented that "the death of our patients is not as stressful to me as dealing

with the dysfunction of some of my colleagues" while another nurse in mid twenties working on a medical-surgical floor wrote: "the patients do not wear me down and make me want to move jobs as much as my coworkers... the positive comments I get in my job usually come from my patients and their families, not my boss or coworkers."

The comments made by some nurses seemed to portray an organizational dimension of bullying. Nurses described situations in which they felt harassed or discriminated against by the management or administration of the hospital. One OR nurse in her forties related her views that management was discriminating against nurses based on their age as a cost saving measure:

> Management would prefer younger less experienced nurses. They can mould them, push them around more, demand more and pay less. I feel management provokes the older staff to quit so they can replace them with younger and cheaper nurses. If you look at the pay grid, you will see why management thinks it aids in budgeting.

Another ER nurse in her thirties wrote about feeling objectified by the health care system:

> The health care system has switched to a business model in my time as a nurse. This type of model does not value human resource but rather money and the bottom line. Nurses are commodities and liabilities within this model – not valued professionals who are truly the backbone of tertiary care in Canada.

In general, the themes of the comments written by nurses in the bullied, self-labelling group reflected high levels of stress and burnout resulting from what they perceived as harassment by colleagues and the hospital organization. Nurses in the bullied, non-labelling group tended to comment more about aggression directed at them

from patients' families rather than their nursing colleagues or other hospital staff:

> The public puts too high of an expectation on the care they receive and expect us NOT to make mistakes and generally feel that their problems are worse than anyone else's. Especially in the emergency – the public can be very self-centred. They exhibit anger and frustration at lengthy wait times and vent on the nurses as though the wait time is the nurse's fault.

Nurses who were not bullied (and who did not self-label as having been bullied) were more likely than nurses in the other three groups to submit comments that reflected positive working relationships with colleagues and greater levels of job satisfaction. For example, one nurse working in a labour and delivery unit wrote: "I am very privileged to work in an area that affords great job satisfaction... I also work with a group of women who are very committed to giving the best care to their clients and each other."

Comments made by nurses in the non-bullied, self-labelling group tended to describe instances of discrimination and harassment based on race and/or age:

> The fact that people judge you by your age and colour. The younger and non black nurses are treated a lot better than us... It is extremely difficult for blacks to excel in this community and there are barriers that are structured to keep us from getting to the top of the ladder. It is sad but I still feel fortunate even though things are not what they ought to be.

A compilation of selected quotations made by nurses in the study can be found in Appendix G.

CHAPTER V

DISCUSSION

The purpose of the present study was to explore the process of self-labelling among nurses experiencing workplace abuse. The results of this study provide strong support for the proposition that the process of labelling experiences as bullying is intrinsically related to the adverse psychological and job related outcomes that are associated with workplace bullying and harassment. The data also suggested that the process of labelling abusive interactions is quite complex and may involve some of our most basic beliefs about the benevolence of people and the world, in general. This study provides more detail about the types of behaviours that occur most frequently in workplace bullying and suggests that some types of behaviours are more distressing than others. The following sections provide discussions of each of the major findings and their relationships to the hypotheses that were proposed. Implications for therapy with victims of workplace bullying will be discussed and considerations for future research will be presented.

A Comparison of Two Measures of Bullying

In the present study, the prevalence rates of bullying among nurses were found to vary considerably depending upon the methods used to identify victims. Roughly 47.2% (n = 163) of respondents met the criteria for Leymann's (1996) operational definition of bullying and indicated that they had experienced at least one negative behaviour in the workplace, on a weekly basis for the past six months. In contrast, only 18.6% (n = 64) of respondents identified themselves as having been "bullied" at their workplace within the last six months. These results are consistent with findings reported previously in the literature which show that studies relying on the use of a single self-labelling item

typically report lower prevalence rates than do studies that use lists of predefined negative behaviours to identify targets or victims of bullying (e.g., Agervold & Mikkelsen, 2004; Mikkelsen & Einarsen, 2001; Salin, 2001).

Experiences of Workplace Bullying: Job-Related Outcomes

Nurses who were bullied in the workplace were expected to report lower levels of job satisfaction and a greater propensity to leave their current jobs than their non-bullied colleagues. This hypothesis was fully supported in that both groups of bullied nurses (self-labellers and non-labellers) reported significantly lower levels of job satisfaction and significantly greater intentions to leave their current jobs than did their non-bullied colleagues. These results are consistent with those reported previously in the literature (e.g., Cortina et al., 2001; Einarsen & Raknes, 1997; Keashly et al., 1994).

Nurses who were bullied in the workplace were also expected to report greater levels of burnout than their non-bullied colleagues. Again, this hypothesis was fully supported in that nurses who were bullied reported greater levels of emotional exhaustion and depersonalization (as measured by the Maslach Burnout Inventory) than did nurses who were not bullied. These results are also consistent with those previously reported in the literature (e.g., Varharma & Bjorkqvist, 2004).

Experiences of Workplace Bullying: Psychological Outcomes

Based on research describing the psychological effects of bullying, it was expected that nurses who were bullied would report greater levels of psychological distress than their non-bullied colleagues. This hypothesis was partially supported. Both groups of nurses who were bullied (i.e., labellers and non-labellers) reported significantly greater levels of anxiety and somatization than did nurses who were not bullied. However, only nurses who were bullied and labelled their experiences as bullying scored

significantly higher than nurses who were not bullied on measures of depression, hostility, and interpersonal sensitivity.

In the present study, a number of bullied nurses who labelled their experiences as bullying made statements to suggest that the negative interactions that they had experienced at work had an adverse impact on their emotional well-being. One nurse in her late fifties working in a labour and delivery unit made the following comment:

> I have worked for over 30 years and feel I have taken abuse from colleagues especially in my early years that has had lasting effects. Eventually I have reached my "break point." Although I have not taken time off for "stress" I am on antidepressants... I was off ill for 7 days last fall, 3 days after being accosted by a staff member who resented that I had taken her to task for consistent lateness.

Research regarding occupational stress among nurses has consistently reported that nurses who work with dying patients experience higher levels of burnout than those working in other areas (e.g., Plante & Bouchard, 1995). It is hard to imagine situations that would be more stressful for nurses to deal with than the death of a patient. As noted previously, one nurse working in a complex continuing care unit commented that "the death of our patients is not as stressful to me as dealing with the dysfunction of some of my colleagues." This statement underscores the distress that nurses experience when they are bullied by colleagues and reinforces the need to offer assistance to nurses who are regularly encountering negative interactions with coworkers.

The Impact of Self-Labelling

A primary focus of this study was to explore the process of self-labelling among nurses who are bullied in the workplace. Language is more than just a means of communication; it also shapes the way in which people give meaning to their perceptions

and experiences. As noted previously, findings reported in the sexual harassment literature suggest that labelling is irrelevant to the psychological distress experienced by women who have been sexually harassed (e.g., Magley et al., 1999). These findings seem to contradict modern models of stress and coping which suggest that an individual's subjective appraisal of a situation as being threatening, is often more strongly associated with psychological distress than the objective experience of the event itself. A main goal of this study was to explore whether the distress associated with workplace bullying results from: (a) the experience of abusive events themselves, (b) nurses' self-labelling as victims of bullying, or (c) a combination of both objective experience and subjective appraisal.

It was hypothesized that bullied nurses who labelled their experiences as bullying would report lower levels of job satisfaction than: (a) their non-bullied colleagues, and (b) bullied nurses who did not label their experiences as such. This hypothesis was fully supported. Nurses who were bullied and labelled their experiences as bullying reported levels of job satisfaction that were significantly lower than those reported by nurses in the non-bullied, non-labelling group and nurses in the bullied, non-labelling group. These results suggest that it is both the objective experience of bullying and the subjective appraisal of these experiences that results in lower levels of job satisfaction for nurses who have been bullied.

It was also hypothesized that nurses in the bullied, self-labelling group would report greater propensities to leave their current jobs than nurses in the bullied, non-labelling group. This hypothesis was not supported. There were no significant differences between the two groups of bullied nurses (i.e., self-labellers, non-labellers) with respect to their scores on the Turnover Cognitions Scale. Both groups of bullied nurses reported

significantly higher scores on the Turnover Cognitions Scale than did nurses who were not bullied. These findings suggest that it is the experience of abusive behaviours in the workplace rather than the subsequent labelling of such experiences that is most strongly associated with nurses' thoughts about leaving their current jobs.

It was also hypothesized that nurses in the bullied, self-labelling group would report higher levels of burnout than nurses in the bullied, non-labelling group. This hypothesis was partially supported. Nurses who were bullied and labelled their experiences as bullying reported significantly higher levels of emotional exhaustion than did nurses in the bullied, non-labelling group. However, there was no significant difference between the two groups of nurses on the depersonalization subscale of the Maslach Burnout Inventory (MBI). As noted previously, research on the MBI has supported a two factor model of burnout consisting of emotional exhaustion and depersonalization with emotional exhaustion being the stronger of the two factors (Kalliath et al., 2000). If emotional exhaustion is viewed as being the primary contributor to feelings of burnout, then the results of this study support the hypothesis that it is both the experience of abusive behaviours in the workplace and the subsequent labelling of such experiences as bullying that are significantly associated with the experience of burnout.

It was also hypothesized that labelling would be significantly associated with levels of psychological distress such that nurses in the bullied, self-labelling group would report greater levels of depression, anxiety, hostility, interpersonal sensitivity, and somatization than nurses in the bullied, non-labelling group. This hypothesis was supported for measures of depression, anxiety, hostility, and interpersonal sensitivity. Nurses in the bullied, self-labelling groups scored significantly higher on each of these

subscales than nurses in the bullied, non-labelling group. No significant differences were obtained between the two groups of bullied nurses (i.e., self-labellers and non-labellers) on a measure of somatization. Overall, these results lend strong support to the hypothesis that the process of labelling events as bullying is quite relevant to the experience of emotional distress. Although results of this study demonstrate that nurses who were bullied experienced greater levels of emotional distress than nurses who were not bullied, findings also show that the relationship between psychological distress and bullying was most salient for nurses who engaged in the self-labelling process.

Since the initial proposal of this study, there has been one publication describing the relationship between self-reported bullying (self-labelling) and health outcomes (Hoel, Faragher, & Cooper, 2004). The authors surveyed 5,288 British employees (2,764 males, 2508 females) about their experiences with bullying in the workplace and various health related outcomes and concluded that it is the experience of abusive events in the workplace, rather than the subjective appraisal or self-labelling of such events, that results in negative health effects. The findings by Hoel et al. contradict the findings reported in the present study. One explanation for this discrepancy can be attributed to the methods to explore the relationship between self-labelling and health outcomes employed by Hoel et al. and those used in the present study.

Although Hoel et al. (2004) used the NAQ and a self-labelling item to identify victims of bullying, they did not use both methods to categorize individuals, as was done in the present study. The authors used correlational analyses to explore the effects of bullying and self-labelling on measures of occupational stress, physical health, and emotional well-being. Although the authors reported some evidence to suggest that both self-labelling and frequency of exposure to abusive behaviour (i.e., scores on the

NAQ) are significantly associated with negative outcomes, the analytical approach employed by Hoel et al. did not allow for an adequate comparison of employees who label harassing behaviours in the workplace as bullying and those who do not. Therefore, the authors' conclusions regarding the relationship between self-labelling and various health outcomes are limited.

In contrast, the analytical approach of the present study allowed for direct comparisons to be made between groups of bullied nurses who differed only in their subjective appraisal of their experiences (i.e., self-labellers versus non-labellers). This type of comparison allowed for the exploration of the independent effect of self-labelling on various health and job-related outcomes and strengthens conclusions about the effects of self-labelling on job satisfaction, turnover intentions, burnout, and psychological distress.

Nurses in the Non-Bullied, Self-Labelling Group: What Can They Tell Us About the Importance of Self-Labelling?

Approximately 10.4 % (n = 40) of nurses in the sample identified themselves as having been bullied despite not meeting the operational criteria for bullying outlined by Leymann (1996). Nurses in this group did not report having experienced any of the behaviours listed on the NAQ on a weekly basis but did acknowledge having experienced at least one of the behaviours on a monthly or less than monthly basis. Items on the NAQ that were most frequently endorsed by nurses in this group reflected behaviours that were aggressive but covert in nature (e.g., neglect of your opinions or views, gossip or rumours about you, someone withholding necessary information so that your work gets complicated, etc.).

In general, nurses in this group did not differ significantly from nurses in the non-

bullied, non-labelling group, and those in the bullied, non-labelling group with respect to their scores on scales measuring psychological distress. If labelling alone could be said to account for the psychological distress associated with bullying, then one would expect that nurses in the non-bullied, self-labelling group to report significantly higher scores on the SA-45 subscales than nurses in the bullied, non-labelling group and nurses in the non-bullied, non-labelling group. This was not the case. The level of distress reported by nurses in the non-bullied, self-labelling group was comparable to that reported by nurses in the non-bullied, non-labelling group, and nurses in the bullied, non-labelling group. These results provide support for the argument that the psychological distress that is associated with bullying most likely results from the combination of the experience of abusive behaviours in the workplace and the subjective appraisal or labelling of these experiences as bullying.

The Benevolence of People

Tennessee Williams' 1947 Pulitzer Prize winning play, "A Streetcar Named Desire," tells the tragic tale of Blanche Dubois, a fading southern belle who is ultimately driven to madness after being violently raped by her brother-in-law. It is the story of an idealist who struggles to remain blind to the harsh realities of her world. It is a depiction of a woman who, despite having "always depended upon the kindness of strangers," finds her world collapsing around her when her basic beliefs about the benevolence of people are shattered. In many respects, the story of Blanche Dubois exemplifies ideas proposed by Ronnie Janoff-Bulman in her Cognitive Theory of Trauma (1989, 1992). Janoff-Bulman suggested that victimization challenges some of the most basic views that people have about themselves, others, and the world. In particular, she proposed that victimization forces the individual to question her beliefs in her own personal

invulnerability, as well as her beliefs about the meaningfulness of the world, and the benevolence of people.

Like Blanche Dubois, many victims of workplace bullying and harassment have found themselves questioning some of their fundamental assumptions about people and the world around them. Exposure to workplace bullying has been found to be related to negative views about one's self, others, and the world (e.g., Mikkelsen & Einarsen, 2002). In the present study, it was hypothesized that nurses who were bullied would report having more negative views about themselves, others, and the world, than their non-bullied colleagues. This hypothesis was partially supported. Nurses in the bullied, self-labelling group were found to hold more negative views about the benevolence of the world than nurses who were not bullied. No significant differences with respect to beliefs about the benevolence of the world were noted between the two groups of bullied nurses (i.e., bullied, self-labellers and bullied, non-labellers). When all four groups of nurses were compared (i.e., non-bullied, non-labellers; non-bullied, self-labellers; bullied, non-labellers; and bullied, self-labellers) with respect to their mean scores on the WAS subscale that assessed beliefs about the benevolence of the world, no statistical differences were noted between the groups. Overall, this pattern of results suggests that, for nurses in the present study, beliefs about the benevolence of the world were not influenced by their experiences with bullying or their subjective interpretations (i.e., self-labelling) of these experiences.

In contrast, beliefs about the benevolence of people were found to vary significantly among the groups of nurses as a function of their exposure to abusive behaviours in the workplace, as well as their subsequent labelling of these behaviours as bullying. Nurses who were bullied and labelled their experiences as bullying held more

negative views about the benevolence of people than did nurses in the bullied, non-labelling group and nurses in the non-bullied, non-labelling group. Although nurses in the non-bullied, self-labelling group did not differ significantly from nurses in the other three groups, their score (M = 18.75) on the Benevolence of People Subscale of the WAS seems to represent an intermediate point between nurses in the bullied, self-labelling group (M = 17.85) and those in the bullied, non-labelling group (M = 19.59). If the general trend of these scores is considered, it appears that labelling of experiences as bullying is more strongly associated with weaker beliefs in the benevolence of people than the actual experience of abusive behaviours in the workplace. This finding lends support to the notion that labelling is integral to the psychological experience of bullying experienced by employees in the workplace.

No significant differences were found between the groups on the remaining subscales of the WAS. These findings are not consistent with those reported by Mikkelsen and Einarsen (2002). One possible reason for this discrepancy in results may relate to differences in the level of distress experienced by participants in each study. A large proportion (i.e., 76%) of the 118 bullied workers interviewed by Mikkelsen and Einarsen presented with symptoms of Post-Traumatic Stress Disorder (PTSD). With respect to symptom severity, Mikkelsen and Einarsen noted that nearly roughly 60% of victims portrayed moderate to severe symptoms. In contrast, nurses in the present study reported relatively mild levels of psychological distress as assessed by the SA-45 (i.e., T scores ranging between 58 and 61). In non-patient samples, a T score of 65 or greater suggests a likely problem area. It is reasonable to argue that a certain level of distress may be needed before people will abandon their basic assumptions about the world, others and themselves.

The Belief in a Just World

As noted previously, most of the just world research has focussed on observers' responses to the misfortunes of others; relatively few studies have focussed on victims' perceptions of their own misfortunes. One of the goals of the present study was to extend the research on just world beliefs and personal deprivation by moving away from the use of artificial laboratory manipulations and student populations, to the exploration of these constructs with real world victims in a natural setting. Another goal of the present study was to explore the strength of association between beliefs in a just world and experiences of bullying. Nurses' scores on the justice subscale of the WAS were used to assess their beliefs in a just world. Higher scores represented stronger beliefs in a just world. Statistical analysis revealed no significant differences among the three groups of nurses on this subscale.

Based on a series of questionnaire studies, Dalbert (1999) found that personal and general beliefs in a just world could clearly be differentiated from one another and that personal beliefs in a just world (i.e., belief related to the individual's perception that she is being treated fairly by others) were more strongly correlated with subjective well-being than general beliefs in a just world (i.e., belief that, by and large, people get what they deserve). The justice subscale of the WAS contains items that assess the general belief in a just world as opposed to the personal belief in a just world. It may be possible that significant differences would have emerged between the groups of nurses had they been asked about their personal beliefs in a just world rather than their general beliefs in a just world. It seems intuitive that experiences with bullying would be more likely to challenge a person's beliefs about how fairly she has been treated by others rather than her beliefs about the world being a fair and just place on the whole. It is recommended

that future research concerning victimization and beliefs in a just world employ scales that tap into individuals' beliefs about their own fate as opposed to their beliefs about the fairness of the world in general.

Supplementary Analyses

A. NAQ Items and Self-Labelling. A secondary aim of the present study was to explore whether some items on the NAQ would be more strongly associated with self-labelling than others. To identify the most discriminating items on the NAQ, point biserial correlations between individual NAQ items and the single self-labelling item were computed. Of the 20 NAQ items used in the present study, 15 were found to be significantly correlated with self-labelling at the .01 level and 3 items were found to be significantly correlated with self-labelling at the .05 level. In general, verbal behaviours that were aggressive and overt in nature were most strongly correlated with self-labelling. These findings correspond to previous research that has demonstrated that abusive behaviours representing verbal hostility and covert hostility are more frequently experienced in the workplace than behaviours that represent physical hostility (e.g., Rospenda & Richman, 2004). Based on the findings of the present study, it appears that although many workers may experience covert types of aggressive behaviours in their workplaces, employees who experience overt and hostile behaviours are more likely to label their experiences as bullying. Future research with the NAQ should attempt to determine whether this pattern holds with different working populations, and other gender segregated occupations (e.g., police work, construction). Bullying behaviours in male dominated work environments may involve more obvious physical forms of harassment (e.g., threats of physical assault and physical assault) that may or may not be labelled as bullying depending on the norms of that particular organization.

B. Job Experience and Victimization. Research concerning the role of age or job experience as risk factors for bullying has reported mixed findings. In the present study, although nurses in the bullied, self-labelling group were found to be significantly younger than nurses in the bullied, non-labelling group and nurses in the non-bullied, non-labelling group, the magnitude of the age difference in years between the groups was only approximately 4 years and was not clinically meaningful.

In contrast, job experience was found to be significantly associated with bullying such that participants who had been employed as nurses for 10 years or less scored significantly higher on the NAQ than participants who had been employed as nurses for 30 years or more. Nurses who had been employed for 10 years or less also reported significantly lower levels of job satisfaction and less exposure to positive events in the workplace than women who had been employed as nurses for 30 years or more. Nurses with less job experience also reported greater levels of burnout and psychological distress than nurses who were close to retirement.

Differences in social power likely account for the increased levels of bullying reported by younger, less experienced workers (e.g., Cortina et al., 2001; Rospenda, 2002). Within the hospital hierarchy, younger nurses are less likely to occupy positions associated with authority (e.g., charge nurse, nurse manager). They are also more likely to have part-time positions and to be "floated" from one unit to another to cover absences. Bullying and harassment have been found to be especially prevalent in work settings characterized by power inequalities between workers, low perceived control over one's work, and role conflict (e.g., Cortina et al., 2001; Einarsen et al., 1994). These characteristics seem to typify the working conditions experienced by younger, less experienced nurses.

Clinical Implications: The Power of Language

Labelling abusive and harassing behaviours as bullying has several important clinical implications. On an organizational level, recognizing and labelling experiences as bullying can help to legitimize the problem. In a recent study of women's experiences of workplace bullying (Lewis & Orford, 2005), participants described the importance of "being heard" and "being believed." When women in the study were able to talk about their experiences with others, they perceived the listening as valuable if they felt that their concerns had been acknowledged. To acknowledge an event involves labelling the event for what it is and not using vague or ambiguous terms to minimize experiences.

Results of the present study suggest that recognizing and labelling abusive behaviours in the workplace as bullying may be difficult for some nurses. Self-blame, shame, denial, and minimization are all factors that may inhibit self-labelling. These same factors may also contribute to feelings of distress and may hinder efforts at help-seeking. Women who label their experiences as bullying are more likely to seek support either formally (i.e., through their unions, mental health professionals, etc.) or informally (i.e., talking with family and friends). Research has shown that social support is a protective factor that moderates the relationship between bullying and adverse psychological outcomes (Einarsen & Skogstad, 1996). The challenge for clinicians is to reach workers who have been abused and harassed in the workplace but who may not yet label these experiences as bullying.

In the present study, nurses who experienced abusive and harassing interactions in the workplace but didn't label their experiences as bullying still scored higher on measures of psychological distress than their non-bullied colleagues. The failure to label their experiences as bullying does not necessarily mean that they did not view these

experiences negatively. It may be that nurses in this group were internalizing their experiences in a way that results in self-blame (e.g., "I must be doing something to encourage this behaviour) or in a way that minimizes their feelings and reactions (e.g., "I'm just being overly sensitive"). Perhaps nurses in this group view these harassing and abusive experiences as a normal part of the nursing/ hospital organizational culture. Clinicians working with clients such as this need to help them find ways of externalizing the problem (i.e., recognizing that the bullying is not due to the client's own behaviour) and legitimizing their feelings. Narrative therapy (e.g., White & Epston, 1990) can be helpful in this respect.

In their book "Narrative Means to Therapeutic Ends" (1990), White and Epston discuss ways in which they use narrative therapy to help clients to retell or recreate the stories of their lives. Language is more than just a means of communication. It also influences the way in which people perceive and think about their world. An objective of clinicians working with clients who have been bullied in the workplace may be to help clients to retell or recreate their stories in such a manner as to help them avoid feelings of self-blame and shame. For clients who have been traumatized by workplace bullying and come to hold negative beliefs about the benevolence of people, a key task for the therapist is to help the client assimilate and integrate the bullying experiences into more positive schemas about people.

Organizational Implications

The findings of the present study also have implications for organizations. How the organization defines bullying is an important factor to consider when treating individual workers. It can be argued that bullied employees will be less likely to label their experiences as bullying if the organizational norms in the workplace reflect a

permissive attitude toward aggressive behaviour. In these types of organizations, hostility and negative interactions between co-workers may be perceived as being 'part of the job' (Mayhew & Chappell, 2001).

In her analysis of the organizational responses to bullying, Ferris (2004) suggested that how organizational representatives respond to bullying situations has a significant influence on the degree of harm suffered by both the individual and the organization. In particular, she argued that the likelihood of harm is greatest when the organization labels bullying as a personality conflict between individuals (i.e., blaming the victim for having the kind of personality that irritated the bully). In contrast, Schat and Kelloway (2003) found that both informational and instrumental support from the organization tended to buffer the negative effects of bullying on the emotional well-being of workers.

Morgan's (1997) systems approach to understanding organizations provides a useful framework for developing occupational interventions aimed at treating and/or preventing workplace bullying. According to the systems approach, organizations are viewed as consisting of a number of interrelated parts or subsystems. These subsystems may represent different work groups and/or different levels in the organizational hierarchy. Morgan suggested that in order for an organization to prosper, there must be harmony between its parts or subsystems. Based on this notion, workplace bullying would not be viewed as a problem between individuals but rather as a symptom of the organization's functioning as a whole. Efforts at treatment and prevention would be focussed on providing instrumental and informational support to individuals, as well as developing an organizational climate (through education and training) that clearly sanctions workers who bully or harass one another.

General Limitations of the Study

Despite the strong support demonstrated for many of the hypotheses proposed in this study, the results should be considered in light of the study's methodological limitations. The main limitation of the present study relates to the cross-sectional nature of its design. No definitive statements about cause-and-effect or temporal relationships among bullying, self-labelling and the dependent variables (e.g., job satisfaction, psychological distress, turnover intentions) can be made. It may be possible that the elevated psychological distress reported by nurses who were bullied is a cause, rather than a consequence, of the bullying that they experience. Although researchers have reported significant and positive correlations between bullying and high levels of neuroticism, narcissism, and negative affectivity (e.g., Acquino & Bradfiled, 2000; Wislar et al., 2000), these variables can only be viewed as correlates of bullying, rather than causes or consequences of such behaviour. Longitudinal studies are needed to help to clarify the temporal relationship between these variables and bullying.

Another limitation of the present study relates to the use of the Negative Acts Questionnaire (NAQ) to assess experiences with bullying in the workplace. Although the NAQ contains a number of items that characterize a variety of negative overt and covert behaviours that may occur between employees in the workplace, there may be some behaviours specific to nursing or hospital settings that this scale did not assess. The context in which bullying behaviours occur undoubtedly bears a strong influence on how these behaviours are interpreted. If certain behaviours are construed as a 'normal' part of the nursing work environment, these behaviours may not be labelled as bullying. This limitation points to the need to develop more situation or context specific measures of workplace bullying.

Methodological Considerations and Suggestions for Future Research

The lack of consensus concerning definitions of workplace abuse, as well as a lack of agreement on appropriate means of assessing the prevalence of bullying continues to dominate discussions in the field (e.g., Cowie et al., 2002). Although it has been argued that prevalence rates of bullying are overestimated when they are based solely on workers' responses to lists of predefined negative acts (e.g., the NAQ), it has also been maintained that prevalence rates of bullying are underestimated when researchers rely solely on self-labelling or subjective methods to identify workers who have been bullied. The findings of the present study emphasize the importance of utilizing multiple methods of assessment to identify victims of workplace bullying and also underscore the importance of considering the victim's subjective appraisal of being bullied.

In a recent study, Liefooghe (2003) used discourse analysis to explore the views of employees regarding bullying in the workplace and argued that "by listening to different voices and using different methods in organisations, different explanations of bullying can be formed" (p. 24). By using discourse analysis to explore individual's perceptions of workplace bullying, Liefooghe directly addressed the idea that language (or "labels") shape how people interpret objective experience:

> Traditionally, psychologists have taken language as being a transparent medium, which is thought to reflect reality unproblematically. This can be seen in standard questionnaires: the language used in the questionnaires is used as a means of getting at, or measuring, some underlying entity, such as a personality trait – it is being taken as useful for the examination of some psychological phenomenon, and no more. DA [Discourse Analysis] rejects this realist assumption and makes language the focus for study in its own right. Language is seen as playing an

> active, constructive role . . . In taking the perspective that language is constructive, discourse analysts argue that the linguistic resources available to a speaker set certain parameters on our understanding and actions. (p. 25)

Through the use of discourse analysis, Liefooghe (2003) found that employees in his study used the term "bullying" in ways that differed substantially from those provided by researchers. In particular, employees were noted to often conceptualize the organization itself, as a bully:

> Rather than talking about bullying as something between two individuals, participants here constructed a collective (rather than individual) identity, and argue that it is 'them' who bully when it suits 'them.' Bullying here then means not being listened to. However, these employees do not necessarily position themselves as victims. . . they counter 'them' with 'us', the 'staff', who can offer resistance. (pp. 29-30).

In the present study, many of the nurses wrote about being feeling unappreciated (not listened to) and harassed by management. For example, one psychiatric nurse commented:

> Within the last 12 months, 6 of my coworkers have been injured by psych patients (kicked, pushed, objects thrown at them, spit on, verbally abused). Management minimizes these problems. . . Management harasses workers re sick time and no positive criticism is ever given.

This particular respondent endorsed a number of items on the NAQ and indicated that she experienced these behaviours on a weekly basis. She also labelled her experiences as bullying. When she was given an opportunity to comment about the situation in her workplace, she chose to write about management's lack of attention to the needs of her

colleagues. In a sense, she appears to have aligned herself more with her colleagues and views management as a collective bully.

Liefooghe (2003) suggests that research in the area of workplace bullying needs to move beyond "discovering the true nature of bullying" to exploring how employees use the term. Future research in the area should employ strategies such as discourse analysis, focus groups, and case studies to generate hypotheses about aspects of workplace bullying that are difficult to define and measure because they may depend more on the subjective perceptions of the victim or target of bullying (e.g., role of power relations in the labelling and maintenance of bullying). The use of face-to-face interviews can also be used to shed light on contextual factors related to the organization that may influence both the incidence of bullying and labelling of particular behaviours as bullying.

Prior research has demonstrated that victims of workplace bullying who demonstrate symptoms of PTSD tend to hold more negative views about the world, others, and themselves, than their non-bullied colleagues. Results of the present study demonstrate that the labelling of experiences as bullying was associated with less positive views about the benevolence of people. If language can indeed shape an individual's reality, future studies should be developed to explore whether clinical interventions such as narrative therapy can be used effectively to help victims of workplace bullying "re-story" their experiences in such a way as to assimilate them into their pre-bullying schemas about the benevolence of people and the world around them.

Although it is important to develop interventions for individual workers who have been bullied, it is equally important to identify workplace interventions that address bullying on an organizational level. In particular, research agenda is needed to examine

the relationship between organizational norms and how employees label negative interactions with coworkers. It is possible that bullying behaviour among employees may be ignored in some organizations if such behaviour leads to increased in productivity (Salin, 2003). Organizations have much to gain by understanding how structures and processes within the organization may precipitate and maintain bullying behaviour among employees. Bullying among employees should be conceptualized as a workplace phenomenon rather than as a conflict between individual workers. Discourse analysis and other means of qualitative inquiry should be used to explore the meaning of bullying for both individuals and organizations as a whole.

Finally, it is suggested that additional research be implemented to explore the phenomenon of workplace bullying among Canadian workers. As noted previously, there is a relative dearth of information related to both the prevalence and consequences of workplace bullying in Canada. A search of the literature results in a handful of citations of journal articles that describe workplace bullying using Canadian samples. Some researchers (e.g., Einarsen, 2000) have argued that there is a link between the progression of research related to workplace bullying and the development of government legislation to prohibit such behaviour. For example, in the Scandinavian countries where accounts of workplace bullying predominate, strong government legislation has been enacted both defines and prohibits workplace bullying.

In contrast, there is presently a lack of federal legislation in Canada concerning the rights of workers with respect to bullying and non-sexual harassment in the workplace. This lack of legislation should not be interpreted to imply that bullying is not an issue in Canadian workplaces. To the contrary, the results of the present study clearly indicate that bullying is experienced frequently by Canadian nurses and that such

workplace abuse is significantly associated with adverse effects on job satisfaction, turnover intentions, and psychological well-being. A lack of legislation at the federal level should be interpreted instead to represent the difficulties involved in defining bullying in the workplace.

The present study demonstrates that process of labelling abusive behaviours as bullying is not clear cut. A worker's appraisal and labelling of a situation as "bullying" likely involves an interplay among factors related to the individual (e.g., prior experiences, personality) and the organizational (e.g., organizational norms, leadership style). Although researchers have suggested that health care workers and nurses, in particular, are at an elevated risk for workplace bullying (Mayhew & Chappell, 2001; Quine, 1999), there has been little discussion and exploration of the contextual factors that may be implicated in this elevated risk. For example, anecdotal accounts in the nursing literature suggest that verbal abuse and bullying of nurses in the operating room is frequent (e.g., Cook et al., 2001; Farrell, 1997; Hamlin, 2000) and may be considered as "just part of the job" because of norms and expectations related to that particular work context. Verbal abuse and bullying of nurses working in other hospital units and settings may be less frequent (e.g., labour and delivery, paediatrics). Future research should be designed with these contextual factors in mind.

REFERENCES

Adams, A. (1992). *Bullying at work: How to confront and overcome it.* London: Virago.

Agervold, M., & Mikkelsen, E.G. (2004). Relationships between bullying, psychosocial work environment and individual stress reactions. *Work & Stress, 18*(4), 336-351.

Aitken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J.A., Clarke, H., Giovannetti, P., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43-53.

Aquino, K., & Bradfield, M. (2000). Perceived victimization in the workplace: The role of situational factors and victim characteristics. *Organization Science, 11*, 525-537.

Aquino, K., & Lamertz, K. (2004). A relational model of workplace victimization: Social roles and patterns of victimization in dyadic relationships. *Journal of Applied Psychology, 89*(6), 1023-1024.

Barak, A., Fisher, W.A., & Houston, S. (1992). Individual difference correlates of the experience of sexual harassment among female university students. *Journal of Applied Social Psychology, 22*, 17-37.

Bartfay, W.J., & Davis, M.T. (2001). Men in nursing: An untapped resource. *Canadian Nurse, 97*(5), 14-18.

Baron, R.A., & Neuman, J.H. (1998). Workplace aggression – the iceberg beneath the tip of workplace violence: Evidence on its forms, frequency, and targets. *Public Administration Quarterly, 21*(4), 446-464.

Baron, R.A., Neuman, J.H., & Geddes, D. (1999). Social and personal determinants of

workplace aggression: Evidence for the impact o f perceived injustice and the Type A behavior pattern. *Aggressive Behavior, 25*, 281-296.

Bjorkqvist, K., Osterman, K., & Hjelt-Back, M. (1994). Aggression among university employees. *Aggressive Behavior, 20*, 27-33.

Bluedorn, A.C. (1982). The theories of turnover: Causes, effects, and meaning. *Research in the Sociology of Organizations, 1*, 75-128.

Bozeman, D.P., & Perrewé, P.L. (2001). The effect of item content overlap on Organizational Commitment Questionnaire – turnover cognitions relationships. *Journal of Applied Psychology, 86,* 161-173.

Bray, C. (2001). Bullying nurses at work: Theorising a gendered experience. *Contemporary Nurse, 10*, 21-29.

Brodsky, C. (1976). *The harassed worker.* Lexington, MA: D.C. Heath.

Bukspan, E. (2004). Bullying at work in France. *British Journal of Guidance & Counselling, 32,* 397-406.

Cameron, S., Armstrong-Stassen, M., Bergeron, S., & Out, J. (2004). Recruitment and retention of nurses: Challenges facing hospital and community employers. *Canadian Journal of Nursing Leadership, 17*(3), 79-92.

Canada Safety Council. (2004). Bullying in the workplace. Retrieved November 2004, from http://www.safety-council.org/info/OSH/bullies.html

Canadian Institute for Health Information (2001). Canada's health care providers. Retrieved January 2005 from http://www.cihi.ca/HCTReport2001/toc.shtml

Church, A.H. (1993). Estimating the effect of incentives on mail survey response rates: A meta-analysis. *Public Opinion Quarterly, 57*, 62-79.

Cohen, J. (1977). *Statistical power analysis for the behavioural sciences*. San Diego,

CA: Academic Press.

Cole, L.L., Grubb, P.L., Sauter, S.L., Swanson, N.G., & Lawless, P. (1997). Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scandinavian Journal of Work, Environment & Health, 23*, 450-457.

Cook, J.K., Green, M., & Topp, R.V. (2001). Exploring the impact of physician verbal abuse on perioperative nurses. *AORN Journal, 74*, 317-331.

Cooper, C., Hoel, H., & Einarsen, S. (2002). *Bullying and emotional abuse in the workplace: International perspectives in research and practice.* New York: Taylor & Francis.

Cortina, L.M., Magley, V.J., Williams, J.H., & Langhout, R.D. (2001). Incivility in the workplace: Incidence and impact. *Journal of Occupational Health Psychology, 9*, 335-349.

Cowie, H., Naylor, P., Rivers, I., Smith, P.K., & Pereira, B. (2002). Measuring workplace bullying. *Aggression and Violent Behavior, 7*, 33-51.

Coyne, I., Seigne, E., & Randall, P. (2000). Predicting workplace victim status from personality. *European Journal of Work and Organizational Psychology, 9*, 335-349.

Dalbert, C. (1999). The world is more just for me than generally: About the Personal Belief in a Just World Scale's validity. *Social Justice Research, 12*, 79-98.

Davenport, N., Schwartz, R.D., Elliott, G.P., & Vidali, S. (1999). *Mobbing: Emotional abuse in the American workplace.* Ames, IA: Civil Society Publishing.

Densten, I.L. (2001). Re-thinking burnout. *Journal of Organizational Behavior, 22*, 833-847.

Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric

rating scale- preliminary report. *Psychopharmacology Bulletin, 9*, 13-27.

Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science, 19*, 1-15.

Diaz, A.L., & McMillin, J.D. (1991). A definition and description of nurse abuse. *Western Journal of Nursing Research, 13*, 97-109.

Dillman, D.A. (2000). *Mail and internet surveys: The tailored design method, 2nd ed.* Toronto: John Wiley & Sons, Inc.

Duffy, E. (1995). Horizontal violence: A conundrum for nursing. *Collegian, 2*(2), 5-9.

Duncan, S.M., Hyndman, K., Estabrooks, C.A., Hesketh, K., Humphrey, C.K., Wong, J.S., Acorn, S., & Giovannetti, P. (2001). Nurses' experience of violence in Alberta and British Columbia hospitals. *Canadian Journal of Nursing Research, 32*, 57-78.

Einarsen, S. (2000). Harassment and bullying at work: A review of the Scandinavian approach. *Aggression and Violent Behavior, 5*, 379-401.

Einarsen, S., Matthiesen, S., & Skogstad, A. (1998). Bullying, burnout and well-being among assistant nurses. *Journal of Occupational Health & Safety (Australia/ New Zealand), 14*, 563-568.

Einarsen, S., & Raknes, B.I. (1997). Harassment in the workplace and the victimization of men. *Violence and Victims, 12*, 247-263.

Einarsen, S., & Skogstad, A. (1996). Bullying at work: Epidemiological findings in public and private organizations. *European Journal of Work and Organizational Psychology, 5*, 185-201.

Einarsen, S., Raknes, B.I., & Matthiesen,. S.B. (1994). Bullying and harassment at work

and their relationship to work environment quality: An exploratory study. *European Journal of Work and Organizational Psychology, 4*, 381-401.

Ellis, S., Barak, A., & Pinto, A. (1991). Moderating effects of personal cognitions on experienced and perceived sexual harassment of women at the workplace. *Journal of Applied Social Psychology, 21*, 1320-1337.

Eriksen, W., & Einarsen, S. (2004). Gender minority as a risk factor of exposure to bullying at work: The case of male assistant nurses. *European Journal of Work and Organizational Psychology, 13*, 473-492.

Farrell, G.A. (1997). Aggression in clinical settings: Nurses' views. *Journal of Advanced Nursing, 25*, 501-508.

Farrell, G.A. (1999). Aggression in clinical settings: Nurses' views – a follow-up study. *Journal of Advanced Nursing, 29*, 532-541.

Farrell, G.A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more. *Journal of Advanced Nursing, 35*, 26-33.

Ferris, P. (2004). A preliminary typology of organisational response to allegations of workplace bullying: See no evil, hear no evil, speak no evil. *British Journal of Guidance & Counselling, 23*(3), 389-395.

Foa, E.B. (1995). Posttraumatic Stress Diagnostic Manual. Minneapolis, MN: National Computer Systems, Inc.

Foa, E.B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*, 445-451.

Fox, S., & Spector, P.E. (Eds.). (2005). *Counterproductive work behaviour: Investigations of actors and targets*. Washington, D: American Psychological

Association.

Freire, P. (1970). *Pedagogy of the oppressed.* New York: Herder and Herder.

Furnham, A. (2003). Belief in a just world: Research progress over the past decade. *Personality and Individual Differences, 34*, 795-817.

Gaab, J., Rohleder, N., Nater, U.M., & Elhert, U. (2005). Psychological determinants of the cortisol stress response: The role of anticipatory cognitive appraisal. *Psychoneuroendocrinology, 30*, 599-610.

Glass, N. (1997). Horizontal violence in nursing: Celebrating conscious healing strategies. *The Australian Journal of Holistic Nursing, 4*(2), 15-23.

Glover, D., & Radcliffe, M. (1998). Why is success in nursing a boy thing? *Nursing Times, 94*(32), 13.

Hafer, C., & Correy, X. (1999). Mediators of the relation between beliefs in a just world and emotional responses to negative outcomes. *Social Justice Research, 12*, 189-204.

Hafer, C., & Olson, J. (1989). Beliefs in a just world and reactions to personal deprivation. *Journal of Personality, 57*, 799-823.

Hafer, C., & Olson, J. (1998). Individual differences in a just world and responses to personal misfortune. In L. Montada, & M. Lerner (Eds.), *Responses to victimization and belief in the just world* (pp. 65-86). New York: Plenum.

Hamlin, L. (2000). Horizontal violence in the operating room. *British Journal of Perioperative Nursing, 10*, 34-42.

Hampshire, M. (2000). Are nurses their own worst enemy? *Nursing Times, 96*(38), 10-11.

Hantler, A.M. (1994). Children's views of bullying. *Health Education, 5*, 8-14.

Harned, M.S. (2004). Does it matter what you call it? The relationship between labelling unwanted sexual experiences and distress. *Journal of Consulting and Clinical Psychology, 72*(6), 1090-1099.

Haynie, D. L., Nansel, T., Eitel, P., Crump, D.A., Saylor, K., Yu, K., & Simons-Morton, B. (2001). Bullies, victims, and bully/victims: Distinct groups of at-risk youth. *Journal of Early Adolescence, 21*, 29-49.

Hoel, H., Cooper, C.L., & Faragher, B. (2001). The experience of bullying in Great Britain: The impact of organizational status. *European Journal of Organizational Psychology, 10*, 443-465.

Hoel, H., Faragher, B., & Cooper, C.L. (2004). Bullying is detrimental to health, but all bullying behaviours are not necessarily equally damaging. *British Journal of Guidance & Counselling, 32*(3), 367-387.

Hofstede, G. (1980). *Cultures consequences: International differences in work related values*. Newbury Park, CA: Sage.

Hogh, A., & Dofradottir, A. (2001). Coping with bullying in the workplace. *European Journal of Work and Organizational Psychology, 10*, 485-495.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events. Applications of the schema construct. *Social Cognition, 7*, 113-136.

Janoff-Bulman, R. (1992). *Shattered assumptions – towards a new psychology of trauma*. New York: The Free Press.

Janoff-Bulman, R., & Frieze, I.H. (1989). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues, 39*(2), 1-17.

Jennifer, D., Cowie, H., & Ananiadou, K. (2003). Perceptions and experience of workplace bullying in five different working populations. *Aggressive Behavior,*

29, 489-496.

Kalist, D.E. (2002). The gender earnings gap in the RN labor market. *Nursing Economics, 20*, 155-162.

Kalliath, T.J., O'Driscoll, M.P., Gillespie, D.F., & Bluedorn, A.C. (2000). A test of the Maslach Burnout Inventory in three samples of healthcare professionals. *Work & Stress, 14*, 35-50.

Keashly, L. (1998). Emotional abuse in the workplace: Conceptual and empirical issues. *Journal of Emotional Abuse, 1*, 85-117.

Keashly, L. (2001). Interpersonal and systemic aspects of emotional abuse at work: The target's perspective. *Violence and Victims, 16*, 233-268.

Keashly, L., Trott, V., & MacLean, L.M. (1994). Abusive behavior in the workplace: A preliminary investigation. *Violence and Victims, 9*, 341-357.

Koss, M.P. (1990). Changed lives: The psychological impact of sexual harassment. In M.A. Paludi (Ed.), *Ivory power: Sexual harassment on campus* (pp. 73-92). Albany, NY: State University of New York Press.

Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lee, D. (2000). An analysis of workplace bullying in the UK. *Personnel Review, 29*, 593-612.

Lee, M.B., & Saeed, I. (2001). Oppression and horizontal violence: The case of nurses in Pakistan. *Nursing Forum, 36*, 15-24.

Legislative Assembly of Ontario. (2004). Bill 70: An act to amend the Occupational and Safety Act with respect to acts of workplace violence. Retrieved in November 2004, from

http://www.ontla.on.ca/documents/Bills/37_Parliament/Session2/b070_e.html

Lerner, M.J. (1980). *The belief in a just world: A fundamental delusion.* New York: Plenum Press.

Lewis, D. (2004). Bullying at work: The impact of shame among university and college lecturers. *British Journal of Guidance & Counselling, 32*(3), 281-299.

Lewis, J., Coursol, D., & Wahl, K.H. (2002). Addressing issues of workplace harassment: Counselling the targets. *Journal of Employment Counseling, 39*, 109-116.

Lewis, S.E., & Orford, J. (2005). Women's experiences of workplace bullying: Changes in social relationships. *Journal of Community & Applied Social Psychology, 15*, 29-47.

Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violence and Victims, 5*, 119-126.

Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work and Organizational Psychology, 5*, 165-184.

Leymann, H., & Gustafsson, A. (1996). Mobbing at work and the development of post-traumatic stress disorder. *European Journal of Work and Organizational Psychology, 5*, 251-276.

Liefooghe, A.P.D. (2003). Employee accounts of bullying at work. *International Journal of Management and Decision Making, 4*, 24-34.

Liefooghe, A.P.D., & Olafsson, R. (1999). "Scientists" and "amateurs": Mapping the bullying domain. *International Journal of Manpower, 20*, 39-49.

Lipkus, I.M., & Siegler, I.C. (1993). The belief in a just world and perceptions of discrimination. *Journal of Psychology, 127*, 465-474.

Magley, V.J., Hulin, C.L., Fitzgerald, L.F., & DeNardo, M. (1999). Outcomes of self-labeling sexual harassment. *Journal of Applied Psychology, 84*, 390-402.

Manderino, M.A., & Berkey, N. (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing, 13*, 48-55.

Maslach, C., & Jackson, S.E. (1986). *Maslach Burnout Inventory, Second Edition.* Palo Alto, CA: Consulting Psychologists Press.

Matthiesen, S.B., & Einarsen, S. (2001). MMPI-2 configurations among victims of bullying at work. *European Journal of Work and Organizational Psychology, 10*, 467-484.

Mayhew, C., & Chappell, D. (2001). *'Internal' violence (or bullying) and the health workforce (Discussion Paper No. 3).* The University of New South Wales.

McCall, E. (1996). Horizontal violence in nursing: The continuing silence. *The Lamp, 53*(3), 28-29, 31.

McKenna, B.G., Smith, N.A., Poole, S.J., & Coverdale, J.H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*, 90-96.

Mikkelsen, E.G., & Einarsen, S. (2001). Bullying in Danish work-life: Prevalence and health correlates. *European Journal of Work and Organizational Psychology, 10*, 393-413.

Mikkelsen, A.G. & Einarsen, S. (2002a). Basic assumptions and symptoms of post-traumatic stress among victims of bullying at work. *European Journal of Work and Organizational Psychology, 11*, 87-111.

Mikkelsen, E.G., & S., Einarsen (2002b). Relationships between exposure to bullying at work and psychological and psychosomatic health complaints: The role of state

negative affectivity and generalized self-efficacy. *Scandinavian Journal of Psychology, 43*, 397-405.

Mobley, W.H., Horner, S.O., & Holliingsworth, A.T. (1978). An evaluation of the precursors of hospital employee turnover. *Journal of Applied Psychology, 63,* 408-414.

Morgan, G. (1997). *Images of organization.* Thousand Oaks, CA: Sage Publications.

Mowday, R.T., Koberg, C.S., & MacArthur, A.W. (1984). The psychology of the withdrawal process: A cross validation test of Mobley's Intermediate Linkages Model of Turnover in two samples. *Academy of Management Journal, 27,* 79-94.

Mowday, R., Steers, R., & Porter, L. (1979). The measurement of organizational commitment. *Journal of Vocational Behavior, 14*, 224-247.

Munson, L.J., Miner, A.G., & Hulin, C. (2001). Labeling sexual harassment in the military: An extension and replication. *Journal of Applied Psychology, 86*(2), 293-303.

Neuman, J.H., & Baron, R.A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management, 24*, 391-419.

Niedl, K. (1996). Mobbing and well-being: Economic and personnel development implications. *European Journal of Work and Organizational Psychology, 5*, 239-249.

Olff, M., Langeland, W., & Gersons, B.P.R. (2005). Effects of appraisal and coping on the neuroendocrine response to extreme stress. *Neuroscience and Biobehavioral Reviews, 29*, 457-467.

Olweus, D. (1993). Victimization by peers: Antecedents, and long-term outcomes. In

K.H. Rubin & J.B. Asendorpf (Eds.), *Social withdrawal, inhibition, and shyness in childhood (pp. 315-342).* Hillsdale, NJ: Erlbaum.

O'Moore, M., Seigne, E., McGuire, K., & Smith, M. (1998). Victims of workplace bullying in Ireland. *The Irish Journal of Psychology, 19*, 345-357.

Pekrul, L. (1993). Nurse abuse in Saskatchewan: A study. *Concern, 22,* 16-18.

Pellegrini, A.D. (1998). Bullies and victims in school: A review and call for research. *Journal of Applied Developmental Psychology, 19*, 165-176.

Plante, A., & Bouchard, L. (1995). Occupational stress, burnout, and professional support in nurses working with dying patients. *Omega: Journal of Death and Dying, 32,* 93-109.

Quine, L. (1999). Workplace bullying in the NHS community trust: Staff questionnaire survey. *British Medical Journal, 318*, 228-232.

Quine, L. (2002). Workplace bullying in junior doctors: Questionnaire survey. *British Medical Journal, 324*, 878-879.

Rayner, C. (1997). The incidence of workplace bullying. *Journal of Community & Applied Social Psychology, 7*, 199-208.

Rayner, C., & Hoel, H. (1997). A summary review of the literature relating to workplace bullying. *Journal of Community & Applied Social Psychology, 7*, 181-191.

Rayner, C., Hoel, H., & Cooper, C.L. (2002). *Workplace bullying: What we know, who is to blame, and what can we do?* London: Taylor & Francis.

Rayner, C., Sheehan, M., & Barker, M. (1999). Theoretical approaches to the studying of bullying at work. *International Journal of Manpower, 20*, 11-16.

Richman, J.A., Flaherty, J.A., & Rospenda, K.M. (1996). Perceived workplace harassment experiences and problem drinking among physicians: Broadening the

stress/alienation paradigm. *Addiction, 91*, 391-403.

Richman, J.A., Rospenda, K.M., Nawyn, S.J., Flaherty, J.A., Fendrich, M., Drum, M.L., & Johnson, T.P. (1999). Sexual harassment and generalized workplace abuse among university employees: Prevalence and mental health correlates. *American Journal of Public Health, 89*, 358-363.

Richman, J.A., Shinsako, S.A., Rospenda, K.M., Flaherty, J.A., & Freels, S. (2002). Workplace harassment/abuse and alcohol-related outcomes: The mediating role of psychological distress. *Journal of Studies on Alcohol, 63*, 412-419.

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

Rosenstein, A.H. (2002). Nurse-physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing, 102*(6), 26-34.

Rospenda, K.M. (2002). Workplace harassment, services utilization, and drinking outcomes. *Journal of Occupational Health Psychology, 7*, 141-155.

Rospenda, K.M., & Richman, J.A. (2004). The factor structure of generalized workplace harassment. *Violence & Victims, 19*(2), 221-238.

Rospenda, K.M., Richman, J.A., Wislar, J.S., & Flaherty, J.A. (2000). Chronicity of sexual harassment and generalized work-place abuse: Effects on drinking outcomes. *Addiction, 95*, 18-5-1820.

Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs: General & Applied, 80*, 1-28.

Rowe, M.M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: Do burned out nurses eat their young? *Journal of Nursing Management, 13*, 242-248.

Royal College of Nursing (2002). Working well? Results from the RCN Working Well

Survey into the well-being and working lives of nurses (001 595). London: Author.

Ryten, E. (1997). *A statistical picture of the past, present and future of registered nurses in Canada.* Ottawa, ON: Canadian Nurses Association.

Salin, D. (2001). Prevalence and forms of bullying among business professionals: A comparison of two different strategies for measuring bullying. *European Journal of Work and Organizational Psychology, 10*, 425-441.

Salin, D. (2003). Ways of explaining workplace bullying: A review of enabling, motivating and precipitating structures and processes in the work environment. *Human Relations, 56*(10), 1213-1232.

Salmivalli, C., & Nieminen, E. (2002). Proactive and reactive aggression among school bullies, victims, and bully-victims. *Aggressive Behavior, 28*, 30-44.

Sauter, M.A., Boyle, D., Wallace, D., Andrews, J.L., Johnson, M.S., Bates, M., et al. (1997). Psychometric evaluation of the Organizational Job Satisfaction Scale. *Journal of Nursing Management, 5*, 53-69.

Schat, A.C.H., & Kelloway, E.K. (2003). Reducing the adverse consequences of workplace aggression and violence: The buffering effects of organizational support. *Journal of Occupational Health Psychology, 8*, 110-122.

Schwartz, D., Dodge, K.A., Pettit, G.S., & Bates, J.E. (1997). The early socialization of aggressive victims of bullying. *Child Development, 68*, 665-675.

Shephard, M.F., & Campbell, J.A. (1992). The Abusive Behavior Inventory: A measure of psychological and physical abuse. *Journal of Interpersonal Violence, 7*, 291-305.

Skillings, L.N. (1992). Perceptions and feelings of nurses about horizontal violence as

an expression of oppressed group behavior. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance, and action: Working papers in the politics of nursing (pp. 167-185).* New York: National League for Nursing Press.

Slavitt, D.B., Stamps, P.L., Piedmont, E.B., & Haase, A,M. (1978). Nurses' satisfaction with their work situation. *Nursing Research, 27*, 114-120.

Smith, P.C., Kendall, L.M., & Hulin, C.L. (1969). *Measurement of satisfaction in work and retirement.* Chicago: Rand-McNally.

Smith, P.K., Singer, M., Hoel, H., & Cooper, C.L. (2003). Victimization in the school and in the workplace: Are there any links? *British Journal of Psychology, 94*, 175-188.

Stockdale, M.S., Vaux, A., & Cashin, J. (1995). Acknowledging sexual harassment: A test of alternative models. *Basic and Applied Social Psychology, 17*, 469-496.

Strategic Advantage Inc. (2000). *Symptom Assessment-45 Questionnaire (SA-45) Technical Manual.* Toronto: MHS.

Strauss, M. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scale. *Journal of Marriage and the Family, 41*, 74-85.

Tabachnick, B.G., & Fidell, L.S. (1996). *Using multivariate statistics (3rd ed.).* New York: HarperCollins.

Tolman, R.M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4*, 159-177.

Varhama, L.M., & Bjorkqvist, K. (2004). Conflicts, workplace bullying and burnout problems among municipal employees. *Psychological Reports, 94,* 1116-1124.

Vartia, M. (1996). The sources of bullying – Psychological work environment and organizational climate. *European Journal of Organizational Psychology, 5*, 203-

214.

Vartia, M. (2001). Consequences of workplace bullying with respect to the well-being of it's targets and the observers of bullying. *Scandinavian Journal of Work, Environment & Health, 27*, 63-69.

Warden, D., & Mackinnon, S. (2003). Prosocial children, bullies and victims: An investigation of their sociometric status, empathy, and social-problem solving strategies. *British Journal of Developmental Psychology, 21*, 367-385.

Weinfurt, K. P. (2000). Chapter 8: Multivariate analysis of variance. In L.G. Grimm and P.R. Yarnold (Eds.)., *Reading and Understanding Multivariate Statistics* (pp. 245-276). Washington, DC: American Psychological Association.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wilkinson, L. (1975). Response variable hypothesis in the multivariate analysis of variance. *Psychological Bulletin, 82*, 408-412.

Williams, C.L. (1995). Hidden advantages for men in nursing. *Nursing Administration Quarterly, 19*, 63-70.

Williams, T. (1947). *A streetcar named desire*. New York: New Directions.

Wilson, M. (2000). Horizontal violence: A challenge for nursing. *Kai Tiaki New Zealand, 6*, 24-25.

Wislar, J.S., Richman, J.A., Frendrich, M., & Flaherty, J.A. (2002). Sexual harassment, generalized workplace abuse and drinking outcomes: The role of personality vulnerability. *Journal of Drug Issues, 32*, 1071-1088.

Zapf, D. (1999). Organisational, work group related and personal causes of mobbing/bullying at work. *International Journal of Manpower, 20*, 70-85.

Zapf, D., & Gross, C. (2001). Conflict escalation and coping with workplace bullying: A replication and extension. *European Journal of Work and Organizational Psychology, 10*, 497-552.

APPENDIX A

QUESTIONNAIRE

Negative Acts Questionnaire (NAQ)
(Selected Items)

Please circle the number that best describes how often have you been subjected to each of the following negative acts in the workplace during the last **SIX MONTHS**.

HOW OFTEN:	0 Never	1 Less Than Monthly	2 Monthly	3 Weekly	4 Daily
1. Someone withholding necessary information so that your work gets complicated.	0	1	2	3	4
2. Unwanted sexual advances	0	1	2	3	4
3. Ridicule or insulting teasing	0	1	2	3	4
4. Ordered to do work below your level of competence.	0	1	2	3	4
5. Being deprived of responsibility or work tasks.	0	1	2	3	4
6. Gossip or rumours about you.	0	1	2	3	4
7. Social exclusion from co-workers or work-group activities.	0	1	2	3	4
8. Repeated offensive remarks about you or your personal life.	0	1	2	3	4
9. Verbal abuse	0	1	2	3	4
10. Unwanted sexual attention	0	1	2	3	4
11. Hints or signals from others that you should quit your job	0	1	2	3	4
12. Physical abuse or threats of physical abuse	0	1	2	3	4
13. Repeated reminders about your blunders	0	1	2	3	4
14. Silence or hostility as a response to your questions or attempts at conversation	0	1	2	3	4
15. Devaluing of your work and efforts	0	1	2	3	4
16. Neglect of your opinions or views	0	1	2	3	4

Negative Acts Questionnaire (NAQ)
(continued)

HOW OFTEN:	0 Never	1 Less Than Monthly	2 Monthly	3 Weekly	4 Daily
17. Offending telephone calls or written messages	0	1	2	3	4
18. Devaluing of your "rights" and opinions with reference to your gender	0	1	2	3	4
19. Devaluing of your "rights" and opinions with reference to your age	0	1	2	3	4
20. Exploitation at work, such as private errands	0	1	2	3	4
Single Self-Labelling Item:					
21. Have you been bullied in the workplace?	0	1	2	3	4

Specific Events in the Workplace
(Positive Events Subscale – Selected Items)

Please circle the number that best describes how often have you been subjected to each of the following events in the workplace during the last **SIX MONTHS**.

HOW OFTEN:	0 Never	1 Less Than Monthly	2 Monthly	3 Weekly	4 Daily
1. Praised for my accomplishments.	0	1	2	3	4
2. Consulted for my opinion.	0	1	2	3	4
3. Given credit for initiative.	0	1	2	3	4
4. Recognized for my work.	0	1	2	3	4
5. Politely asked to perform a duty.	0	1	2	3	4
6. Thanked for staying late.	0	1	2	3	4
7. Told that my feelings are important.	0	1	2	3	4
8. Apologized to for inappropriate behaviour.	0	1	2	3	4
9. Given constructive feedback.	0	1	2	3	4

Ward Organisational Features Scale (WOFS)
Job Satisfaction Subscale

Below you will find statements related to different aspects of job satisfaction. Please read each statement carefully and decide to what extent you personally agree or disagree with it. Circle the number that corresponds to this judgement. Make sure you circle a number for ever statement.

	Strongly Disgree ▼	Somewhat Disgree ▼	Somewhat Agree ▼	Strongly Agree ▼
1. This job does not live up to my expectations.	1	2	3	4
2. Knowing what I do now, I would apply for this job again.	1	2	3	4
3. I often feel like resigning.	1	2	3	4
4. I know that I am doing a really worthwhile job.	1	2	3	4
5. I am satisfied with the relationships I have with my ward nursing colleagues.	1	2	3	4
6. I worry that this job is undermining my health.	1	2	3	4
7. On the whole, I am satisfied with my working relationships with doctors.	1	2	3	4

Turnover Cognition Items

Below you will find several statements related to employees' thoughts and intentions about leaving their jobs. Please read each statement carefully and decide to what extent you personally agree or disagree with it. Circle the number that corresponds to this judgement. Make sure you circle a number for every statement.

	Strongly Disgree ▼	Somewhat Disgree ▼	Somewhat Agree ▼	Strongly Agree ▼
1. I will probably look for a new job in the near future.	1	2	3	4
2. At the present time, I am actively searching for another job in a different hospital or agency.	1	2	3	4
3. I do not intend to quit my job.	1	2	3	4
4. It is unlikely that I will actively look for a different hospital or agency to work for in the next year.	1	2	3	4
5. I am not thinking about quitting my job at the present time.	1	2	3	4

Human Services Survey
(Maslach Burnout Inventory)

Below you will find 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way.

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN: 0 – 6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job
4. _____	I can easily understand how my patients feel about things.
5. _____	I feel I treat some patients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my patients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my patients.
18. _____	I feel exhilarated after working closely with my patients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel patients blame me for some of their problems.

World Assumptions Scale (WAS)

Below you will find 32 statements related to people's beliefs about the world, themselves, and others. Please read each statement carefully and decide to what extent you personally agree or disagree with it. Circle the number that corresponds to this judgement. Make sure you circle a number for ever statement.

	Strongly Disagree ▼ 1	2	3	4	5	Strongly Agree ▼ 6
1. Misfortune is least likely to strike worthy, decent people.	1	2	3	4	5	6
2. People are naturally unfriendly and unkind.	1	2	3	4	5	6
3. Bad events are distributed to people at random.	1	2	3	4	5	6
4. Human nature is basically good.	1	2	3	4	5	6
5. The good things that happen in this world far outnumber the bad.	1	2	3	4	5	6
6. The course of our lives is largely determined by chance.	1	2	3	4	5	6
7. Generally, people deserve what they get in this world.	1	2	3	4	5	6
8. I often think I am no good at all.	1	2	3	4	5	6
9. There is more good than evil in the world.	1	2	3	4	5	6
10. I am basically a lucky person.	1	2	3	4	5	6
11. People's misfortunes result from mistakes they have made.	1	2	3	4	5	6
12. People don't really care what happens to the next person.	1	2	3	4	5	6
13. I usually behave in ways that are likely to maximize good results for me.	1	2	3	4	5	6
14. People will experience good fortune if they themselves are good.	1	2	3	4	5	6
15. Life is too full of uncertainties that are determined by chance.	1	2	3	4	5	6
16. When I think about it, I consider myself to be lucky.	1	2	3	4	5	6

World Assumptions Scale (WAS)
(continued)

	Strongly Disagree ▼ 1	2	3	4	5	Strongly Agree ▼ 6
17. I almost always make an effort to prevent bad things from happening to me.	1	2	3	4	5	6
18. I have a low opinion of myself.	1	2	3	4	5	6
19. By and large, good people get what they deserve in this world.	1	2	3	4	5	6
20. Through our actions we can prevent bad things from happening to us.	1	2	3	4	5	6
21. Looking at my life, I realize that chance events have worked out well for me.	1	2	3	4	5	6
22. If people took preventive actions, most misfortune could be avoided.	1	2	3	4	5	6
23. I take the actions necessary to protect myself against misfortune.	1	2	3	4	5	6
24. In general, life is mostly a gamble.	1	2	3	4	5	6
25. The world is a good place.	1	2	3	4	5	6
26. People are basically kind and helpful.	1	2	3	4	5	6
27. I usually behave so as to bring about the greatest good for me.	1	2	3	4	5	6
28. I am very satisfied with the kind of person I am.	1	2	3	4	5	6
29. When bad things happen, it is typically because people have not taken the necessary actions to protect themselves.	1	2	3	4	5	6
30. If you look closely enough, you will see that the world is full of goodness.	1	2	3	4	5	6
31. I have reason to be ashamed of my personal character.	1	2	3	4	5	6
32. I am luckier than most people.	1	2	3	4	5	6

DEMOGRAPHICS

This section contains several items that ask you to provide us with some background information about yourself. This information will be used to compare different groups of nurses.

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1. In which city is your hospital located? _____
2. In what type of unit/setting do you currently work? _____
3. How many years have you been employed in your current position? ____ years
4. How many years have you been employed in your current workplace? ____ years
5. How many years have you been employed as a nurse? _____ years
6. Do you work full-time or part-time?

   □ Full-time Average hours per week: _____
   □ Part-time Average hours per week: _____

7. In addition to your present position, are you currently employed somewhere else?

   □ No
   □ Yes Type of unit/setting ; _____

8. What shift do you typically work:

   □ Days □ Afternoons □ Evenings □ More than one shift

9. Have you changed units/ settings during the past year?

   □ No
   □ Yes For what reason: _____
   _____
   _____

10. Did you take any sick leave during the past 12 months?

    □ No
    □ Yes Approximate number of days: _____

11. Have you taken any sick leave during the past 12 months due to stress?

    □ No
    □ Yes Approximate number of days: _____

12. Please indicate your age: _____ years

13. Your marital status is:

□ Single	□ Separated	□ Other (please specify):
□ Married	□ Divorced	_____
□ Common-law	□ Widowed	

14. What is your highest level of education?

- □ R.N. college diploma
- □ R.N. hospital-based school of nursing diploma
- □ Baccalaureate degree in nursing
- □ Baccalaureate degree in other area
- □ Masters degree in nursing
- □ Masters degree in other area
- □ Doctorate in nursing
- □ Doctorate in other area

15. To which ethnic or cultural group(s) do you belong?

- □ Aboriginal (Inuit, Métis, North American Indian)
- □ Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- □ Black (e.g., African, Haitian, Jamaican, Somali)
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Latin American
- □ South Asian
- □ South East Asian
- □ White (Caucasian)
- □ Other (please specify): _____

16. Can you think of any sources of stress that may have affected your experiences or relationships at work?

- □ No
- □ Yes Please specify:

_____

_____

_____

_____

_____

_____

APPENDIX B

Cover Letter

UNIVERSITY OF
WINDSOR

June 25, 2004.

Dear Nurse,

I am a graduate student at the University of Windsor working on my dissertation in clinical psychology and I need your help to volunteer to participate in a study about the quality of nurses' work lives.

The purpose of this study is to learn about particular sources of stress that nurses may encounter at their jobs and how this affects their overall health and general level of job satisfaction. Research suggests that occupational stress and job satisfaction are integral to nurse retention. Given the nursing shortage that we currently face in Ontario, your individual experience as a nurse will make a valuable contribution to this study.

Your name was randomly drawn from a mailing list of registered nurses obtained from the College of Nurses of Ontario (CNO). The release of this information does not reflect the endorsement or support of this research by the CNO. Results from the survey will be used to help identify what nurses perceive to be the major causes of stress in their work environments and to explore whether these stressors are significantly associated with job turnover.

If you agree to participate in the study, you will be asked to complete a survey containing questions about aspects of your work environment, job satisfaction, and overall level of health and well-being. It should take you approximately 30 minutes to complete the survey.

Your answers to the survey are completely confidential and will be released only as summaries in which no individual's answers can be identified. When you return your completed questionnaire, your name will be deleted from the mailing list and never connected to your answers in any way. Your participation is voluntary and you may withdraw from the study at any time. The return of a completed questionnaire implies your consent to participate in this research. For your convenience, a return envelop with prepaid postage is included with this package.

Enclosed, please find a small token of appreciation as a way of saying thanks for your help and participation. If you have any questions or comments about this study, please feel free to contact me, or my faculty advisor, Dr. Kathryn Lafreniere. Our contact information can be found on the consent form.

Thank you very much for helping me with this important study.

Sincerely,

Jennifer Out, M.A.
Department of Psychology
University of Windsor

APPENDIX C

Consent Form

UNIVERSITY OF WINDSOR

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: **Quality of Nurses' Work Lives**

You are asked to participate in a dissertation research study conducted by Jennifer Out, M.A., and from the Department of Psychology at the University of Windsor. This research is being supervised by Dr. Kathryn Lafreniere, Associate Professor, Department of Psychology.

If you have any questions or concerns about the research, please feel to contact Dr. Lafreniere at (519) 253-3000 ext. 2233.

- **PURPOSE OF THE STUDY**

The purpose of the study is to learn about particular sources of stress that nurses may encounter at their jobs and how this affects their overall health and general level of job satisfaction.

- **PROCEDURES**

If you volunteer to participate in this study, please complete the enclosed questionnaire and return it to the researchers using the return envelope that is provided for you in this package. The return of a completed questionnaire constitutes your implied consent to participate in this study. It should take you approximately 30 minutes to complete this survey.

- **POTENTIAL RISKS AND DISCOMFORTS**

There are no risks or discomforts anticipated to you through your participation in this study. Enclosed, please find a list of resources and references that may be helpful to you, should you have any concerns or questions about health and safety issues at your workplace.

- **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

Results from the survey will be used to help understand some of the unique sources of stress that nurses encounter in their daily work environments and may be helpful in improving the quality of nurses' work lives.

- **PAYMENT FOR PARTICIPATION**

Enclosed, you will find an herbal tea bag and thank you card as a small token of appreciation for your participation in this study.

- **CONFIDENTIALITY**

On the front page of the questionnaire, you will find an individual identification number printed in the right upper hand corner. The purpose of this identification number is to ensure that follow-up mailings are only sent to nurses who have not returned their questionnaires. When you return your completed questionnaire, your name will be deleted from the mailing list and never connected to your answers in any way. Your answers to the survey are completely confidential and will be released only as summaries in which no individual's answers can be identified.

- **PARTICIPATION AND WITHDRAWAL**

Your participation in this study is voluntary. You may withdraw at any time without consequences of any kind. Although you may choose to skip any questions that you do not wish to answer, you are encouraged to answer as many items as possible for statistical purposes.

- **FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS**

It is anticipated that the findings of this study will be available by October 2004. A summary of the results will be posted on Dr. Lafreniere's web page, located at the following address:

http://cronus.uwindsor.ca/users/k/kathy/main.nsf

- **RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and has received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research subject, contact:

Research Ethics Coordinator
University of Windsor
Windsor, Ontario
N9B 3P4

Telephone: (519) 253-3000, ext. 3916
E-mail: ethics@uwindsor.ca

- **SIGNATURE OF INVESTIGATOR**

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

APPENDIX D

Occupational Stress Resources

Canadian Centre for Occupational Health and Safety (CCOHS)
135 Hunter Street East
Hamilton, Ontario
L8N 1M5

Tel. 1-800-263-8466
Fax. 1-905-572-4500
E-mail: mgr-inquiries@ccohs.ca
Website address: http://www.ccohs.ca

The CCHOS Inquiries Service is a free, confidential service available to Canadians to provide information about any health or safety concerns that employees may have about the work they do.

Workplace Health Strategies Bureau (WHSB)
Workplace Health and Public Safety Programme
171 Slater Street, 12th Floor
P.L. 3712D
Ottawa, Ontario
K1A 0K9

E-mail: whb-smt@hc-sc.gc.ca
Website address: http://www.hc-sc.gc.ca/hecs-sesc/workplace/publications.htm

The WHSB provides information about issues related to occupational health and works to support the development of organizations that are interested in promoting comprehensive workplace health.

Institute for Work & Health
481 University Avenue
Suite 800
Toronto, Ontario
M5G 2E9

Tel. (416) 927-2027, ext.2131
Fax. (416) 927-4167
E-mail: info@iwh.on.ca
Website address: http://www.iwh.on.ca

The Institute for Work & Health is an independent, not-for-profit organization whose mission is to conduct and share research with workers, labour, employers, clinicians, and policy-makers to promote, protect, and improve the health of working people.

APPENDIX E

Second Cover Letter

UNIVERSITY OF
WINDSOR

July 30, 2004.

Dear Nurse,

Approximately 3-4 weeks ago, a questionnaire seeking your opinions about the quality of nurses' work lives was mailed to you. Your name was randomly drawn from a mailing list of registered nurses obtained from the College of Nurses of Ontario (CNO).

The purpose of this study is to learn about particular sources of stress that nurses may encounter at their jobs and how this affects their overall health and general level of job satisfaction. Research suggests that occupational stress and job satisfaction are integral to nurse retention. Given the nursing shortage that we currently face in Ontario, your individual experience as a nurse will make a valuable contribution to this study.

If you have already completed and returned the questionnaire, please accept my sincere thanks. If you haven't but still wish to participate in the study, please complete the enclosed questionnaire today. You can help me very much by taking a few minutes to share your experiences and opinions about the sources of stress that you encounter on the job and how this affects your quality of life.

Enclosed, please find a small token of my appreciation and thanks for your participation.

Sincerely,

Jennifer Out, M.A.
Department of Psychology
University of Windsor

APPENDIX F

Psychometric Data for Nurses in the Non-Bullied, Self-Labelling Group ($n = 40$)

Table 20

Means and Standard Deviations of Selected Demographic Characteristics for Nurses in the Non-Bullied, Self-Labelling Group (n = 40)

Variable	*M*	*SD*
Age (in years)	45.60	9.23
Years Employed as a Nurse	20.45	10.05
Years Employed in Current Workplace	4.64	10.33
Years Employed in Current Position	9.60	8.07
Average Hours Worked per Week	37.72	4.63
No. of Days of Sick Leave	7.28	9.96
No. of Days of Sick Leave due to Stress	0.58	1.17

Table 21

Frequencies of Selected Demographic Characteristics for Nurses in the Non-Bullied, Self-Labelling Group (n = 40)

Variable	*n* (%)
Cultural / Ethnic Group	
Caucasian	29 (72.5%)
Visible Minority	11 (27.5%)
Marital Status	
Single	6 (15.0%)
Married / Common-Law	28 (70.0%)
Other	6 (15.0%)
Level of Education	
R.N. (college or hospital – based school of nursing)	28 (70.0%)
Baccalaureate degree in nursing or non-nursing	11 (27.5%)
Masters degree in nursing or non-nursing	1 (2.5%)
Doctorate degree in nursing or non-nursing	0 (0.0%)
Work Unit / Setting	
Medical/Surgical	7 (17.5%)
ER; Critical Coronary; Special	10 (25.0%)
Psychiatry; Mental Health	2 (5.0%)
Pediatrics; NICU	2 (5.0%)
OR/Recovery	10 (25.0%)
Labour and Delivery	8 (20.0%)
Complex Continuing Care//LTC	0 (0.0%)
Education; Development; Administration	1 (2.5%)
Research	0 (0.0%)
Shift Worked	
Days	16 (40.0%)
Evenings	1 (2.5%)
More than one shift	23 (57.5%)

Table 22

Means and Standard Deviations of Selected Scales and Subscales for Nurses in the Non-Bullied, Self-Labelling Group (n = 40)

Scale	*M*	*SD*	Range
Negative Acts Questionnaire (NAQ)	9.33	4.98	1 - 20
Positive Events	14.90	5.46	3 - 26
Job Satisfaction	21.68	3.59	14 - 28
Turnover Cognitions	8.33	4.09	5 - 19
Maslach Burnout Inventory (MBI)			
Emotional Exhaustion	22.90	9.92	7 - 44
Depersonalization	4.38	3.81	0 - 15
Personal Accomplishment	36.75	6.21	20 - 46
World Assumption Scale (WAS)			
Benevolence of the World	18.18	3.95	10 - 24
Benevolence of People	18.75	3.36	10 - 24
Justice	10.75	4.14	4 - 21
Controllability	11.63	3.80	4 - 20
Randomness	13.73	4.40	4 - 21
Self-Worth	20.53	3.18	11 - 24
Self-Controllability	18.10	3.72	9 - 24
Luck	16.35	4.63	4 - 24

(continued)

Table 22 (continued)

Means and Standard Deviations of Selected Scales and Subscales Nurses in the Non-Bullied, Self-Labelling Group (n = 40)

Scale	*M*	*SD*	Range
SA-45			
Depression	55.78	6.49	47 - 74
Anxiety	56.05	6.92	46 - 72
Hostility	58.75	5.03	54 - 69
Interpersonal Sensitivity	57.55	5.56	48 - 67
Somatization	62.60	8.35	46 - 76

APPENDIX G

Compilation of Selected Qualitative Responses by Group

Bullied, Self-Labellers

ID#	Group	Response
0594	Bullied, Self-Labeller	The patients do not wear me down and make me want to move jobs as much as coworkers...The positive comments I get in my job usually come from my patients and their parents, not my boss or coworkers.
0964	Bullied, Self-Labeller	Within the last 12 months 6 of my coworkers have been injured by psych patients (kicked, pushed, objects thrown at them, spit on, verbally abused). Management minimizes these problems... Management harasses workers re sick time and no positive criticism is ever given.
0324	Bullied, Self-Labeller	Nurses refusing to go to break with another nurse because they "don't like her." If I had to do it over again, I would never ever choose nursing as my life's occupation and neither would any of my friends... Our opinions are not considered valid unless you are a 'degree' nurse or clinical educator or nurse practitioner. Nursing as a profession should be ashamed – we fail to stand behind and beside each other and instead tear each other down. At every opportunity there is negative talk, criticism, gossiping, defaming others' character and calling into question colleagues' competency instead of supporting and encouraging each other. The lack of professionalism in the workplace has reached epic proportions – on a daily basis I have witnessed and also have been the victim of nurses yelling at other nurses in front of patients and family, gossiping about other nurses in front of patients, not working as a team because a coworker has a grudge against another and therefore patient care suffers.
0207	Bullied, Self-Labeller	Being devalued as an active member of the health care team. A definite hierarchy among the team (e.g., class system) exists.
1019	Bullied, Self-Labeller	Our hospital motto is "Our family caring for your family." However, where once I truly felt it was a 'family,' times have changed. The general opinion is that we (staff) are a very dysfunctional group that no one really cares about. It is truly amazing that we are able to still care for patients the way we do when staff feel management is not interested in their (staff) needs.

0773	Bullied, Self-Labeller	I also feel that how I am feeling today is reflective of the accumulative effect of the abusive nature of the nursing profession. I have worked over 30 years and feel I have taken abuse from colleagues especially in my early years that has had lasting effects. Eventually I have reached my "break point." Although I have not taken time off for "stress" I am on antidepressants and live on the edge of doing so. I was off ill for 7 days last fall, 3 days after being accosted by a staff member who resented that I had taken her to task for consistent lateness.
0105	Bullied, Self-Labeller	Another stressor is that nurses' suggestions on how to improve the work place generally fall on deaf ears. Hospital managers are only concerned with "the bottom line" and seem to expect that a nursing unit can be run the same way as a factory.
0116	Bullied, Self-Labeller	I'm not ashamed to say I'm burnt out after 15 years in a busy OR where I was forced to do things that were not "my job" and gave me less time to spend with my patients... I was also blamed by surgeons and other departments when I was in charge and when the system failed us (even though I was the middle man).
1002	Bullied, Self-Labeller	Also management would prefer younger less experienced nurses. They can mould them, push them around more, demand more and pay less. I feel management provokes the older staff to quit so they can replace them with younger and cheaper nurses. If you look at the pay grid, you will see why management thinks it aids in budgeting.
1092	Bullied, Self-Labeller	The death of our patients is not as stressful to me as dealing with the dysfunction of some of my colleagues.
0273	Bullied, Self-Labeller	I think nurses should learn alternative dispute resolution. Everyone has to work together. Even after a dispute, RNs must learn ways of distilling the tension (e.g., mediation). "Getting to Yes" should be required reading.
0944	Bullied, Self-Labeller	Surgeons do not treat RNs with respect. Managers do not address issues. Managers do not give praise. Surgeons swear and throw things and act like children. I strongly feel RNs are burnt out because they have such little tie allowed for vacation. I get 3 weeks/year. When I worked at Chrysler I got 8! The max. amt. of vacation for an RN with high seniority is 6 weeks! That's why people are always phoning in sick – they work too much!

1136	Bullied, Self-Labeller	The difficult personality of a peer caused conflict within one month of employment on the unit. This causes me to walk on egg shells when this peer is on the unit.
1073	Bullied, Self-Labeller	RNs who are wives and mothers think I should work harder schedules and more consecutive nights because I'm single.
0485	Bullied, Self-Labeller	Team leaders are very harsh on new staff. They pick on them! The general stress of the unit rises excessively.
0974	Bullied, Self-Labeller	Nursing has become a career in which you get little recognition for all of your efforts and life saving care. Unfortunately, each year that I nurse, I feel less satisfaction and gratification from the work I do.
0176	Bullied, Self-Labeller	In our particular department, we do not have a nurse manager who is our advocate as a nurse. She has been directed to be a "manager" and is away at meetings making decisions about her department when she rarely enters it to find out what is happening. I am at the end of my career and plan to retire in 2005. I still love my job and hope I do give my patients good care. Many internal issues make delivery of good care an ongoing challenge. Unfortunately, many nurses fail to support each other. The reasons are many: full vs. part-time, even age. Younger nurses do not acknowledge senior nurses' many years of experience.
0535	Bullied, Self-Labeller	Most of the RNs I work with on my unit feel the same as I do – overworked, tired, unappreciated by the administration and some patients. If I could afford to quit, I would. I'm tired of fighting to get more staff for a safer work place. I'm tired of lifting and lugging patients because there are no orderlies anymore. I wish quite often that I would have chosen another career path.

Bullied, Non-Labellers

ID#	Group	Response
0397	Bullied, Non-Labeller	The public puts too high of an expectation on the care they receive and expect us NOT to make mistakes and generally feel that their problems are worse than anyone else's. Especially in the emergency – the public can be very self-centred. They exhibit anger and frustration at lengthy wait times and vent on the nurses as though the wait time is the nurse's fault.
0313	Bullied, Non-Labeller	I may not get much feedback from the doctors and "charge nurses/managers" but daily, I get praised from my patients and that is why I stay...
0261	Bullied, Non-Labeller	Praise is not given by my supervisor but only by my peers. My supervisor/manager is more interested in making her budget and pleasing patients' families or other consultants than standing behind her staff. Where I am currently employed, the staff would be much more forgiving, flexible and happy if she (our manager) would show us some respect.
0209	Bullied, Non-Labeller	Over the years of working, I find that nurses don't help each other as much as they used to. They generally look after their patients (good!!!) but don't extend their assistance to other nurses who may be struggling with a heavy assignment. Years ago we pitched in to help. This can be stressful.
0984	Bullied, Non-Labeller	Families are more assertive and aggressive when speaking with nurses – no longer appreciate nurses' care or knowledge.
1178	Bullied, Non-Labeller	I work now with great doctors, tops in their field, using my skills in what I was trained for. I say I am lucky because I love my job, I use my skills, I get lots of positive feedback from coworkers, clients and occasionally physicians. I was at the right place at the right time – therefore my "lucky chance."
0658	Bullied, Non-Labeller	Nurses have very little say in the decisions that affect them. In comparison to other professions – social workers, physiotherapists, speech language pathologists, etc. – nurses are the lower class yet nurses are the professionals that are there 24/7 for the patient.

0287	Bullied, Non-Labeller	I have not worked as a bedside nurse for 7 years. Prior to beginning my current role (risk management), I was a clinical educator for 6.5 years. I experienced a great deal of stress in that role. Most often, it related to lack of timely information from my manager, lack of resources and support for the work I did. I was never sure whether my work was adequate.
1072	Bullied, Non-Labeller	For the past year and a half there have been changes in my workplace that have compounded the general complexity of nursing. More often than not I am emotionally, mentally and physically done. It seems the harder I try, the faster I work, the more I want to give the more I'm reminded it's not enough or not good enough.
1022	Bullied, Non-Labeller	Another struggle is the assembly line work load they (administration) seem to think we can do. A lot of our work is talking and teaching the family how to care and not be afraid of their premature infant but the work load now limits the time we have to provide that . . . I feel very frustrated that I'm having a hard time keeping up to standards I hold myself to and I do feel stressed more than ever before. I used to leave work every day knowing I helped some family and was appreciated by that family, now all too often I leave work thinking "only one more day and I'll have 2 days off." The satisfaction with my job is going fast!
0090	Bullied, Non-Labeller	I am retiring in Sept 2004. I am looking forward to this. I have loved being a nurse. I do feel it is an honorable and privileged profession. I am grateful to be in good health – physically and emotionally. However with the state of the art today I would not encourage my daughter to enter this profession. It is an angry profession and for that I am sad.
0404	Bullied, Non-Labeller	My work place was amazing until 3 years ago, when our manager retired and a new manager was hired. We are now told if we offer suggestions or ask questions "if you don't like it here – go elsewhere!" . . . I have four years until retirement and find it very upsetting that I will end all those nursing years with such negative feelings. Because of my present work situation, I will never encourage a young person looking at nursing as a career to pursue nursing. If you need time off for medical reasons (e.g., doctor's appointment or minor procedures) you are forced to take sick time because you cannot get annual leave or time owing - then you are harassed about your sick time. Every day there is someone upset – on the verge of tears. I am very grateful to have a busy productive life away from work – and most days can leave the negative things behind.

Non-Bullied, Non-Labellers

ID#	Group	Response
0097	Non-Bullied, Non-Labeller	I spoke up at a staff meeting recently to object about hearing about the unit's budge, especially due to illness and other staff experiences. I feel that those people who chronically abuse the illness time but are available at other times for overtime should be addressed individually, not the entire staff when many work their best possible and see few signs of appreciation. I felt that my charge nurse avoided me for some time afterwards.
1103	Non-Bullied, Non-Labeller	Most nurses enter the profession because they want to support and care for others. The culture in the hospital is however, very unhealthy. Nurses are expected to care for increasingly more complex health care problems with fewer staff. Despite their continuing education and abundant work experience, they are treated as inferiors rather than as an important part of the health care team by the physician groups. Many nurses (especially new grads) feel intimidated by physicians and so rather than asking questions freely, they're intimidated to even call the physician. More nurses would stay in the profession if they were staffed appropriately and acknowledged and consulted as the health care professionals they are.
1053	Non-Bullied, Non-Labeller	I am very privileged to work in an area that affords great job satisfaction... I also work with a group of women who are very committed to giving the best care to their clients and each other.
0169	Non-Bullied, Non-Labeller	In my years of nursing in Canada and in the UK, I have always found that it is the nursing colleagues that make the difference. If one feels that they are working with a group of nurses that support and help each other, anything is possible.
0743	Non-Bullied, Non-Labeller	My clinical load takes 100% of my time. I thoroughly enjoy working with the patients, their families and the nursing staff. My case load is heavy, leaving me with little time to attend educational sessions to further my knowledge, or to prepare educational sessions for staff. I do teach nursing staff a lot but all the preparation is done on my time. My husband is frustrated with my long hours. I am often fatigued when I arrive home. I am forever feeling the pressure (mostly put on myself) to do research and write protocols for nursing practice.

0997	Non-Bullied, Non-Labeller	I feel that on many occasions I cannot do enough for my patients due to lack of time. I work on a unit where staff give 110% and sometimes management does not recognize the effort of the staff... I am generally a calm natured, easy going nurse whom others often approach for advice but at times I am "brewing on the inside" with the frustration of my job – and due to staff shortages it's getting worse instead of better. Just how much father are the hospitals going to cut back? I plan to retire at 60 but I honestly don't think I'll make it.
0503	Non-Bullied, Non-Labeller	I am very concerned about the near future shortage of nurses. In the next18 months a large number of my colleagues (age 55 up) are going to retire due to bridge pensioning. New young nurses coming up the ranks do not have the same dedication or experience that we "older" nurses have. I am called almost daily on my days off to work overtime. We do not have enough specialty care nurses to fill all of our positions. There are a number of full-time nurses working 12-20 hours overtime / wk. Some are getting very tired and burnt out. In my son's recent graduating class from high school only one person was going into nursing. This really concerned me.
0384	Non-Bullied, Non-Labeller	Most nurses are women. Apart from being a nurse, they are usually also someone's wife and mother. When someone in the family is ill or has an appointment I truly believe that the mother/wife should be able to take a special leave day and not have to use a STAT or VAC day to look after these needs. Nurses book dentist, doctor, car, kid appointments on their day off or take the morning of a 3-11 shift. Government workers are entitled to 5 personal absence days / year for family matters.
0414	Non-Bullied, Non-Labeller	The health care system has switched to a business model in my time as a nurse. This type of model does not value human resource but rather money and the bottom line. Nurses are commodities and liabilities within this model – not valued professionals who are truly the backbone of tertiary care in Canada.

Non-Bullied, Self-Labellers

ID#	Group	Response
0160	Non-Bullied, Self-Labeller	The fact that people judge you by your age and colour. The younger and non black nurses are treated a lot better than us... It is extremely difficult for blacks to excel in this community as there are barriers that are structured to keep us from getting to the top of the ladder. It is extremely difficult for blacks to excel in this community as there are barriers that are structured to keep us from getting to the top of the ladder. It is sad but I still feel fortunate even though things are not what they ought to be.
0667	Non-Bullied, Self-Labeller	I feel that doctors can be very condescending and devalue RNs' work. Most of the RNs I work with are supportive and helpful with each other. How my day goes is very dependent on whether or not I am working with a "good" group.
0816	Non-Bullied, Self-Labeller	Unfair assignments... isolated due to being one of the few Caucasian nurses working amongst majority of African decent and Philippines. They only talked and helped each other and spoke in the nursing station, patient rooms, etc. in their native language. The nurse manager did nothing to solve this.
0874	Non-Bullied, Self-Labeller	I am very pleased with my work. I enjoy it very much. However, I feel I am not allowed to think and make decisions. I feel I am being babysat by my supervisors. Even when I was given a managerial position (temporary) it was impossible to make a simple decision without checking with the "higher beings." The doctors don't realize that nurses are educated beings.
0778	Non-Bullied, Self-Labeller	[Nurse discussing her transition to manager for a new health initiate project within the hospital]. ... since the project makes me a different category of employee I am now left out of the group and basically ignored... Most MDs are supportive but as usual it is always the one or two "bad apples" that make me miserable. Nurses are "jealous" of my freedom, street clothes, and hours and this has been difficult at times. RNS have shown very little interest in the project and their apathy is hard on me personally and professionally.

0115	Non-Bullied, Self-Labeller	As a front line worker it is emotionally draining to work in an unsafe, poorly staffed, stressful environment. The equipment is old and breaks down often. On several occasions there has not been enough monitors or staff to provide effective care. There is always enough money to fund more studies or conferences. The federal and provincial funding must improve and the O.H.A. must learn how to invest these funds correctly. CEOs do not need an increase. Management needs to be downsized and nursing increased. An investment in equipment and availability needs to be done. I feel this would improve my work environment.
0295	Non-Bullied, Self-Labeller	Nursing coordinator does not understand the day to day workings of the floor and though her stats look good on paper, patients and patient care changes from hour to hour on the unit. She does not give credit where it is due but continually finds fault with how things are done on the floor, offering suggestions that are clinically useless. The staff on the floor are wonderful, helping each other whenever possible, but it is becoming increasingly stressful to work in an atmosphere where you feel you are not appreciated for any good thing you do by management. I have no answer for how to fix this problem – do you?

VITA AUCTORIS

Jennifer W. Out was born on June 1st, 1972 in Windsor, Ontario, Canada. In June of 1991 she graduated from F.J. Brennan Catholic High School in Windsor, Ontario. Jennifer then pursued her post secondary education at the University of Windsor where she graduated with a Bachelor of Science degree in Biology in 1995 and a Bachelor of Arts (Honours) degree in Psychology in 1996. She then enrolled in the graduate program in adult clinical psychology at the University of Windsor where she obtained her Master of Arts degree in October of 1998. Jennifer has been enrolled in the doctoral program in adult clinical psychology at the University of Windsor since October of 1998. From September of 2003 to August of 2004, she completed a CPA accredited predoctoral clinical internship at Windsor Regional Hospital. Jennifer is presently employed as a psychologist with the Greater Essex County District School Board and is also a member of the Board of Directors for Family Service Windsor-Essex County.