THE DEVELOPMENT OF A TOOL TO MEASURE FEELINGS OF RESPECT IN NURSES

by

Carolyn A. Taylor
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Committee:

Dr. P. J. Maddox, Chair

Dr. Heibatollah Baghi, 1st Reader

Dr. Sandra Cheldelin, 2nd Reader

Dr. Anne M.Nicotera, 3rd Reader

Dr. Kathy C. Richards, Assistant Dean, Doctoral Division and Research Development

Dr. Thomas R. Prohaska, Dean, College of Health and Human Services

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By

Carolyn A. Taylor
Master of Business Administration
George Mason University, 1994
Master of Science
George Mason University, 1986
Bachelor of Science
George Mason University, 1978

Director: P. J. Maddox, Professor
College of Health and Human Services

Spring Semester 2014
George Mason University
Fairfax, VA

DEDICATION

This work is dedicated to Leslie H. Taylor, my husband, best friend, and the father of our three lovely daughters, Tresha, Traci, and Kelley, and the grandfather of our six grandchildren, Chrysta, Taylor, Kara, Ethan, Alexandra, and Elle. You have given me unconditional love, respect, caring, support, and "tough love" when I needed it throughout this journey and throughout our 47 years of marriage. You are my other self. I cannot imagine traveling this road without your love, friendship, companionship, support, and belief in me. I love you and feel extremely blessed to have you in my life.

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ABSTRACT

THE DEVELOPMENT OF A TOOL TO MEASURE FEELINGS OF RESPECT IN NURSES

Carolyn A. Taylor, Ph.D.

George Mason University, 2014

Dissertation Director: Dr. P. J. Maddox

Today's healthcare organizations are complex entities faced with numerous challenges where corporate climate, productivity, and quality are important management considerations. Increasingly the cost of healthcare, proliferation of technology, and human resources management dollars are among the endemic challenges in healthcare organizations. Additionally, the health and safety of a diverse workforce, and the challenges of recruitment and retention of qualified staff due to periodic shortages, continue to challenge the role of healthcare managers. In hospitals nurses are a large component of the workforce and the most costly. They often cite lack of respect as one of the reasons they are dissatisfied with their jobs and work environment. Although lack of respect (i.e., disrespect) is cited in numerous studies as a reason nurses leave the organization and is a factor affecting workplace environments, there is no common definition of respect and there are no tools to measure feelings of respect in nurses. The conceptual framework for this study was the Conceptual and Operational Definition of

Respect. Structurational Divergence (SD) was an additional framework used in this study.

This exploratory study used qualitative and quantitative methods to develop and test a survey instrument, the Taylor Feelings of Respect Scale (TFORS), to measure feelings of respect/disrespect among working nurses and to explore the TFORS' theoretical construct/framework. The study also sought to validate the Taylor concept of respect as defined by this study and to explore how respect/disrespect is perceived by nurses on the job utilizing the Taylor Respect/Disrespect Framework and Structurational Divergence. The psychometric properties of the Taylor Feelings of Respect Scale (TFORS) were also analyzed.

The item pool for the TFORS (a 59-item instrument) was designed using the literature, a qualitative preliminary study, a pilot study, and a focus group. The TFORS was administered to a convenience sample of 207 respondents. The data was analyzed to answer the primary research questions: What is the validated conceptual framework and operational definition of respect? What are the psychometric properties of the TFORS? What is the relationship between Structurational Divergence (SD) and nurses' feelings of respect? Exploratory factor analysis was used to demonstrate construct validity. The principal components analysis of the 59 items in TFORS extracted 5 domains, which explained 46.5% of the total variance. There were no criteria set for minimum and maximum factor loadings for this exploratory study.

The 5 domains that emerged were: Meaning of Respect, Personal Feelings of Respect, Interpersonal Feelings of Respect, Organizational Feelings of Respect, and

Cultural Feelings of Respect. The data validated the definition of respect. The findings obtained in the study were used to revise the TFORS instrument. There was no practically significant relationship between SD and the TFORS.

Implications for the future include testing the TFORS on larger and more diverse geographical samples to improve the instrument, as well as to test and identify whether or not there is a relationships between TFORS scores and the demographic data obtained. Implications for nursing practice, management, administration, and the financial impact of the Respect/Disrespect Framework could be tested. All of these areas of extended exploration could have a profound impact on healthcare organizations.

CHAPTER 1: THE PROBLEM

Today's healthcare organizations are complex entities and faced with numerous challenges where corporate climate, productivity, and quality are important management considerations. The complexity of assuring quality is an ongoing challenge for even the most experienced administrators, managers, and staff. Increasingly the cost of healthcare, proliferation of technology, and human resources management dollars are among the endemic challenges in healthcare organizations. Additionally, the health and safety of a diverse workforce and the challenges of the recruitment and retention of qualified staff due to periodic shortages continue to challenge the role of healthcare managers (DeLellis, 2000; Wilson, Squires, Widger, & Cranley, 2008). In hospitals nurses are a large component of the workforce and the most costly (Surakka, 2008). They often cite lack of respect as one of the reasons they are dissatisfied with their jobs and work environment (Hambleton, 2006; Stracboda, Normandin, O'Brien, Clary, & Krukow, 2003; Spence-Spence-Laschinger, 2004; Spence-Laschinger & Finegan, 2005; Stephen, 1994; Ulrich et al., 2006; Andrews, Manthrope, & Watson, 2005). The financial cost of disrespect as it may influence turnover, productivity, and a variety of organizational phenomenon is greater than 4.3 billion dollars per year (Hutton, 2006; Pearson & Porath, 2009; Spence-Laschinger, Leiter, Day, Gilin-Gore, & Mackinnon, 2012).

Disrespect appears to influence organizational uncertainty and factors associated with dysfunctional or poor work performance. If ignored by organizational leaders, workplace disrespect may create a spiral that can result in safety gaps and may contribute to the death of 1,000 people per year related to workplace violence (Hutton, 2006). Although respect/disrespect is cited in numerous studies as a reason nurses leave an organization and is a factor affecting workplace environments, there is no common definition of respect (Bell, 2006; Browne, 1993; Cortina & Magley, 2003; Kupperschmidt, 2008; Parse, 2010; Spence-Laschinger, 2004).

Among the factors that disrespect may influence is deliberate disregard for a person that can result in feeling devalued, lacking acknowledgement, dishonored, or being dismissed lightly or thoughtlessly (Browne, 1993; Spence-Laschinger, 2004). Disrespect has a profound effect on nurses and their workplace environment (Allan, Tschudin, & Horton, 2008; DeLellis, 2000; Judge & Bretz, 1992; Katsuhara, 2005; Khowaja, Merchant, & Harani, 2005), in addition to the financial cost of disrespect in the workplace. To illustrate the impact of disrespect the Agency for Healthcare Research and Quality (AHRQ, 2009) presented the following case in *Morbidity and Mortality Rounds*:

> An 89-year old man was admitted to the orthopedic service after sustaining a hip fracture. The patient's physician requested a cardiology evaluation. Surgery was delayed while the consultant evaluated the patient. The cardiologist identified a severe aortic stenosis (echocardiogram showed an aortic valve area of 0.9 cm^2) and recommended that the patient not go to surgery. On the late afternoon following the cardiologist's report, the orthopedic resident called the operating

room to schedule the patient for surgery later that evening. The nurse on the floor paged the orthopedic resident and read the cardiologist's conclusions and recommendations over the phone. The resident came to the floor, told the nurse she was "stupid" and confidently explained that the case would be done under spinal anesthesia, so the cardiologist's concerns were nothing to worry about.

Spinal anesthesia can cause unexpected and sudden hypotension resulting in hypo perfusion of the coronary arteries and sudden death. At 7:00 PM, the nurse called the hospital's Chief Medical Officer (CMO), who was getting ready to leave for the day. The CMO promptly paged the orthopedic resident, who was meeting with the attending orthopedic surgeon to review x-rays of the case. The CMO went to the x-ray department and talked with two residents and the attending. The CMO patiently explained the risk of perioperative death associated with hypotension in the presence of severe aortic stenosis. The attending then called the operating room to cancel the case. The following day the CMO reviewed the nurse's intervention with the Chief Nursing Officer (CNO).

Two days later, the patient suddenly arrested on the floor. Resuscitation efforts were unsuccessful. (p. 1)

This case is an example of the lack of respect for the nurse's assessment of the patient's status by the orthopedic resident and the consequences that could have transpired had the nurse failed to alert the Chief Medical Officer in this situation. If the orthopedic resident had proceeded, the patient's chances of surviving the surgery were poor. This example illustrates the complexity and interdependence of hospital working relationships and the

role that respect/disrespect may play in functional versus dysfunctional working relationships among team members; it also illustrates how disrespect contributes to or impedes healthcare quality and safety.

Paying attention to one another and taking each other seriously reflects respect in a social setting. When a person is ignored, neglected, disregarded, or dismissed nonchalantly or inconsiderately, this is perceived as disrespectful. Respect is also associated with advocacy; Negarandeh, Oskouie, Ahmadi, and Nikravesh (2008) discussed the importance of respect in a study related to patient advocacy. The researchers also contended that advocacy occurs when respect for human rights and dignity are shown.

A variety of healthcare organizations face periodic shortages of nurses, chiefly in long-term care organizations and hospitals where the majority of nurses are employed. Among the issues impacting the workforce shortage are the retirement of nurses and fewer individuals entering the profession (Jones, 2004; Spence-Laschinger et al., 2012). It is widely recognized that workplace satisfaction and safety are issues that affect the retention of qualified nurses. As such, respect is among the issues identified in numerous studies as a reason nurses cite for leaving the organization (Bell, 2006; Browne, 1993; Cortina & Magley, 2003; Kupperschmidt, 2008; Spence-Laschinger, 2004). Respect is also commonly cited in the literature as a factor affecting nurses' workplace environments (Browne, 1993; Spence-Laschinger, 2004) as it relates to nurse dissatisfaction and therefore to nurse turnover or retention and other nursing phenomena, and its specific contribution is not known.

Lambert, Hogan, and Barton (2001) found that the work environment is more important in shaping worker job satisfaction than demographic characteristics, and that job dissatisfaction is a highly salient antecedent of turnover intent. Workers prefer to build careers in organizations that have values-based cultures that recognize and value their contributions (Korner & Wesley, 2008). Additionally, numerous researchers have described the impact of negative work environments on dissatisfaction and have demonstrated that dissatisfaction is inversely related to nurse retention (Cortina, Magley, Hunter-Williams, & Langhout, 2001; Dellasega, 2009; Kleinman, 2004; Kupperschmidt, 2003; Parsons & Newcomb, 2007).

Many managers believe that where there are respectful relationships, trust may more readily be established (Kerfoot, 2000; Korner & Wesley, 2008). Spence-Spence-Laschinger's research found that a lack of respect is a common complaint of nurses, although empirical research in the literature available on this phenomenon is not found (2004). From this researcher's extensive review of the relevant literature on respect, it was determined that there are no instruments to measure nurses' perceptions about respect in the workplace and definitions of respect vary widely.

There are five definitions of respect that were considered for use in this study. Browne (1993) defined the term in her conceptual analysis of respect. Purnell (1999) defined the term related to multicultural aspects of respect. Spence-Laschinger (2004) and Parse (2006) also contributed to this definition of respect. According to Browne (1993), respect is a primary nursing ethic that serves as a basis for attitudinal, cognitive, and behavioral orientation toward the healthcare community. Respect is a part of, and an

antecedent to, caring, presence, confirmation, and civilized care (1993). According to Spence-Laschinger, respect is a moral principle that implies valuing another person's essential dignity and worth (2004). Paying attention to another and taking that person seriously reflect respect in a social setting. When a person is ignored, neglected, disregarded, or dismissed nonchalantly or inconsiderately, these are behaviors that are perceived as disrespectful (La King & McInerny, 2006).

Based on the definition of respect adapted for this study, a survey to elicit nurse perceptions of respect/disrepect in healthcare organizations was developed and piloted: the Taylor Feelings of Respect Scale (TFORS).

Statement of the Problem

Respect/disrespect is an important phenomenon that may influence healthcare cost, quality and safety, and working relations. The lack of a universally accepted theoretical basis for defining and measuring respect in the workplace as it is perceived by nurses in healthcare organizations is problematic to understanding its contribution to complex organizational phenomenon. This study sought to explore the working nurses' perceptions of respect and the impact of respect and disrespect on nurses' working relationships and other phenomena such as job satisfaction/dissatisfaction.

Need for the Study

Prior to this study there were no instruments available to measure respect in nurses, in part because of its subjective nature, and perhaps more fundamentally because the conceptual frameworks for respect in nursing are still evolving (Browne, 1993; Milton, 2005; Spence-Laschinger, 2004). There was a need for a valid and reliable way to

assess/evaluate respect in the nursing workforce to support healthcare management's amenable strategies and interventions to understand if not improve workplace conditions and working relationships influenced by respect/disrespect. The development of a framework was needed to explore the contribution of respect and disrespect on selected organizational phenomena. Lack of respect in the workplace, stress arising from poor interpersonal relations, and work overload all contribute to feelings of disrespect (Lewis, 2006; Manojlovich, 2005; Parse, 2010; Spence-Laschinger, 2004).

In this study the concept of respect was examined and a tool to measure nurses' feelings of respect was developed and tested. In addition, this study identified working nurses' feelings of respect and explored how respect may influence nurse satisfaction and working relationships. As such, the results of this study may be useful to nurse managers and other healthcare leaders in improving strategies to establish more functional and productive organizations.

Purpose

The purpose of this study was to develop and test a survey instrument, the Taylor Feelings of Respect Scale (TFORS), to measure feelings of respect/disrespect among working nurses and to explore the TFORS' theoretical construct/framework. The study also sought to validate Taylor's concept of respect as defined by this study and to explore how respect/disrespect is perceived by nurses on the job utilizing the Taylor Respect/Disrespect Framework and Structurational Divergence. The psychometric properties of the TFORS were also analyzed.

Research Questions

The purpose of this study was to develop an instrument to assess nurses' perceptions of and feelings about respect in the workplace. The following study questions were examined:

1. What is the validity of the conceptual framework and operational definition of respect?
2. What are the psychometric properties of the Taylor Feelings of Respect Scale (TFORS)?
3. What is the relationship between Structurational Divergence (SD) and nurses' feelings of respect?

The breakdown of the research questions and the research design are presented in Chapter 3.

Definition of Terms

Several terms were defined conceptually and operationally for use in this study; additionally, their contributions to the study framework (TFORS) were defined with conceptual and operational definitions and their TFORS application: respect, disrespect, feelings of respect, workplace incivility, favorable interaction effect, unfavorable interactive effect, enculturation of respect, organizational culture, and Structurational Divergence (SD). A table that summarizes these theoretical and operational definitions may be found in Appendix A.

Significance

Respectful behavior has been shown to influence one's self-regard positively, while disrespectful behavior may create negative impressions of an individual's self-regard (Miller, 2001). Disrespect is thought to contribute to a negative work environment and adversely affects retention and recruitment (La King & McInerney, 2006; Lambert, Hogan, & Ringl, 2008; Smith, Waldman, Hood, & Smith, 2005). In the face of nursing and allied health personnel shortages, it is incumbent on healthcare organizations to acknowledge and deal with the issue of respect and other phenomena that influence working relationships and quality of care.

Workplace disrespect may contribute to healthcare performance problems that result in the death of 1,000 people per year (Hutton, 2006). Nurses want to feel empowered, valued, and respected (Faulkner & Laschinger, 2008), and researchers have shown that professional respect is considered more important in recruitment and retention than financial incentives (2008). Nurse perceptions of respect were also negatively related to mental health outcomes such as exhaustion and depression (Ramarajan, Barsade, & Burack, 2007; Spence-Laschinger, 2004). An improved understanding of respect/disrespect and its relationship to organizational phenomena may inform healthcare mangers' decisions.

More than two-thirds of Americans describe disrespectful behavior in their workplaces (Cortina & Magley, 2003). Disrespectful behavior, if unchecked, may escalate and lead to violence. The financial cost of workplace incivility exceeds 4.3 billion dollars a year (Hutton, 2006; Pearson & Porath, 2009). To reduce dysfunctional

behavior in healthcare organizations, all interactions between parties at all levels must be based on respect (DeLellis, 2000, 2006). As stated earlier, no empirical studies of nurses' perceptions of respect have been found, nor have any tools specifically related to nurses' feelings of respect in healthcare organizations. From a management strategy, this study provides a more robust framework and survey tool for use in healthcare organizational research and may contribute a valid and reliable methodology for future studies. The above-mentioned researchers included an aspect of respect by definition and/or by frame of reference with other constructs, but did not assess or report the measurement of respect as a distinct construct. The assertions of respect are referenced but not supported by research findings nor by other developments. This study could have powerful implications for healthcare, administration, and human resource policy.

Summary

In Chapter 1, a description of the problem, need for the study, purpose, conceptual framework, research questions, definition of terms, and significance were presented. In Chapter 2, the literature related to the concept of respect, terms used interchangeably with respect, respect in other research, job satisfaction, tool development, and the concept Structurational Divergence as a phenomenon that may be related to the impact of respect or disrespect in organizations will be reviewed. In Chapter 3, the steps utilized to develop the TFORS, and the study's population and sample, instrumentation, pilot study results, data collection procedures, ethical considerations, and data analysis are described. In Chapter 4, study findings and interpretation of the results of the study are presented. In

Chapter 5, the discussion of finding, implications, limitations, delimitations, and suggestions for future research are discussed.

The importance of being respected is an issue that has been described by numerous researchers, particularly as related to healthcare; when respect is not afforded, job dissatisfaction is a natural consequence. For nurses, a healthy work environment is one in which there is low turnover intention and where job satisfaction contributes to improved patient safety (Armstrong, Laschinger, & Wong, 2009). The development of the TFORS provided the basis to validate the conceptual framework and offers empirical evidence related to the constructs that comprise respect/disrespect as it is perceived in healthcare organizations. Finally, it is hoped that information on respect and related constructs may help health administrators understand how nurses may deal with or confront disrespectful behaviors and their impact in the healthcare setting (Kupperschmidt, 2008). Common complaints among staff nurses in hospitals include not being given the respect they deserve for their contributions to patient care and organizational goals (Parsons & Newcomb, 2007; Schat & Kelloway, 2003; Siu, Spence-Laschinger, & Finegan, 2008; Spence-Laschinger, 2004). Disrespect in healthcare may result in financial loss and adversely affect the health of employees (Hutton & Gates, 2008). Hutton (2006) asserted that if the financial cost of an initial incident such as disrespect could be alleviated, the resultant decrease in cost to the healthcare organization would be enormous.

CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews the literature and conceptual framework that contributed significantly to the approach for this study. Five computerized databases were used for the literature review of this study: Cumulative Index Nursing and Allied Health Literature (CINAHL), MEDLINE, Ovid Healthstar, ProQuest, and Science Direct. Articles from 1970 to 2012 were reviewed; the search terms used were: respect, disrespect, civility, incivility, nurses, organizational culture, Structurational Divergence, job satisfaction/dissatisfaction, job retention/turnover, and tool development. A comprehensive review of the literature was completed; older but seminal articles were used to track research efforts that informed a complete understanding of the concept of respect among nurses by different theorists using a variety of research methods.

Conceptual Underpinnings for the Study

Concepts are abstract terms derived from particular attributes and may be used to denote a label or class of phenomena, which could be things, events, experiences, ideas, and other forms of reality (Kim, 1983). Concepts have specific meanings and semantic value. Concepts may be readily observable or concrete (a rash or lesion), indirectly observable or inferential (pain, temperature), or abstract (respect, love) (1983). After a concept is identified and developed, it can be utilized to further explain and develop its use in real-life situations. Conceptual frameworks are defined as structures that relate

concepts in a meaningful way (1983). A conceptual framework is a theoretical framework related to the topic and purpose being discussed. Theoretical frameworks guide the construction of research problems or questions. The concept of respect guided the development of the research framework for this study. Additionally, Structurational Divergence (SD) was also a construct used in this study.

Respect

The conceptual framework for this study was based on the definitions of respect originally postulated by Browne (1993), Parse (2006), Purnell (1999), and Spence-Laschinger (2004), which will be discussed in detail later in this chapter. The definitions were adapted by the researcher to create the definition of respect that was used to develop the framework for this study. The conceptual definition of respect as utilized in this study, as defined by the researcher and hereafter known as the Taylor definition of respect, is the manifestation of a mental process which leads to a conclusion of self-worth or value. It is a fundamental human concept which is a conditional and complex expression of moral value. It is derived from the Latin word *respicere*, which means the art of looking back. It is foundational in its meaning to receivers and givers of respect and is closely aligned with the values of human dignity, and deference for persons, caring, honor, trust, worthiness, deference, courtesy, and kindness. The outward expression of respect is civility. As it is experienced in everyday encounters, respect is either present or not. Antecedents of perceived respect are beliefs about justice, civility, acknowledgement and esteem; it can be applied to persons, objects or animals.

Respect for an individual can be for one's title, position, or profession. In this case, respect may be provided even if the person giving the respect dislikes the receiver of the respect. Likability is not a condition for perceived respect. Respect (disrespect) may come from an individual whether they or liked or disliked. The meaning of respect is differentiated by and sensitive to cultural norms, and values. Respect of individuals is a basic human need, that when present may result in reduction of stress and despondency, improvement of team work, creation of satisfactory work environments, improvement of productivity, and work satisfaction. Lack of respect may result in an increase in stress, may incite violence, foster depression, sadness, and unhealthy work environments. Respect is sensitive to cultural norms and values, it may reduce stress and despondency, improve teamwork, work satisfaction, and productivity. The outward expression of respect is civility. Expressed disrespect may result in increased stress, may incite violence, foster depression, sadness and unhealthy work environments.

As such, respect is an important contribution of perceived culture in an organization. As explained in the preceding definition, lack of respect may contribute adversely to the organizational context, or a person with a high level of perceived respect may enhance the determinants of corporate culture. Among the studies reviewed, the Taylor definition of respect offers a clarified definition that is validated in this study.

Because the antecedent influence of respect/disrespect in organizations is important to the values and beliefs of these organizations, the literature on organizational culture was reviewed.

Organizational Culture

According to Schein, culture is defined as a

> (a) pattern of basic assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked well enough to be considered valid and, therefore (e) is to taught to new members as the (f) correct way to perceive, think, and feel in relation to those problems. (1990, p. 111)

Organizational culture is an inherent component in the workplace, whether effective or ineffective. It consists of deep underlying assumptions, beliefs, and values that are shared by members of the organizations and typically operates unconsciously (Casida, 2008). Having an understanding of culture may provide a better grasp of how respect or disrespect is inherent in the organization. The culture of the organization is composed of the values, norms, and mores that drive the organizational mission and vision (Erien, 1998). Numerous studies identify organizational culture as being important to nurse satisfaction/dissatisfaction (Kovner, Greene, Brewer, & Fairchild, 2009; Shirey, 2006; Stracbota, Normandin, O'Brien, Clary, & Krukow, 2003).

The purpose of this study was to define the concept "feelings of respect" in nursing and to understand how respect/disrespect is perceived and impacts nurses on the job—that is, within their organizational culture. As noted in the previous section, the term respect is pervasive in biomedical and ethics literature, and across healthcare disciplines (Milton, 2005). The American Nurses Association (ANA) *Code of Ethics for Nurses With Interpretive Statements* (2001) included a statement that nurses should, "practice with

compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social and economic status, personal attributes, or the nature of health problems" (p. 7). Nurse administrators have been called to "contribute to an environment of mutual respect and understanding" (p. 7).

Many researchers have demonstrated that nurses want to work in settings in which they are able to develop supportive and respectful relationships with other nurses, physicians, and the entire healthcare team (DeCicco, Spence-Laschinger, & Kerr, 2006; Faulkner & Spence-Laschinger, 2008; McNeese-Smith & Cook, 2005). Respect is important in the workplace, in part because it contributes to efforts such as retention and the reduction of interpersonal conflict (Bell, 2006; Ellemers, Doosje, & Spears, 2004; Donohue, 2007; McGuire, Houser, Jarrar, Moy, & Wall, 2003; Parsons & Stonestreet, 2003; Pendry & Beck, 2004).

Organizational Phenomena

A variety of organizational phenomena were reviewed for purposes of understanding the anticipated confluence of the Respect/Disrespect Framework in healthcare organizations. Among them were: satisfaction, stress, cohesion, and Structurational Divergence (SD) and the condition of work.

Shader, Broome, Broome, West, and Nash (2001) examined the relationship between work satisfaction, stress, age, cohesion, work schedule, and anticipated turnover in an academic medical center. The researchers used a cross-sectional survey design in which nurses from 12 units in a 908-bed university hospital in the southeastern United States completed a questionnaire to measure nurses' perceptions of job stress, work

satisfaction, group cohesion, and anticipated turnover. Shader et al. concluded that when job stress was high, group cohesion was low, and when work satisfaction was low, expected work turnover was higher. These factors were each independent predictors of turnover versus independent variables related only as a group. High work satisfaction and high group cohesion each were significantly related to low turnover. Job stress was significantly inversely related to the lower group cohesion ($r = -0.41$, $p < 0.001$), and lower work satisfaction ($r = 0.51$, $p < 0.001$). Job stress was significantly correlated with anticipated turnover ($r = 0.37$, $p < 0.001$). Increased work satisfaction predicted higher group cohesion ($r = 0.42$, $p < 0.001$) and lowered anticipated turnover ($r = -0.47$, $p < 0.001$). The more stable the nurses' individual schedule, the less work-related stress ($r = -0.205$, $p < 0.001$), the lower the anticipated turnover ($r = -0.29$, $p < 0.001$), the higher the group cohesion ($r = -0.43$, $p < 0.001$), and the higher work satisfaction ($r = .44$, $p < 0.001$). The researchers concluded that consideration of the factors that influenced turnover is essential to creating a work environment that retains nurses, and that nurse leaders need to be engaged in innovative solutions for their units.

Flexible scheduling and transformational leadership approaches to manage today's workforce could result in positive changes based on the findings of this research. Transformational leadership is the ability to create supportive environments of shared responsibility that lead to new ways of gaining knowledge (Ward, 2002). The results of Shader et al.'s (2001) study have been applied in the American Organization of Nurse Executives (AONE) Transforming Care at the Bedside (TCAB) program. TCAB is an innovative national program initiative instituted by the Robert Wood Johnson Foundation

(RWJF) and the Institute for Healthcare Improvement (IHI) to redesign the work environment on medical-surgical units to engage leaders at levels of the organization to improve the quality and safety of patient care on these units (O'Neil, Morijikian, Cherner, Hirshkorn, & West, 2008). Additionally, the goal of the program included increasing retention and improving the vitality of nurses, and to engage and improve patients and family members' experience of care. One unique feature of the program is to engage and empower frontline staff (O'Neil et al., 2008).

Cowin (2002), an Australian researcher, studied the relationship between nurses' job satisfaction and retention. The researcher used a multigroup longitudinal design to elicit nurses' job satisfaction and retention plans. There were two groups in the sample, differentiated by their nursing experience. Job satisfaction and retention were measured at two points in time 8 months apart with the same group of participants. The sample participants in Group I were in the last semester of the Bachelor of Nursing program and drawn from six universities in the Sidney region. Group II participants were randomly selected from the New South Wales (NSW) Nurses Registration Board database. From the initial participant pool of 506 for Group I, 110 nurses were selected to participate in the second phase of the study. Similarly, of the participant pool of 528 for Group II, a total of 332 nurses were selected for the second phase. Professional status (student vs. practicing) was a significant predictor of retention. Cowin also concluded that job satisfaction remained relatively stable over time for experienced nurses (Groups I and II: 528 and 332, 100%). For new graduates (n = 506/110) the issue of pay became a significant area of dissatisfaction in the transition from student to registered nurse. Cowin

concluded that professional status, autonomy, and remuneration were issues of great concern for nurses, and were especially relevant for the retention of the newly registered nurse (2002). The researcher added a qualitative component to the second round of the survey (at the request of the participants) to allow participants to express their opinions on any issues related to the nursing profession. Absent from the first round of the survey, the qualitative findings added a richness that would have been beneficial for the entire study. Generalizability of the quantitative data may be limited since this study included experienced and newly graduated nurses in New South Wales, Australia.

Researchers in South Carolina (SC) examined factors affecting the job satisfaction of registered nurses (Ma, Samuels, & Alexander, 2003). Using secondary data they conducted a cross-sectional study designed to identify the individual work and geographic factors that influenced nurses' work and job satisfaction across the state. The data came from three sources: a statewide SC Nursing survey, the year 2000 RN relicensure application forms, and an SC Health Alliance (SCHA) internal data file. The study included licensed nurses in the state of South Carolina who worked in public and private settings but excluded nurses employed by the military, federal government, and the Veterans Administration. The SC nursing survey was designed by the Tripp Umbach Synergies research team in cooperation with SCHA and the SC Organizations of Nurse Executives (SCONE) (Ma et al., 2003). In October 2000, a 27-question survey was sent to 17,500 RNs in South Carolina; surveys from the 3,772 respondents were completed anonymously. One-way and multivariate statistics were used to determine which variables contributed significantly to job satisfaction. Two-thirds of the respondents'

satisfaction remained the same or had lessened over the preceding 2 years. Statistically significant differences were revealed between job satisfaction and years of service, job position, hospital retirement, and geographic area. The correlation coefficient (r^2) for age and job satisfaction was 0.00178 (p =.9186); for years of service and job satisfaction the correlation coefficient was -.02946 (p = .0929). A weakness of this study was a lack of racial diversity in the sample. Expanding the study sample geographically and to include licensed practical nurses and nurses' aides would increase the generalizability of the study findings.

Hutton (2006) reviewed the literature related to civility, defined as a violation of workplace norms for mutual respect, and found that the research on workplace civility raised significant concerns. First, there were no longitudinal studies on civility in the workplace. Second, few authors used the definition of incivility created by Andersson and Pearson (1999). The variation in the definitions of civility created difficulty when researchers looked for similarities between study findings (Hutton, 2006). Hutton also asserted that workers blame managers if the managers fail to intervene. The collateral damage of workplace incivility or disrespect may create a toxic work environment with significant psychological and monetary costs to the organization (2006).

As noted earlier, researchers have demonstrated that nurses want to work in settings where they are able to develop supportive and respectful relationships with other nurses, physicians, and healthcare teams (DeCicco et al., 2006; Faulkner & Spence-Laschinger, 2008; McGuire et al., 2003). Factors that contribute to work satisfaction include stress and cohesion (Shader et al., 2001). Many of these factors are related to

respect, but no researcher measured respect directly. Respect is critical in the workplace because it contributes to efforts such as retention and the reduction of conflict (Bell, 2006). Respect is an ill-defined concept; understanding what is known about the concept is the foundation to measure it.

Structurational Divergence

Nicotera, Clinkscales, and Walter (2003) and Nicotera and Clinkscales (2010) developed a theoretical framework called Structurational Divergence (SD). The assertion of the SD framework is that in an organization there are values, mores, and traditions that exist within the culture that are entrenched in that organization. SD is identified as a phenomenon where members of an organization are at a point where communication difficulties are created resulting from the interpenetration of incompatible social structures (Nicotera et al., 2003; Nicotera, Mahon, & Zhao, 2010). These interpenetrating structures create an SD-nexus; the individual caught in the nexus experiences the SD-cycle. The communication difficulties force interpersonal exchanges that result in a downward spiral of negative communication that immobilizes the individual (Nicotera et al., 2010). This ultimately creates unresolved conflicts and erodes the organization and individual development (Nicotera et al., 2003; Nicotera et al., 2010). The Respect/Disrespect model has been used to demonstrate the enculturation of respect and disrespect in the organizational culture of healthcare organizations. The Respect/Disrespect model shows an increase or decrease in positive or negative communication related to the enculturation of respect or disrespect into the organizational culture which may result in positive or negative outcomes for the organization. For

purposes of this study, SD was explored as a possible contributing factor to understanding the impact of respect/disrespect on organizational phenomena. The SD framework has been used to assess and resolve organizational conflict in healthcare settings among nurses (Nicotera et al., 2003, Mahon & Nicotera, 2011).

Constructs of Respect

Respect as a noun had its origins in Middle English from the Latin *respectus*, meaning the art of looking back, from *respicere*, to look back ("Respect," 2008a). Respect is defined as "the giving of particular attention, high or special regards, and expressions of deference" (2008a). As a verb, "to respect is to consider another worthy of esteem, to refrain from obtruding or interfering, to be concerned, and to show respect" (2008a). Respect has numerous meanings including conditions of being honored, esteemed, or well-regarded. In *Oxford American Writer's Thesaurus* ("Respect," 2008b), synonyms of respect include deference, recognition, and appreciation. Respect is distinguished from these because use of these synonyms may create the perception that respect is related to an ethical principle (Browne, 1993; Darwall, 1977), and deference, esteem, and admiration are unrelated to ethics or morality (1993). Respect is also viewed as the courteous expression by either deed of esteem, or regard ("Respect," 2008b). Definitions of respect and how it is manifested vary between people, often depending on age and culture (Browne, 1997). Different cultures demonstrate respect in different ways. Browne (1993) wrote, "facial expressions, body posture, tone of voice, language, and use of names must be conveyed with consideration to the patient's cultural orientation in

order for respect to be related in a culturally sensitive manner" (p. 214). Respect, then, is conveyed as being within a cultural context, not just with words.

Seminal Scholars of Respect in Nursing

In one of the earliest writings on respect in nursing, Gaut (1983) described respect; however, she did not explore respect as an independent concept. As the purpose of Gaut's article was to develop a theoretically adequate description of caring, Gaut examined respect as it related to caring in the context of the ethical principle "respect for persons." She considered respect a fundamental attitude necessary for caring relationships and also believed that respect may lead to attachment or affection. Gaut described the reasons respect for self and for others are necessary conditions for rational actions, especially caring. Additionally, the author believed that "respect for persons" entails an essential attitude in the person administering the caring actions. Further, respect for other people begins with respect for one's self (1983). That caring as a dimension of respect may lead to attachment and affection is relevant in professional nursing roles because the notion of respect is integral to understand caring.

During this same period, Silva (1983) undertook an analysis of the American Nurses Association position statement on *Nursing and Social Policy: Philosophical and Ethical Dimensions*. Respect is the first ethical injunction in the American Nurses Association (1978) code for nurses: "the nurse in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by conditions of social or economic status, personal attributes, of nature of health problems" (p. 6). Silva asserted, "that respect for persons suggests that

nurses recognize human beings' self-determining quality and allow them to act on their decisions even if we disagree with them" (p. 149). Silva cited Beauchamp and Childress's 1979 work as the originator of the principle of respect for autonomy. Beauchamp and Childress wrote about the principle as it is applied to clinical ethics; their 1979 work was grounded in many years of ethical writings and based directly on the *Belmont Report* (M. Mahon, personal communication, George Mason University, 2010).

In 1984, American Association of Colleges of Nursing (AACN) received a grant from the Pew Memorial Trust to define education necessary for professional nursing. This was the first comprehensive national effort to define essential knowledge, practice, and values that the baccalaureate nurse should possess (1986). Panelists addressed the value of respect for human dignity in a model for differentiated practice in baccalaureate education. Differentiation is the process of dividing a single clearly defined unit into units that differ both in structure and function to enhance the wider system (1986). One of the seven values addressed was respectfulness. These behaviors were cited as indicators of respectfulness: "safeguards the individual's right to privacy, addresses individuals as they prefer to be called, maintains confidentiality of patients/clients and staff, and treats others with respect regardless of background" (AACN, 1986, p. 20). While several of these dimensions are mechanistic, task-oriented manifestations of respect, the last dimension captures the value of respect in human interaction.

Three of Annette Browne's studies have influenced the development of an empirically validated construct of respect. The goal of her first study (1993) was an analysis of the concept of respect. To clarify the concept and to consider its significance

in nursing practice, she reviewed relevant literature and developed the following definition:

> Respect is a basic moral principle and human right that is accountable to the values of human dignity, worthiness, uniqueness of persons and self-determination. As a guiding principle for actions toward others, respect is conveyed through the unconditional acceptance, recognition, and acknowledgement of the above values in all persons. As a primary ethic of nursing, respect is the basis for all our attitudinal, cognitive and behavioral orientation toward all persons. (p. 213)

Browne further explored the concept of respect in a second study, an ethnographic study of five Cree-Ojibway informants. Her goal was to explore the meaning of respect from the perspective of the Cree informants during clinical interactions (1995). Four women and one man, ages 27 to 51, were interviewed over a 2-week period. All were fluent in English, although their first language was the Cree dialect (1995). Research questions addressed in this study were: What is the meaning of respect for Cree-Ojibway clients? In what ways are respectful interactions described? In what ways are interactions that lacked respect described? What, if any, are the implications of respect or lack of respect for clients?

Prior to Browne's 1995 study, respect was analyzed as a concept in the domain of nursing action (Browne, 1993). The four domains developed by Kim are: The Domain of Client, The Client–Nurse Domain, The Practice Domain of Nursing, and The Domain of Environment (1983, 2000). Within the Practice Domain of nursing is the Domain of

Nursing Action (1983, 2000). The richness of the responses from the respondents in Browne's 1995 study revealed feelings of respect and/or lack of respect that affect the way culturally sensitive care is provided to patients. This is a universal issue and has implications for nursing related to caring for minority patients.

Browne's third study (1997) represented the fieldwork phase of a larger study to develop the concept of respect using a Hybrid Model of Concept Development. The design of the study was also ethnographic, and the informants were interviewed during two phases over a 6-week period. A distinct feature of the Hybrid Model is the capacity to interface clinically based on empirical data with theoretical perspectives gained from the literature. This approach to concept analysis is reflected in the model's three phases (1997). The theoretical phase includes an extensive review of the literature, the fieldwork phase generated clinically based empirical data describing the concept, and the final analytical phase synthesized theoretical and empirical findings to validate and finalize the concept's definition and key indicators (1997). Browne relied on her two earlier articles (1993, 1995) to construct an overview of a concepts analysis of respect.

The focus of the fieldwork phase was on obtaining descriptions of a single concept rather than one more complex description of multiple concepts. The 12-week period of data collection met the recommended minimum time required for the Hybrid Model (Browne, 1997). The author concluded that respect has tangible components that patients can identify in the behaviors of nurses and other healthcare providers (1997). The researcher further clarified the concept of respect related to patient interactions with nurses and physicians and patients' perceptions (feelings) of respect or lack of respect.

These clinically based descriptions helped to operationalize respect (an abstract concept) into identifiable patterns of behaviors, actions, and attitudes. Additionally, findings from this study provided support for respect as a central relevant concept for nursing. Although the central tenets of respect had been described in the literature, data from the fieldwork phases provided actual examples of respect in the context of everyday clinical interactions (Browne, 1997).

Browne (1997) described preliminary indicators of respect from the theoretical phase of the model (which included a review of the literature):

1. Nonverbal messages conveyed to patients through eye contact, facial expression posture, and position relative to the patient.
2. Verbal messages directed to patients including tone of voice, use of the patient's real name, expressions of honesty and acceptance, and conveyance of a genuine interest in the patient as a person.
3. Nursing actions aimed at protecting patients' sense of privacy and modesty, allowing patient to make choices concerning their care, and explaining procedures fully before carrying them out. (p. 765)

Generalizations drawn from the theoretical phase and both sets of empirical data formed the basis for the revisions of the three preliminary indicators of respect (1997).

Browne believed that the hybrid model was well supported for her study because this method was able to be recognized by the patients, coworkers, and others in the healthcare practice setting. Further perceptions of these individuals (patients, coworkers) of these nurses' behaviors formed the perception of the presence of respect/disrespect.

This study relied a great deal on insights generated from clinical practice (Browne, 1997). Based on empirical findings in the above study, Brown modified her 1993 definition to include status equality among persons and a reference to the demonstrable qualities of respect:

> Respect is a basic moral principle and human right that is accountable to the values of status equality among persons, human dignity, inherent worthiness, and self-determination. As a guiding principle for action toward others, respect is conveyed through the recognition and acknowledgement of the above values in all persons. As a primary ethic of nursing, respect forms the basis of our attitudinal, cognitive, and behavioral orientation toward all persons, and is most obviously demonstrated in the manner with which the one person treats another other during direct interactions. (p. 777)

Browne's work is the most comprehensive and noteworthy work in nursing on respect; however, her modified definition still does not define respect. Respect cannot be accountable to a value, only humans can. Browne provides an excellent description of respect and how it is actualized in patient experiences. The final modification on demonstrable qualities provides evidence of the validity and reliability of the construct of respect in nursing practice.

Purnell (1999) undertook a study to describe and compare the health promotion and wellness practices of Panamanians and Panamanian-Americans, and the amount of respect they believed was given them by healthcare providers. The population consisted of a convenience sample of 70 subjects, 50 in the Republic of Panama and 20 from the

Delaware, Maryland, and Virginia (Del-Mar-VA) Peninsula in the United States (Purnell, 1999). The researcher selected primary and secondary characteristics of culture and selected domains from the Purnell Model of Cultural Competency as guides for questionnaire development, data analysis, and discussion of findings. The perceived meaning of respect based on the responses from the informants was included and provided rich data for improving the health of this population group. Purnell (1999) operationalized respect by developing guidelines for demonstrating respect to Panamanian clients:

1. Watch tone of voice so that it is not perceived as loud, snappy, or rude.
2. Maintain eye contact when communicating with clients.
3. Explain procedures at every opportunity.
4. Ask permission and explain the necessity for touching body parts during and examination.
5. Maintain presence when talking with or giving direct care to clients; check facial expression and remain connected.
6. Give full explanation regarding prescriptions and treatments, and explain why a procedure may be altered or a disability slip not be given.
7. Greet the client with a handshake and call him or her by name and title.
8. Maintain a professional demeanor while being friendly and personal. (p. 338)

The researcher used a 44-item open-ended questionnaire collected over a 9-month period in 1997. The results included informative comments about what the respondents perceived as respectful and disrespectful behaviors from healthcare providers. In some

cases the participants knew they had interacted with physicians, however, when interacting with nonphysician providers, respondents were often unaware if they had interacted with a nurse or an unlicensed nursing assistant. This study is the first that specifically identified Panamanian health beliefs and the meaning of respect given them by healthcare providers (Purnell, 1999). Generalizability of findings from this study is limited related to the lack of diversity of the sample and the sample characteristics and size. Additionally, key informants were known to some participants and that may have biased some of the reported data.

Spence-Laschinger (2004) surveyed a random sample of 285 nurses from Ontario, Canada teaching hospitals to test an exploratory model of antecedents and consequences of nurses' perceptions of respect in hospital settings. Respondents described that lack of recognition, stress arising from poor interpersonal relations, and work overload contributed to feelings related to respect. More than half of the respondents (150) reported that they believed their managers did not show concern, or relate to them in a sensitive and truthful manner, regarding decisions related to the respondents' jobs. The strongest predictors of perceptions of respect were interactional organizational justice (r = .72), followed by structural empowerment (r = .471), and job stress resulting from lack of recognition, poor interpersonal relationships, and heavy workloads. Respect was significantly correlated with greater job satisfaction (r^2 = .42), trust in management (r = .42), and reduced emotional exhaustion (r = -.35), as well as higher nurse ratings of quality of patient care and perceived staffing adequacy on their units (r = .30) (2004).

When nurses are treated with dignity and respect, they are more likely to work harder and participate in extra-role activities (Spence-Laschinger, 2004). Organizational effectiveness is affected throughout the organization when these conditions exist (2004). This study may have been the first in which empirical data related to nurses' perceptions of respect were reported (2004). The author concluded that a positive work environment increases nurses' perception of respect; this is beneficial for both the organization and the nurse. The findings of this study were not generalizable due to the cross-sectional exploratory characteristics of the design. Subjects were randomly selected; however, only the respondents who completed all the items in the questionnaire were used in the analysis.

Spence-Laschinger and Finegan (2005) evaluated the effects of employee empowerment on perceptions of organizational justice, respect, and trust in management. They hypothesized that job satisfaction and organizational commitment ultimately benefit from efforts to improve employee perceptions of empowerment. The purpose of the study was to test a model linking nurses' empowerment to organizational justice, respect, and trust in management, as well as job satisfaction and organizational commitment. They surveyed 273 medical surgical and critical care nurses. Rosabeth Moss Kanter's theoretical framework of organizational empowerment was the model used for this research study (Spence-Laschinger, 2004). Respect was measured by the Siegrist Esteem Scale, which contains three items designed to measure nurses' perceptions of respect they receive from managers and peers (Spence-Laschinger & Finegan, 2005). The authors concluded that structural empowerment had a cascading effect on interactional justice,

respect, and organizational trust (2005). The authors suggested that creating conditions that empower nurses to practice according to professional standards and promote positive working relationships that include trust and respect can increase the retention of nurses in healthcare organizations.

Rosemarie Rizzo Parse is a nurse theorist and researcher who developed the Human Becoming Mode of Inquiry and the Parse method of research. As with Annette Browne, Rosemarie Rizzo Parse has done much work on the topic of respect. The studies below utilized her method of research related to understanding the continuum from respected to not respected in nursing practice settings.

The human becoming theory encompasses three modes of inquiry (Parse, 1992): one method is applied and two are basic methods of research. The basic methods, the Parse method and the human becoming method, are the methods of choice when the researcher plans to expand knowledge of humanly lived experiences (Parse, 2005). The applied research method (qualitative, descriptive method) is the method used when the researcher wishes to discover what happens when human becoming is the theoretical guide for practice with individuals and groups in a variety of settings (Parse, 2005). Art in research using the Parse method was the basis for Malinski, Mitchell, and Halifax's research (2005). The project involved researchers, artists, and research participants to explore eight universal lived experiences important to persons in the community with the Parse method. The intent was to use art that complements story and text to enhance understanding of this method of research (Malinski et al., 2005).

The authors presented the first attempt of including an embedded artist with Parse methods involving one participant who spoke about her experiences of feeling respected-not respected. According to Malinski et al. (2005), researchers and educators are using the arts to inform and improve knowledge development, translation of research findings, and teaching learning. Human becoming scholars are merging patterns of art-science that enhance understanding about life and universal lived experience. The Parse method has been used by researchers around the world in order to study universal lived experiences such as feeling loved (Bauman, 2000), feeling very tired (Bauman, 2003; Huch & Bournes, 2003; Parse, 2003), having courage (Bournes, 2002), waiting (Bournes & Mitchell, 2002), feeling cared for (Bunkers, 2004), being listened to (Jonas-Simpson, 2003), and hope (Parse, 1990). Again, Parse's method offers researchers the opportunity to integrate art into the research process. In Malinski et al.'s (2005) first project, the artist was present as the participant and researcher completed a dialogical engagement a0out feeling respected on videotape. The engagement lasted approximately 90 minutes. The participant was a student volunteer interested in learning about the research process. She gave written consent for the researcher to videotape the dialogical engagement and to complete the extraction synthesis process, for the artist to create art works based on her description, and for the findings and art to be disseminated in presentations and publications (Malinski et al., 2005). The process of embedding the artist in the project showed how art works to enhance understanding of universal experiences in a complementary way with Parse method research findings. Both the researcher and artist worked separately and identified core ideas that stood out in the story of feeling

respected-not respected. An excerpt from the participant story provides a vivid picture of her perception of feeling respected-not respected:

> Eva said that feeling respected-not respected is a "mutual kind of thing that happens in so many ways" with different people, some close others distant. She believes that feeling respected-not respected is always present; it has to do with values and standards and when you step outside the boundaries, something is wrong." "It has to do with feeling understood or misunderstood." Feeling respected-not respected surfaces when things flow and do not flow with positive and negative energy and when disrespect and displacements contrast time of carrying on with a wonderful feeling; like people are on the same page as you, going places, willing to help, they value you like a person, you are contributing, and you don't have to worry, there is no stress or static, which may come up with disrespect, which is upsetting. Feelings of relief and elation counter times of hurt, frustration and real anger. Respect is important but disrespect decreases morale. Feeling respected-not respected is at times "uplifting and disappointing as you make decisions to show or keep your values hidden until you find someone who shares the same passion." Eva thinks about respecting and disrespecting herself and the way she carries out her thoughts. Eva said, "I could choose to be a bad person and think negatively about people…vengeful, but I choose not to and I give myself a lot of respect that makes me feel proud." (p. 107)

This process of embedding the artist in the project demonstrates how art increases the understanding of a universal experience in a complementary way using the Parse method

(Malinski et al., 2005). This project was limited to one participant (a student at that). The process needed refinement and a larger study sample, as 10 participant descriptions were recommended by the authors to fully utilize the Parse method. This study provided additional knowledge regarding the concept of respect. The authors asserted that having a professional artist translate the respondent's feelings of respect to the canvas was rich and powerful.

Parse (2006) then conducted a study on feeling respected with 10 participants. This study was conducted included dialogical engagement, extraction synthesis, and heuristic interpretation. Participants were 10 men and women who were 18 years of age, spoke and understood English, agreed to meet with the researcher, and signed a consent form. The dialogues were audiotaped and took place in a convenient setting determined by each participant. The dialogues began with "Please tell me about your experience of feeling respected." The dialogs were transcribed. According to Parse, the dialogical engagement is not an interview. It is true presence with the researcher and the participant. The focus is on the phenomenon under study as it is described by the study respondents (2006). The finding of the study is the structure: The lived experience of feeling respected is fortifying assuredness and potential disregard emerging with the fulfilling delight of valued alliances (2006). The structure is discussed in relationship to the human becoming school of thought. Parse's definition of respect is:

> the reverent recognition or acknowledgement of a presence. The presence may be a person, animal, object, idea, or situation. Respect is regard for that which is worthy of admiration. It is a valued lived phenomenon, a universal lived

> experience of health and quality of life, about which human beings are deeply concerned. (p. 51)

This study added knowledge to the general and nursing literatures on the concept of respect and its connection to perceptions of health and quality of life. Further phenomenologic study is suggested related to the lived experiences of nurses in order to validate the construct

Building on Parse's work, a study by Bournes and Milton (2009) was designed to enhance the understanding of nurses' experiences of feeling respected and to explore whether there was a relationship between qualities of work-life and feeling respected-not respected. The Parse method was used to answer the research question, "What is the structure of the lived experience of feeling respected-not respected?" Participants were 37 nurses in staff and leadership positions in a large teaching hospital in Canada. They agreed to speak about their feelings of being respected-not respected in 12 small groups of two to five participants. Recruitment was by email or flyer, or through personal contacts with managers or directors of nursing connected to inpatient or outpatient settings at multiple sites of the hospital system.

Dialogical engagements led to similar descriptions of the lived experience. Participants described feeling respected-not respected as affirming-not affirming; alternate discourse by nurse leaders, colleagues, other health professionals, patients, and families; either fortified their confidence or demoralized, angered, and frustrated them. They specified that feeling respected-not respected was lived in ways of feeling happy or disappointed with others' consideration of their opinions and with the feedback or lack of

it from leaders. Participants also reported that feeling respected or not respected was connected with feeling appreciated or not appreciated for their hard work. When managers offered formal commendations they felt appreciated, but this happened infrequently. They expressed that managers often yelled at them and showed no appreciation for their accomplishments. Participants also said that feeling respected or not respected felt safe, good, comfortable, or insecure and uncomfortable, and that it builds or shatters confidence (Bournes & Milton, 2009). Feeling respected was considered important in determining quality of life, particularly quality of work life. Additionally, the researchers' findings provide:

1. An understanding of the empirically validated support for the psychometrics of feeling respected-not respected from the perspective of groups of nurses in an acute care teaching hospital.
2. Differentiation and classification of dichotomous feelings as follows: of feeling respected-not respected that may lead to feeling revered or not revered; feeling trusted or not trusted; feeling recognized or not recognized; feeling confident or not confident; feeling guarded or feeling free to speak; feeling patronized and others.
3. Support for constructs of how nurses' feeling respected-not respected is fundamental to other quality of life and to the quality of care they are able to provide.

4. Understanding how nurses feeling respected-not respected may help healthcare leaders enhance understanding of the importance of respect among healthcare team members. (p. 46)

There are three important factors that one can take from the studies discussed above using the Parse method. First, respect is conveyed in more than words; the Parse methodology captures this dimension. Second, the use of a professional artist in the embedded artist study may be essential in capturing the essence of respect from the respondent. Third, the use of another nonverbal media enhanced understanding of multidimensional concepts. These studies provide further descriptive evidence that has contributed to the understanding of the concept of respect.

Terms Used Interchangeably With Respect

Respect is sometimes used interchangeably with the term "civility," which Hutton (2006) defined as a violation of workplace norms for mutual respect. Hutton concluded that incivility pervades workplaces, including healthcare organizations (2006). Andersson and Pearson (1999) defined civility as:

> Behavior involving politeness and regard for others in the workplace, within workplace norms for respect. Incivility is low intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, display a lack of regard for others. (p. 407)

Workplace incivility is quite prevalent in the American workplace with over two-thirds of employees reporting disrespect, condescension, and social exclusion (Clark &

Springer, 2007; Cortina et al., 2001; Peck, 2006,). The outward expression of respect is civility. The appearance of civility does not ensure the underlying feeling of respect. That is, I may treat you with complete civility; however, I may not respect you.

Spence-Laschinger, Finegan, and Wilk (2009) conducted a study to examine the combined effect of supportive professional practice environments, civil working relationships, and empowerment on new graduates' experiences of burnout in at work. The researchers conducted an analysis of a subset of cross-sectional data collected from staff nurses in 2006 in a large Ontario, Canada provincial study. This study (N = 3,160) was designed to examine the impact workplace empowerment unit and individual nursing outcomes. Nurses selected for this analysis had been in the profession for less than 2 years. This generated a sample of new nurses (n = 247). Registered nurses in the larger study were from 271 inpatient units and received a questionnaire sent through hospital mail with ethical approval. The Dillman Total Design Methodology was use to increase return rates. The larger study had a return rate of 40%. Using this methodology, a reminder letter was sent 3 weeks following the initial survey package, and a second survey package was sent 1 month after the reminder letter. One instrument used in this study was the Practice Environmental Scale of the Nursing Work Index (NWI-PES). This scale consisted of 31 items rated on a 4-point Likert-type scale. In this study, Cronback's Alpha reliabilities ranged from 0.72 to 0.85 and 0.92 for the total NWI-PES. Construct validity for the NWI-PES was demonstrated by a confirmatory factor analysis. On their units, workplace civility was measured by 4 items from Shortell, Rousseau, Gillies, Deverse, and Simons' 1991 ICU Nurse-Physician Questionnaire. Sample items included:

nurses on the unit seem to have a low opinion of other nurses, and nurses do not receive the cooperation they need from each other. Items were rated on a 5-point scale then summed and averaged to create an index of workplace civility. Higher scores reflected low workplace civility on their units: Cronback's Alpha was 0.82. Empowerment was measured by the 2-item Global Empowerment Scale; items measure how much the respondents feel empowered to work effectively in their current workplace (2009). Alpha reliability was reported as 0.92.

The last scale used in the Spence-Laschinger et al. (2009) study was the Emotional Exhaustion (EE) subscale of the Maslach Burnout Inventory-General Survey to measure burnout. Cronback's Alpha coefficients for the EE scale ranged from 0.65 to 0.91. In this study, the Alpha reliability coefficient was 0.91. New graduates perceived their hospitals to have overall moderate levels of Magnet hospital characteristics. These respondents also felt their work environments were somewhat empowering. The participants in this study reported that workplace civility was somewhat positive; this is contrary to other reports in the literature. The researchers speculate that the measure of incivility may not be as sensitive to the full range of the phenomena (2009). These respondents also reported low levels of conflict among nurses on their units. The researchers found that the new graduates in the study reported high levels of EE, that is, 66% were in the severe burnout category. This study suggested that work environments that allow new graduates to practice based on professional standards and to experience civil and respectful behaviors from colleagues are important. Work environments with these attributes may protect new graduates from burnout. The study should be replicated

using experienced nurses, as well as a more sensitive indicator of incivility. The Spence-Spence-Laschinger et al. (2009) study has powerful implications for future research related to the study of nurse burnout, mentoring, and engaging new graduates during initial orientation programs in healthcare organizations regarding indicators of burnout in the work environment.

Constructs With Dimensions of Respect

There are few empirical studies of respect; however, many researchers have addressed respect as a dimension of other constructs as follows: caring (Gaut, 1983), dignity (Gallagher, 2004), leadership (DeLellis, 2000), organizational support (Spence-Laschinger, Purdy, Cho & Almost, 2006), cross-cultural collaboration (DeLellis, 2006), patient safety (American Nurses Credentialing Center [ANCC], 2004), nursing education (Kalb & O'Connor-Von, 2007), healthy work environment (Ulrich, 2007, Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007; Ulrich, Lavandero, Hart, Woods, Leggitt, & Taylor, 2006; Cline, Reilly, & Moore, 2004), nurse–patient relationship (Summer, 2008), and organizational satisfaction (Gilster & Dalessandro, 2008).

Respect is a moral principle that implies valuing another person's essential dignity and worth (McGee, 1994; Milton, 2005; Spence-Laschinger, 2004). In organizational theory, respect is represented in terms of perceived values or organizational culture. Respect is also an important construct also be found in organizational trust literature (Velez, 2006). Another area where respect can be found is in the literature related to organizational justice (Spence-Laschinger, 2004).

Johnston (1997) described job dissatisfaction as a source of conflict and dissention within the healthcare delivery system. The author undertook a cross-sectional descriptive survey of the nursing organization in a 450 bed not-for-profit hospital in the southwestern United States. She surveyed 317 registered nurses; the instrument was a two-part scale intended to measure six components believed to define job satisfaction. Thirty nurses were selected at random for an additional in-depth interview about job satisfaction. The results indicated a low level of job satisfaction overall, yet the nurses indicated that there was respect and value for nursing in the institution (1997).

Ingersoll, Olson, Drew-Gates, DeVinney, and Davies (2002) described the characteristics of the nursing workforce of a mixed urban/rural region of New York State, and assessed nurses' level of job satisfaction and commitment to the work setting. A random sample of 4,000 RNs was drawn from a group of 12,000 nurses in the region. The researchers used two commonly used surveys to measure job satisfaction, The Organization Commitment Questionnaire and the 44-item Index of Work Satisfaction. There were 1,853 respondents, a 46% response rate; the nurses were predominately female, European American, and older. Almost two-thirds were over 40 years: 37.5% ranged in age from 41 to 50 (692), 24.8% (457) were between the ages of 51 to 60, and 10.6% were greater than 60 years (197). Personal and organizational characteristics contributed to differences in levels of job satisfaction, organizational commitment, and one- and five-year intent to leave. Many of the most satisfied and committed nurses reported their intent to leave within the next five years. Unlike the Johnston (1997) study, there was no reference to respect; however, the instrument for satisfaction was the same

and implications of respect are inherent in the subscales of commitment, job satisfaction, autonomy, interaction, organizational policies, pay, professional status, and task requirements. The investigation did not include LPNs and Nursing Assistants.

As described earlier in this chapter, after a thorough review of relevant literature, the following is the conceptual definition of respect that was developed for this study. Respect is the manifestation of a mental process which leads to a conclusion about worth or value. It is a fundamental human concept which is a conditional and complex expression of moral value. It is derived from the Latin word *respicere*, which means the art of looking back. It is foundational in its meaning to receivers and givers of respect and is closely aligned with the values of human dignity and deference for persons, caring, honor, trust, worthiness, deference, courtesy, and kindness. The outward expression of respect is civility. On first encounter, respect is either present or not. Antecedents of respect are beliefs about justice, civility, acknowledgement and esteem; it can be applied to persons, objects, or animals.

Respect can be for one's title, position, or profession. In this case, respect may be provided even if the person giving the respect dislikes the receiver of the respect.
Its meaning is differentiated by and sensitive to cultural norms and values. According to selected extent studies, respect in nursing is a basic human need that, when present, may result in reduction of stress and despondency, improvement of team work, creation of satisfactory work environments, improvement of productivity, and work satisfaction; lack of respect may result in increase in stress, incites to violence, and foster depression,

sadness, and unhealthy work environments (La King and McInerney, 2006; Parse, 2006; Shader et al., 2001; Spence-Laschinger et al., 2012).

All of the research cited in this section addressed the issue of respect directly or indirectly within each study. Each supports the existence and significance of the impact of respect. What is lacking, however, is empirical support for the specific contribution of a uniformly defined and measured concept of respect. As such, this study makes an important contribution in operationalizing and understanding respect and the study of respect in healthcare organizations.

Literature on Tool Development

Measurement tools are essential for conducting research. DeVellis (2003) listed six steps to tool development:

1. Determine the item to be measured
2. Generate an item pool
3. Determine the format of the tool
4. Have the item pool reviewed
5. Administer items to a sample
6. Evaluate the pilot.

The first step in tool development is to determine what is to be measured. Using a conceptual framework provides clarity to what the researcher is intending to measure. Ravet, Williams, and Fosbinder (1997) developed the Interpersonal Competence tool to measure four categories of patient–nurse interaction: translating, getting to know you, establishing trust, and going the extra mile. The conceptual framework that informed the

development of Ravet et al.'s study was the Fosbinder Interpersonal Model. It was developed from a qualitative study which involved observations of nurse–patient interactions and interviews with patients on an orthopedic chest medicine and cardiology units in private, acute care, teaching hospital (Ravet et al., 1997). The study included 245 observations and 85 audiotaped, semistructured interviews using open-ended questions. The Interpersonal Competence Model for Nurses guided the development of the Interpersonal Competence Instrument for Nurses. The item pool was generated from a review of the transcripts of each patient interview; 125 items were generated based on data bits gleaned from the transcripts. The items were reviewed by two doctoral nurses with an expertise in instrument development, and revisions were made. The instrument used a Likert-type scale ranging from 1-5: never, seldom, occasionally, often, and always. The items were assembled in a quantifiable format for content validity testing. A 4-point scale was used on the validation tool: not relevant, unable to assess relevance without item revision or item in need of such revision that it would no longer be relevant, relevant but needs minor alteration, and very relevant and succinct. Ten nurse experts whose expertise were in the content/domain provided content validity testing of the instrument and were invited to participate on the panel. The experts' backgrounds were diverse and relevant. The readability level was established at the ninth grade level.

The Content Validity Index (CVI) for the instrument was calculated for each item; all of the items but one had content validity, 125 items were judged and 105 had content validity, 6 were revised for a total of 111 valid items. The reading level was recalculated to the 8.09 grade level. The overall content validity was .84. This concluded the

development of the tool for content validity. This study provides an excellent example of the steps for tool development recommended by Pedhuzur and Schmelkin (1991). Further testing for internal consistency would be evaluated using Cronbach's coefficient alpha and item analysis. The internal structure of the instrument would be assessed using factor analysis.

The Nursing Workplace Satisfaction Questionnaire (NWSQ) was developed by a project group of nurses searching for a suitable job satisfaction tool to track as an outcome in a large Sidney, Australia, hospital-wide models of nursing care project (Fairbrother, Jones, & Rivas, 2009). The researchers decided to develop a new tool because existing tools were too long. They believed the tools were North American-based, tended to investigate the organization as a whole rather than specific work areas, and did not address the internal character of nursing job satisfaction (Fairbrother et al., 2009). The existing tools focused on measuring the external practice and organizational environment. A review of the literature of related to job satisfaction was conducted and three existing instruments were reported as widely used in Australia, North America, and Europe: the Nursing Work Index—Revised (NWI-R) by Aiken and Patrician, the Mueller-McCloskey Satisfaction Scale (MMSS) by Mueller and McCloskey, and the Maslach Burnout Inventory (MBI) by Maslach and Jackson. The NWI-R contained 57 items, the MMSS 33 items, and the MBI 22 items.

After a focus group discussion of nurses from both the clinical and education specialty areas ($N = 8$), this group reviewed the tools to determine the benefit of using the tools in the pilot and model of care work. The researchers also used the focus group to act

as a reference group for the design of a new tool if needed. Participants had more than five years of clinical and unit-based experience; four participants had more than 20 years' experience. The group was dissatisfied with tools and decided a new tool was needed to suit the purpose of their work.

The Fairbrother et al. (2009) focus group decided on three domains: intrinsic (six items), extrinsic (eight items), and relational (four items). The tool was piloted and there were statistical and content validity grounds for accepting the group's determination that the tool was useful as a pre- and postmeasure of job satisfaction. Following the pilot study a large hospital-wide study was conducted, a data set of 220 NWSQ from 12 wards was analyzed. Exploratory Factor Analysis was used. There were three principal components isolated yielding eigenvalues of < 1. The three-component model was shown to explain 59.8% of the variance. Internal consistency was determined by a follow-up study one year later among the same units for a combined sample (N = 459). Reliability analysis of the scores in the three domains yielded a high coefficient of internal consistency, the total score on the NWSQ (Cronbach's Alpha = 0.90). The development of this tool facilitated the purpose and needs of this Models of Care group. The process provided and opportunity for nurses to study job satisfaction at the operational and unit-based levels. A larger validity study would further explore the properties of the tool. The above studies demonstrate the steps of tool development as well as the benefit and use of focus groups.

Respect Conceptual Framework

As noted earlier, the conceptual framework for this study was based on the definition of respect originally postulated by Browne (1993), Parse (2006), Purnell (1999), and Spence-Laschinger (2004. The definition was further clarified by the researcher as described in the beginning of this chapter and was used to develop the framework for this study.

Structurational Divergence Component

SD is derived from Structuation theory (ST), developed by Anthony Giddens. As such, it is a collective term denoting approaches of social theory that describes the making and maintenance of social order without giving priority to either side of social theory's classical opposition (Saranson, Dean, & Dillard, 2006). According to Saranson et al. (2006), SD is the reciprocal interaction of human actors and social structure. Human actors or agents are both enabled and constrained by structures, yet these structures are the result of previous actions by agents and are carried forward only by the agents as memory traces (2006). Structuation theory attempts to recast structure and agency as a mutually dependent duality. Structuration theory was included in this study because it was thought to provide an important missing construct for understanding how expressed respect is perceived in the organization. As such, it was a relevant construct for inclusion in the conceptual framework for this study on respect/disrespect.

Structurational Divergence (SD) was developed by Nicotera et al. (2003) and Nicotera and Clinkscales (2010). SD exists when incompatible meaning structures are positioned in social structures that interpenetrate, compelling the individuals to perform

incompatible responsibilities from multiple rules systems. If the rules are incompatible with the individual's value systems, the individual's position is unsustainable (Nicotera & Clinkscales, 2010; Nicotera and Mahon 2013).

Nicotera and Clinkscales (2010) conducted a case study of nurses at the nexus in a small, full-sized urban hospital center on a geriatric unit staffed by approximately 60 persons. The composition of the staff included registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), and medical/surgical technicians (techs) as well as nonmedical and administrative staff. Other allied health personnel who worked on the unit such as respiratory therapists were based in other departments. The nurses in the case study were faced with multiple social structures which interpenetrated and generated conflict in their value systems, resulting in poor communication and creating a downward spiral of negativity (2010). According to Nicotera and Clinkscales, these nurses were at a nexus, which occurs in the SD-cycle. This downward spiral ultimately leads to immobilization of the individuals and a lack of forward progress for the unit or organization (Nicotera & Clinkscales, 2010). The researchers concluded that the SD phenomenon was evident in this case study (Nicotera & Clinkscales, 2010). They reported that the nurses in this unit were immobilized by several dimensions of Structurational incompatibility (2010). Further, the experience of SD was provoking a negative spiral of communication. Nicotera and Clinkscales identified this to be associated with the leadership style of the director while other observations were linked to the traditional hierarchy of the organization. The communication spiral in the SD is

akin to the increase and decrease in favorable and unfavorable communication in the Respect/Disrespect model.

Taylor Respect/Disrespect Model

The Taylor Respect/Disrespect model explains the progression of perceived respect as it is influenced by interaction among actors in an organization. Figure 1 links the relationship of the Structurational Divergence (SD) variables on respect as explained in the Taylor framework of respect on the SD framework. Figure 2 illustrates the point at which the nexus may occur and therefore, according to Nicotera and Clinkscales (2010), should explain the SD cycle.

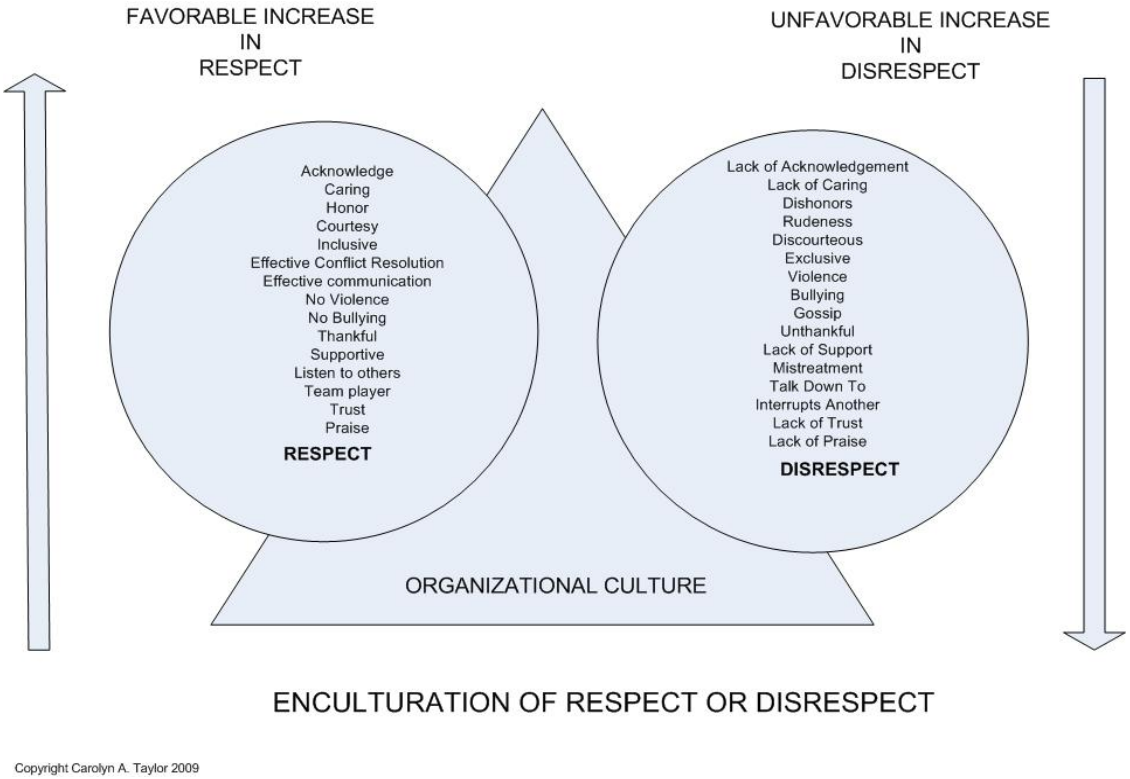

Figure 1. The enculturation of respect/disrespect on the organization.

Figure 1 symbolizes the enculturation of respect on the Respect/Disrespect model; the triangle represents the organizational culture; the two circles represent descriptors of respect and disrespect as these concepts are introduced into the organizational culture. The arrows on the right and left side of the figure represent the increase or decrease in respectful or disrespectful communication that can occur under these circumstances. As in the SD studies discussed above, an increase in negative communication (disrespect) can create a negative work environment and result in negative consequences for all concerned. An increase in positive communication (respect) can result in a positive work environment and benefit the organization.

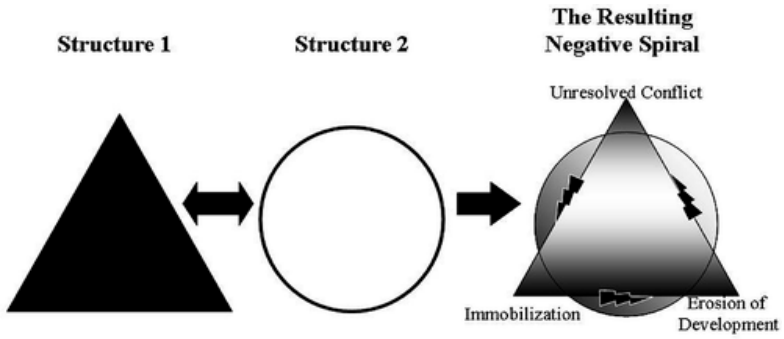

Figure 2. The Structurational Divergence (SD) Nexus and SD Cycle (Nicotera & Clinkscales, 2010). Used with permission.

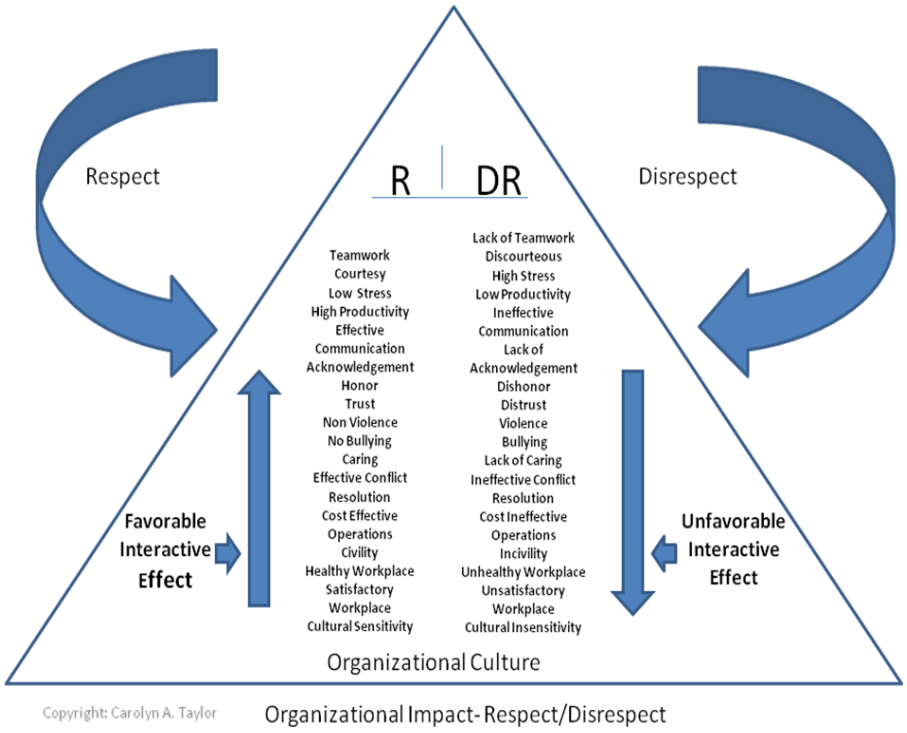

Figure 3. The organizational impact of the Respect/Disrespect Model.

Figure 3 graphically illustrates the impact of respect/disrespect has on organizational culture. The triangle represents the organizational culture; the external left and right arrows symbolize respect and disrespect among employees that ultimately produce the values and beliefs that form the organizational culture. The internal arrows represent the increase or decrease in favorable or unfavorable interactive effects of the respectful and disrespectful behaviors within the organizational environment. The respect/disrespect columns contain employee behaviors or characteristics of behaviors found among employees in the organization and shape the organization's values and beliefs, therefore producing its culture.

Summary

In this chapter the conceptual definition and underpinnings of the theory of Respect/Disrespect (R/DR), Structurational Divergence (SD), and other organizational phenomena related to R/DR and/or the antecedent influence of respect/disrespect among employees or selected ongoing phenomena such as job satisfaction. After completion of the study, additional publications on SD appeared in the communications literature, including the identification of construct domains. Variations in research methods were analyzed, and adopting the Taylor framework and the Taylor Feelings of Respect Scale (TFORS) was presented. This literature review demonstrated the need for this study and further clarified and supported the definitions of respect utilized in the study. Additionally, it supported the need for a more robust tool to measure feelings of respect in nurses, the need to retain qualified nurses, to reduce the incidence of absenteeism, bullying, decreased productivity, decrease in quality of care, reduce the potential for violence, and increase in health-related illness due to stress. All of these are compelling reasons that support the importance of respect and its influence on organizational phenomena in healthcare and support the need for the approach utilized in this study.

CHAPTER 3: METHODS

In this chapter, the research design and methods utilized are described in detail. The problem, purpose, and research questions are overviewed; the six steps of instrument development are described; the development of the Taylor Feelings of Respect Scale (TFORS) is summarized; and data collection procedures, data analysis, and ethical considerations are discussed.

This exploratory, descriptive study was undertaken to develop and test a framework and instrument to define and measure nurses' feelings of respect/disrespect in healthcare organizations. Prior to this study there were no tools to measure feelings of respect in nursing and lack of consensus regarding a definition (Browne, 1993, 1995, 1997; Cortina & Magley, 2003; Faulkner & Spence-Laschinger, 2008; Parse, 2001; Purnell, 1999). An instrument that measures feelings of respect in nurses was constructed, and psychometric testing was undertaken to validate the tool.

The research questions were:

1. What is the validated conceptual framework and operational definition of respect?
2. What are the psychometric properties of the TFORS?
    a. Reliability
    b. Validity

3. What is the relationship between SD and nurses' feelings of respect?

Development of the Taylor Feelings of Respect Scale (TFORS)

To answer the research questions, a descriptive, mixed method research design was used to explore the TFORS' potential questions and relationship between SD and nurses' feelings of respect. Factor analysis and reliability statistics were used to determine the psychometric properties of the TFORS. Following IRB approvals, using the DeVellis (2003) method, the TFORS instrument was developed as follows.

1. Develop conceptual definition
2. Conduct qualitative study and synthesize themes from qualitative findings from interview data; draft and develop construct validity for TFORS instrument
3. Establish content validity
4. Conduct pilot study to test reliability, and
5. Conduct focus group to refine TFORS instrument.

Step 1: Develop Conceptual Definition

The conceptual and operational clarifications of the definitions of respect were proposed based upon extant scholarly contributions identified from the review of the literature and the decision to use qualitative interviews to further clarify the meaning of respect in nurses (see Appendix B).

Step 2: Qualitative Study and Synthesis of Qualitative Findings, Construct Validity

Data from a study that was conducted previously by the researcher was used to inform the development of the TFORS item pool. Data from qualitative key informant

interviews was analyzed using qualitative methods yielding identification of TFORS domains. The convenience sample of three professional nurses from the Northern Virginia area and the George Mason University campus community was drawn from a list of student names from list of colleagues (Table 1). Three informants were chosen based on the projected time constraints of the class project. Prior to conducting the interviews, verbal consent was obtained from all respondents. Written consent was then obtained from each respondent to utilize the data obtained from their interview for the development of the TFORS.

A qualitative approach was used to conduct the interviews, this involved the use of one to one interviews as the primary method of collecting information (Creswell, 2003). The questions were presented to the respondents during personal interview sessions conducted by the student researcher. The first interview was conducted in the respondent's home, the second interview was conducted in the campus library, and the third interview was conducted in a conference room in a building on campus. The sessions lasted approximately 30 minutes and were tape recorded. The data was transcribed by a transcription company and coded by the researcher using NVivo version 8. Permission was obtained from the GMU Human Services Review Board (HSRB) to utilize the existing data to develop the initial item pool and themes for the instrument by the researcher.

Table 1

Key Informant Demographics

Name/ Number	Age/Sex	Race/Ethnic Background	Occupation/Current Job	Years in the Workforce	Years in This Position	Education
1. Ms. AKA	51/F	African American	Nurse/ Case/UR Manager	29	2	BSN, MSN
2. Ms. Loren	51/F	Caucasian American	Nurse/ Director	22	4	AND, BSN, MSN, PhD Student
3. Mr. Shake	54/M	Caucasian American	Nurse/ Associate Professor	30	9	BSN, MSN PhD Student

Note. Names are pseudonyms.

The initial domains were extracted using NVivo version 8 software, which produced the following: Meaning of Respect; Personal, Interpersonal, and Organizational/Cultural feelings of respect. The first draft of the TFORS instrument and item pool was generated from these findings (see Appendix C). The item pool and the related quantitative instrument development were generated from the results of Step 2.

Step 3: Psychometric Testing: Establish Content Validity

Standard methodology (Polit & Beck, 2008), was used to establish content validity (the degree to which items in an instrument adequately represent the universe of content for the concept being measured). Psychometric testing to establish content validity was achieved by having a group of expert nurses review the instrument based on the following criteria using a 4-point Likert scale. The three criteria were:

1. The items measure feelings of respect

2. Interpretation of the scores is relevant to feelings of respect
3. The items are not sensitive or biased.

Clarity was rated using a 4-point Likert scale. The ratings for clarity were 4 – very clear, 3 – clear, 2 – mostly unclear, and 1 – unclear. One question was rated by one reviewer as unclear.

Construct validity was analyzed using principle components analysis with varimax rotation. Reliability was analyzed using Cronbach's Coefficient Alpha to estimate internal consistency of the data. For psychometric testing, face validity and reliability of the Taylor Feelings of Respect Scale (TFORS) were established using principle components analysis, and initial construct validity of TFORS domains were also tested. The content and construct validity, and reliability of the Taylor Feelings of Respect Scale (TFORS), were established using a variety of activities to assure the instrument accurately measured feelings of respect in nursing.

Step 4: Conduct Pilot Study

A convenience sample of 22 nurses was surveyed to pilot test the psychometric properties of the instrument. For content validity, findings were used to further refine the TFORS. A proprietary web-based survey service was utilized to administer the pilot study survey. The TFORS survey instrument was uploaded to the Pyschdata web site preceded by a consent form for participation (see Appendix D). Emails were sent to nurse colleagues and friends to announce the pilot and to encourage participation (see Appendix D). Once the respondents consented and registered to take the survey, a password could be set up to allow the respondents to stop the survey and return at a later

time. Resumption of the survey began at the point where a respondent stopped the survey. To prevent missing data, participants were not permitted to skip items before moving forward in the survey. The only question that was optional to answer was the final open-ended question, "This study has been about respect, do you have any specific comments about respect that I should consider?" The power analysis for the pilot study yielded a sample size requirement of 30. The total number of nurses that registered on the Psychdata site was 22 and all 22 nurses completed the survey.

The reliability coefficient for the pilot study found from the Cronbach's Alpha Statistic was 729 for $n = 58$. The highest alpha was .740 and the lowest was .695. Therefore no items were deleted.

Step 5: Conduct Focus Group

After the pilot study was completed and the instrument revised, a focus group was utilized to collect data that was qualitatively analyzed to support the refinement of the first draft of the TFORS domains and item pool and further refine the instrument with the approval of the GMU Human Subjects Review Board. The review of the literature provided support for conceptual and operational definitions of respect there were adapted for this study. Additionally, the operational definition of respect was mapped to the TFORS (Appendix A). Focus groups may be used at any time during the tool development process to further refine the tool (Nassar-McMillan, Wyer, Ryder-Burge 2010; Plummer-D'Amato, 2008). Qualitative data collection methods such as focus group interviews are a practical means for obtaining individuals' personal experiences, beliefs, and perceptions (Hudson, 2003; Wyatt, Krauskopt, & Davidson, 2008). Focus groups are

a form of group interview designed to gather multiple perceptions about a defined area of interest (Hudson, 2003).

The focus group was held in a private office conference room. The informants were recruited via a convenience sample of nurses from a list of graduate master's program alumni to participant via an email invitation (see Appendix D) with the subject, date, time, and place of the focus group meeting. The meeting was held on a Saturday in late January 2012, in an office conference facility in Springfield, Virginia. Due to icy weather conditions, only five of the eight invitees participated. The participants signed informed consent forms and were given instructions by the moderator regarding the agenda and conduct of the focus group meeting. The group responded to three questions related to respect (see Appendix E). The meeting lasted 2 hours including a break at the end of the meeting for refreshments. The focus group participants were thanked for their participation and the meeting adjourned. The tape recording of the meeting was sent to a transcription company. The transcription of the focus group meeting proceedings was reviewed, and as a result of analyzing the transcription, trust was added to the TFORS under the domain Meaning of Respect.

Analysis to Create TFORS

Synthesis of the qualitative findings consisted of retrieving the transcribed informant interviews and coded data. The themes that emerged, along with the information obtained from the review of the literature, were used to develop the initial item pool for the TFORS. Four themes emerged from the interviews: the meaning of respect, personal feelings of respect, interpersonal feelings of respect, and

organizational/cultural feelings of respect. In each of the interviews the same themes were present. At this time the researcher decided to name the survey the Taylor Feelings of Respect Scale (TFORS).

TFORS Pilot Test

The pilot of the TFORS instrument was administered using a Web-based survey service called Psychdata.com. The researcher purchased a professional license to use this service to conduct the pilot survey. A convenience sample of 60 nurses was recruited via an email letter (see Appendix D). The respondents were asked to go to the web-based survey service called Pyschdata.com to participate in pilot study. The respondents were given a link to the site and a password to gain access.

TFORS Survey of Virginia RNs

Population and Sample

The TFORS was conducted on a sample of Virginia nurses. The Virginia RN licensure database was used after two other methodologies failed to yield an adequate response. The revised design employed a random sample of nurses licensed in the Commonwealth of Virginia. The power analysis indicated a sample of 350 was required. The instrument was administered using the web-based survey service Pyschdata.com. The researcher purchased a professional license to use this service.

This method included the purchase of a database from the state health professionals licensing agency in the state of Virginia which included registered nurses (RNs) in the state of Virginia and others who were part of the Virginia Board of Licensing Partnership. A random sample of 1,500 nurses was selected from the dataset by

license number. Three areas in the state were selected to send a direct mailing advertising the study. The letter included an introduction of the researcher and the purpose of the study, a statement of informed consent, directions for accessing the survey online, and the incentives for completing the survey (see Appendix D).

Five hundred letters were sent to licensed RNs in each selected area in the state. After sending the first mailing, the researcher discovered that the randomization of the dataset by license number represented licenses that were arranged in order of the date the license was obtained by the nurse, meaning this group would inordinately represent the oldest nurses. To remedy this unintended bias, an additional sample of 500 nurses was selected from the bottom of the database (licenses obtained by a younger set of nurses) divided equally among the three original locations selected. A total of 2,000 mailings were sent. This final method yielded 207 respondents (a 10.39% response rate), an adequate number of respondents to conduct an analysis of the data with meaningful results.

Study Instrument

The TFORS was the instrument used to conduct the pilot test and study surveys. The instrument consists of 59 items on respect (13 items on the definition of respect and 46 questions on nurses' feelings of respect) and 17 items on Structurational Divergence, an intent to leave section (6 questions), a demographic profile section (16 questions), and a final open-ended question soliciting any additional comments on respect from the respondents. The last item on the survey provided the respondents the option to opt out of the drawing for the incentive giveaways and included instructions for participating. The

TFORS uses a 5-point Likert scale in which number – strongly agree; 2 – agree, 3 – neutral, 4 – disagree, and 5 – strongly disagree.

Survey Administration Procedures

Data was collected using the Web-based survey company Psychdata.com. This company is used throughout the country for survey research. Once the TFORS was loaded onto the site, the respondents were able to access the survey by providing a password. The respondents gave consent prior to proceeding to the survey. Once the respondents had access they were able to respond to questions in sequence. Participants were not able to move forward in the survey until each question was answered. The respondents were also able to stop the survey, save it, and return to complete it at another time. This method was selected to increase the number of completed surveys and significantly reduce or avoid the issue of missing data (Polit & Beck, 2008).

Data Analysis

A descriptive data analysis was conducted to describe the characteristics of the sample respondents using Factor Analysis in the SPSS version 20 statistical software package used. The four basic steps employed for factor analysis were:

1. Conduct item analysis (mean, standard deviation, item total calculation)
2. Construct validity evidence and factor analysis
3. Reliability evidence for each factor domain, and
4. Interpret the results. (George & Mallery, 2005)

The results of the item analysis, construct validity evidence and factor analysis, reliability evidence for each domain, and the interpretation of the results are found in Chapter 4.

Ethical Considerations

The initial use of the existing data from the qualitative study and permission to conduct a focus group received approval from the GMU HSRB (see Appendix D) at the proposal stage. The researcher gained the approval of the GMU HSRB and the participating institutions for the study once the study's proposal was successfully defended. Completed IRB applications are included in Appendix D. All respondent data was kept confidential with unique alphanumeric identifiers for each survey and was kept locked in a cabinet.

Summary

In this chapter, the methodology for the development and testing of the TFORS was outlined. In the next chapter, the findings of the study will be presented and discussed. These results include the demographic data for the survey respondents, and the answers to the three research questions.

CHAPTER 4: RESULTS

This chapter presents the study results. First, the demographic data for the TFORS survey respondents will be analyzed; next, the three research questions will be answered. Other miscellaneous findings will be presented.

In the initial phase, the TFORS survey instrument was developed using Pedhazer and Schmelkin (1991). In the second phase of this study, the instrument was pilot tested, after which the TFORS instrument was revised and the study was initiated. A discussion of the initial and revised survey administration procedures was discussed in depth in Chapter 3. Because the response rate during the initial survey administration was grossly inadequate, the survey design was revised and survey administration procedures were modified. Findings for respondents from the revised study design are presented and discussed in depth based on the sociodemographics of respondents and the research questions. Finally, the results of the psychometric testing of the TFORS relative to the study framework and study limitations based upon findings are also discussed.

Respondent Demographics

In the final administration of the TFORS, 2,000 randomly selected names from the active nurse licenses listed on the Virginia Department of Health Professional Licensure Data Base were invited to participate. Of these, 207 (10.3%) responded, which was considered an adequate sample.

The demographics for study respondents are presented in Tables 3 through 6. Of RNs, 8.7% did not complete the demographic data section. This is categorized as missing data in each of the categories in the demographics tables. In Table 2, participants were listed by their nurse licensure and 91.3% listed their designation as RN. There were no LPNs respondents in the study.

Table 2

Demographic Data: Licensure Designation, Highest Level of Education, Specialty Certification

Demographic Variable	*n*	Percentage
Licensure Designation		
RN	189	91.3
Missing	18	8.7
Total	207	100.0
Highest Level of Education		
Diploma	26	12.1
ADN	31	15.0
BSN	53	25.6
MSN	43	20.8
MBA	2	1.0
PhD	4	2.1
Other	31	15.0
Missing	18	8.7
Total	207	100.0
Specialty Certification		
Yes	87	42.0
No	102	49.3
Missing	18	8.7
Total	207	100.0

Education

The education of survey respondents was reported as follows in the demographic section. Twenty-six (12.1%) of the respondents were diploma graduates, 31(13%) were

Associate Degree Nurses (ADN), 53 (25.6%) reported Baccalaureate Degrees, 43(20.8%) had a Master's in Nursing, 2 (1%) a Master's in Business Administration (MBAs), and 4 (2.1%) had Doctor of Philosophy Degrees (PhDs). Finally, 31(15%) of the nurse respondents listed other as their highest education achieved.

Specialty Certifications

Eighty-seven of the respondents (42%) had specialty certifications; 102 (49.3%) of the nurse respondents were not specialty certified.

Table 3 presents respondents' demographic data in the areas of age, gender, and race/ethnicity.

Table 3

Demographic Data: Age, Gender, Race/Ethnicity

Item	*n*	Minimum	Maximum	*M*	*SD*
Age	189	21	79	56.1	13.286

Demographic Variable	*n*	Percentage
Gender		
Female	178	94.2
Male	11	5.8
Missing	18	8.7
Total	207	100.0
Race/Ethnicity		
African American	16	7.7
Asian American	3	1.4
Caucasian	159	76.8
Hispanic	4	1.9
Pacific Islander	2	1.0
American Indian	1	.5
Other	4	1.9
Missing	18	8.7
Total	207	100.0

Note. $N = 207$.

Age Range

The age range for the sample (with a 91.3% response rate or 189 out of 207 respondents) was 21 years and 79 years, the mean was 56.1 years and the standard deviation was 13.286. This sample mean age is higher than the mean for national data statistics (46 years) according to the Health Resources and Services Administration (HRSA) data for the registered nurse population (2013, p. 2). The sample mean age is also higher than the mean age of 47 years for RNs in the state of Virginia (Virginia Healthcare Workforce Data Center, 2012).

Gender

There were 178 (94.2% female respondents and 11(5.8%) male. This finding is roughly consistent with the gender distribution of nurses licensed in Virginia.

Ethnicity/Race

The ethnicity/race of the respondents was as follows: Caucasian 159 (76.8%), African Americans 16 (7.7%), Hispanics 4 (1.9%), other 4 (1.0%), Asian Americans 3 (1.4%), Pacific Islanders 2 (1%), and lastly, American Indian 1 (.5%).

Table 4 presents the respondents' demographic data for marital status, number of children, and religious affiliation.

Table 4

Demographic Data: Marital Status, Number of Children, Religious Affiliation

Demographic Variable	*n*	Percentage
Marital Status		
Single (never married)	10	4.8
Married	131	63.3
Divorced	29	14.0
Separated	3	1.4
Widowed	16	7.7
Missing	18	8.7
Total	207	100.0
Number of Children		
None	37	17.9
One	30	14.5
Two	73	35.3
Three	33	15.8
Four	14	6.8
Five or more	2	1.0
Missing	18	8.7
Total	207	100.0
Religious Affiliation		
Protestant	86	41.5
Catholic	49	23.7
Jewish	3	1.4
Other	51	24.6
Missing	18	8.7
Total	207	100.0

Marital Status

Marital status was the next demographic question; 131 (63.3%) were married, 29 (14%) were divorced, 16 (7.7%) were widowed, 10 (3.8) were single (never married) and 3 (1.4%) were separated.

Number of Children

Among 207 respondents 189 reported having children in the household. The largest proportion reported having two children: 73 (35.3%); those that reported none

were 37 (17.4%), three were 33(15.9%), one was 30 (14.5%), four were 14 (6.8%) and those reporting five or more were 3 (1.1%).

Religious Affiliation

Religious affiliation was the next question. Respondents that reported Protestant were the highest number: 86 (41.5%); the “other” category was next highest at 51 (24.6%), Catholics were 49 (23.7%), and Jewish were 3 (1.4%).

Table 5 presents the demographics for work department, work status, and length of time employed.

Table 5

Demographics: Work Department, Work Status, Length of Time Employed

Demographic Variable	*n*	Percentage
Work Department		
Medical/Surgical	14	6.8
Labor/Delivery	4	1.9
Postpartum	1	.5
Mother Baby	3	1.4
Pediatrics	6	2.9
Critical Care	7	3.4
Operating Room	17	6.2
Emergency Room	6	2.9
Ambulatory Services	2	1.0
Administration	10	4.8
Academic Setting	10	4.8
Other	109	57.7
Missing	18	8.7
Total	207	100.0
Work Status		
Part Time	40	19.3
Full Time	96	48.4
Other	53	25.6
Missing	18	8.7
Total	207	100.0
Length of Time Employed in Present Organization		
1 year or less	28	13.5
2 years	19	9.2
3 years	12	5.8
4-6 years	15	7.2
7-10 years	23	11.1
10-15 years	29	14.0
16-20 years	19	9.2
20+ years	44	21.3
Missing	18	8.7
Total	207	100.0

Work Department

In terms of work department, “other” was the highest response with 108 (57.7%), next was the operating room with 17 (6.2%), medical surgical followed with 14 (6.8%),

administration services and academic setting were both 10 (4.8%), and critical care was 7 (3.4%).

Work Status

Work status was the next demographic variable. Of respondents, 40 (19.3%) worked part time, 96 (48.4%) respondents selected full time, and the respondents that listed other totaled 53 (25.6%).

Length of Time in Present Organization

The highest length of time in respondents present organization were 44 (21.3%) for 20+ years. The lowest length of time was 28 (13.5%) for one year or less.

Magnet Status

Magnet status was the last category; 69 (29%) of the respondents selected yes, 129 (68.3%) selected no.

At the conclusion of the survey, which was posted on the Pyschdata online site for three months (January-March), a total of 207 nurses responded. Although 100% of the respondents completed the survey questions, 18 nurses did not complete items in the intent to leave section. In future studies, more specific questions regarding work status will need to be included. Some of the unanswered items were questions related to the hospital characteristics and some questions were not answered by respondents because of their retired status. See Tables 2-5 for a summary of demographic data.

Synthesis of Qualitative Findings: Data for TFORS Item Pool Development

Synthesis of the qualitative findings consisted of retrieving the transcribed interviews and coded data. The themes were used to develop the initial item pool for the

TFORS. The themes that emerged were meaning of respect, personal feelings of respect, and organizational/cultural feelings of respect. These themes along with information from the review of the literature were used to develop the questions for the TFORS instrument.

Quantitative Process

As noted in Chapter 3, quantitative instrument development was completed using the steps for instrument development by DeVellis (2003). The steps are described in depth below.

1. Determine the construct to be measured. Nurses' feelings of respect was the construct that was selected to measure for this study. The Conceptual Definition of Respect and Structurational Divergence (SD) were the conceptual frameworks upon which this study was based. A qualitative study of existing data from key informant interviews was the data source for the development of the TFORS in this study. Three nurses were interviewed about their feelings related to respect in the workplace and the information obtained was used to develop the items to measure.
2. Generate an item pool. The item pool was generated by choosing items that reflected the instrument's purpose. Information gathered from the key informant interviews was coded in four categories that provided the basis for item generation. The item pool was generated by utilizing the themes identified from the qualitative study and review of the literature for the TFORS instrument.

3. Determine the format. The format of the TFORS is a 5-point Likert scale with 59 items, a demographic profile section, and a section on intent to leave. The number 1 represents strongly agree; 2 – agree, 3 – neutral, 4 – disagree, and 5 – strongly disagree.
4. Have item pool reviewed. The item pool was reviewed for content validity by experts. Doctoral students (8) in a doctoral-level measurement class and doctoral candidates (10) in addition to the class professor, Dr. Jean B. Moore, PhD, RN, in a dissertation proposal class at George Mason University reviewed the instrument for content validity. The two experts groups found the instrument's content was valid.
5. Administer pilot. A pilot study of 22 nursing master's degree students was used to test the instrument.
6. Evaluate items. Evaluation of the items was done by factor analysis, descriptive statistics (mean, standard deviation), and using Cronbach's alpha to evaluate internal consistency and reliability. The relationship between SD and nurses' feelings of respect was examined using correlation statistics. There was no relationship between the five domains and the SD construct.

Following these six steps, the TFORS was developed and piloted. The survey consisted of 99 questions: 13 on the meaning of respect, 46 questions regarding nurses' feelings of respect, 17 on SD, 6 on intent to leave, 16 demographic questions, and one open-ended question, "This study has been about respect, do you have any specific comments about respect that I should consider?" The formats of the survey questions

were matrix, multiple choice, single select vertical and one open-ended question format. The high score on the TFORS scale was represented by the number 1 which indicated strongly agree; the lowest score, 5, indicated the least agreement, and the number 3 indicated being neutral. The subjects of the questions were based on the domains that emerged from the initial review of the literature, the qualitative study, and the quantitative analysis from which the five domains were identified. The final question gave the respondents the option to participate in the giveaway of a Kindle Fire and four $50 gift cards by emailing their name, email address and phone number to a specific email address noted in the letter addressed to each respondent and in the survey following the final question. Of the 2,000 letters sent, 207 nurses responded to the survey on the Pyschdata website during the main study period.

Answering the Research Questions

Research Questions 1: What is the Validated Conceptual and Operational Definition of Respect?

The conceptual and operational definition of respect was clarified by a review of the literature, qualitative interviews, and focus group findings. Following is the clarified definition of respect as presented in Chapter 2, the Taylor definition of respect: Respect is the manifestation of a mental process which leads to a conclusion about worth or value. It is a fundamental human concept which is a conditional and complex expression of moral value. It is derived from the Latin word *respicere,* which means the art of looking back. It is foundational in its meaning to receivers and givers of respect and is closely aligned with the values of human dignity and deference for persons, caring, honor, trust,

worthiness, deference, courtesy, and kindness. The outward expression of respect is civility. On first encounter, respect is either present or not. Antecedents of respect are beliefs about justice, civility, acknowledgement and esteem; it can be applied to persons, objects, or animals.

Respect can be for one's title, position, or profession. In this case, respect may be provided even if the person giving the respect dislikes the receiver of the respect. Its meaning is differentiated by and sensitive to cultural norms and values. Respect in nursing is a basic human need that, when present, may result in reduction of stress and despondency, improvement of team work, creation of satisfactory work environments, improvement of productivity, and work satisfaction; lack of respect may result in increase in stress, incites to violence, and foster depression, sadness, and unhealthy work environments.

Research Question 2: What are the Psychometric Properties of the Taylor Feelings of Respect Scale (TFORS)?

Results of the administration of the TFORS. The initial study administration was conducted using the Pyschdata web site. Permission was obtained from the participating healthcare institution's Internal Review Board (IHS-IRB) to utilize the system's electronic bulletin board to post a flyer advertising the study (see Appendix D). After two months there were no responses to the posting. After many attempts to recruit respondents the incentives were enhanced and the advertisement modified to reflect the changes. This change yielded 9 respondents. This method was abandoned and a second method was adopted, using the same setting.

This new method involved using a "snowball method," a variant of convenience sampling (Polit & Beck, 2008). An email was sent to colleagues known to the researcher requesting them to participate and to send the email to 10 other colleagues known to them that might agree to participate in the study. This method yielded 24 respondents.

Revised survey design and administration procedure. Because the factor analysis required a minimum of 150 respondents to conduct the analysis, as a result a third change was made. A new method was initiated to increase the number of respondents. A database was purchased from the state licensing agency for health professionals in Virginia. A letter was sent to a random sample of 2,000 RNs in three areas in Virginia from this database. The sample included nurses in other localities because of the cooperative between states regarding nurse licensures. The incentives were enhanced again and a new letter was drafted which included the new incentive and instructions for accessing the site (See Appendix D). This method yielded 207 RN respondents, a 10.3% response rate for the 2,000 potential respondents.

Frequency distribution. The TFORS instrument was administered to these 207 respondents. The respondents answered all 59 questions related to respect in the survey. There were 13 questions answered related to the meaning of respect, 15 questions related to personal feeling of respect, 21 questions related to interpersonal feelings of respect, 9 questions related to organizational feelings of respect, and 3 questions related to cultural feelings of respect. The number 1 represents strongly agree and number 5 represents strongly disagree in the 5-point Likert scale of the TFORS.

Domain I. Meaning of Respect. The 13 responses from the domain Meaning of Respect (questions 1-13) demonstrate a high level of agreement with the questions related to the domain Meaning of Respect. The percentage of respondents scoring strongly agree to the questions in this domain ranged from 88% (183) to 35.7% (74).

Domain II. Personal Feelings of Respect. Fifteen responses were related to the domain Personal Feelings of Respect. Interesting responses under this domain were questions related to working relationships. Of respondents, 104 (50%) strongly agreed with the question "I feel respected when I am supported my co-workers. Eighty (38.6%) of respondents strongly agreed that "I feel respected when my work schedules are flexible and self-scheduling is an option." Responses to the question "I feel good when I am respected" were 148 (71.5%) strongly agree, 57 (27.5%) agree; only 1 person selected disagree, 1 neutral, and 0 strongly disagree. On the other hand, 58 (28%) of respondents strongly agreed and 84 (40.6%) agreed to the question "I feel angry when I am not respected."

Domain III. Interpersonal Feelings of Respect. In domain III, Interpersonal Feelings of Respect, some interesting responses included for "I feel others are rude to me," 51 (24.6%) selected strongly agree, 92 (44.4%) agree, and 35 (16%) selected neutral. Approximately 65% of this sample perceived others were rude to them. This response has significant implications for administrators, managers and educators. The response to the question "I feel sad when I am not respected" was 44 (21.3%) strongly agree and 105 agree (50.7%). For another question, 120 (58%) strongly agreed and 75 (36.2%) agreed with, "I feel motivated when I am respected." For question V59, "I avoid

others when I am not respected," 14 (6.8%) selected strongly agree, 66 (31.9%) selected agree, and 64 (30.9%) disagree. These responses may have implications related to the retention of staff.

Domain IV. Organizational Feelings of Respect. Some highlights from domain IV, Organizational Feelings of Respect, follow. For question V30, "I feel physicians respect me," 65 (31.4%) strongly agreed, 94 (45.4%) agreed, 29 (14%) were neutral, and 7 (3.4%) and 4 (1.9%) disagreed and strongly disagreed respectively. Question V21 was a reverse answer, "I feel respected when there are poor working relationships between departments," and 1 (.5%) strongly agreed, 1 (.5%) agreed, 11 (5.3%) neutral, 78 (37.7%) disagreed, and 116 strongly disagreed (56.0%). The implication here is that nurses may prefer to work in a supportive and collaborative work environment.

Domain V: Cultural Feelings of Respect. Domain V, Cultural Feelings of Respect, had three questions. This domain emerged from the factor analysis. There were four initial domains for the TFORS, after the factor analysis a fifth domain emerged in that the fourth domain, organizational/cultural feelings of respect, was split to create cultural feelings of respect as the fifth domain. Variable 12, "Treating others in an uncivil manner," was a reverse response answer. Of respondents 6 (2.9%) selected strongly agree, 2 (1%) selected agree, 2 (1%) neutral, 32 (15.5%) disagree, and 165 (79.9%) strongly disagree. For question V29, "I believe respect has different meaning in different cultures," 70 (33.8%) of respondents selected strongly agree, 105 (50.7%) selected agree, meaning approximately 84% of respondents agreed. The detailed responses are displayed in the Frequency Distribution (Table 6).

Table 6

Taylor Feelings of Respect Scale (TFORS) Frequency Distribution

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
1. Treating other like you want to be treated	183	88.4	20	9.7	1	.5	1	.5	2	1.0
2. Caring about others	135	65.2	43	20.8	20	9.7	7	3.4	2	1.0
3. Not talking down to others	173	83.6	30	14.5	0	0	2	1.0	2	1.0
4. Treating others with Courtesy	181	87.4	23	11.1	0	0	1	.5	2	1.0
5. Treating other with dignity	184	88.9	18	8.7	2	1.0	1	.5	2	1.0
6. Honoring others	126	60.9	56	27.1	18	8.7	2	1.9	3	1.4
7. Recognizing others	138	66.7	51	24.6	12	5.8	3	1.4	3	1.4
8. Including others	112	54.1	68	32.9	20	9.7	4	1.9	2	1.4
9. Acknowledging others	138	66.7	61	29.5	4	1.9	2	1.0	2	1.0
10. Valuing others	138	66.7	54	26.1	8	3.9	4	1.9	3	1.4
11. Criticizing others	9	4.3	9	4.3	19	9.2	69	33.3	161	48.8
12. Treating others in an uncivil manner	6	2.9	2	1.0	2	1.0	32	15.5	165	79.7
13. Trusting others	74	35.7	68	32.9	43	20.8	14	6.8	8	3.9
14. I am not valued my others	12	5.8	24	11.6	25	12.1	89.	43.0	57	27.5
15. I feel respected when I am supported by my co-workers	104	50.2	87	42.0	7	3.4	6	2.9	3	1.4
16. I do not respect myself	2	1.0	1	.5	5	2.4	51	24.6	148	71.5
17. I feel mistreated by others	4	1.9	25	12.1	23	11.1	79	38.2	76	36.7
18. I feel respected when a strong ethics committee encourages ethical reflection	50	24.2	64	30.9	70	33.8	17	8.2	6	2.9

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
19. I feel my family respects me	128	61.8	67	32.4	7	3.4	4	1.9	1	.5
20. I feel respected when work schedules are flexible and self-scheduling is an option	80	38.6	77	37.2	38	18.4	10	3.8	2	1.0
21. I feel respected when are poor working relationships between departments	1	.5	1	.5	11	5.3	78	37.7	116	56.0
22. I feel good when I am respected	148	71.5	57	27.5	1	.5	1	.5	0	0
23. I feel angry when I am not respected	58	28.0	84	40.6	33	15.6	25	12.1	7	3.4
24. I feel patients and families do not respect me	1	.5	6	2.9	24	11.8	82	39.6	94	45.4
25. I am acknowledged by others	64	30.9	109	52.7	25	12.1	8	3.9	1	.5
26. I feel respected when the organization assures the work environment is safe	89	43.0	92	44.4	22	10.6	3	1.4	1	.5
27. I feel honored by my co-workers	50	24.2	83	40.1	55	26.6	15	7.2	4	1.9
28. I respect myself	139	67.1	62	30.0	3	1.4	1	.5	2	1.0
29. I believe respect has different meaning in different cultures	70	33.8	105	50.7	14	6.8	13	6.3	5	2.4
30. I am not recognized by others	6	2.9	14	6.8	24	11.6	91	44.0	72	34.8
31. I feel respected when nurse leaders are competent and represent nursing concerns	99	47.8	87	42.0	15	7.2	5	2.4	1	.5
32. I feel respected when I am bullied by my co-workers	0	0	4	1.9	2	1.0	26	12.6	167	80.7
33. I feel respected by my co-workers	73	35.3	95	45.9	22	10.6	8	3.9	1	.5
34. I do not feel respected when I am unjustly blamed by my co-workers	82	39.6	84	40.6	22	10.6	6	2.9	5	2.4
35. I feel others care about me	64	30.9	114	55.1	15	7.2	5	2.4	1	.5

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
36. I feel respected when physicians and nurses work collaboratively in the workplace	137	66.2	60	29.0	1	.5	0	0	1.	.5
37. I feel respected by my supervisors	76	36.7	82	39.6	24	11.6	14	6.8	3	1.4
38. I feel others are rude to me	51	24.6	92	44.4	35	16.9	18	8.7	3	1.4
39. I don't feel respected when my unit is understaffed	48	23.2	58	28.0	54	26.1	32	15.5	7	3.4
40. I feel ignored by other	8	3.9	14	6.8	27	13.0	88	42.5	62	30.0
41. I feel my work environment promotes respectful behaviors	45	21.7	95	45.9	31	15.0	23	11.1	3	2.4
42. I feel sad when I am not respected	44	21.3	105	50.7	26	12.6	21	10.1	3	1.4
43. I feel my family does not respect me	2	1.0	6	2.9	5	2.4	56	27.1	130	62.8
44. I feel motivated when I am respected	120	58.0	75	36.2	3	1.4	1	.5	0	0
45. I feel respected when my pay reflects my value as a nurse	104	50.2	76	36.7	14	6.8	5	2.4	0	0
46. I do not feel respected when my supervisor yells at me	97	46.9	59	28.65	25	12.1	9	4.3	9	4.3
47. I feel respected when I have sufficient resources to do my job	97	46.9	90	43.5	9	4.3	3	1.4	0	0
48. I feel honored by others	42	20.3	96	46.4	45	21.7	11	5.3	5	2.4
49. I feel I get yelled at by others	3	1.4	9	4.3	18	8.7	84	40.6	85	41.1
50. I feel physicians do not respect me	8	3.9	12	5.8	32	15.5	86	41.5	61	29.5
51. I feel respected when my organization values and acknowledges my contribution	115	55.6	81	39.1	2	1.0	0	0	1	.5
52. I feel respected when I am not valued	2	1.0	3	1.4	9	4.3	76	36.7	109	52.7
53. I treat patients better when I am respected	31	15.0	58	28.0	36	17.4	51	24.6	23	11.1
54. I feel physicians respect me	65	31.4	94	45.4	29	14.0	7	3.4	4	1.9
55. I feel my family respects me	119	57.5	69	33.3	6	2.9	4	1.9	1	.5

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
56. I am acknowledge by others	69	33.3	102	49.3	20	9.7	8	3.9	0	0
57. I feel sad when I am not acknowledged by others	24	11.6	70	33.8	61	29.5	38	18.4	6	2.9
58. I feel respected when nursing leadership participates at the highest levels of the organization	72	34.8	75	36.2	41	19.8	9	4.3	2	1.0
59. I avoid others when I am not respected	14	6.8	66	31.9	46	22.2	64	30.9	9	4.3

Construct Validity and Reliability for Research Question Two, TFORS Psychometric Properties

Content validity of the TFORS was discussed in Chapter 3, Methodology, and supported by the review of the literature (Chapter 2), as well as a focus group and the pilot study, also presented in Chapter 3. Construct validity was evaluated by exploratory factor analysis. Reliability of the TFORS was analyzed by using Cronbach's Alpha Coefficient and Correlation Statistics.

A. Construct validity evidence. Exploratory Factor Analysis was used to determine construct validity for the TFORS. A principal components extraction method with varimax rotation was used to generate the output for the TFORS using SPSS version 20. According to Nunnally and Bernstein (1994), principal components analysis is recommended for exploratory factor analysis when there are more than 20 variables. Each of the 59 TFORS variables was evaluated by factor analysis. The initial analysis was done using four factors based on the qualitative existing data, literature review, pilot study, and focus group findings. However, four domains did not provide interpretable results. The second analysis yielded five factors which produced a more interpretable result (See Figure 4). The components that emerged were Domain I, Meaning of Respect; Domain II, Personal Feelings of Respect; Domain III, Interpersonal Feelings of Respect; Domain IV, Organizational Feelings of Respect; and finally Domain V, Cultural Feelings of Respect.

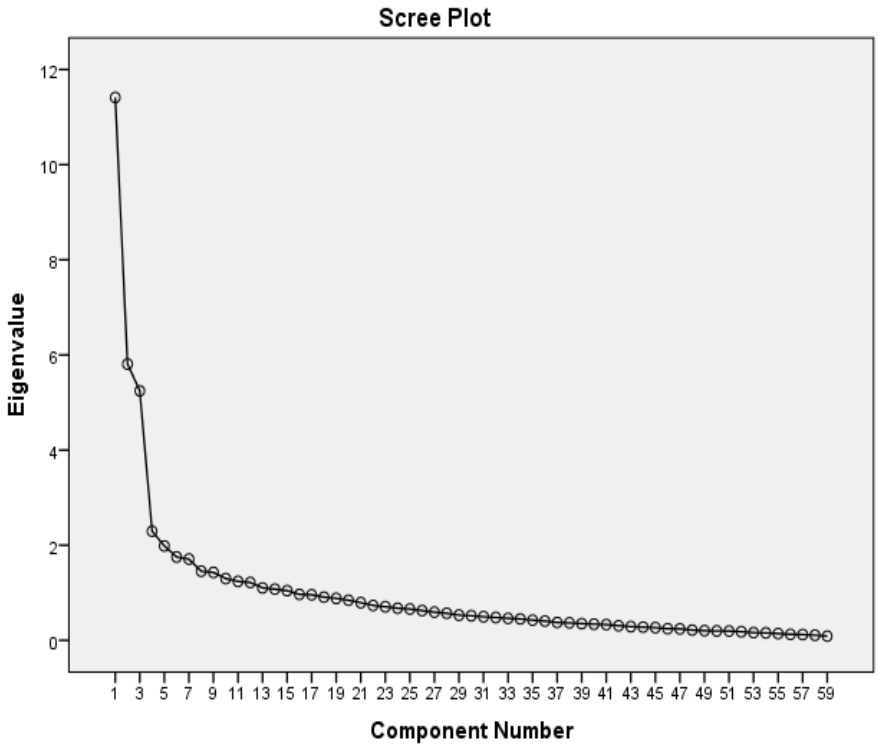

Figure 4. Scree plot.

The principal components analysis of the 59 items in TFORS extracted five domains, which explained 46.5% of the total variance. There were no criteria set for minimum and maximum factor loadings for this exploratory study. However, Nunnally and Bernstein (1994) recommend a minimum criterion of .40, whereas Tabachnick and Fiddell (2007) recommend a loading of .32 or above. In Domain I – Meaning of Respect 11 items loaded at .535 or above. The highest loading was .855 and the lowest was .534. In Domain II, 15 items loaded at .214 or above. The highest loadings were .768 and the lowest was .214; in Domain III, 21 items loaded at .311 or above. The highest loading for this domain was .669 and the lowest was .311. In Domain IV 9 items loaded at .296 or

above, the highest loading was .684 and the lowest were .296. Finally, in Domain V, 3 items loaded at .247 or above. The highest loading was -.640 and .247 the; factor loadings for the 5 domains in TFORS are presented in Tables 7-11.

Table 7

Descriptive Statistics: Factor Loading and Reliability Estimates: Domain I: Meaning of Respect

Item		*M*	*SD*	*N*	Loading
V9	Acknowledging others	1.46	.675	207	.855
V8	Including other	1.64	.847	207	.818
V6	Honoring others	1.56	.845	207	.814
V5	Treating others with dignity	1.16	.547	207	.804
V2	Caring about others	1.54	.874	207	.797
V7	Recognizing	1.46	.703	207	.795
V3	Not taking down to others	1.21	.586	207	.758
V10	Valuing others	1.145	.786	207	.748
V1	Treating others like you want to be treated	1.16	.539	207	.733
V13	Trusting others	2.10	1.086	207	.535
V4	Treating others with courtesy	1.16	.533	207	.782

Note. Cronbach's alpha = .928, number of items (K) = 11, percentage of variance explained = 19.5%.

Table 8

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain II: Personal Feelings of Respect

Items	*M*	*SD*	*N*	Loading
V33 I feel respected by my coworkers	1.84	.813	207	.768
V56 I am acknowledge by other	1.63	.764	207	.759
V17 I feel mistreated by others*	2.03	1.058	207	.724
V41 I feel my work environment promotes respectful behaviors	2.24	.958	207	.710
V37 I feel respected by my supervisors	2.24	.958	207	.704
V49 I feel I get yelled at by others*	1.92	.893	207	-.694
V38 I feel others are rude to me*	2.15	.956	207	-.667
V25 I am acknowledged by others	1.63	.764	207	.768
V30 I am not recognized by others	3.85	1.012	207	-.661
V48 I feel honored by others	2.20	.921	207	.932
V40 I feel ignored by others*	1.93	1.043	207	-.632
V27 I feel honored by my co-workers	2.20	.968	207	.612
V35 I feel others care about me	3.91	.716	207	.566
V14 I feel I am valued by others	2.23	1.130	207	.543
V32 I feel respected when I am bullied by my co-workers*	1.23	.664	207	.214

Note. *Reverse coded items. Cronbach's alpha = .397, number of items (K) = 15, percentage of variance explained = 10%.

Table 9

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain III: Interpersonal Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V44 I feel motivated when I am respected	1.42	.553	207	.669
V26 I feel respected when the organization assures the work environment is safe	1.71	.748	207	.609
V31 I feel respected when nursing leaders are competent and represent nursing concerns	1.65	.769	207	.607
V42 I feel sad when I am not respected	2.17	.942	207	.580
V22 I feel good when I am respected	1.30	.502	207	.578
V47 I feel respected when I have sufficient resources to do my job	1.59	.652	207	.573
V57 I feel sad when I am not acknowledged	2.66	1.017	207	.539
V20 I feel respected when work schedules are flexible and self-scheduling is an option	1.90	.916	207	.534
V39 I don't feel respected when my unit is understaffed	3.54	1.127	207	-.518
V45 I feel respected when my pay reflects my value as a nurse	1.60	.731	207	.493
V36 I feel respected when physician and nurses work collaboratively with me in the work environment	1.33	.542	207	.486
V51 I feel respected when my organization values and acknowledges my contributions	1.45	.574	207	.474
V34 I do not feel respected when I am unjustly blamed by my co-workers	1.83	.920	207	.461
V46 I do not feel respected when my supervisor yells at me	1.86	1.090	207	-.453
V15 I feel respected when I am supported by my co-workers	1.63	.816	199	.432
V52 I feel respected when I am not valued*	1.56	.742	199	.418
V23 I feel angry when I am not respected	2.22	1.092	199	.383
V58 I feel respected when nursing leadership participates at the highest levels of organization	1.96	.916	199	.365
V53 I treat patients better when I am respected	2.88	1.276	199	.362
V18 I feel respected when a strong ethic committee encourages ethical reflection	2.31	1.002	199	.354
V59 I avoid others when I do not feel respected	2.94	1.057	199	.311

Note. *Reverse coded items. Cronbach's alpha = .676, number of items (K) = 21, percentage of variance explained = 9%.

Table 10

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain IV: Organizational Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V43 I feel my family does not respect me*	4.54	.777	199	-.684
V55 I feel my family respects me	1.49	.703	199	.672
V19 I feel my family respect me	1.46	.702	199	.601
V24 I feel patients and families do not respect me*	4.28	.805	199	-.505
V50 I feel physicians do not respect me	2.10	1.033	199	.499
V54 I feel Physicians respect me	1.95	.892	199	.475
V16 I do not respect myself*	1.33	.603	199	.465
V28 I respect myself	1.39	.649	199	.463
V21 I feel respected when there are poor working relationships between departments*	4.48	.673	199	.296

Note. *Reverse coded items. Cronbach's alpha = .426, number of items (K) = 9, percentage of variance explained = 4%.

Table 11

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain V: Cultural Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V12 Treating others in an uncivil manner	4.70	.792	207	-.650
V11 Criticizing others	4.19	1.058	207	.-543
V29 I believe respect has different meanings in different cultures	1.93	.935	207	.247

Note. Cronbach's alpha = .364, number of items (K) = 3, percentage of variance explained = 4%.

B. Reliability evidence. Cronbach's alpha coefficient measure of reliability for internal consistency for Domain I – Meaning of Respect was .928, for Domain II – Personal Feelings of Respect was .397, for Domain III – Interpersonal Feelings of Respect was .676, for Domain IV – Organizational Feelings of Respect was .426, and for Domain V – Cultural Feelings of Respect was .364 (see Tables 7-11).

Research Question 3: What is the Relationship Between Structurational Divergence (SD) and Nurses' Feelings of Respect?

The correlation matrix displaying the results of the examination of the relationship between SD and nurses' feelings of respect (Research Question 3) is presented in Table 12.

Table 12

Correlation Matrix: Structurational Divergence (SD) and Nurses' Feelings of Respect

		SD_Scale	Domain I	Domain II	Domain III	Domain IV	Domain V
SD_Scale	Pearson Correlation	1	-.048	.037	.210	.119	.128
	Sig (2- tailed)		.500	.609	.003	.093	.071
	N	199	199	199	199	199	199
Domain I	Pearson Correlation		1	.172	.141	.008	-.208
	Sig (2- tailed)			.013	.043	.910	.003
	N		207	207	207	207	207
Domain II	Pearson Correlation			1	.587	.770	.222
	Sig (2- tailed)				.003	.000	.001
	N			207	207	207	207
Domain III	Pearson Correlation					.536.	.126
	Sig (2- tailed)					.000	.071
	N					207	207
Domain IV	Pearson Correlation						.131
	Sig (2- tailed)						.060
	N						207
Domain V	Pearson Correlation						1
	Sig (2- tailed)						
	N						

Pearson's Product Moment Correlation is the examination of the calculation of each item in the TFORS with the 17 questions related to SD. The correlation statistic can range from -1.00 to +1.00 with strong relationships closer to -1.00 and weaker relationship closer to 0 (Polit & Beck, 2008). In Table 9, Domain III – Interpersonal

Feelings of Respect, a correlation between SD and nurses' feelings of respect at the .210 level and .003 level is noted. This is a significant correlation. However, there was no significant correlation between the two constructs in Domain I – Meaning of Respect, II – Personal Feelings of Respect), IV – Organizational Feelings of Respect, and V – Cultural Feelings of Respect.

Summary

The purposes of this study were to further clarify the conceptual definition of respect, develop a tool to measure to measure feelings of respect in nurses, examine the psychometric properties and determine the reliability and validity of the TFORS tool, and determine the relationship between SD and nurses' feelings of respect. A clarified conceptual definition of respect was presented in Chapter 3. The TFORS tool was developed, piloted, and ultimately administered to a random sample of 207 RNs. This study is a survey of nurses. Demographic data was collected; however, within- and between-group differences were not examined. The psychometric properties of the TFORS were tested for validity and reliability. The factor analysis conducted on the TFORS revealed five domains: Meaning of Respect, Personal Feelings of Respect, Interpersonal Feelings of Respect, Organizational Feelings of Respect, and Cultural Feelings of Respect. The interpretation of the results of the study and a sampling of the responses to the open-ended questions are presented in Chapter 5.

CHAPTER 5: DISCUSSION OF RESULTS

This study sought to clarify and define the concept of respect, and develop and test a tool to measure feelings of respect in nurses. The discussion in this chapter will focus on the results of the findings in Chapter 4, the implications of those findings, limitations, and recommendations for future research.

After a lengthy process using a variety of qualitative methods and different development procedures, the Taylor Feelings of Respect Scale (TFORS) was developed to measure nurses' perceptions of respect/disrespect. The instrument and the study were developed and implemented to test the instrument's validity and reliability. The relationship between Stucturational Divergence and nurses' perceptions of respect/disrespect was also analyzed.

Sample

The total number of respondents that completed the TFORS survey, $N = 207$, was a sufficient number to test the psychometric adequacy of the instrument using factor analysis, taking into consideration sampling error and to produce interpretable results (DeVellis, 2003). The sample's demographic findings profiles the respondent group as predominately Caucasian, married, Christian, women with children, college educated, with a high ratio of nursing practice specialty certification. There were fewer men in the sample, 11 (5.8%), while the number of females was 178 (94.2%), and a wide range of

practice settings. The mean age (56.1 years) of the sample was higher than in the national statistics (47.8) (HRSA, 2010) and in Virginia (46%) (Virginia Workforce Survey Statistics, 2010-2012).

Research Question 1. What is the Validated Conceptual and Operational Definition of Respect?

The model of the Organizational Enculturation of Respect/Disrespect in Chapter 4 illustrated the relationship between study variables related to respect/disrespect and explained an organizational phenomenon. Figure 5 demonstrates how respect/disrespect impacts an organizational culture: As perceptions of respect increase in the organization, a positive, favorable, interactive effect may occur in the organizational culture; conversely, as perceptions of disrespect increase in the organization, an unfavorable, negative effect may be created.

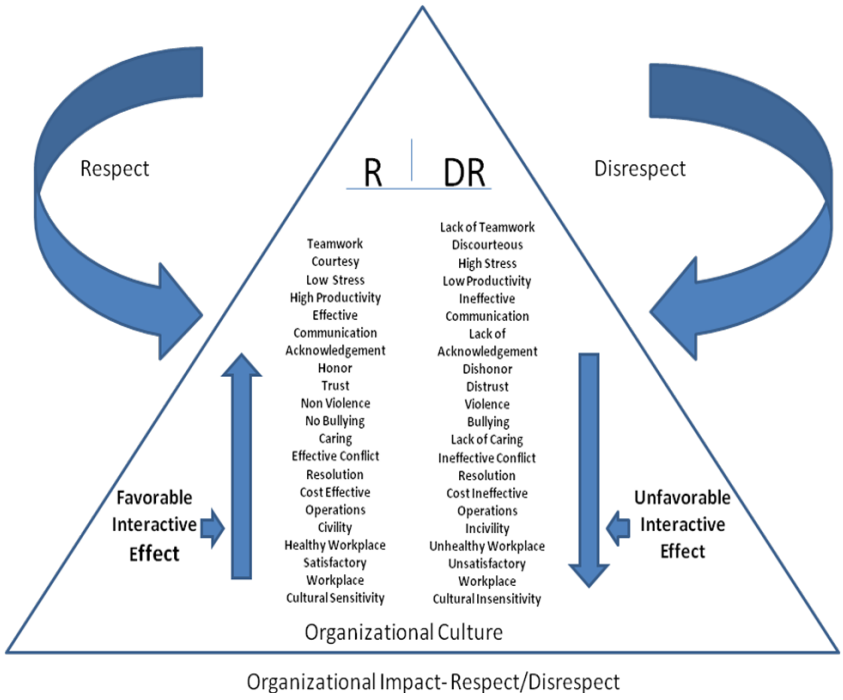

Figure 5. Organizational impact of Respect/Disrespect Model.

Findings from the TFORS survey of Virginia RNs, by category and the specific questions in the TFORS instrument, are: Teamwork/Lack of Team Work (8, 21, 40, 59), Courtesy/Discourtesy (4), Low Stress/High Stress (23, 42, 49), High Productivity/Low Productivity (36, 39, 47), Effective Communication/Ineffective Communication (38, 41, 49), Acknowledgement/Lack of Acknowledgement (9, 25, 51), Honor/Dishonor (6, 27, 48), Trust/Distrust (13), Nonviolence/Violence (26), No Bullying/Bullying (32), Caring/Lack of Caring (2, 35), Effective Conflict Resolution/Ineffective Conflict Resolution (34), Cost Effective Operations/Cost Ineffective Operations (20, 39); Civility/Incivility (3, 12, 38, 41, 46), Healthy Workplace/Unhealthy Workplace (21, 31, 37, 45), Satisfactory Workplace/Unsatisfactory (36), and Cultural Sensitivity/Cultural Insensitivity (29). The specific detailed frequencies were reported in Chapter 4, Table 6.

Respondents' answers validated the organizational impacts of respect/disrespect. For example, for question 15, "I feel respected when I am supported by my co-workers," 50.3% of respondents strongly agreed and 0% agreed, whereas 2.5% disagreed and 1.4% strongly disagreed; 3.4% reported neutral.

Research Question 2: What are the Psychometric Properties of the Taylor Feelings of Respect Scale (TFORS), Including Reliability and Validity?

The TFORS was developed using qualitative and quantitative methods. Content was adapted from extant respect/disrespect theorists and tested using descriptive statistics and exploratory factor analysis. The TFORS tool tested consisted of 99 questions; 59 questions were related to the concept of respect (13 on the meaning of respect and 46 on feelings of respect). There were 17 questions related to SD, as well as 6 questions related to intent to leave, participant demographics (16 questions), and a final open-ended question. Four domains comprised the initial TFORS instrument: Meaning of Respect, Personal Feelings of Respect, Interpersonal Feelings of Respect, and Organizational/ Cultural Feelings of Respect. Once the factor analysis was completed the TFORS was modified to include an additional domain, so five domains emerged. The final domain was separated into two: Organizational Feelings of Respect and Cultural Feelings of Respect.

Validity

The psychometric adequacy of the TFORS survey was examined using descriptive statistics (frequency, mean, and standard deviation) for participant

demographics and by TFORS items. Principal components factor analysis with a varimax rotation was used to determine the construct validity of the survey.

Reliability

The construct Meaning of Respect produced the highest reliability score. The higher the reliability scores of the instrument, the lower the amount of error in the scores (Polit & Beck, 2008). Cronbach's alpha was 928. The score for the construct Personal Feelings of Respect was 397, Interpersonal Feelings of Respect scored 676, Organizational Feelings of Respect scored .426, and the construct Cultural Feelings of Respect scored .364. The scores for Personal Feelings of Respect and Cultural Feelings of Respect were low, which may be indicative of too few items for these constructs/domains on the TFORS (DeVellis, 2003).

Instrument Properties

Domain I: Meaning of Respect

The strength and consistency of the loadings on domain I suggest that this is a cogent subscale. This conclusion is supported by the reliability score of .928 as reported above.

Domain II: Personal Feelings of Respect

All the items on domain II loaded strongly except for V32 ("I am respected when I am bullied by my co-workers"). Nine of the 15 items loaded on more than one factor. As stated earlier, there were no cut-off limits for these loadings due to the exploratory nature of this study. The recommended cut-off for items that have weak loadings and load on multiple domains is usually .30. Items that load on multiple factors will reduce

explained variance (DeVellis, 2003) in the frequency distributions, and this may explain why this subscales' loading was weak.

Domain III: Interpersonal Feelings of Respect

This scale had 10 items that loaded on more than one scale. Of these items several loaded on either domain I or IV. The alpha was moderately strong at .676. In future testing, this will need to be addressed.

Domain IV: Organizational Feelings of Respect

Items on this scale loaded on multiple factors as well. Eight of the nine items loaded on more than one factor. Three of the items loaded negatively V43 ("I feel my family does not respect me") and V24 ("I feel patients and families do not respect me") on factor 2, and V30 ("I am not recognized by others") on factor 3. The alpha statistic was .426, a low range of moderate. Based on these results this factor should be evaluated for theoretical clarity. Future deletion of some items may strengthen this scale (DeVellis, 2003).

Domain V: Cultural Feelings of Respect

This scale had the lowest alpha (.364). Two of the items, V12 ("Treating others in an uncivil manner") and V11 ("Criticizing others") loaded positively on factor 1 and negatively on factor 2. Conceptually these variables are consistent with domain I; however, there is a strong negative loading with domain V. V29 ("I believe respect has different meanings for different cultures") loaded negatively on domain IV and positively on factor 5.

Research Question 3: What is the Relationship Between Structurational Divergence and Nurses' Feelings of Respect?

Correlation Matrix

The correlation matrix revealed that only one of the five TFORS domains showed a relationship between SD and nurses' feelings of respect. Domain III had a significant correlation (r = .210, p-value = .003). The result for this domain indicates a weak positive relationship between the two constructs in domain III: As SD increases, nurses' feelings of respect decrease (Polit & Beck, 2008). However, this does not indicate a practically significant relationship.

Since a relationship between SD and respect was assumed, it is important to consider why it was not observed in this study. It may be that the measures of SD and of respect were too broad to display the specific relationships between them, or that SD is not conceptually distinct from other phenomenon such as satisfaction/dissatisfaction, conflict, and other organizational phenomenon. Future iterations of the TFORS with items eliminated to increase precision may reveal a stronger relationship with SD and/or other constructs. Future research on the TFORS should examine the subdomains of SD and other organizational phenomenon to develop a revised version of the TFORS that is theoretically more sound.

Implications

This study has significant implications for nursing administration/management, practice, policy, and the work environment. The study has practice implications regarding the retention and recruitment of nurses in the workplace. Quality of work life is a

mainstream issue in the healthcare organizations. Nurses want to work within an environment that is safe and collaborative. There are also implications for future research on within- and between-group differences of the demographic data that was collected during this study. Gender, age, race/ethnicity, location, education, marital status, and years in the work place may all have an impact on respect/disrespect.

Administration/Management

Prior to this study, there were no tools to measure nurses' feelings of respect. The TFORS instrument and the Respect/Disrespect model may provide administrators an opportunity to determine the impact respect and disrespect have on the organizational culture of healthcare institutions.

Practice

In this study nurses expressed their feelings about respect and disrespect in the practice setting in comments responding to the open-ended question, "This study has been about respect, do you have any specific comments about respect that I should consider?" Some of the respondents' comments are presented below.

Respondent 1:

> I left my last position due to feeling disrespected. I had been their [sic] almost ten years. A new manager came in with poor leadership skills and conflict and stress followed. I left on good terms but I miss my clients and the staff. They respected me and wanted me to stay. Managers must be fair and willing to make sacrifice themselves. Not take people for granted. Not pick their favorites. Not allow some to get by but sacrifice another. Have compassion.

Respondent 2:

We have talked at work about the lack of respect show to us by our patients. Many patients have no idea the amount of education needed to become an RN. Also it seemed that when everyone began wearing scrubs respect lessened. I wouldn't want to start wearing our caps again.

Respondent 3:

I don't expect everyone to respect me because I'm a nurse with 30 years' experience. I do however, like to be respected for the work I perform, the way I treat my patients, the way I interact with my colleagues, etc. I am respected in my workplace, but people do not all have the same values and therefore don't show respect for the same things. Time and experience has helped me gain more self-confidence and self-respect which seems to have helped me be more philosophical about the lack of respect I experience from time to time. I have learned that trying to prove myself to gain respect doesn't always work either. I've tried to focus on meeting my own high expectations rather than trying to meet others expectations of me or what I think they expect.

All that said, I believe most nurses work hard and do an outstanding job of taking care of patients while dealing with the chaos of hospital organizations and healthcare in general. As a group they do not always get the respect they deserve for the contributions they make toward improving the health of patients. In fact, I believe it is nursing that is the "glue" that holds the healthcare system together and stay grounded in the needs of their patients. Rather than creating hostile work

environments, there should be more efforts put toward improving working conditions, especially in this turbulent time of dwindling resources. Nurses who feel good about their work, who believe their work is valued, may be more inclined to stay in nursing where they are so desperately needed.

Respondent 4:

Over the years, I developed a high self-respect and the work I did was highly valued by individual patients, nurses and physicians. The organization frequently faced with financial concerns had difficulty seeing the dollar value of what I was doing. Even poor QA reports showing low pain relief were dismissed. This institutional disrespect chipped away at my self-respect and contributed to my fatigue and need to retire. I saw many younger nurses leave because of feeling overwhelmed by the workload—which became translated into "Why can't you do all of this by yourself?"

Toward the end of my career, I was given a job (take it or leave the institution) that had requirements taking far more than the usual work week. I regained my self-respect by finding a position in a different dept. at lower pay where my talents were valued. I was not the only person to receive this treatment, I retired from my nursing position knowing that I accomplished a great deal, but, in truth, my psyche is still a little bruised.

Respondent 5:

Respect is earned by treating others with respect and dignity. You will always encounter those who are difficult to get along with, that is part of life. Simply

"being a nurse" does not afford respect, but acting with professionalism and dignity, not "playing games" and working to get along with others will.

Respondent 6:

I have personally had disrespectful incidents with physicians when I worked in QA/Utilization Review. I believe if you command respect from them and give repect [sic], very often (and if it is earned) you will get it. One must often "teach" them (physicians) how one wants to be treated/respected!! Could elaborate more.....[sic] but, I am not sure you want all of my stories!!

Respondent 7:

I would focus on the new age of those entering the workforce. I have found as a nursing coordinator, it has very little do to with level of certification (MA, LPN, RN) and more to do with the generations coming on board. They are entitled and have little to no respect for any authority figures. It's generally very disappointing. This generation is the ones who all received trophys [sic] for participating, no one was a loser, they all get ahead because their mommys [sic] and daddys [sic] still do their bidding and tell the[m] how great they are even when they are not. They all need a serious dose of reality or perhaps, the workforce needs better tools for how to handle them.

Respondent 9:

In working for great leaders that treat each member of the team as valuable from housekeeping up to physicians, the atmosphere of the unit is set. We have a great

team now and for the team to stay that way leaders have to be intolerant of staff members being disrespectful to each other.

These comments are indicative of the concerns expressed by working nurses about their practice environment; the staff/colleagues they work with; the leaders that supervise them; and the overall sense of values, acknowledgement, and core beliefs that influence their behaviors on a day-to-day basis. These responses may have implications for the healthcare environment and the individuals that are employed there. Several noted researchers (Buerhaus, Donnellan, Ulrich, DesRoches, & Dittus, 2007; DeLellis, 2000; Hutton, 2006; Spence-Laschinger & Finegan, 2005; Spence-Laschinger, Leiter, Day, Gillin-Gore, & MacKinnion Hambleton, 2006) have all written about the importance of respect in the practice environment.

Limitations and Delimitations

Limitations are conditions that weaken or restrict conclusions that may be drawn from the study (Polit & Creswell, 2001). Because portions of this study relied on qualitative interviews, the following limitations may apply:

1. Some participants' responses may not be representative of all registered nurses (RNs) and licensed practical nurses (LPNs) in the study.
2. Bias in responses may have occurred due to respondent interests and "feelings" about the concept of respect.
3. Bias in responses may have occurred due to focus group participant interests and "feelings" about the concept of respect.

Delimitations define how the study was narrowed in scope. This study was delimited as follows (Polit & Creswell, 2001):

1. The sample was local versus national; thus regional variations outside of Virginia were not captured.
2. Generalizability was limited: Only nurses included in the Virginia State Health Professional Licensure Data Base were included.
3. Only licensed nurses (RNs) were included; of these, only nurses working in a healthcare setting were included.

There are several limitations that affect the generalizability of findings from this study. From the qualitative interviews conducted as part of developing the TFORS instrument, bias regarding the concept of respect, focus group respondent bias, sample size, and data collection procedures may not be representative or objective because prior to this study there were no instruments developed to measure this concept in nurses from which baseline data could be compared.

Recommendations for Future Research

The replication of this study in the future may increase the generalizability of the findings (DeVellis, 2003). An increase in the sample size to include a broader geographical profile (e.g., nurses from other states) may improve the reliability and validity of the TFORS tool, so replication of the study with a regional or national sample would be a logical next step. The relationships among the variables in the TFORS could be studied along with their relationship(s) to the demographic data collected in the current study. A financial model should be developed and tested to determine the cost

impact of disrespect, using the Respect/Disrespect model. Conducting confirmatory factor analysis on the TFORS would be helpful once the reliability and validity scores are consistent and stronger.

Conclusion

The purpose of this study was to clarify the Taylor conceptual definition of respect, develop an instrument to measure feelings of respect in nurses, test the psychometric adequacy of the instrument (including validity and reliability) and the instrument's variables, and determine if there was a relationship between Structurational Divergence (SD) and nurses' feelings of respect. There was no evidence that SD as measured in the survey was related to the five TFORS' domains. Therefore, SD is not recommended for further inclusion; if it is included, it must be further researched.

The research questions were answered. The overall Cronbach's alpha for the TFORS was 46.5. Five domains were extracted from the analysis: Meaning of Respect, Personal Feelings of Respect, Interpersonal Feelings of Respect, Organizational Feelings of Respect, and Cultural Feelings of Respect. Further testing of a revised TFORS with added dimensions is needed to increase its reliability and validity. The five domains that emerged from the principal components factor analysis with varimax rotation support the clarification of the conceptual definition of respect, and Feelings of Respect adds more clarity to the conceptual framework. Respect can be quantified, and if nurse managers can measure it, then performance monitoring tools may include metrics related to respectful or disrespectful behaviors. Consequently, individuals who exhibit disrespectful behavior can be managed and positive discipline can be initiated. This type of monitoring

and management also provide an opportunity to reward/acknowledge individuals who exhibit respectful behaviors. This may have significant impacts on the work environment.

The Taylor Feelings of Respect Scale (TFORS) may offer a quantitative measure of the construct of Respect/Disrespect. Quantitative evidence from this study adds to the body of knowledge of the science of nursing, and further research and refinement of the Taylor Feelings of Respect Scale and framework may contribute further to nursing knowledge. The Taylor validated definition of Respect/Disrespect may also create an opportunity to develop Taylor's Theory of Respect/Disrespect.

APPENDIX A. CONCEPTUAL AND OPERATIONAL DEFINITIONS

Appendix (B)

Conceptual and Operational Definition of Terms

Term	Conceptual Definition	Operational Definition	Operational Measurement by TFORS
1. Respect	Is as the manifestation of a mental process which leads to a conclusion of self worth or value. It is a fundamental human concept which is a conditional and complex expression of moral value. It is derived from the Latin word respicere, which means the art of looking back. It is foundational in its meaning to receivers and givers of respect and is closely aligned with the values of human dignity, and deference for persons, caring, honor, trust, worthiness, deference, courtesy, and kindness. The outward expression of Respect is Civility. A person may treat you with civility but may not respect you. As it is experienced in everyday encounters, respect is either present or not. Antecedents of perceived respect are beliefs about justice, civility,	Respect is acknowledging a person when he/she walks into the room, calling a person by name, including a person in group discussion, use of appropriate body language (Purnell, 1999)	TFORS questions: 1-13

11/14/12
Revised 2/11/13
Revised 4/12/13
Revised- 12/20/13
Revised 1/7/14
Revised 2/11/14

Appendix (B)

Conceptual and Operational Definition of Terms

Term	Conceptual Definition	Operational Definition	Operational Measurement by TFORS
	acknowledgement and esteem; it can be applied to persons, objects or animals. Respect for an individual can be for one's title, position, or profession. In this case, respect may be provided even if the person giving the respect dislikes the receiver of the respect. Likability is not a condition for perceived respect. Respect (disrespect) may come from an individual whether they or liked or disliked. The meaning of respect is differentiated by and sensitive to cultural norms, and values. Respect of individuals is a basic human need, that when present may result in reduction of stress and despondency, improvement of team work, creation of satisfactory work environments, improvement of productivity, and work		

11/14/12
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Revised 4/12/13
Revised- 12/20/13
Revised 1/7/14
Revised 2/11/14

Appendix (B)

Conceptual and Operational Definition of Terms

Term	Conceptual Definition	Operational Definition	Operational Measurement by TFORS
	satisfaction. Lack of respect may result in an increase in stress, may incite violence, foster depression, sadness, and unhealthy work environments (Taylor, 2010). Respect is a basic moral principle and human right that is accountable to the values of human dignity, worthiness, uniqueness of person and self determination. As a guiding principle for action toward others, respect is conveyed through the unconditional acceptance, recognition and acknowledgement of the above values in all persons. As a primary nursing ethic (Brown, 1993, p.213).		
2. Disrespect	Disrespect occurs when a person is ignored, neglected, disregarded, or dismissed lightly or thoughtlessly (Spence-Laschinger, 2004)	Disrespect occurs when a person is not called by name, is interrupted or deliberately give a person the silent treatment, treats an elderly person like child, or "gossips" about a colleague in or out of earshot (Dellesega, 2002)	TFORS questions: 17, 23, 30, 40, 49-50, 60, 74
3. Feelings of Respect	Respect is the manifestation of a mental process that leads to a	Respect includes feeling valued, well regarded, recognized, understood,	TFORS questions:

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Revised 2/11/13
Revised 4/12/13
Revised- 12/20/13
Revised 1/7/14
Revised 2/11/14

Appendix (B)

Conceptual and Operational Definition of Terms

Term	Conceptual Definition	Operational Definition	Operational Measurement by TFORS
Conceptual; Definition	conclusion about worth or value. It is a fundamental human concept that is a conditional and complex expression of moral value (Taylor, 2010). Respect is	honored , acknowledged, trusted, treated with deference, courtesy, civility, and tolerance.	2, 3, 7, 9, 10, 13-59
4. Workplace Incivility	Workplace incivility is "low intensity," deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect (Andersson & Pearson, 1999)	Workplace incivility is rude behavior, name-calling gossiping, excluding others from social interactions, behaving aggressively, and bullying (Andersson & Pearson, 1999)	TFORS question(s) 40, 49, 69,
5. Favorable Interactive Effect	A continuous positive increase or advantage in movement Any self-reinforcing process that creates a valuable resource as it grows	Continuous favorable increase in respect in an organization	TFORS question(s): 15, 18, 20, 22, 25, 26-29, 31, 33, 36, 37, 41, 45, 47, 48, 51, 53, 54, 56, 58, 64, 67, 71,
6. Unfavorable Interactive Effect	A continuous negative decrease or disadvantage in movement Any self reinforcing process that creates a diminishing resource as it grows	Continuous unfavorable increase in disrespect in an organization	TFORS question(s): 14, 17, 21, 23, 24, 30, 34, 36, 38, 39, 40, 46, 49-50, 57, 59; 83

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Revised 4/12/13
Revised- 12/20/13
Revised 1/7/14
Revised 2/11/14

Appendix (B)

Conceptual and Operational Definition of Terms

Term	Conceptual Definition	Operational Definition	Operational Measurement by TFORS
7. Enculturation of Respect	The process by which an individual learns the traditional values and norms associated with a particular culture or group	The process by which an individual or groups are influenced by respectful or disrespectful values and norms in an organization.	TFORS question(s): 29
8. Organizational Culture	The norms and values inherent among groups of people in an organization	The entity where groups of people work in an specific setting guided by traditional values and norms	TFORS question(s): 15, 18, 29, 21, 26, 31,32, 33, 46, 37, 39,41, 45-47, 50, 51, 53,
9. Structurational Divergence (SD)	The reciprocal interaction of human actors and social structure. Human actors or agents are both enabled and constrained by structures, yet these structures are the result of previous actions by agents and carried forward only by the agents as memory traces. (Sarasan, Dean, & Dillard, 2006)	SD exists when incompatible interpenetrating meaning structures are positioned in social structures that create an SD nexus and the individuals caught in that nexus experiences the SD-cycle (Nicotera, Mahon, & Zhao, 2010, p. 362)	TFORS question(s): 60-77

11/14/12
Revised 2/11/13
Revised 4/12/13
Revised- 12/20/13
Revised 1/7/14
Revised 2/11/14

APPENDIX B. QUALITATIVE INTERVIEW QUESTIONS

Appendix E

Interview Questions-**Existing Data**

1. Is respect a value in the culture of the organization your work in? How do you know?
2. How do you define respect?
3. On a scale of 1-10 what value do you place on being respected in the workplace and why?
4. Have you ever been disrespected in the workplace? If yes, list some examples.
5. Have you witnessed others being disrespected in your work environment? If yes, please provide an example.
6. Are you respected by your employer, your supervisor, your co-worker, patients, and physicians? If yes, give examples of how you are respected.
7. Are your disrespected by your employer, your supervisor, your co-worker, patients, and physicians? If yes, give example of how you are disrespected.
8. Do you treat others with respect? How do you demonstrate respect?
9. Would you stay in an organization where you are not respected? If the answer is yes, why would you stay?
10. Would you encourage others to leave an organization that does not respect employees? What is your reason for doing so?

Demographic Data:

Number	Age	Ethnic Background	Education	Occupation/current job title	Years in the workforce	Years in this position

Carolyn A. Taylor- HSRB Application

APPENDIX C. PROCEDURES USED TO IDENTIFY TFORS DOMAINS AND ITEM POOL

Development and Draft of Instrument Quantitative instrument development was completed using the six steps for instrument development by Pedhazur and Schmelkin (2001). The steps are described below.

1. Determine the item to be measured. Nurses' feelings of respect was the item that was selected to measure for this study. The conceptual definition of respect and Structurational Divergence (SD) was the conceptual frameworks upon which this study was based. A qualitative study of existing data and review of the literature was the data source for this study. Three nurses were interviewed about their feelings related to respect in the workplace and the information obtained was used to develop the items to measure.
2. Generate an item pool. The item pool was generated by choosing items that reflected the instrument's purpose. Information gathered from the interviews was coded in four categories that provided the basis for item generation. The item pool was generated by utilizing the themes identified from the qualitative study for the TFORS instrument and from the review of the literature.
3. Determine the format. The format of the TFORS is a 5-point Likert scale with 59 items (13 on the meaning of respect and 46 questions on nurses' feelings of respect, personal, interpersonal and organizational and cultural) and 17

questions on SD, an intent to leave section (6 questions) a demographic profile section (16 questions, and a and a open-ended question related to respect. The number 1 represents Strongly Agree; 2, Agree, 3, Neutral; 4, Disagree; and Strongly Disagree; 5.

4. Establish Content Validity. The item pool was reviewed for content validity by experts. Doctoral students (8) in a doctoral-level measurement class, additionally, Dr. Jean B. Moore and doctoral candidates (10) in a dissertation proposal class at George Mason University reviewed the instrument for content validity.
5. The Instrument was pilot tested. A pilot study of 22 Nursing master's degree students (N = 22) participated in the pilot test of the TFORS
6. Evaluate items. Evaluation of the items was done by item analysis, descriptive statistics (mean, standard deviation), and Cronbach's Alpha for internal consistency and reliability.

APPENDIX D. RESEARCH PROTOCOL DOCUMENTS

GEORGE MASON UNIVERSITY

Office of Research Subject Protections

Research 1 Building, 4400 University Drive, MS 4C6, Fairfax, Virginia 22030
Phone: 703-993-4121; Fax: 703-993-9590

TO: Mimi Mahon, College of Health and Human Service

FROM: Sandra M. Sanford, RN, MSN, CIP
Director, Office of Research Subject Protections

PROTOCOL: 6377 Research Level: Doctoral Dissertation

PROPOSAL NO.: N/A

TITLE: The development of a tool to determine the impact of feelings of respect on a nurses' intent to leave the organization

DATE: May 26, 2010

Cc: Carolyn Taylor

At its meeting on May 26, 2010, the George Mason University Human Subjects Review Board (GMU HSRB) reviewed and approved the continuation of the above-cited protocol as submitted. You indicated that there have been no adverse events to participants or data confidentiality.

Please note the following:

1. Copies of the final approved consent documents are attached. You must use these copies with the HSRB stamp of approval for your research. Please keep copies of the signed consent forms used for this research for 3 years after the completion of the research.
2. **Any modification to your research (including the protocol, consent, advertisements, instruments, funding, etc.) must be submitted to the Office of Research Subject Protections for review and approval prior to implementation.**
3. Any adverse events or unanticipated problems involving risks to subjects including problems involving confidentiality of the data identifying the participants must be reported to Office of Research Subject Protections and reviewed by the HSRB.

The anniversary date of this study is 5/25/2011. **You may not collect data beyond that date without GMU HSRB approval.** A continuing review form must be completed and submitted to the Office of Research Subject Protections 30 days prior to the anniversary date or upon completion of the project. A copy of the continuing review form is attached. In addition, prior to that date, the Office of Research Subject Protections will send you a reminder regarding continuing review procedures.

If you have any questions, please do not hesitate to contact me at 703-993-4015.

E-mail recruitment message

Dear Colleagues,

I am requesting your participation is a focus group which will be conducted to provide information for my dissertation entitled: "The Development of a Tool to Determine the Impact Feelings of Respect Have on Nurses' Intent to Leave the Organization." Since retention is a critical issue in our profession, I am hoping to gain valuable insight related to the retention of qualified healthcare professionals. The focus groups will take place at the offices of Taylor-Oden Enterprises, Inc., Springfield, Virginia 22150. The date and time for the session will determined once a sufficient number of participants is obtained.

Prior to the beginning of the session each participant will be asked to sign a consent form. The focus group session will be tape recorded and each participant will be given an alias to use during the discussion. At any time prior to, during or after the focus group starts, a participant may opt out of the session.

The focus group facilitator will ask three questions related to respect in the workplace. Each participant will be given an opportunity to respond to each question.

The information will be used to develop a tool to determine the impact feelings of respect have on nurses' intent to leave the organization.

Refreshment will be provided upon completion of the focus group.

Thank you in advance for time and participation.

Yours truly,

Carolyn A. Taylor, RNC, MBA, PhD (c)

Approval for the use of this document EXPIRES

MAY 25 2011

Protocol # 6377
George Mason University

Informed Consent- Existing Data

Development of a Tool to Determine the Impact Feelings of Respect Have on Nurses' Intent to Leave the Organization.

RESEARCH PROCEDURES

The research project is being conducted to guide development of a tool to determine the impact feelings of respect have on nurses' intent to leave the organization. You participated in a study conducted by Carolyn A. Taylor, RNC, MBA, PhD(c) for a school project for George Mason University in the Spring semester of 2008. You were interviewed and the session was taped recorded. At that time, you gave verbal consent to participate in the study. I am requesting your permission to use the data I gathered from the interview to use in my dissertation work to develop themes and domains for the tool I am developing for my dissertation topic mentioned above. I need your written signature of consent on this form.

RISKS
There are no foreseeable risks, discomforts, or harm associated with participation in this study.

BENEFITS
There are no benefits to you as a participant other than to further research in nursing. There are no personal benefits or monetary gain for participation

CONFIDENTIALITY

All data in this study will be confidential; all person-identifiable data will be coded so that you cannot be identified. Information will be kept in a locked cabinet with access only by the researcher for a period of no longer than five years at which time, the information will be destroyed.

PARTICIPATION

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party.

ALTERNATIVES TO PARTICIPATION
There are no alternatives to participation in this study.

CONTACT

This research study is being conducted by Carolyn A. Taylor, RNC, MBA, PhD(c), and a doctoral nursing student at George Mason University, under the supervision of her professor.

She may be reached at 703-455-9019, or you can call the professor, Mimi Mahon, PhD, RN, at 703-993-1932 for questions or to report a research-related problem. You may also contact the George Mason University Office of Sponsored Programs at 703-993-4121 if you have questions or comments regarding your rights as a participant in this research study. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.
This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form and agree that the data collected from my interview can be used for the above study. .

_____
Name

_____
Date of Signature

Version date: 4/2009:

Approval for the use
of this document
EXPIRES

MAY 25 2011

Protocol #6377
George Mason University

Approval for the use of this document EXPIRES

MAY 25 2011

Protocol # 6377
George Mason University

Informed Consent- Focus Group

<Development of a Tool to Determine the Impact Feelings of Respect Have on Nurses' Intent to Leave the Organization.>

RESEARCH PROCEDURES

The research project is being conducted to develop a tool to determine the impact feelings of respect have on nurses' intent to leave the organization. Once developed, the tool will be piloted to establish reliability and validity. Consequently, the tool will be used to gain valuable knowledge about nurses' feelings that influence retention and recruitment. If you agree to participate your will be asked to participate in a one hour long focus group of six people. The group will be asked three questions related to the word respect. The focus group section will be audio -taped. You will also be asked to complete a sheet requesting demographic information.

RISKS
There are no foreseeable risks, discomforts, or harm associated with participation in this study.

BENEFITS
There are no benefits to you as a participant other than to further research in nursing. There are no personal benefits or monetary gain for participation

CONFIDENTIALITY

All data in this study will be confidential; all person-identifiable data will be coded so that you cannot be identified. Information will be kept in a locked cabinet with access only by the researcher for a period of no longer than five years at which time, the information will be destroyed.

PARTICIPATION

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party.

ALTERNATIVES TO PARTICIPATION
There are no alternatives to participation in this study.

CONTACT

This research study is being conducted by Carolyn A. Taylor, RNC, MBA, PhD(c), and a doctoral nursing student at George Mason University, under the supervision of her professor. She may be reached at 703-455-9019, or you can call the professor, Dr. Mimi Mahon, PhD, RN,

at 703-993-1932 for questions or to report a research-related problem. You may also contact the George Mason University "Office of Research Subject Protections" at 703-993-4121 if you have questions or comments regarding your rights as a participant in this research study. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.
This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form and agree to participate in this study.

_____
Name

_____
Date of Signature

Version date: 4/2009:

Approval for the use of this document EXPIRES

MAY 25 2011

Protocol # 6377
George Mason University

Additional Protocol Documents

Dear Colleagues,

I am a doctoral student at George Mason University, College of Health and Human Services and my dissertation research is on the concept of respect and the impact nurses feelings respect have on retention and conflict in nursing. Nurses often cite a lack of respect as one of the reasons they are dissatisfied with their work environment. **The title of my dissertation is: "The Development of a Tool to Measure Feelings of Respect in Nurses."**

Your assistance is needed to establish the psychometric properties of this tool. I am inviting **RNs and LPNs** to participate by going to the website **Psychdata.com** and enter survey **#147634. Your password is the word Respect.** The password is case sensitive and the "R" is capitalized. This will take you to the consent, once you click continue, you will able to access the survey. The survey will take approximately10-15 minutes to complete.

Your participation is voluntary and your may withdraw at any time with no consequences. Your information will be kept confidential. Thank you in advance for your participation in this most important study.

A Kindle Fire and four (4) $50.00 gift cards will be given out among selected surveys at the end of the survey period. If you want to participate in the give away of the items listed above you will need to send your name, email address and phone number to this email address: ctaylor@toeinc.com.

Yours truly,

Carolyn A. Taylor

Contact:

Carolyn A. Taylor, RNC, MSN, MBA, PhD(c)

703-455-9019

Email address: ctaylor6@gmu.edu

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Informed Consent-Main Survey

<Development of a Tool to Measure Feelings of Respect in Nurses>

INFORMED CONSENT FORM

RESEARCH PROCEDURES

This research main study is being conducted to learn about nurses' feelings of respect. In addition, this researcher hopes to learn about nurses' experiences of respect and conflict in the workplace. If you agree to participate, you will be asked to complete an online survey which will take no more than ten-fifteen minutes of your time. If you are interrupted while taking the survey, you can click on "Save and Exit" at any time, log-on later and pick up where you left off.

RISKS
There are no foreseeable risks for participating in this research.

BENEFITS
There are no benefits to you as a participant other than to further research in nursing. There are no personal benefits or monetary gain for your participation.

CONFIDENTIALITY
All the data in this study will be confidential; all personally-identifiable data will be coded so that you cannot be identified. Information will be kept in a locked cabinet with access only by the researcher for a period of no longer than five years at which time, the information will be destroyed.

PARTICIPATION

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party. If you have read and understand the above statements, please click on the "Continue" button below to indicate your consent to participate in this study. A paper copy of this informed consent is available if requested, by contacting the researcher. A Kindle Fire and four (4) $50.00 gift cards from various retailers will be given away at the end of the survey period. If you want to participate in the given away of the items listed above, you will need to send your name, email address and phone number to this email address:ctaylor@toeinc.com.

CONTACT
This research is being conducted by Carolyn A. Taylor, RNC, MSN, MBA, PhD(c), a doctoral student at George Mason University, under the supervision of her professor. She may be reached at 703-455-9019, or you can call the professor, Dr. P. J. Maddox, EdD, RN, at 703-993-1982 for questions or comments regarding your rights as a participant in this research study. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if

you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form and agree to participate in this study.

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6377
George Mason University

Version date: 11/25/12

Hello Nursing Colleagues!

RNs and LPNs are invited to participate in a research study on **RESPECT!**

Title: The Development of a Tool to Measure Feelings of Respect in Nurses

Researcher: Carolyn A. Taylor, RNC, MSN, MBA, PhD-c

I am a doctoral student at George Mason University. College of Health and Human Services and my dissertation work is on the concept of respect and the impact respect has on retention and conflict in nursing. Nurses often cite a lack of respect as one of the reasons they are dissatisfied with their work environment.

Participation: You can participate by going to the website PsychData.com and enter survey **#146665**, your password is **Respect**, this will take you to the consent, once you click continue you will be able to access the **Taylor Feelings of Respect Scale (TFORS).** It will take approximately 10-15 minutes to complete the survey. If you need to stop the survey for any reason you can click save and exit and return to the survey at a later time.

Your participation is voluntary and you may withdraw at any time with no consequences. Your information will be kept totally confidential. Your identity will not be known. Thank you in advance for your participation in this most important study.

An IPOD and three $50 gift cards will be given away at the end of the survey period.

Contact:

Carolyn A. Taylor, RNC, MSN, MBA, PhD-c

703-455-9019 or 703-754-2630

Email address: ctaylor6@gmu.edu

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6377
George Mason University

Recruitment e-mail for survey:

Dear Friends and Colleagues:

I am in the final phase of my dissertation work. True to the dissertation process, I have confronted some challenges and will have to modify my data collection plan.

I am developing a tool to measure nurses' feelings of respect in the workplace. I am at the stage where I need 300+ nurses to complete the scale so I can establish its psychometric properties.

Would you please take the survey and send the link to 10 of your RN or LPN colleagues and ask them to complete the survey. It takes approximately 10-20 minutes to complete. There will be a drawing for an Ipod and gift cards among completed surveys.

The link is:
https//www.psychdata.com/s.asp?SID=146665 the password is respect. Or you may go to psychdata.com and enter survey # 146665 the password is respect.

I have received permission to conduct this study from the George Mason University Human Subjects Review Board (HSRB). Please contact me with any questions. I can reached at ctaylor6@gmu.edu or 703-455-9019
Thank you for your help with this process,

Best regards,
Carolyn A. Taylor

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George Mason University

Email Letter-Pilot Survey-Protocol 6367

Dear Colleagues:

I am conducting the pilot for my doctoral dissertation, "The Development of a Tool to Measure Feelings of Respect in Nurses". Your participation in this pilot will allow me to conduct the initial reliability and validity testing of my instrument, "The Taylor Feelings of Respect Scale (TFORS)." By conducting this pilot, I hope to further refine my instrument for the final phase of my dissertation work.

Please go the website Psychdata.com and type in survey number: XXXXX. Prior to completing the survey which will take 10-15 minutes to complete, you must read the informed consent. Once you agree to complete the survey you will be able to proceed to the survey questions. If you need to stop the survey for any reason you may save and return to the place you stopped and pick up where you left off at a later time.

Your participation in this pilot is completely voluntary and you may stop your participation at any time. Thank you in advance for your participation in this pilot survey.

Sincerely,

Carolyn A. Taylor, RNC, MSN, MBA, PhD(c)

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Informed Consent-Pilot Survey

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George Mason University

<Development of a Tool to Determine the Impact Feelings of Respect Have on Nurses' Intent to Leave the Organization>

INFORMED CONSENT FORM

RESEARCH PROCEDURES

This research pilot study is being conducted to learn about nurses' feelings of respect. In addition, this researcher hopes to learn about nurses' experiences of respect and conflict in the workplace. If you agree to participate, you will be asked to complete an online survey which will take no more than ten-fifteen minutes of your time. If you are interrupted while taking the survey, you can click on "Save and Exit" at any time, log-on later and pick up where you left off.

RISKS
There are no foreseeable risks for participating in this research.

BENEFITS
There are no benefits to you as a participant other than to further research in nursing. There are no personal benefits or monetary gain for your participation.

CONFIDENTIALITY
All the data in this study will be confidential; all personally-identifiable data will be coded so that you cannot be identified. Information will be kept in a locked cabinet with access only by the researcher for a period of no longer than five years at which time, the information will be destroyed.

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party. If you have read and understand the above statements, please click on the "Continue" button below to indicate your consent to participate in this study. A paper copy of this informed consent is available if requested, by contacting the researcher.

CONTACT
This research is being conducted by Carolyn A. Taylor, RNC, MSN, MBA, PhD(c), a doctoral student at George Mason University, under the supervision of her professor. She may be reached at 703-455-9019, or you can call the professor, Mimi Mahon, PhD, RN, at 703-993-1932 for questions or comments regarding your rights as a participant in this research study. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

Version date:
Revised 07/2005

APPENDIX E. FOCUS GROUP QUESTIONS

Appendix: F

Focus Group Questions

Topic: Respect

Instructions: Time will be allocated to discuss each of the three questions.

The facilitator will announce the end of each discussion.

1. What does respect mean to you?

2. Talk about a time you felt respected in the workplace.

3. Talk about a time you felt disrespected in the workplace.

Carolyn A. Taylor-HSRB Application

APPENDIX F. PILOT SURVEY PROTOCOL

Appendix:G

Email Letter-Pilot Survey-Protocol 6367

Dear Colleagues:

I am conducting the pilot for my doctoral dissertation, "The Development of a Tool to Measure Feelings of Respect in Nurses". Your participation in this pilot will allow me to conduct the initial reliability and validity testing of my instrument, "The Taylor Feelings of Respect Scale (TFORS)." By conducting this pilot, I hope to further refine my instrument for the final phase of my dissertation work.

Please go the website Psychdata.com and type in survey number: XXXXX. Prior to completing the survey which will take 10-15 minutes to complete, you must read the informed consent. Once you agree to complete the survey you will be able to proceed to the survey questions. If you need to stop the survey for any reason you may save and return to the place you stopped and pick up where you left off at a later time.

Your participation in this pilot is completely voluntary and you may stop your participation at any time. Thank you in advance for your participation in this pilot survey.

Sincerely,

Carolyn A. Taylor, RNC, MSN, MBA, PhD(c)

APPENDIX G. TAYLOR FEELINGS OF RESPECT SCALE (TFORS)

Taylor Feelings of Respect Scale (TFORS)

Instructions: Please place a check in the box under the column that represents your response to each statement.

Legend: Strongly Agree (SA)-1; Agree (A)-2; Neutral (N)-3; Disagree (D)-4; Strongly Disagree (SD)-5

Item	Strongly Agree (SA-1)	Agree (A-2)	Neutral (N-3)	Disagree (D-4)	Strongly Disagree (SD-5)
Respect (Respect means)					
1. Treating others like you want to be treated					
2. Caring about others					
3. Not talking down to others					
4. Treating others with courtesy					
5. Treating others with dignity					
6. Honoring others					
7. Recognizing others					
8. Including others					
9. Acknowledging others					
10. Valuing others					
11. Criticizing others					
12. Treating others in an uncivil manner					
13. Trusting others					
Feelings of Respect					
14. I feel I am not valued by others					
15. I feel respected when I am supported by my co-workers					
16. I do not respect myself					
17. I feel mistreated by others					
18. I feel respected when an ethics committee encourages ethical reflection					
19. I feel my family respects me					
20. I feel respected when work schedules are flexible and self-scheduling is an option					
21. I feel respected when there are poor work relationships between departments					
22. I feel good when I am respected					
23. I feel angry when I am not respected					
24. I feel patients and families do not respect me					
25. I am acknowledged by others					
26. I feel respected when the organization assures the work environment is safe					
27. I feel honored by my co-workers					
28. I respect myself					
29. I believe respect has different meanings in different cultures					
30. I am not recognized by others					

Revision- 02/2013

1

Taylor Feelings of Respect Scale (TFORS)

Item	Strongly Agree (SA-1)	Agree (A-2)	Neutral (N-3)	Disagree (D-4)	Strongly Disagree (SD-5)
31. I feel respected when nursing leaders are competent and represent nursing concerns					
32. I feel respected when I am bullied by my co-workers					
33. I feel respected by my co-workers					
34. I do not feel respected when I am unjustly blamed by my co-workers					
35. I feel others care about me					
36. I feel respected when physicians and nurses work collaboratively with me in the work environment					
37. I feel respected by my supervisors					
38. I feel others are rude to me					
39. I don't feel respected when my unit is understaffed					
40. I feel ignored by others					
41. I feel my work environment promotes respectful behaviors					
42. I feel sad when I am not respected					
43. I feel my family does not respect me					
44. I feel motivated when I am respected					
45. I feel respected when my pay reflects my value as a nurse					
46. I do not feel respected when my supervisor yells at me					
47. I feel respected when I have sufficient resources to do my job					
48. I feel honored by others					
49. I feel I get yelled at by others					
50. I feel physicians do not respect me					
51. I feel respected when my organization values and acknowledges my contributions					
52. I feel respected when I am not valued					
53. I treat patients better when I am respected					
54. I feel physicians respect me					
55. I feel my family respects me					
56. I am acknowledged by others					
57. I feel sad when I am not acknowledged					
58. I feel respected when nursing leadership participates in decision –making at the highest level of the organization					
59. I avoid others when I do not feel respected					
60. I feel devalued when I am not respected					
61. I feel like I am fighting unnecessary fires at work.					
62. People are caught in a cycle of undermining one another.					
63. I feel obligated to fulfill opposing demands at the					

Revision- 02/2013

Taylor Feelings of Respect Scale (TFORS)

Item	Strongly Agree (SA-1)	Agree (A-2)	Neutral (N-3)	Disagree (D-4)	Strongly Disagree (SD-5)
same time.					
64. I am treated with respect by my management.					
65. I experience unnecessary stress at work because of people playing games.					
66. The politics of hospital/organization prevent patients from having their needs addressed.					
67. People at my hospital/organization are team players.					
68. The concerns of the hospital/organization surpass the needs of the patients.					
69. People at my workplace sabotage one another.					
70. I am "damned if I do, damned if I don't."					
71. My supervisor will help me out if I tell him/her I am overwhelmed.					
72. People at my organization/hospital hold personal vendettas.					
73. Nurses and physician/surgeons view patients differently, and this causes conflict.					
74. Backstabbing is a problem at my hospital/organization.					
75. Administrative procedures get in the way of what's best for the patient.					
76. I can't go to my nurse's manager for help resolving conflicts because she won't do anything to help.					
77. I feel like I am "between a rock and a hard place."					

Taylor Feelings of Respect Scale (TFORS)

Intent to leave: I plan to leave the organization in:					
Legion: Very likely (VL)-1; Slightly likely (SL)-2; Uncertain (UC)-3; Unlikely-(UL)4					
	Very Likely (VL-1	**Slightly Likely (SL-2)**	**Uncertain (UC-4)**	**Unlikely (UL)**	
78. 2-3 weeks					
79. 2-3 months					
80. 6 months					
81. 1 years					
82. 2 years					

83. **I plan to leave the organization because:**

A. I am not respected
B. The organization does not support respectful behavior toward nurses.
C. My co-workers are not respectful of each other
D. My supervisor(s) are not respectful toward nurses
E. Physicians are not respectful towards nurses
F. Patent/families are not respectful toward nurses
G. All of the above
H. None of the above
I. Other

Comment:_____

_____

Taylor Feelings of Respect Scale (TFORS)

Instructions:

Please complete the information below by selecting your response from the answers provided.

Demographic Data:

What is your workplace state and zip code?

1. State_____ 2. Zip Code_____

What is your licensure designation?

1. RN ____
2. LPN ____

What is the highest level of education completed?

1. Diploma ____
2. ADN ____
3. BSN ____
4. MSN ____
5. MBA ____
6. DNP ____
7. PhD ____
8. Other (please specify)_____

What is your gender?

1. Female _____
2. Male _____

What is your age? _____

What is your race/ethnicity?

1. African American _____
2. Asian American _____
3. Caucasian _____
4. Hispanic _____
5. Native Hawaiian _____
6. Pacific Islander _____
7. American Indian _____
8. Alaska Native _____
9. Other (please specify) _____

Taylor Feelings of Respect Scale (TFORS)

What is your marital Status?

1. Single (never married) _____
2. Married _____
3. Divorced _____
4. Separated _____
5. Widowed _____

How many children do you have?

1. None _____
2. 0ne _____
3. Two _____
4. Three _____
5. Four _____
6. Five or more _____

What is your religious affiliation?

1. Protestant _____
2. Catholic _____
3. Jewish _____
4. Muslim _____
5. Other (please specify)_____

What department do you work in?

1. Medical/Surgical _____
2. Labor/Delivery _____
3. Post Partum _____
4. Mother Baby _____
5. Pediatrics _____
6. Critical Care _____
7. Operating Room (OR) _____
8. Emergency Room _____
9. Administration _____
10. Other (please specify_____

Taylor Feelings of Respect Scale (TFORS)

Are you certified in your specialty area?

1. Yes (please specify)_____
2. No_____

How many beds does your hospital have?

1. Below 100 _____
2. 101-250 _____
3. 251-350 _____
4. 351-450 _____
5. 451-550 _____
6. 550-650 _____
7. 651-750 _____
8. 750+ _____
9. Don't Know _____

What is your work status?

1. Part time _____
2. Full time _____
3. Other (please specify)_____

How long have you been employed in your present organization?

1. One year or less _____
2. Two years _____
3. Three years _____
4. 4-6 years _____
5. 7-10 years _____
6. 10-15 years _____
7. 16-20 years _____
8. 20 + _____

Taylor Feelings of Respect Scale (TFORS)

What is your hospital's designation?

1. Primary _____
2. Secondary _____
3. Tertiary _____
4. Other (please specify)_____

Does your hospital/organization have magnet status?

1. Yes _____
2. No _____

"This study has been about respect, do you have any specific comments about respect that I should consider?"_____

_____

_____

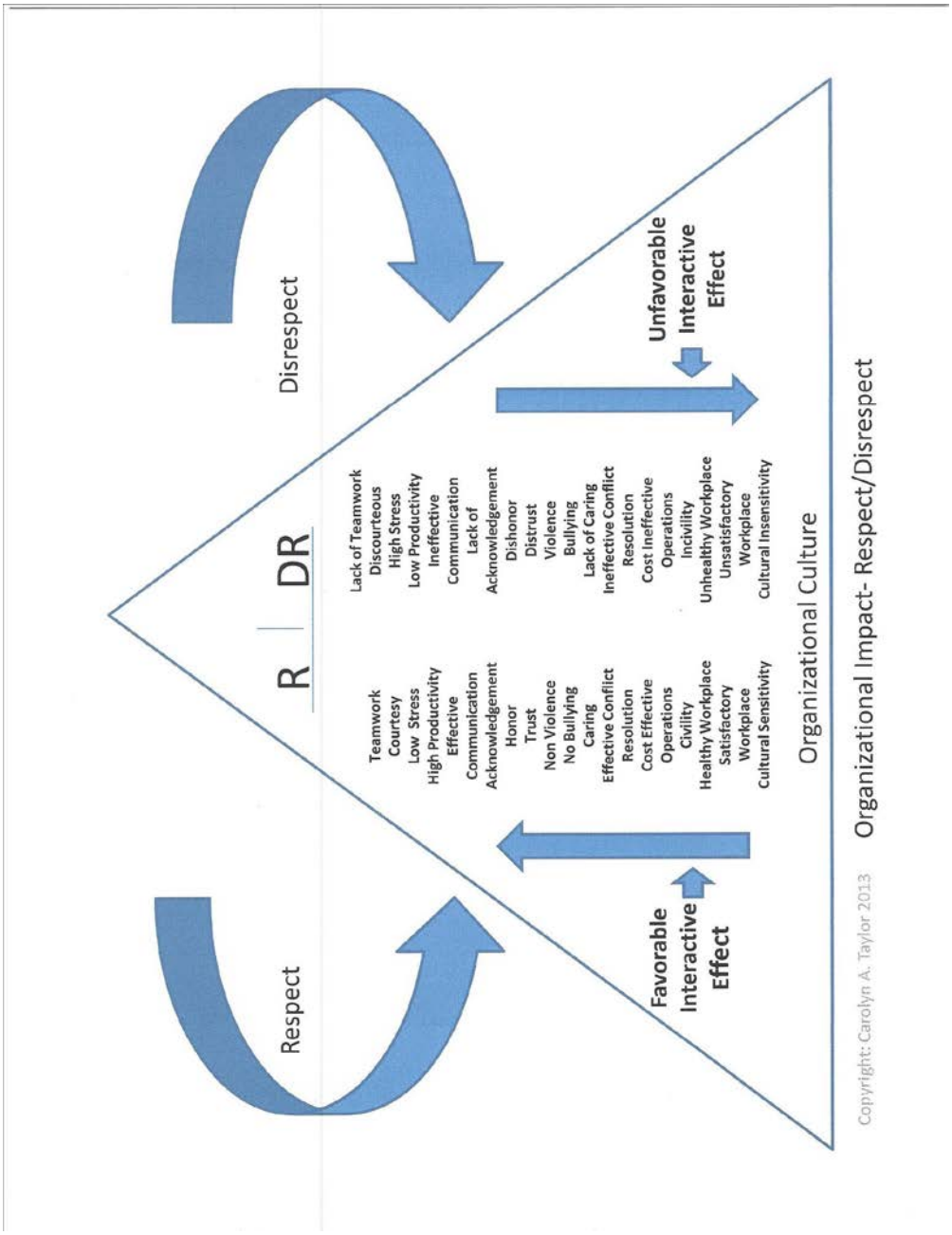
If you desire to participate in the Kindle Fire and the four (4) $50.00 gift cards give away among selected surveys at the close of the survey period, please send your name, email address and phone number to this email address: ctaylor@toeinc.com.

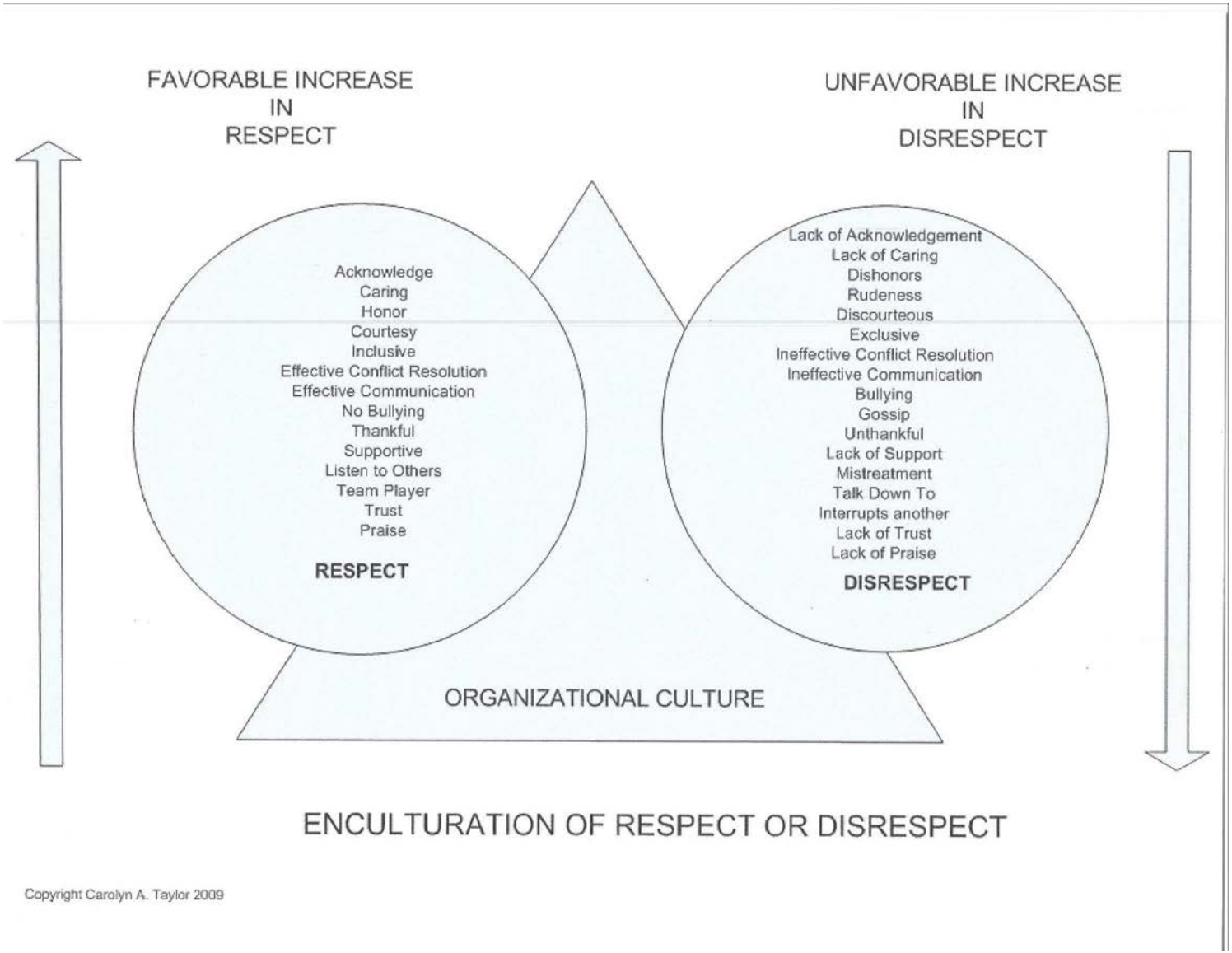
_____

_____

Thank You!

APPENDIX H. SELECTED FIGURES AND TABLES





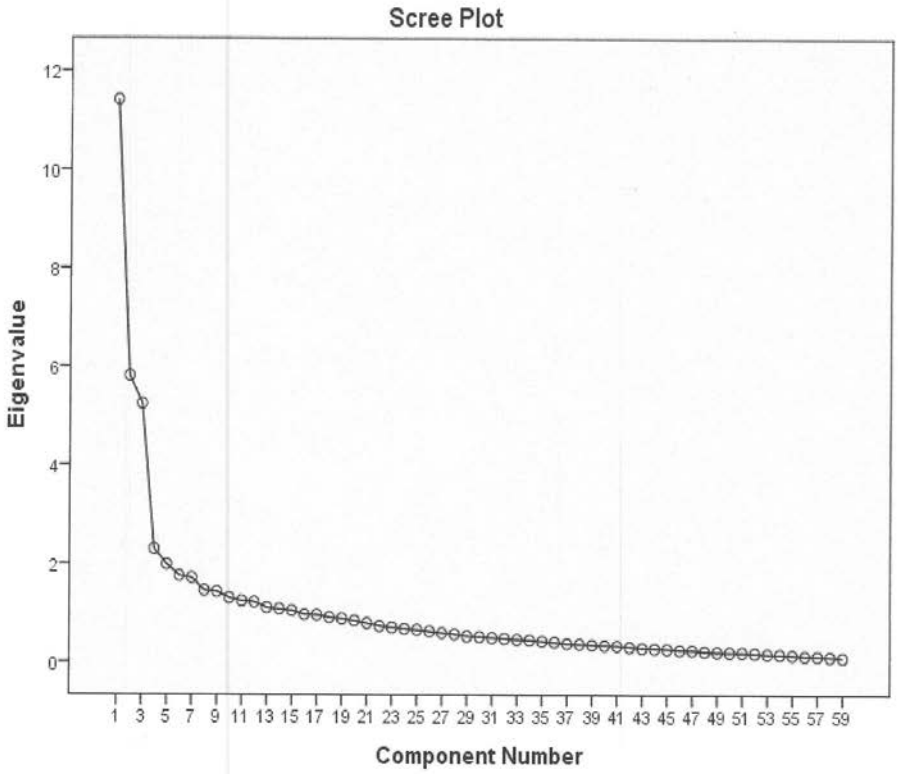


Figure 4: Scree Plot

Table 3

Demographic Data: Licensure Designation and Highest Level of Education, Specialty Certification

Demographic Variable	N	Percent
Licensure Designation		
RN	189	91.3
Missing	18	8.7
Total	207	100.0
Highest Level of Education		
Diploma	26	12.1
ADN	31	15.0
BSN	53	25.6
MSN	43	20.8
MBA	2	1.0
PhD	4	2.1
Other	31	15.0
Missing	18	8.7
Total	207	100.0
Specialty Certification		
Yes	87	42.0
No	102	49.3
Missing	18	8.7
Total	207	100.0

Table 4

TFORS Frequency Distribution

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	F	%	F	%	F	%	F	%	F	%
1. Treating other like you want to be treated	183	88.4	20	9.7	1	.5	1	.5	2	1.0
2. Caring about others	135	65.2	43	20.8	20	9.7	7	3.4	2	1.0
3. Not talking down to others	173	83.6	30	14.5	0	0	2	1.0	2	1.0
4. Treating others with Courtesy	181	87.4	23	11.1	0	0	1	.5	2	1.0
5. Treating other with dignity	184	88.9	18	8.7	2	1.0	1	.5	2	1.0
6. Honoring others	126	60.9	56	27.1	18	8.7	2	1.9	3	1.4
7. Recognizing others	138	66.7	51	24.6	12	5.8	3	1.4	3	1.4
8. Including others	112	54.1	68	32.9	20	9.7	4	1.9	2	1.4
9. Acknowledging others	138	66.7	61	29.5	4	1.9	2	1.0	2	1.0
10. Valuing others	138	66.7	54	26.1	8	3.9	4	1.9	3	1.4
11. Criticizing others	9	4.3	9	4.3	19	9.2	69	33.3	161	48.8
12. Treating others in an uncivil manner	6	2.9	2	1.0	2	1.0	32	15.5	165	79.7
13. Trusting others	74	35.7	68	32.9	43	20.8	14	6.8	8	3.9
14. I am not valued my others	12	5.8	24	11.6	25	12.1	89.	43.0	57	27.5
15. I feel respected when I am supported by my co-workers	104	50.2	87	42.0	7	3.4	6	2.9	3	1.4
16. I do not respect myself	2	1.0	1	.5	5	2.4	51	24.6	148	71.5
17. I feel mistreated by others	4	1.9	25	12.1	23	11.1	79	38.2	76	36.7
18. I feel respected when a strong ethics committee encourages ethical reflection	50	24.2	64	30.9	70	33.8	17	8.2	6	2.9

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	F	%	F	%	F	%	F	%	F	%
19. I feel my family respects me	128	61.8	67	32.4	7	3.4	4	1.9	1	.5
20. I feel respected when work schedules are flexible and self-scheduling is an option	80	38.6	77	37.2	38	18.4	10	3.8	2	1.0
21. I feel respected when are poor working relationships between departments	1	.5	1	.5	11	5.3	78	37.7	116	56.0
22. I feel good when I am respected	148	71.5	57	27.5	1	.5	1	.5	0	0
23. I feel angry when I am not respected	58	28.0	84	40.6	33	15.6	25	12.1	7	3.4
24. I feel patients and families do not respect me	1	.5	6	2.9	24	11.8	82	39.6	94	45.4
25. I am acknowledged by others	64	30.9	109	52.7	25	12.1	8	3.9	1	.5
26. I feel respected when the organization assures the work environment is safe	89	43.0	92	44.4	22	10.6	3	1.4	1	.5
27. I feel honored by my co-workers	50	24.2	83	40.1	55	26.6	15	7.2	4	1.9
28. I respect myself	139	67.1	62	30.0	3	1.4	1	.5	2	1.0
29. I believe respect has different meaning in different cultures	70	33.8	105	50.7	14	6.8	13	6.3	5	2.4
30. I am not recognized by others	6	2.9	14	6.8	24	11.6	91	44.0	72	34.8
31. I feel respected when nurse leaders are competent and represent nursing concerns	99	47.8	87	42.0	15	7.2	5	2.4	1	.5
32. I feel respected when I am bullied by my co-workers	0	0	4	1.9	2	1.0	26	12.6	167	80.7
33. I feel respected by my co-workers	73	35.3	95	45.9	22	10.6	8	3.9	1	.5
34. I do not feel respected when I am unjustly blamed by my co-workers	82	39.6	84	40.6	22	10.6	6	2.9	5	2.4
35. I feel others care about me	64	30.9	114	55.1	15	7.2	5	2.4	1	.5
36. I feel respected when physicians and nurses work	137	66.2	60	29.0	1	.5	0	0	1.	.5

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	F	%	F	%	F	%	F	%	F	%
collaboratively in the workplace										
37. I feel respected by my supervisors	76	36.7	82	39.6	24	11.6	14	6.8	3	1.4
38. I feel others are rude to me	51	24.6	92	44.4	35	16.9	18	8.7	3	1.4
39. I don't feel respected when my unit is understaffed	48	23.2	58	28.0	54	26.1	32	15.5	7	3.4
40. I feel ignored by other	8	3.9	14	6.8	27	13.0	88	42.5	62	30.0
41. I feel my work environment promotes respectful behaviors	45	21.7	95	45.9	31	15.0	23	11.1	3	2.4
42. I feel sad when I am not respected	44	21.3	105	50.7	26	12.6	21	10.1	3	1.4
43. I feel my family does not respect me	2	1.0	6	2.9	5	2.4	56	27.1	130	62.8
44. I feel motivated when I am respected	120	58.0	75	36.2	3	1.4	1	.5	0	0
45. I feel respected when my pay reflects my value as a nurse	104	50.2	76	36.7	14	6.8	5	2.4	0	0
46. I do not feel respected when my supervisor yells at me	97	46.9	59	28.65	25	12.1	9	4.3	9	4.3
47. I feel respected when I have sufficient resources to do my job	97	46.9	90	43.5	9	4.3	3	1.4	0	0
48. I feel honored by others	42	20.3	96	46.4	45	21.7	11	5.3	5	2.4
49. I feel I get yelled at by others	3	1.4	9	4.3	18	8.7	84	40.6	85	41.1
50. I feel physicians do not respect me	8	3.9	12	5.8	32	15.5	86	41.5	61	29.5
51. I feel respected when my organization values and acknowledges my contribution	115	55.6	81	39.1	2	1.0	0	0	1	.5
52. I feel respected when I am not valued	2	1.0	3	1.4	9	4.3	76	36.7	109	52.7
53. I treat patients better when I am respected	31	15.0	58	28.0	36	17.4	51	24.6	23	11.1
54. I feel physicians respect me	65	31.4	94	45.4	29	14.0	7	3.4	4	1.9
55. I feel my family respects me	119	57.5	69	33.3	6	2.9	4	1.9	1	.5
56. I am acknowledge by others	69	33.3	102	49.3	20	9.7	8	3.9	0	0

Scale	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
Item	F	%	F	%	F	%	F	%	F	%
57. I feel sad when I am not acknowledged by others	24	11.6	70	33.8	61	29.5	38	18.4	6	2.9
58. I feel respected when nursing leadership participates at the highest levels of the organization	72	34.8	75	36.2	41	19.8	9	4.3	2	1.0
59. I avoid others when I am not respected	14	6.8	66	31.9	46	22.2	64	30.9	9	4.3

Table 6

Demographics: Work Department, Work Status, Length of Time Employed

Demographic Variable	*N*	Per Cent
Work Department		
Medical/Surgical	14	6.8
Labor/Delivery	4	1.9
Post Partum	1	.5
Mother Baby	3	1.4
Pediatrics	6	2.9
Critical Care	7	3.4
Operating Room	17	6.2
Emergency Room	6	2.9
Ambulatory Services	2	1.0
Administration	10	4.8
Academic Setting	10	4.8
Other	109	57.7
Missing	18	8.7
Total	207	100.0
Work Status		
Part Time	40	19.3
Full Time	96	48.4
Other	53	25.6
Missing	18	8.7
Total	207	100.0
Length of Time Employed in Present organization		
One year or less	28	13.5
Two years	19	9.2
Three years	12	5.8
4-6 years	15	7.2
7-10 years	23	11.1
10-15 years	29	14.0
16-20 years	19	9.2
20+ years	44	21.3
Missing	18	8.7
Total	207	100.0

Table 8

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain III: Interpersonal Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V44 I feel motivated when I am respected	1.42	.553	207	.669
V26 I feel respected when the organization assures the work environment is safe	1.71	.748	207	.609
V31 I feel respected when nursing leaders are competent and represent nursing concerns	1.65	.769	207	.607
V42 I feel sad when I am not respected	2.17	.942	207	.580
V22 I feel good when I am respected	1.30	.502	207	.578
V47 I feel respected when I have sufficient resources to do my job	1.59	.652	207	.573
V57 I feel sad when I am not acknowledged	2.66	1.017	207	.539
V20 I feel respected when work schedules are flexible and self scheduling is an option	1.90	.916	207	.534
V 39 I don't feel respected when my unit is understaffed	3.54	1.127	207	-.518
V45 I feel respected when my pay reflects my value as a nurse	1.60	.731	207	.493
V36 I feel respected when physician and nurses work collaboratively with me in the work environment	1.33	.542	207	.486
V51 I feel respected when my organization values and acknowledges my contributions	1.45	.574	207	.474
V34 I do not feel respected when I am unjustly blamed by my co-workers	1.83	.920	207	.461
V46 I do not feel respected when my supervisor yells at me	1.86	1.090	207	-.453
V15 I feel respected when I am supported by my co-workers	1.63	.816	199	.432
V52 I feel respected when I am not valued *	1.56	.742	199	.418
V23 I feel angry when I am not respected	2.22	1.092	199	.383
V58 I feel respected when nursing leadership participates at the highest levels of organization	1.96	.916	199	.365
V53 I treat patients better when I am respected	2.88	1.276	199	.362
V18 I feel respected when a strong ethic committee encourages ethical reflection	2.31	1.002	199	.354
V59 I avoid others when I do not feel respected	2.94	1.057	199	.311

Note. * Reverse coded item- Cronbach's alpha = .676, number of items (K) = 21, percentage of variance explained = 9%.

Table 9

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain IV: Organizational Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V43 I feel my family does not respect me*	4.54	.777	199	-.684
V55 I feel my family respects me	1.49	.703	199	.672
V19 I feel my family respect me	1.46	.702	199	.601
V24 I feel patients and families do not respect me*	4.28	.805	199	-.505
V50 I feel physicians do not respect me	2.10	1.033	199	.499
V54 I feel Physicians respect me	1.95	.892	199	.475
V16 I do not respect myself*	1.33	.603	199	.465
V28 I respect myself	1.39	.649	199	.463
V21 I feel respected when there are poor working relationships between departments*	4.48	.673	199	.296

Note. * Reversed coded item Cronbach's alpha = .426, number of items (K) = 9, percentage of variance explained = 4%.

Table 10

Descriptive Statistics: Factor Loadings and Reliability Estimates: Domain V: Cultural Feelings of Respect

Item	*M*	*SD*	*N*	Loading
V12 Treating others in an uncivil manner	4.70	.792	207	-.650
V11 Criticizing others	4.19	1.058	207	.-543
V29 I believe respect has different meanings in different cultures	1.93	.935	207	.247

Note. * Reverse coded items-Cronbach's alpha = .364, number of items (K) = 3, percentage of variance explained = 4%.

Table 11

Correlation Matrix: Structurational Divergence (SD) and Nurses' Feelings of Respect

		SD_Scale	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
SD_Scale	Pearson Correlation	1	-.048	.037	.210	.119	.128
	Sig (2- tailed)		.500	.609	.003	.093	.071
	N	199	199	199	199	199	199
Domain 1	Pearson Correlation		1	.172	.141	.008	-.208
	Sig (2- tailed)			.013	.043	.910	.003
	N		207	207	207	207	207
Domain 2	Pearson Correlation			1	.587	.770	.222
	Sig (2- tailed)				.003	.000	.001
	N			207	207	207	207
Domain 3	Pearson Correlation					.536.	.126
	Sig (2- tailed)					.000	.071
	N					207	207
Domain 4	Pearson Correlation						.131
	Sig (2- tailed)						.060
	N						207
Domain 5	Pearson Correlation						1
	Sig (2- tailed)						
	N						

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BIOGRAPHY

Carolyn A. Taylor received her Bachelor of Science in Nursing in 1978 and her Master of Science in Nursing in 1986 from George Mason University (GMU). She completed a residency in International Business and Finance at Oxford University in Oxford, England in 1993. She completed a Master of Business Administration in 1994 from GMU. She has more than 36 years experience in the healthcare industry as a clinician, manager, executive administrator, educator, and mentor. Currently and for the last 14 years she has been Corporate Operations Officer for Taylor-Oden Enterprises (TOE), Inc., an information technology and healthcare consulting firm. She is an adjunct faculty member at George Mason University in the College of Health and Human Services and serves on the Dean's Advisory Board. She is the newly elected chair of the Northern Virginia Area Health Education Center (NVAHEC) Board of Directors. She is a member of the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN) and the American Nurses Association (ANA).