ORGANIZATIONAL BETRAYAL, AVOIDANT LEADERSHIP PRACTICES, AND WELL-BEING AMONG NURSES EXPOSED TO WORKPLACE BULLYING

by

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A Dissertation
Submitted to the
Graduate Faculty
of
George Mason University
in Partial Fulfillment of
The Requirements for the Degree
of
Doctor of Philosophy
Nursing

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ACKNOWLEDGEMENTS

I would like to thank my dissertation chair, Dr. Kyeung Mi Oh, for her tireless patience and wisdom with this journey, as well as my wonderful committee, Dr. Panagiota Kitsantas and Dr. Xiaoquan Zhao, for their ideas, time, and suggestions.

I would like to acknowledge many of the women in my family who inspire me, especially my grandmothers Florence Cardoni and Patricia McArdle, my daughters Eden and Evelyn, and my mother Mary Pat Cardoni. They are all fierce, family-oriented, faith-centered women. I would like to thank my husband Michael for all his patience with this journey and my father Robert Cardoni for his listening ear. To all my family and friends who helped with ideas and encouragement. I would also like to thank my colleague Dr. Amy Graham, for never letting me give up, Dr. Kevin Mallinson, for helping me onto the road of scholarship, and all the wonderful faculty and staff at George Mason University who assisted me, large and small, on this venture.

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ABSTRACT

ORGANIZATIONAL BETRAYAL, AVOIDANT LEADERSHIP PRACTICES AND WELL-BEING AMONG NURSES EXPOSED TO WORKPLACE BULLYING

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Background: The work environment and organizational culture are theoretically important in the profession of nursing. Nurses trust that the organizations in which they practice will provide support and safety for them and for their patients, including safety and support in response to issues such as workplace bullying. Organizational betrayal can occur if a nurse's organization betrays the trust for safety and support in response to a negative workplace event. Ineffective response to a workplace issue could also be considered avoidant leadership; avoidant leadership has been defined as hostility towards the person who was bullied, normalizing the bullying, and equivocation regarding the bullying. Organizational betrayal and avoidant leadership could impact nurses' workplace well-being, which is a concern for health systems leaders because well-being is associated with healthcare outcomes.

Study Aims: The aims of this study are: 1) to describe the prevalence of weekly/daily bullying among nurses; 2) to describe associations of demographic and workplace

characteristics and workplace well-being (burnout, job dissatisfaction, and absenteeism) among nurses who have experienced any bullying behaviors; 3) to explore associations of organizational betrayal and support with workplace well-being (burnout, job dissatisfaction and absenteeism) after controlling for demographic and workplace characteristics among nurses who have experienced bullying behaviors; 4) to describe frequencies of types of avoidant leadership in response to bullying among nurses who have experienced bullying behaviors; 5) to examine associations between types of avoidant leadership in response to bullying (hostility, normalizing, equivocation) and workplace well-being (burnout, job dissatisfaction and absenteeism) among nurses who experienced bullying behaviors; and 6) to estimate the size and direction of associations between covariates (experiencing who experienced bullying behaviors acts of avoidant leadership, and demographic and workplace characteristics) and workplace well-being among nurses who experienced bullying behaviors.

Methods: A cross-sectional study was conducted using an online survey. The target population was registered nurses in the U.S. The inclusion criteria were to have been working in nursing job for at least six months as a registered nurse. Participants were recruited using advertisements and direct outreach on social media.

Study variables were demographics/workplace characteristics, bullying, organizational betrayal and support, burnout, job satisfaction, and absenteeism. Bullying was measured using the Negative Acts Questionnaire-Revised for Nursing. Organizational betrayal and avoidant leadership were measured using the Institutional Betrayal Questionnaire for Health (IBQ-H). Burnout was measured using the Well-Being

Index (WBI). Job satisfaction was measured using a satisfaction Likert scale question. Absenteeism was measured by asking respondents how many days of work were missed in the past 12 months for illness or personal reasons. Demographic and workplace characteristics were also collected, including age, gender, race/ethnicity, workplace type, work role, years of experience in nursing, hours worked per week, and Magnet Recognition Program® designation of workplace.

Descriptive statistics were used to describe the characteristics of the sample, prevalence of bullying and prevalence of avoidant leadership types. Testing of normality showed non-normal distribution of some dependent variables; thus, non-parametric tests were used. Cut scores were used to dichotomize variables. Cut score for the WBI was based on the published cut score. For the IBQ-H subscales, a score of 1 was used to determine exposure to any act of betrayal, support, or avoidant leadership (hostility, normalizing, equivocation). Cut scores for absenteeism were based on sample mean. Chi square tests were used to analyze bivariate relationships between categorical variables. Logistic regression analyses were used to examine the size and direction of associations between independent variables variates (organizational betrayal and support, experiencing acts of avoidant leadership, and demographic and workplace characteristics) and workplace well-being among nurses who experienced bullying behaviors. Institutional review board approval was obtained.

Results: There were 242 total responses to the survey. There was complete data for the NAQR-US scale. Prevalence of weekly or daily bullying was 31%. (N=242). Among nurses who had experienced at least one bullying behavior (N=173), organizational

betrayal increased the odds of burnout, OR =2.62, 95% CI [1.14,6.03], job dissatisfaction, OR =2.97, 95% CI [1.01,8.73], and absenteeism, OR= 6.11, 95% CI [2.26,16.54]. Organizational support decreased the odds of job dissatisfaction, OR= .30, 95% CI [.15,.60] and absenteeism, OR= .50, 95% CI [.25,.99].

For avoidant leadership, many nurses who experienced bullying behaviors reported experiencing at least one act of hostility (n=132, 76%), of normalizing (n=131, 75%), and of equivocation (n=115, 66%). In chi-square tests, the three types of avoidant leadership all had significant relationships with burnout, job dissatisfaction, and absenteeism. In the logistic regression models, equivocation was associated with burnout, and normalizing was associated with job dissatisfaction after controlling for demographic and workplace characteristics. Experiencing at least on act of equivocation increased odds of burnout, OR = 3.78, 95% CI [1.35,10.53], and experiencing at least one act of normalizing was increased odds of job dissatisfaction, OR =5.03, 95% CI [1.16,21.72]. None of the avoidant leadership types were significantly associated with absenteeism.

Conclusion: In this study, organizational betrayal was associated with increased odds of burnout, job dissatisfaction, and absenteeism. Organizational support was associated with decreased odds of job dissatisfaction and being absent from work. Avoidant leadership was associated with higher rates of poor workplace well-being. Normalizing the bullying increased likelihood of burnout, and equivocation (e.g. showing lack of concern) of bullying increased the likelihood of job dissatisfaction. Nurse leaders should be aware that organizational betrayal is a negative work environment experience, and that avoidant leadership is problematic towards nurses' workplace well-being. Future studies could

employ wider recruitment strategies to increase sample size and diversity to better match the target population, provide more controls for organizational and individual characteristics such as recruitment from specific health systems, and could employ longitudinal design to capture better cause-and-effect relationships.

CHAPTER ONE

Background

Workplace Bullying

Workplace bullying is a prominent work environment issue in nursing (American Nurses Association, 2015a). Bullying has harmful effects on well-being. A meta-analysis of 173 cross-sectional studies of workplace bullying (N=77,121) found bullying was associated with health concerns, including mental health problems (r =.34, p<.001), burnout (r=.27, p<.001), and physical health problems (r=.21, p<.001). Bullying was associated with organizational outcomes, including intent to leave (r=.28, p<.001), job satisfaction (r= -.22, p<.001), performance, (r= -.12, p<.001) and absenteeism (r =.11, p<.001) among employees (Nielsen & Einarsen, 2012).

Nursing is not immune to bullying despite being recognized as a profession of caring (Broome & Williams-Evans, 2016). The outcomes of bullying nurse well-being include increased burnout (Allen et al., 2015), physical health issues, higher intent to leave the organizations, and negative effects on patient care (Hutchinson, Wilkes, Jackson, & Vickers, 2010; Read & Laschinger, 2013; Reknes et al., 2014; Spence Laschinger & Nosko, 2015). Though scarce cost estimates of bullying are available for the U.S., worldwide cost estimates related to medical care, lost productivity, and other organizational outcomes are around $23 billion (Gillen et al., 2017).

Organizations have a responsibility to promote support for nurses who are bullied through efforts towards prevention and mitigation (American Nurses Association, 2015a). In terms of organizational support after bullying, a qualitative study of nurses who experienced bullying explored the role of the organization in coping with bullying (Gaffney et al., 2012). In the study, nurses described a sense of dismay and disappointment when complaints about bullying were ignored by the administration. Gaffney et al. (2012) also found that nurses whose managers took steps to act on the bullied nurse's behalf felt an enormous sense of relief, and increased satisfaction with their jobs.

Organizational Response: Support and Betrayal

Organizational support for all members of the clinical team is a conceptual determinant of clinician well-being (Brigham et al., 2018). In nursing, evidence suggests supportive organizations have positive effects on nurse well-being (Wei et al., 2018). Nursing unit structural empowerment (r=.52, p<.001) and unit support for professional practice (r=.68, p<.001) have been found to be associated with job satisfaction among nurses (Spence Laschinger et al., 2011). Magnet Recognition Program ® designation (hereunto referred to as Magnet) could be considered a proxy for a supportive work environment, because the facility has been recognized as upholding the value and importance of professional nursing practice. Nurses working in Magnet® organizations have been found to have decreased odds of job dissatisfaction ($p < .05$) and decreased odds of burnout ($p < .05$) (Kelly et al., 2011). Nurses working in Magnet® facilities also

had lower levels of job dissatisfaction, OR=.82, 95% [CI .72-.94] and burnout, OR=.87, 95% [CI .87-.97] even after adjusting for wages (McHugh & Ma, 2014).

A lack of organizational support can be considered organizational betrayal. Studies of organizational-level betrayal among various populations, including nurses, suggest it has negative impacts on well-being (Smith, 2017; Smith & Freyd, 2013; Trybou, et al., 2016). Non-supportive action by an organization is also known as institutional betrayal, which occurs when an institution (e.g. individuals, policies and/or systems) betrays the trust of an individual within that institution. Smith & Freyd (2013) found that among college women who experienced sexual assault, institutional betrayal by the university was associated with increased anxiety, dissociation, and trauma. Smith (2017) found that among patients who experienced a medical error, institutional betrayal by the medical system was associated with decreased levels of trust and increased levels of disengagement.

Betrayal at the organizational level has also been studied as psychological contract violation. Trybou et al. (2016) examined psychological contract violation among nurses, and found that self-reported contract breach was a significant predictor of contract violation (b = .61, p<.001), job satisfaction (b =-.60, p<.001), affective commitment (b = -.51, p<.001), and intent to leave (b= .36, p<.001), and controlling for sex, organizational tenure, profession, and work schedule. The study by Salin and Notelaers (2017) found negative organizational responses to bullying, such as denying the bullying took place or refusing to investigate the report, is perceived as a violation of psychological contract, and was associated with intent to quit (r=.52, p<.001). In a qualitative study of manager

and organizational actions after bullying, nurses described being ignored after they reported bullying, and that the non-supportive responses led them to feel frustrated and/or deflated (Gaffney et al., 2012).

Organizational Response: Avoidant Leadership

Avoidant leadership is a management style in which there is a lack of timely, effective response to employee issues or concerns (Jackson et al., 2013). Though there are several definitions in the literature, avoidant leadership is generally considered a passive or laissez-faire style of management. It is characterized as by the inability to address workplace issues adequately, such as by giving false assurance that the problem will be dealt with, responding with no sense of urgency, or intimating that the issue is not really a concern. In more aggressive forms of avoidant leadership, leaders might even react with hostility or punish the person who reports the workplace issue (Grill et al., 2019; Manning, 2016).

Avoidant leadership is considered problematic in terms of addressing issues, particularly in high hazard occupations where employee safety is important. Avoidant leadership can contribute to an unsafe work environment because workplace safety issues are not dealt with, and employee trust is diminished (Grill et al., 2019). In workplaces where employees reported being bullied, avoidance and non –response to the issue of bullying by leaders was found to increase likelihood of continued bullying in the workplace (Glambek et al., 2018). In nursing, where bullying remains an issue (American Nurses Association, 2015), avoidant leadership in responding to bullying among nurses can diminish nurses' commitment to their work and their organization (Jackson et al.,

2013). Avoidant leadership among nurses has also been shown to negatively influence nurse engagement (Manning, 2016) and nurse job satisfaction (Bormann & Abrahamson, 2014).

Avoidant leadership is similar to institutional betrayal. Institutional betrayal occurs when an organization (e.g. employer) commits acts of omission or commission which betray the trust of a member of that organization (Smith & Freyd, 2014). Avoidant leadership might differ from institutional betrayal because in avoidant leadership, the leaders' actions or attitudes contribute to the overall workplace climate and might not necessarily be construed as a feeling of betrayal by those working there.

Nurse Well-Being

Burnout and other issues of well-being are critical factors in healthcare delivery, and reducing clinician burnout has been called a national priority (Dyrbye et al., 2017). Well-being of nurses and other clinicians has been linked to many important health care outcomes, including patient safety and quality of care (Salyers et al., 2016). Enhancing health and reducing burnout in nurses and other clinicians contributes to high quality health care services and reducing attrition, medical errors, and operational costs (Brigham et al., 2018). Nurse well-being, and specifically burnout, has been named one of the focus areas in exploring the future of the nursing profession (National Academies of Sciences, Engineering, and Medicine, 2019).

Advancing New Knowledge of Organizational Response to Bullying in Nursing

Though bullying is a known issue in nursing, organizational response to bullying is less studied. It is important to understand organizational response as both a mechanism

for improving the practice of nursing leadership and administration, as well as increasing the understanding of organizational behavior as a determinant of health. In this study, the population of interest is registered nurses, grouped by their shared occupation and shared theoretical expectations of the employer. The determinant of health in this study is the organizational behavior related to mitigating a workplace issue, and the effects of that behavior on the health and workplace well-being of the population of interest. Though several studies have measured psychological contract violation or institutional betrayal, the studies either did not measure these concepts among nurses or did not measure them in the specific context of bullying.

Specific Aims

The purpose of this study is to explore bullying, experiences of organizational response, and workplace well-being among registered nurses. The specific aims are:

1. To describe the prevalence of weekly/daily bullying among nurses;
2. To describe associations of demographic and workplace characteristics and workplace well-being (burnout, job dissatisfaction, and absenteeism) among nurses who have experienced bullying behaviors;
3. To estimate size and direction of associations of organizational betrayal and support with workplace well-being (burnout, job dissatisfaction and absenteeism) after controlling for demographic and workplace characteristics among nurses who have experienced bullying behaviors;

4. To describe frequencies of types of avoidant leadership (hostility, normalizing, equivocation) in response to bullying among nurses who experienced bullying behaviors;
5. To examine relationships between types of avoidant leadership in response to bullying (hostility, normalizing, equivocation) and workplace well-being (burnout, job dissatisfaction and absenteeism) among nurses who experienced bullying behaviors;
6. To estimate the size and direction of associations between experiencing acts of avoidant leadership and demographic and workplace characteristics with workplace well-being among nurses who experienced bullying behaviors.

Significance

The significance of this study is that it explores organizational and social behavioral concepts that are pertinent in health service administration. Clinician well-being is an important issue for health systems leaders and researchers. Nurse well-being, and particularly burnout, is associated with negative workforce outcomes and negative patient outcomes. The study was modeled to reflect the outcomes (i.e. clinician well-being) addressed by the National Academy of Medicine clinician well-being workgroup (Dyrbye et al., 2017) and the National Academy of Medicine Future of Nursing 2020-2030 consensus report workgroup (National Academies of Sciences, Engineering, and Medicine, 2019).

The study also provides evidence for the nursing administration practice specialty. Nurse leaders can use the evidence in this study to determine best practices for

responding to bullying. The evidence in this study also adds to the current body of knowledge of the importance of the nursing work environment and workplace culture as a factor in nursing practice and nursing quality of care. It also increases the understanding of organizational behavior and leadership styles as possible determinants of health within the context of the workplace.

Theoretical Framework

This study uses a nursing ethical framework as the theoretical basis for the relationships among concepts. Ethically, healthcare organizational leaders are obligated to provide a safe and healthy work environment for nursing practice (American Nurses Association, 2015b). Organizational betrayal is linked to bullying in that nurses trust their organization (i.e. employer's systems and policies) to provide psychological and physical safety in the work environment, and that trust includes prevention bullying and justice if it occurs (American Nurses Association, 2015a). If the trust is violated, as when an organization ignores reports or even punishes the reporter, theoretically organizational betrayal can occur.

The National Academy of Medicine's clinician well-being conceptual model was a key model used to determine the concepts for study (National Academy of Medicine, 2018). The framework describes the many multiple factors that can influence clinician well-being. The framework examines the impacts of workplace and individual concepts as they relate to clinician well-being, and is meant to apply across clinician workplaces, levels of experience, and specialties (Brigham et al., 2018). The framework depicts how clinician well-being is conceptually related to clinician and patient relationships, and

ultimately to patient care and the health of patients. The centrality of patient care and the interaction of clinician health and patient care are demonstrated in the model.

The framework describes two categories of factors that affect clinician well-being: Individual Factors and External Factors. The specific types of Individual Factors are Personal Factors and Skills and Abilities. The specific External Factors are Society and Culture, Rules and Regulations, Learning and Practice Environment, Healthcare Responsibilities, and Organizational Factors.

Within each specific factor, exemplars are given. Personal Factors include family dynamics, work-life balance, and personality traits. Skills and Abilities include competency, coping skills, and resilience. Society and Culture includes social determinants of health and political climate. Rules and Regulations include documentation requirements and compensation. Learning and Practice Environment includes workplace safety and violence, teamwork, and scope of practice. Healthcare Responsibilities include workload and administrative, clinical, and teaching responsibilities. Organizational Factors include levels of support, leadership, and harassment.

It is within Organizational Factors that the concept for this dissertation study was identified. The exemplar suggests that support for all members of the clinical team is important to clinician well-being.

Dissertation Conceptual Frameworks

Two conceptual models guided this study. One conceptual model depicts the relationships of organizational betrayal with well-being. A second model depicts the

conceptual categorization of acts of betrayal as types of avoidant leadership, and then describes the conceptual relationships with well-being. Though the models differ slightly in the conceptualization of organizational response, they represent an adaptation of a larger framework devised by the National Academy of Medicine (National Academy of Medicine, 2018).

The conceptual model for organizational betrayal as a response to workplace bullying depicted in Figure 1. In this model, the conceptual process is that bullying occurs in the nurse's workplace, then the organization responds to the bullying by either supporting or betraying the nurse, and then the support or the betrayal is related to well-being.

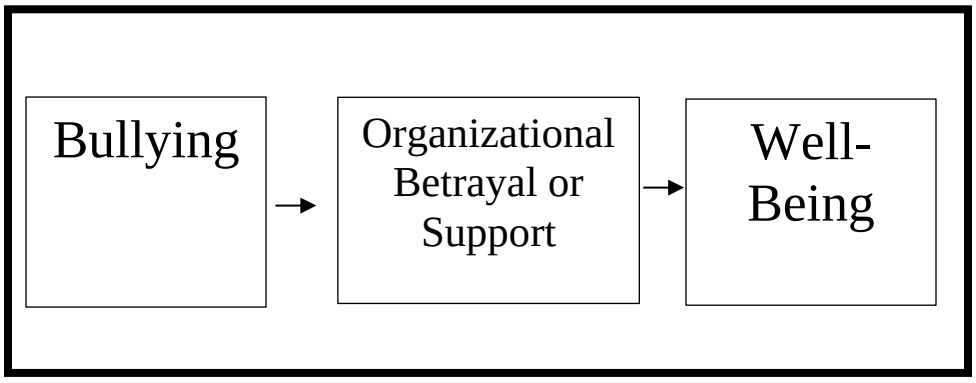

Figure 1.

Conceptual Model of Organizational Betrayal and Support with Well-being.

Notes: Adapted from National Academy of Medicine conceptual framework on factors affecting clinician well-being (National Academy of Medicine, 2018).

The conceptual model related to avoidant leadership is depicted in Figure 2, and tests new concepts (avoidant leadership types) as specific factors of leadership in the relationship with well-being. Avoidant leadership is typed in three factors: hostility, normalizing and equivocation. The factors were selected based on a qualitative study of avoidant leadership in response to bullying among nurses (Jackson et al., 2013). The factors then relate to workplace well-being.

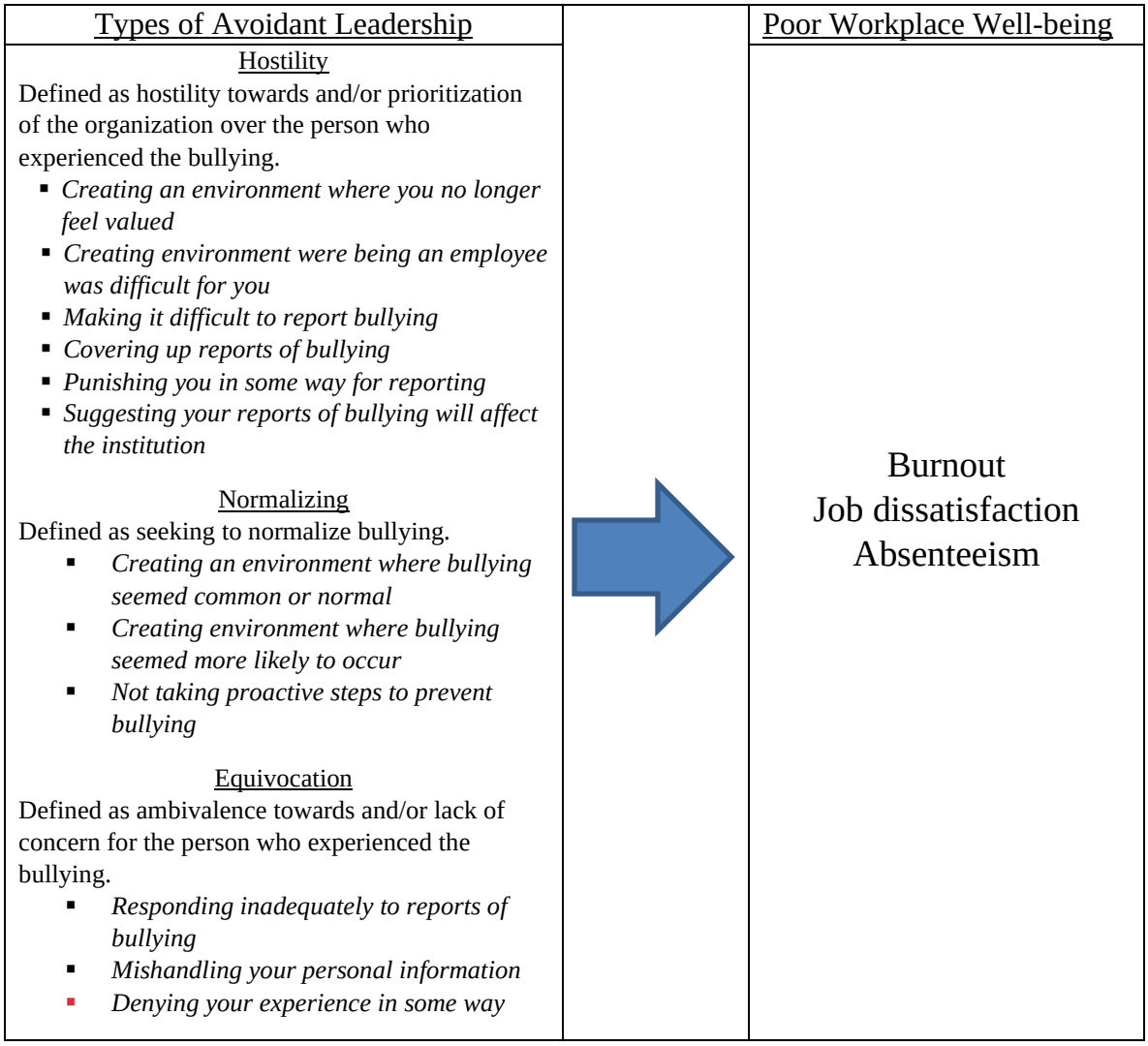

Figure 2.

Conceptual Model of Avoidant Leadership

Notes: Adapted from avoidant leadership types as described by Jackson et al., 2013. In the first column, the definition of each concept is listed, followed by the items on the IBQ-H scale that

matches that definition and were grouped in the subscale. The avoidant leadership types are then conceptually linked to poor workplace well-being, which are listed in the second column.

Conceptual Definitions for Study Variables

Bullying

The conceptual definition of bullying is negative actions or behaviors directed at a targeted group or individual over a prolonged period that cause distress in the recipient. This definition is consistent with the literature (Nielsen & Einarsen, 2012). The key component of bullying that differentiate it from other forms of workplace hostility (e.g. incivility) is the prolonged duration of the behaviors. The definition of bullying in this dissertation is consistent with others used in the nurse bullying literature (Hutchinson et al., 2010; Read & Laschinger, 2015; Sauer & McCoy, 2017).

The concept of bullying is operationalized as negative workplace behaviors, including sabotage, belittlement, gossip, and social exclusion. Bullying was measured using the Negative Acts Questionnaire Revised for Nursing (NAQR-US) (Simons et al., 2011). The NAQR-US is designed to measure bullying among nurses specifically, and is an adaptation of the Negative Acts Questionnaire-Revised (Einarsen et al., 2009). The NAQR-US was chosen for this study because of its validation among nurses and for its parsimony.

Organizational Response

The conceptual definition of organizational response is actions or inactions in response to occurrence of workplace bullying on the part of the organization (i.e.

systems, policies, and individual leaders considered as one entity). Organizational response was further defined as three concepts: organizational betrayal, organizational support, and avoidant leadership.

An important distinction in this study is that the organizational response is not necessarily the actions of one person, e.g. a manager. In this study, the organization is mean to encompass the systems and the people that make up the organization to which a nurse belongs. This distinction is important because organizational trust is particularly salient in nursing. Nursing is a profession that is grounded in principles of caring, compassion, and caring relationships are expected among nurses and between the nurse and the employer.

The measurement strategy for organizational response in the workplace is the Institutional Betrayal Questionnaire for Healthcare (IBQ-H). The IBQ-H was developed to measure the experiences of members of an organization that either supported or betrayed their trust in that organization (Smith, 2017). This instrument allows for measurement of different types of responses to a negative event and measures actions at an organization level (i.e. not just the actions of an individual person such as a manager).

Betrayal and Support

Organizational betrayal was considered as an organizational response which betrayed the trust of the nurse when the organization did not fulfill its obligation for support and safety after bullying. This could include failure to prevent the negative act, failure to take the report seriously, blaming the victim for their experience, or retaliation for the report (Smith & Freyd, 2013). Organizational support was the opposite of

betrayal, in that the nurse felt the organization upheld its obligation for trust. This could include providing resources to cope with the event and providing a safe means of reporting (Smith, 2017). The operational definitions of betrayal and support were selected because of the theoretical importance of organizational trust in nursing. The measurement strategy for organizational betrayal and support were the main two subscales of the IBQ-H.

Avoidant Leadership

Avoidant leadership is a concept where an organizational leader or member, including managers, respond ineffectively to a workplace problem. In this study, the specific workplace problem of interest is workplace bullying. Avoidant leadership in handling events of workplace bullying is operationalized as hostility, normalizing and equivocation, and were inspired by a qualitative study of avoidant leadership in response to bullying among nurses (Jackson et al., 2013). Hostility is defined as hostility towards and/or prioritization of the organization over the person who experienced the bullying. Normalizing bullying is defined as trying to placate the person reporting the problem or seeking to make the bullying seem like a normal part of the work environment. Equivocation is defined as ambivalence toward and/or lack of concern for the person who experienced the bullying. The measurement strategy for avoidant leadership was subscales of the IBQ-H created for the study.

Well-Being

The concept of workplace well-being is defined as the presence of joy and engagement in healthcare practice and the limitation of burnout, fatigue and distress

(Brigham et al., 2018). The operational definitions of well-being are burnout, job dissatisfaction, and absenteeism (Trépanier et al., 2016). Burnout is a critical determinant of well-being in relation to health and work outcomes (Dyrbye et al., 2017). Burnout was measured using the Well Being Index (WBI), which measures job engagement, burnout, and physical and mental health (Dyrbye et al., 2016). Absenteeism reflects poor physical health and reduced desire to be in the workplace (*Absenteeism*, 2019) and was measured by self-report of days missed of work due to illness or other personal reasons. Job dissatisfaction indicates how pleasing a job is to the employee and is a national metric of nursing quality (Kelly et al., 2011). Job dissatisfaction was measured using a Likert scale.

The demographic and workplace characteristics for this study were selected using the National Sample Survey of Registered Nurses to allow for comparison with the general population of nurses in the U.S.

Limitations

The study had several limitations. The cross-sectional nature limited the ability to determine prediction or temporal relationships of the variables. Therefore, future longitudinal studies are warranted to measure organizational betrayal and avoidant leadership over time to determine if any temporal relationships exist between organizational response (betrayal, support, avoidant leadership) and workplace well-being (burnout, job dissatisfaction, absenteeism). The study also appeared to lack racial diversity, limiting generalization of the findings.

There are possible confounding factors that could have influenced the relationship between organizational betrayal and avoidant leadership and well-being among the nurses

in this study. The National Academy of Medicine framework for clinician well-being includes many factors related to individual or organizational situations which can have relationships with well-being (National Academy of Medicine, 2018); these factors might include workload, scope of practice limitations, training for one's job, salary, and personal life situations (e.g. family responsibilities). However, it was not feasible to measure all factors in one study.

Self-report instruments and use of a convenience sample presented risk of both recall and response bias. Use of the convenience sample limits generalizability of the findings to the general nursing population. Asking about events in the past presented a risk of recall bias. The use of social media and electronic survey methods increased the risk for recruitment bias because nurses who do not have Facebook ® might not be recruited as participants. Non-response could not be measured. Though the threats to bias exist, analysis of social media for health research concludes the threats are no greater than those that exist in any survey research (Thornton, 2016).

There were no validated scales to measure trait betrayal. The subscales were developed based on theory and grouping of items was subjective. The absenteeism cut score was estimated and might not adequately reflect problematic absenteeism in the workplace. Future studies could use a single scale question asking the respondent to indicate the level of betrayal they experienced (e.g. mild to severe).

Summary

Bullying is a recognized issue in nursing, however the organizational response to bullying is less studied. Organizational response, in terms of organizational betrayal and avoidant leadership, could be an important determinant of nurse well-being. Therefore, this study explores the associations of organizational response with well-being among nurses that experienced workplace bullying. The study uses organizational responses (organizational betrayal and support, avoidant leadership [hostility, normalizing, equivocation] as the independent variables, and nurse well-being (burnout, job dissatisfaction, and absenteeism) as the dependent variable. The concepts are theoretically linked using ethical tenants of nursing practice, and the ethical obligations of employers to nurses for safe work environments. This study fills a research gap of understanding organizational response to bullying as a possible determinant of workplace well-being among nurses.

CHAPTER TWO

The literature review was an important step in understanding the connection between bullying, organizational response, and workplace well-being among nurses. The literature review was conducted using the MEDLINE and CINAHL databases. Search terms included “nurse”, “bullying”, “betrayal in bullying”, “organizational response”, “organizational support”, “institutional support”, “organizational betrayal”, “institutional betrayal”, “organization response in bullying”, “nurse well-being”, “outcomes of bullying” and “avoidant leadership in nursing”. Reference lists from the selected studies were also used to identify additional studies for review. Meta-analyses, systematic reviews, literature reviews, integrative reviews, quantitative studies, qualitative studies, mixed-method studies, theory descriptions, and concept analyses were considered for review. The search was not limited by a timeframe; however, care was taken to provide as current evidence as possible. The review was an iterative, ongoing process.

The first section of the review includes studies that examine the bullying and bullying in nursing as a social factor of work organizations. The second section reviews the primary literature related to the concepts of organizational response, specifically organizational betrayal and avoidant leadership. The third section reviews literature which demonstrates the complexity of well-being, including the studies that indicate well-being can have impacts on patient outcomes. The fourth section examines studies

which examine effects of organizational betrayal and support on well-being. The fifth section reviews studies that have examined avoidant leadership in nursing and relationships with well-being. The final section describes potential research gaps.

Workplace bullying

Workplace bullying is a complex social phenomenon. Bullying is largely defined as negative behaviors, whether subtle or obvious, directed at a person or group over a long duration of time used to elicit a form of social control (Einarsen et al., 2009; Gillen et al., 2017). Einarsen et al., (2009) described bullying as acts meant to denigrate a person's stature within a social group (e.g. gossiping, keeping personal jokes, or ostracizing a person from a group), acts meant to cause a person to feel denigrated or inferior in relation to their competence or performance, acts related to one's work (e.g. excessive criticism, receipt of an unmanageable workload, sabotage, and humiliation in connection with work performance) or acts of overt hostility. Einarsen et al., (2009) developed and published the Negative Acts Questionnaire-Revised (NAQ-R), which captures many of the described bullying behaviors. The NAQ-R is widely used in bullying studies and provides a consistent basis for study and comparison of findings. Bullying has been found to have negative effects on emotional and physical health.

A meta-analysis by Nielsen and Einarsen (2012) provides strong evidence of the theoretical link of a negative social experience (bullying) with physical and emotional health problems. The effects of bullying were evident in both cross-sectional and longitudinal studies, indicating that there is a likely temporal relationship of bullying and

health issues. Nielsen and Einarsen (2012) conducted two studies within the meta-analysis, one study looking at cross-sectional studies, and a second that examined longitudinal studies. As a result of the systematic search, the analysis was conducted on 137 cross-sectional studies (N=77,721), and 13 longitudinal studies (N=62,916). The findings of the meta-analysis demonstrated strong correlations. Bullying was found to be positively associated with health problems, including mental health problems (r=.34, p<.001), burnout (r=.27, p<.001), and physical health problems (r=.21, p<.001). Bullying was found to be associated with organizational outcomes, including intent to leave (r=.28, p<.001), job satisfaction (r= -.22, p<.001), performance, (r= -.12, p<.001) and absenteeism (r =.11). Among the longitudinal studies, bullying was found to be associated with mental health problems (r=.20, p<.001) and absenteeism (r=.12, p<.001). The number of studies included in the meta-analysis and the precision with which the studies were selected (i.e. using only studies that defined bullying as a prolonged series of negative behaviors) are notable strengths to the conclusions.

Bullying in Nursing

Bullying in nursing would seem antithetical to a profession that is grounded in caring and compassion, yet, is an ongoing issue in nursing (American Nurses Association, 2015a; Roberts, 2015; Sauer & McCoy, 2018). A theoretical framework for the study of bullying in nursing is oppressed group behavior (Purpora et al., 2012; Roberts et al., 2009; Simons, 2008). Oppressed group behavior, in study of colonized populations, demonstrated how inferior groups that are oppressed by superior ones (Freire, 1970). The literature suggests that nurses have displayed characteristics of

oppressed groups, especially dis-empowering behaviors, though few studies have sought to specifically contribute empirical evidence towards Freire's theory within nursing (Matheson & Bobay, 2007).

In nursing, Roberts et al. (2009) suggest that the ongoing oppression in nursing culminates in acts of hostility and aggression towards others of the same identity. Nurses act verbally or even physically abuse towards one another in order to achieve a sense of control. Nursing leaders are marginalized because they identify with both the oppressed group (i.e. nurses) and the superior group (i.e. administrators) and are unable to fully correct the imbalance of power in nursing due to the marginalization (Roberts et al., 2009). Identification with oppressed group characteristics has been correlated with increased levels of bullying in the workplace among nurses (Purpora et al., 2012).

Croft & Cash (2012) suggest that the view of bullying through a post-colonial feminist lens can explain a great deal of how organizational systems, structures, and decisions create a hegemony in nursing. The authors suggest that nurses must realize how these influences have led to social norms in nursing, such as the normalization of bullying. The authors argue organizations that are top-down, hierarchical, corporate, and cost-driven are the greatest influences of hegemony, which then causes nurses to be disillusioned with their work, and with their organization, and to ultimately distrust the organization's actions and statements.

The development of a positive work environment is instrumental in mitigating the issue of bullying (Gaffney et al., 2012; Hutchinson & Hurley, 2013; Roberts, 2015). Autonomy of practice, shared governance, and open communication are theoretically

akin to the use of dialogue in education as a means of liberating an oppressed group (Roberts et al., 2009). Evidence-based strategies to reversing oppression could include acknowledgement of the existence of oppression in nursing, cultivation of caring and supportive environments among groups of nurses, and empowerment at all levels of nursing to be involved in decision making in nursing practice and team-based nursing care (Purpora et al., 2012).

Prevalence and Outcomes of Bullying in Nursing

Studies indicate the frequency of bullying in nursing varies. Of those studies using the NAQ-R, frequency of bullying ranged from 21% to 31% (Olender, 2017; Sauer & McCoy, 2018; Simons, 2008). One of the noted difficulties in determining bullying frequency is the inconsistent definition of bullying (i.e. some studies would describe the study of bullying, however conceptual definitions and study measures were more like to incivility or lateral violence).

The antecedents and consequences of bullying are largely synthesized in an integrated review conducted by Trépanier et al. (2016). Trépanier et al. (2016) found ample evidence to support authentic leadership as a factor that influenced bullying, in that the perception of authentic leadership prevented bullying behaviors. Positive job characteristics (e.g. job control) and negative job characteristics (e.g. work overload) were also found to be highly related to prevalence of bullying. Outcomes of the bullying experience are issues with well-being (psychological, behavioral and attitudinal) and outcomes on patient care.

Studies of effects of bullying in nursing has demonstrated evidence of negative outcomes (Allen et al., 2015; Olender, 2017; Read & Laschinger, 2013; Sauer & McCoy, 2018; Sauer & McCoy, 2017; Simons, 2008; Spence Laschinger & Nosko, 2015).
In a large longitudinal study of Norwegian nurses (N=1582), bullying predicted anxiety ($\beta = .06$, $p < .01$) and fatigue ($\beta = .06$, $p < .01$) (Reknes et al., 2014). Read and Laschinger (2013) found significant relationships between bullying and several organizational and health outcomes (n=342). Bullying was found to be associated with emotional exhaustion (r=.46, p<.05), job satisfaction (r= -.46, p<.05), engagement (r= -.27, p<.05), and mental health complaints (r=.32, p<.05). Spence Laschinger & Nosko (2015) examined post-traumatic stress symptoms (PTSD) as an outcome of bullying in a cross-sectional study of nurses in Ontario. Bullying was found to be associated with PTSD symptoms in both groups (r = .55 and r =.60, respectively). Bullying was also associated with psychological capital in both groups (r =-.32 and r= -.29). The variance explained by bullying and psychological capital in PTSD symptoms for both groups was moderate (R^2 =.36 and R^2 =.40).

Analysis of the identified findings indicates there is evidence of a link between a bullying and negative impacts on health and wellness. Several of the studies feature large sample sizes and longitudinal design, which provides greater generalizability of findings. The studies of bullying among nurses, combined with the large meta-analysis of bullying in general adult populations, indicate a great deal of evidence exists for the harm bullying may cause among those who experience it.

Many of the use of the NAQ or the NAQ-R to measure bullying (Olender, 2017; Read & Laschinger, 2013; Reknes et al., 2014; Sauer & McCoy, 2018; Sauer & McCoy, 2017; Simons, 2008). This lends considerable reliability to findings that bullying, measured consistently is both occurring in nursing and is related to negative impacts on nurse health.

Organizational Response

Betrayal and Support

Some theories suggest that organizations (e.g. workplaces, schools, churches, associations, governments) may have relationships with members beyond simple transactional needs (Smith & Freyd, 2014). The organization might have an unwritten psychological agreement with their employees or members to provide for their needs, including justice, safety and security (Trybou et al., 2016). When an organization provides that level of safety and security, the member feels supported. When the organization defies that expectation, the result is a form of betrayal (Smith & Freyd, 2013).

Betrayal could take the form of psychological contract violation, in which an individual experiences and imbalanced relationship with their organization. In the guise of an employer-employee relationship, organizational members (i.e. employees) give of their physical and emotional resources to the organization (i.e. employer) and in return, expect physical and emotional resources (e.g. wages, praise, feelings of fulfillment) to be provided by the organization (Trybou et al., 2016).

In a slightly different conceptual definition, institutional betrayal posits that organizations can betray the trust of members through acts of omission or commission in response to a negative event (Smith & Freyd, 2013). Institutional betrayal is an expansion of the study of betrayal trauma theory, which posits that when a person is harmed by someone they trust or have a relationship with, the betrayal of trust intensifies the sequelae (Freyd, 1996).

Organizational support would be the opposite of betrayal or trust violation. In organizational support, the organization (e.g. employer) provides resources to support the employee and enhance their experience within the organization. Organizational support and supportive workplace culture are particularly important in nursing (Wei et al., 2018). Some studies have used Kanter's model of workplace empowerment as a model for exploring workplace support, defining organizational support as the presence of supportive guidance and assistance from colleagues, managers, and others within the workplace (Spence Laschinger et al., 2011; Wing et al., 2015). Magnet designation is another example of organizational support at the systems level; healthcare facilities which have achieved Magnet ® designation have demonstrated outstanding, lasting commitment to nursing excellence and provide organizations in which nurses are supported and valued (*Magnet Recognition Program® | ANCC*, n.d.). Nurses working in Magnet® facilities have higher likelihoods of engagement with their work (Kelly et al., 2011) .

Avoidant Leadership

Avoidant leadership is a type of leadership practice where organizational leaders act inadequately or ineffectively, particularly as a response to a negative event. (Jackson et al. 2013). Many studies have explored the concept of avoidant leadership as either passive-aggressive leadership and/or laissez-faire leadership (Grill et al., 2019; Skogstad et al., 2014). The Multifactor Leadership Questionnaire™ is often used to study all leadership types, including a form of avoidant leadership (Kanste et al., 2007). This questionnaire includes items measuring transformational, transactional (including active and passive management by exception) and passive-avoidant leadership. In transactional leadership, the leader might only react after an issue becomes serious or might punish the person who reports an issue. In passive-avoidant leadership, there is an absence of leadership altogether. A limitation of this mode of measurement is that it does not adequately highlight negative styles of leadership, nor give a firm understanding of how the impact of negative leadership (Hutchinson & Jackson, 2013).

Defined measures of avoidant leadership have yet to be developed, and there is an apparent research gap of the study of avoidant leadership in nursing (Jackson et al., 2013). The most comprehensive study to date of the types of avoidant leadership nurses experience was conducted by Jackson et al (2013). In a secondary analysis of qualitative data, Jackson et al. (2013) identified three categories of avoidant leadership: avoidance, equivocal avoidance, and hostile avoidance. In placating avoidance, leaders gave false assurance that the issue would be addressed. Leaders might promise that the issue would be addressed, or changes would be made, but would not follow through. Other types of

placating avoidance were normalization, where the person who reported the problem was encouraged to simply adapt to the issue's occurrence because it was just part of the work environment and they would in a sense 'get over it'. Equivocal avoidance was the second theme and represented leaders' responses which were unpredictable or nonchalant. Leaders would react to the reports without urgency or regard and would take no action, including no action to prevent the problem from happening again. Leaders might treat people reporting the issue or information regarding the reports of the issue sloppily and at times would simply postpone addressing the issue for long periods of time, implying they wished it would just go away on its own. In hostile avoidance, the leaders would react with hostility towards the person reporting the issue. The reports were treated almost as treachery towards the leader and the person reporting the issue could be punished or demeaned, as opposed to punishing the person who inflicted the wrongdoing. Retaliation was also a theme in this type of avoidant leadership. Nurses who experienced this type of leadership response described feelings of being demeaned, stressed, and emotionally hurt.

The study by Jackson et al. (2013) offered a robust discussion of what types of leadership behaviors and actions constitute avoidant leadership in response to a workplace issue. While other studies have examined avoidant leadership in broader terms (Grill et al., 2019; Manning, 2016; Skogstad et al., 2014), the study by Jackson et al. (2013) gave granular examples of types of avoidant leadership. The focus on avoidant leadership in nursing research could help highlight examples of these types of negative leadership behaviors (Hutchinson & Jackson, 2013).

Nurse Well-Being

Nurse well-being is a concept that encompasses aspects of emotional and physical health at work (Dyrbye et al., 2017). The concept well-being is a holistic embodiment of work and professional performance. To address clinician well-being, a collaboration to promote the issue of clinician well-being was initiated at the National Academy of Medicine. Representatives of many health care professions, including the American Nurses Association, declared that clinician burnout was an insidious issue in healthcare, and threatened to undermine efforts to improve health and health care in the U.S. Though burnout is a central part of clinician wellness, the concept of burnout was expanded to include issues of job engagement and physical and mental health, with a focus on wellness and well-being as a holistic compliment of these various factors.

A large meta-analysis synthesizes many of the relationships of clinician burnout and patient outcomes (Salyers et al., 2016). Salyers et al. (2016) reviewed 82 with a total sample of 210,669 healthcare providers, including physicians and nurses. The meta-analysis of the studies was among 63 independent samples and indicated that there were significant correlations between burnout and both dependent variables. Burnout was found to have a negative relationship with patient quality (r= -.26, 95% CI = -.29 to -.23) and a large amount of heterogeneity (Q statistic was significant, I^2 = 93%). Burnout was also found to have a negative relationship with patient safety (r= -.23, 95% CI = -.28 to -.17), and had a large amount of heterogeneity (Q statistic was significant, I^2= 97%).

The large sample and large heterogeneity are strengths to the meta-analysis. Though the variance explained in patient care quality and patient safety was small (7%

and 5%, respectively), the complexity of impacts on patient quality and safety would suggest that even small amounts of variance are helpful in determining interventions to improve overall patient outcomes.

Relationships of Organizational Betrayal and Well-Being

Organizational betrayal can occur when an organization betrays the trust of a member of that organization (Smith & Freyd, 2014). Organizational betrayal has been found to have harmful effects on psychological health and workplace well-being (Salin & Notelaers, 2017; Smith, 2017; Smith & Freyd, 2013; Trybou et al., 2016). In a study by Trybou et al. (2016), the researchers sought to determine if psychological contract violation was a mediating factor among psychological contract breach and outcomes among nurses in Sweden (N=237), including registered nurses (n=109) and nurses' aides (n=128). Concepts were measured using a scale in which the participant is asked to rate a level of agreement with statements such as "I feel betrayed by my organization". Outcome variables were intent to leave, affective organizational commitment and job satisfaction, and were measured using various scales. Betrayal was found to have significant associations with contract breach (r=.66, p<.001), job satisfaction (r= -.66, p<.001), affective job commitment (r= -.50, p<.001), and intent to leave (r=.46, p<.001). Multiple regression analysis indicated that contract breach was a significant predictor of contract violation (B = .61, p<.001), job satisfaction (B = .-60, p<.001), affective commitment (B = -.51, p<.001), and intent to leave (B = .36, p<.001), and controlling for sex, organizational tenure, profession, and work schedule.

In a study by Salin and Notelaers (2017), researchers examined the concept of perceived contract violation as a form of workplace betrayal. Salin and Notelaers (2017) explored contract violation as a mediating factor in the relationship between bullying and known outcomes, such as turnover intentions. The study was conducted among in a sample of business professionals in Finland (n=1148). Bullying was measured using the NAQ. Psychological contract violation was measured using four items that asked about perception of betrayal and contract violation. Turnover intentions were measured using a continuous scale. Psychological contract violation was also associated with turnover intentions (r=.52, p<.001). The authors conclude that the findings suggest that psychological contract violation could be a contributing factor in the relationship of bullying and outcomes.

The Institutional Betrayal Questionnaire (IBQ) is a concrete way of measuring organizational betrayal was developed by Smith and Freyd (2013). Smith and Freyd first used the IBQ to examine relationships of sexual misconduct, betrayal and trauma in college women (n=233). The Sexual Experiences Scale (SES), the IBQ, and the Trauma Symptoms Checklist (TSC) were analyzed to determine relationships. In a multiple regression model, relationships of IBQ and SES on TSC were analyzed. The IBQ accounted for a significant amount of variance on four of the six subscales. These included sexual assault trauma index (R^2=.17, p<.05), sexual dysfunction (R^2=.12, p<.05), dissociation (R^2=.11, p<.05) and anxiety (R^2=.10, p<.05). Smith (2017) revised the IBQ to include indicator of betrayal in healthcare – the institutional betrayal questionnaire for health (IBQ-H) the concept of institutional betrayal in the context of adverse medical

events to determine relationships with disengagement in healthcare and trust in health care systems. Smith conducted a survey of registered workers in an online system (N=707). A correlation analysis indicated that institutional betrayal was associated with trust in health care (r= -.45, p<.001) and disengagement (r=.36, p<.001), even when the severity of medical events scores was controlled. Mediation analysis using path analysis indicated that institutional betrayal predicted trust in health care (b_1= -.05, p<.001). The effect size for the regression analysis was small, however was meaningful in contributing to the variance in a complex emotion such as trust.

The studies demonstrate largely consistent results for the effects of organizational betrayal. Some issues were noted in consistency of study design and measurement strategies. For example, the study by Trybou et al., (2016) does not measure organizational betrayal as concretely as Smith and Freyd (2013) and Smith (2017). Trybou et al. (2016) used validated scales, however measured the concepts in somewhat vague terms. For example, the scale items used to measure contract breach simply asked the participant if they had not received something they expected from the employer. This could be any number of physical or emotional resources, from wages to a promotion to simply feelings of usefulness in the work environment. Though the findings of the studies could provide some theoretical evidence for the existence of the concept of contract violation and betrayal as a factor in nurse well-being, the study does not give specific acts that led to those feelings of betrayal. Thus, it is difficult to translate these findings to practice because nurse administrators and leaders do not have a concrete idea of what exactly the nurse was expecting, or what exactly betrayed the nurses' trust.

Though the IBQ and IBQ-H represent a concrete way of measuring organizational betrayal, measurement issues remain. An issue with the scoring of the IBQ and IBQ-H is the nature of the questionnaire. Smith and Freyd (2013) explain that the checklist format of the questionnaire is meant to quantify the number of ways a person might be betrayed by their institution, and to measure experiences rather than a trait. This assumes that the action of the organization did indeed break the psychological trust of the individual member. Caution should be taken with the analyses of findings because the IBQ might not necessarily indicate a person was betrayed, but rather can be an indicator that the betraying experience contributed to an outcome. Another issue is that the IBQ does not indicate the isolated or systemic nature of the experiences. This is an area that is recommended for future research (Smith & Freyd, 2014).

Finally, the study populations varied making it difficult to compare the theoretical links between the organization and trust of those members. Trybou et al. (2016) conducted their study among nurses, however it blended registered nurses and nurses' assistants – registered nurses have a theoretical trust for safety from their employer according the code of ethics, whereas nurses' assistants do not. Smith (2017) measured betrayal and outcomes among medical patients, which offers a better parallel to nursing in that healthcare is an area of distinct trust. Thus, there are potential theoretical differences in ethical obligations and expectations among the study populations, and it is possible that the relationships of organizational betrayal and outcomes might be stronger in professions or groups where there is a recognized trust between organization and members.

Relationships of Organizational Support and Well-being

Few studies were identified that measured organizational support as a specific concept. However, using workplace empowerment and accreditation of nursing excellence as proxies, organizational support appears to have a positive impact on nurse health and workplace well-being (Kelly et al., 2011; McHugh & Ma, 2014; Wei et al., 2018). Some studies examined the effects of organizational support on emotional health. Spence Laschinger et al. (2011) conducted a longitudinal study of nurses in 49 hospital units in Canada (N=545). Among individual nurses, unit structural empowerment was associated with job satisfaction (r=.52, p<.001), as was unit support for professional practice (r=.68, p<.001). At the unit level, support for professional practice was associated with job satisfaction (r=.68, p<.001). The researchers concluded that the model indicated that empowerment was important to achieving job satisfaction and well-being among nurses. Wing, et al. (2015) examined incivility as a mediator in the relationship between structural empowerment and mental health symptoms among new graduate nurses (N=394), and found the relationship between empowerment and mental health symptoms (ß= -.286, p<.001) was also partially mediated by incivility (ß= -.221, p<.001), with small effect size (R^2=.14).

Other studies have found relationships of organizational support on nurse workplace well-being, such as job satisfaction and burnout. McHugh and Ma (2014) found that nurses working in a Magnet® designated workplace had lower odds of being dissatisfied at work (OR=.82, 95% CI [.71-.94]), and lower odds, but not significantly lower odds, of being burned out (OR=.90, 95% CI [.80-1.00]), even after adjusting for

wages. Kelly, McHugh, & Aiken (2011) found that nurses in Magnet® hospitals were less likely to report job dissatisfaction (OR=.82, 95% CI =.82-.89, *p*=.01), burnout (OR=.86, 95% CI=.80-.92, *p*<.03), and turnover intention (OR=87, 95% CI=.80-.94, *p*=.07)

Studies appears to consistently demonstrate that organizational support has relationships with nurse well-being. However, is difficult to analyze because there were so few studies that were identified which measured organizational support after a negative workplace event and its effects on well-being. Though the studies reviewed did indicate that a supportive organizational culture was important in nursing and had associations with well-being, it is difficult to identify if these results are consistent with the concept of organizational support in the context of a negative event. This is a distinct research gap.

Relationships of Avoidant Leadership and Well-Being

Very few studies were identified which explored relationships of specific types of avoidant leadership with workplace well-being among nurses. Other studies have examined Manning (2016) examined general types of leadership with staff nurse work engagement among nurses. Manning (2016) measured leadership style using the Multifactor Leadership Questionnaire™ 5X short form (www.mindgarden.com). Work engagement was measured using the Utrecht Work Engagement Scale, using the identified subscales for the instrument (vigor, dedication, and absorption). The sample were staff nurses working in three acute care hospitals (N=441). Findings of the study by Manning (2016) indicated in multivariate analysis, passive-avoidant leadership style

predicted lower levels on two of the three work engagement subscales. Specifically, passive-avoidant leadership predicted lower levels of dedication (*ß*= -.456, *p*<.001) and absorption (*ß*= -.456, *p*<.001). Manning (2016) concludes that absent leadership (i.e. lack of effective response to an employee issue or concern) can decrease nurse engagement and affective commitment to the workplace. The author recommends further study of leadership types with potential alternative research measurement strategies.

The study by Manning (2016) offered the most detailed examination of avoidant leadership and relationships with well-being. The cross-sectional design limits generalizability and causality, and the survey methodology introduce possible bias. Power was not reported however the sample size was large. The study used a measurement strategy for leadership type that is prominent in the literature, and the reliability of the scale was adequate. However, the measure for avoidant leadership was not as robust and detailed and offers a limited view of types of inadequate leadership (Hutchinson & Jackson, 2012).

Synthesis and Identified Research Gaps

In general, several meta-analyses and systematic reviews contribute to an understanding of the concepts of bullying, organizational response, and well-being (Gillen et al., 2017; Nielsen & Einarsen, 2012; Salyers et al., 2016; Trépanier et al., 2016; Wei et al., 2018). Studies have consistently indicated that bullying is a negative workplace experience, and the NAQ-R appears to be the most consistent measurement strategy for assessing bullying using a standard definition (Gillen at al., 2017). Studies have consistently indicated that a negative organizational response can have negative

impacts on emotional and workplace well-being; however, measurement of organizational response is inconsistent. The IBQ-H appears to be the most descriptive measure, though measurement of organizational betrayal appears to be an emerging area of study. Well-being appears to be an important area of health systems research, particularly because it has effects on patient outcomes.

Overall, however, scarce studies were identified that examine relationships of organizational response to workplace bullying among nurses. Though some studies examine organizational betrayal in a nurse population (Trybou et al., 2016), the measurement for betrayal was not specific. Studies of organizational support as defined experience were very scarce. There were very few studies identified that examined avoidant leadership and possible relationships with well-being. The study by Manning (2016) was informative but lacked specificity of actions of avoidant leadership and relationships with employee well-being. Organizational response measured as betrayal or as avoidant leadership appear to be newer concepts in nursing research. This current study seeks to fill a research gap of avoidant leadership by testing a new conceptual model.

CHAPTER THREE

This chapter describes the research methods, including the design, target population, sampling, data collection procedures, study measures, data analysis methods, ethical considerations, and limitations.

Methods

Research Design

This study used an exploratory, cross-sectional design. The exploratory design is appropriate because few studies were identified that examined the relationships of bullying, organizational response and well-being among nurses.

Population and Sample

The target population was registered nurses in the United States. The study used a convenience sample. Inclusion criteria were to have worked in a nursing job for at least six months as a registered nurse.

The sample was obtained using social media. Social media recruitment for health research has been identified as a cost effective and timely method, especially for cross-sectional studies Thornton et al., 2016; Topolovec-Vranic & Natarajan, 2016; Whitaker et al., 2017). Strategies for recruitment were consistent with social media engagement strategies used in other studies (Akers & Gordon, 2018). A first strategy was targeted marketing on Facebook ®. A page was created for the study, which is the landing site for

information about the study and the link to the survey (Akers & Gordon, 2018). Advertisements were created to promote the page and provided a direct access to the survey. The advertisements were created using Facebook settings so that the ad appears on the news feed of Facebook® users that have identified themselves as a registered nurse in their job description or have "liked" pages that pertain to nursing associations and organizations (Akers & Gordon, 2018). A second round of advertisements were created to reach any general Facebook® user over the age of 18 years that was in the United States. Advertisements were populated to Instagram® using the seamless promotion functionality through Facebook®. The ads ran for seven days. Facebook® analytics indicated more than 4,000 users were reached, and the ads had about 150 clicks. Limitations in funding prevented longer timespans of paid advertisements.

A second strategy was direct recruitment through using personal outreach. These included using the researcher's Facebook page, posts to several different Facebook user groups for nurses, and the allnurses.com social media site. A post advertising the survey was placed, and then three reminders posted over five weeks. These strategies and timelines are akin to the recommended strategies for email recruitment (Dillman, et al., 2014).

Users were invited to share the link. Sharing allows those users to share the Facebook® page, the link to the survey, or both, with other nurses on Facebook®. This serves as a form of snowball sampling. Though analytics are available for the paid advertisements, they are not available for personal posts. An estimated response rate was less than 5 percent, based on the reach and actual final sample size.

The necessary sample size to achieve desired power of .8 was approximately 150. The sample size was calculated for a multiple regression analysis with power of .8, the use of eleven predictors (bullying, organizational betrayal, organizational support, age, gender, race/ethnicity, hours worked per week, role in nursing, type of workplace), and an estimated R^2 of .11. The R^2 of .11 was drawn from the literature that explores the relationships of negative experiences, betrayal, and well-being (Smith & Freyd, 2013).

Data Collection

The data were collected via electronic survey in the Qualtrics® system. Data were collected for a period of six weeks from December 2018 through January 2019.

A screening question on the survey was used to determine if the respondent meets the inclusion criteria. The respondent had to click 'yes' for the survey to continue. The settings for the survey were set to only allow one survey response per IP address to avoid duplicate entries (Arigo et al., 2018).

Demographic and Workplace Characteristics

Demographic and workplace characteristics theoretically pertinent to the study were collected. The characteristics were age, gender, race/ethnicity, years in nursing, hours worked per week, current nursing role, employment setting, and Magnet® status of workplace. Age was collected categorically, using ten-year spans starting as 20-29 to over 70 years of age. Gender was categorical, collected as female, male, or other. Race/ethnicity was a categorical variable, with the race and ethnicities aligning with census tract: White non-Hispanic; Black/African American non-Hispanic; Asian; Pacific Islander/Native Hawaiian; American Indian-Alaskan native; Hispanic; two or more races.

Years of nursing was categorical (Less than 1 years; 1-5 years; 6-10 years; 10-15 years; 15-20 years; More than 20 years). Average hours worked per week was categorical (More than 40 hours per week; 30-40 hours per week; 16-29 hours per week; Less than 16 hours per week). Role in nursing was collected as categorical (staff nurse, management/administration, education/instruction, advanced practice, other). Work setting was collected as categorical (hospital; clinic/ambulatory Care; health department; academia/educational setting; long-term care; other). Magnet® status of workplace was dichotomous yes/no. These categories are comparable to those used in other studies of nurse bullying (Simons, 2008).

Instruments and Measures

The instruments used in this study were the Negative Acts Questionnaire Revised for Nursing (NAQR-US), the Institutional Betrayal Questionnaire-Healthcare (IBQ-H), and the Well-Being Index (WBI). Job satisfaction was measured using a single Likert scale question. Absenteeism was measured using a single question. The instruments and score meanings are described in Table 1.

Bullying

The NAQR-US (Simons et al., 2011) was selected to measure bullying. It was selected for this study because it is a parsimonious version of a widely used bullying scale developed to measure bullying in nursing specifically. The NAQR-US has four items, which are items from the Negative Acts Questionnaire-Revised (NAQ-R) (Einarsen et al., 2009). The items describe a bullying behavior and asks the participant to indicate how frequently they experienced the behavior using a 5-point scale (1=*never*,

2=*now and then*, 3=*monthly*, 4=*weekly*, 5=*daily*). Scores range from 4 to 20, with higher scores indicating greater exposure to bullying behaviors. Permission was obtained to use the NAQR-US.

Simons et al. (2011) developed the NAQR-US to measure bullying among nurses and described the psychometric testing of the instrument. The NAQR-US was developed using data collected from a study of registered nurses (N=511) that responded to the 22 items from the NAQ-R. In factor analysis on the scores of the NAQ-R, four dimensions were present. Validity testing of the four items demonstrated the highest amount of variance in predicting intent to leave (R^2=.25) and job satisfaction (R^2=.30). The four items also predicted self-report of being bullied (R^2=.30). Reliability testing indicated a good Cronbach's alpha (.75). The NAQR-US has not been widely used in published studies, and no cut scores have been published. However, its utility as a succinct scale to measure bullying specifically among nurses makes it a suitable instrument for the study.

In this study, to determine prevalence of bullying, the summed scores were dichotomized at a score of 10 to indicate weekly/daily bullying. A score of 10 would indicate the respondent was exposed to at least two bullying behaviors on a minimum weekly basis. Though various definitions of bullying vary in the literature, there are studies which have defined bullying at a weekly level. Thus, using a metric of weekly bullying in this study allows for comparison with other studies.

For specific aims in which the inclusion criteria were to have experienced at least one bullying behavior, nurses with an NAQR-US score of $\geq$5 were included. This score

would indicate that the nurse was exposed to at least one bullying behavior at some point in the past six months.

Organizational Response

Organizational response was measured using the IBQ-H. This instrument was selected because it lists individual acts of betrayal and support, allowing for a precise measurement of the act of omission or commission that the nurse experienced. The IBQ-H is a revision of the Institutional Betrayal Questionnaire (IBQ), which was developed by Smith & Freyd (2013) as a mechanism for measuring actions of omission or commission by an organization towards its member after a serious event. The IBQ-H asks the respondent to think about an institution as a larger entity to which the person belongs, such as a university, church, or employer. The scale is a checklist of experiences that describe acts of omission or commission by an organization to reports of a harmful event. Negative acts include covering up the report, siding with the perpetrator, or failure to abide by set policies against such actions. Supportive acts include believing the respondent and actively supporting the respondent. The IBQ-H was modified to reference bullying as opposed to a medical safety event. Permission was obtained to use and modify the instrument.

Reliability for the IBQ-H was not reported in the literature, however the IBQ from which is derived is considered a valid measure of betrayal, with only one factor loading (Eigenvalue =1.96 with 28.03% of variance explained). The IBQ-H has been used to determine effects of medical safety events (Smith, 2017), however has not been used

among nurses. Content validity was conducted among three nurse administrators and experts in nurse wellness for this study.

Organizational Betrayal and Support

The IBQ-H has two main subscales – betrayal and support. The subscales were treated as separate scales for analysis because of the distinct nature of the experience. The participant was asked if the experience has occurred within the context of bullying, and then response options were Yes and No. The scores can range from 0 to 12 for the betrayal subscale and can 0 to 8 for the support subscale. When used as a categorical measure, the scores were dichotomized at a score of 1 (0=*did not experience*, ≥1=*experienced at least one act*). The betrayal subscale has been used in prior studies (Smith & Freyd, 2017; Smith, 2017; Smith & Freyd, 2013). The support subscale is less studied.

Avoidant Leadership

A second set of subscales of the IBQ-H were developed by the author of this study to explore acts of betrayal through the conceptual lens of avoidant leadership. Though the IBQ-H was originally designed to measure institutional betrayal as a larger concept, it can be considered an adequate measure for avoidant leadership because of the similarities between betrayal and avoidant leadership. Measuring acts of organizational betrayal as types of avoidant leadership allows for a more granular view of problematic organizational actions.

The subscales created for this study were hostility, normalizing, and equivocation, and represent the types of avoidant leadership identified in the literature (Jackson et al.,

2013). The subscales were created from the twelve items of the IBQ-H which measure negative organizational response (i.e. the acts that betray the trust of the organization member). Each item on the IBQ-H that represented a negative organizational action was reviewed and grouped into one of the subscales based on its match with the conceptual definition. The grouping of items is depicted in Figure 1. The items use dichotomous yes/no scoring. Scores ranged from 0-6 for the hostility scale and 0-3 for the equivocation and normalizing scales. Scores were summed, then dichotomized at a score of 1 (0=*did not experience any action,* $\geq$1 = *experienced at least one action of avoidant leadership type*). Though this was the first identified study to measure avoidant leadership with this strategy, the reliability in this study was similar to findings for other metrics of avoidant leadership (Kanste et al., 2007; Manning, 2016).

Burnout

Burnout was measured using the Well-Being Index (WBI) (Dyrbye, Satele, & Shanafelt, 2016). Though other metrics of burnout are available, such as the Malasch Burnout Inventory, the WBI was selected because it is recommended by the National Academy of Medicine as a measure of well-being. The WBI is a nine-item instrument designed to measure indicators of work wellness, including burnout, physical and mental health, and job engagement. Seven of the items ask the participant if they have experienced a symptom, with a dichotomous yes/no response option. Two items ask the participant to indicate their level of job engagement using a 7-point Likert scale. The scale responses range from strongly agree to strongly disagree. The scale items were derived from qualitative interviews, and from validated instruments (e.g. Malasch

Burnout Inventory). Permission has been obtained to use the instrument (Dyrbye et al., 2016).

The WBI instrument was validated among a sample of nurses in the U.S. (N=637) (Dyrbye, Johnson, Johnson, Satele, & Shanafelt, 2018). Criterion validity was conducted comparing scores on the WBI with scores on other metrics of well-being, including burnout and overall quality of life. Nurses who reported the highest scores on the WBI had higher likelihood experiencing poor quality of life (OR = 12.47, 95% CI = 4.90-33.63) and burnout (OR = 22.42, 95% CI = 5.55-45.15) (Dyrbye et al., 2018).

The WBI is a continuous scale, and scores were summed with a possible range of -2 to 9, with higher scores indicating greater risk of burnout. Two questions on the scale ask about finding meaning in work, with responses scored -1 to 1. The negative score indicates that a participant that finds a high degree of meaning in work has a point subtracted from the overall scale score. Thus, there is the possibility for an overall negative score. The instrument has been validated in nurses using criterion validity. A cut off score of 2 was used to determine burnout. The cut off score for the WBI was dichotomized using a published study testing the psychometric properties of the WBI among nurses (Dyrbye et al., 2018). Comparisons of scores on the WBI and an analogous quality of life scale indicated that a score of 2 on the WBI indicated that the person was half as likely to report low quality of life. The scale authors conclude that a score of 2 or greater is indicative of risk for distress and burnout, and a score of 4 or greater at extreme risk for burnout.

Job satisfaction

Job satisfaction was measured using a single item asking about level of satisfaction with the current job. The item asks the participant to rate the level of satisfaction with the current job using a 4-point Likert scale. The responses range from very satisfied to very dissatisfied. Scores range from 1 to 4, with higher scores indicating higher levels of dissatisfaction. The four-point scale allows for dichotomization of the variable if necessary. The single item has been used in other studies of nursing work environments (Kelly, et al., 2011; Stimpfel, et al., 2012). Job satisfaction was dichotomized to include responses of satisfied and very satisfied together as satisfied and dissatisfied and very dissatisfied as dissatisfied.

Absenteeism

Absenteeism was measured using a single question asking participants the number of days missed from work for illness or other personal reasons. The statement of absenteeism reflects a recognized definition of absenteeism (*Absenteeism*, 2019). Though limited published evidence was identified to provide a concrete number of days missed to indicate absenteeism, a cut score of three or more was estimated based on the sample mean to determine absenteeism.

Table 1 Scales used to measure independent and dependent variables

Independent Variables	Instrument	Level of Measurement
Workplace bullying	Negative Acts Questionnaire Revised-US (NAQR-US)	• Continuous • Four items • Measured with 5-point Likert scale of frequency of bullying behaviors • Range 4 to 20 • Higher scores indicate greater exposure to bullying behaviors • Cut score of $\geq$10 to measure prevalence of bullying on a weekly/daily basis; and of $\geq$5 to indicate exposure to any bullying • Published Cronbach's alpha =.75
Organizational response	Institutional Betrayal Questionnaire-Health (IBQ-H)	• Dichotomous yes/no responses, Yes=1, No=0 • Twenty items (12 betrayal items, 8 support items) • Betrayal and support measured using two major subscales (betrayal and support) • Avoidant leadership subscales (hostility, normalizing, and equivocation) created using betrayal items. • Scale scores dichotomized using scores $\geq$1 and 0 • Validity established in literature
Dependent Variables	**Instrument**	**Level of Measurement**
Workplace Well-being	Well-Being Index	• Continuous • Nine items • Seven dichotomous items; two items 5-point Likert scale of agreement • Range -2 to 9

		• Higher scores indicate greater risk of negative well-being • Measures burnout, exhaustion, job engagement. • Cut score of ≥2 used to indicate burnout. • Published validity established among nurses
Job satisfaction	Level of satisfaction with the current job.	• One item • Uses a 4-point Likert scale of satisfaction • Higher scores indicate higher levels of dissatisfaction • Grouped as satisfied (*very satisfied* and *satisfied*) and dissatisfied (*very dissatisfied* and *dissatisfied*) • Similar measure used in other published studies
Absenteeism	Days missed of work for illness or personal reasons	• Continuous text entry of days missed at work over the past six months • Participant self-report • Cut score of ≥3 days to indicate absenteeism based on sample mean • Definition consistent with published definitions

Data analysis

Demographic and workplace variables were grouped to allow for more even distribution of participants into categories. All demographic and workplace characteristics were categorical variables. Demographic and workplace characteristics were analyzed using descriptive statistics (i.e. frequency and percentage).

Continuous level data were assessed for normality, linearity and homoscedasticity using descriptive statistics for skewness, histograms, plots of residuals and predicted

values, and scatterplots (Mertler & Vanatta, 2013). Minor skews were noted in burnout and job satisfaction scores but, a major deviation was noted was in the absenteeism data. To increase clarity in explaining the results from a clinical implications perspective, and to address the issues of non-normality in one of the three dependent variables, all the dependent variables were dichotomized for analysis and non-parametric testing conducted.

Specific aims 1 and 2 were to examine prevalence of bullying and bivariate relationships between bullying and demographic and workplace characteristics. For the analyses of specific aims 1 and 2, all nurses in the sample were include (N=242). Frequency and percentage were used to determine prevalence of bullying at a cut score of 10 (N=242). This strategy was selected to allow for comparison with other studies that measured prevalence of bullying among the same target population (i.e. registered nurses). Chi square tests were used to determine bivariate relationships between demographic/workplace characteristics and bullying (N=242).

Specific aim 3 was to examine associations between institutional betrayal/support and three variables of well-being, namely burnout, job satisfaction and absenteeism, controlling for individual factors such as demographic and workplace characteristics, among nurses who have experienced bullying. For this analysis, nurses with complete data and who had experienced at least one act of bullying were included (N=173). Hierarchical multiple logistic regression analyses were used to determine the size and direction of associations between independent variables variates (organizational betrayal and support; demographic and workplace characteristics) and workplace well-being. The

variables were the categorical individual and workplace characteristics, and the dichotomized well-being variables (burnout, job satisfaction, absenteeism). Cut scores were used to create dichotomous groups for the well-being variables. Hierarchical logistic regression analyses were conducted on each indicator of well-being: burnout, job satisfaction, and absenteeism (N=173). In the first regression model, individual factors including nurses' demographic and workplace characteristics were entered as independent variables to examine their association with each of the well-being measures. In the adjusted final model, institutional betrayal and institutional support were entered as independent variables to examine their association with each indicator of well-being. Hosmer and Lemeshow tests of significance and tests model fit were conducted. Nagelkerke pseudo R^2 was analyzed.

Specific kaim 4 was to examine prevalence of avoidant leadership types. The dichotomized scores on the hostility, normalizing and equivocation subscales were used. Frequencies and percentages were analyzed.

Specific aim 5 was to examine bivariate relationships of avoidant leadership types with workplace well-being. Avoidant leadership subscale and workplace well-being scale dichotomous scores were used. Frequencies and percentages were compared, and chi-square tests were used to determine significant differences.

Specific aim 6 was to examine associations of avoidant leadership types and demographic and workplace characteristics with workplace well-being. Simultaneous logistic regression was used to determine the size and direction of the associations between the three different types of avoidant leadership and each of the dependent

measures of well-being (burnout, job dissatisfaction and absenteeism). In the logistic regression models, demographic and workplace characteristics and types of avoidant leadership (hostility, normalizing and equivocation) were entered simultaneously into each of the three models as independent variables. Hosmer and Lemeshow tests, model fit statistics, and Nagelkerke pseudo R^2 were reviewed to determine model fit and variance.

A significance level of .05 was set for all hypothesis testing. Data were analyzed in SPSS Version 26 (IBM Inc., 2018).

Human Subjects Considerations

The study was conducted in accordance with the Common Rule governing ethical conduct of human subjects' research in the United States, and the professional code of ethics for nurses (American Nurses Association, 2015a). The research was reviewed by the George Mason University Office of Research Integrity and Assurance, IRB Number 1356663-1.

Privacy and confidentiality were maintained for participants. The survey was conducted using the Qualtrics ® survey software, which offers high-level cloud security to prevent unauthorized access. The survey data was password protected. All records were anonymous, with no identifying information collected. Though time stamp was collected in the survey via embedded data, this cannot be deactivated in Qualtrics®, however the time was immediately deleted from the data after export to Excel. Data will be stored securely in a locked location for five years in accordance with the ethical requirements.

Privacy considerations on social media were taken to avoid any identification of survey responses and social media activity (Gelinas et al., 2017). The Qualtrics social media application was not used, so that there was no link between Facebook® recruitment and responses in the survey. Notifications of participation in the survey on social media, such as posting a notification that a participant completed the survey, was at the participant's discretion. In addition, the participant could use settings in Facebook® to hide information about activity from others' view. Though aggregate click information was collected by Facebook® and provided to the page owner (in this case the researcher), it was not shared with any other entity per Facebook® privacy rules.

Signed consent was waived, however consent to participate was explained on the introduction page of the survey. A check box was included for participants to acknowledge the risks and benefits of the study and to consent to participate. Participants were advised they could discontinue the survey at any time. Data of participants that ended the survey before completion of all items were not included in the final analysis.

Involvement in the quantitative study was thought to present minimal risk. Participants might have experienced stress, anxiety, or other psychological stress from recalling their experiences and answering the items. A statement in the consent indicated this risk. The final page of the survey encouraged any participant that experienced distress to seek appropriate care from a healthcare provider, counselor, or other source of behavioral treatment. There was no benefit to participation in the survey.

The study methods and data storage strategies were reviewed and approved for exempt status by the George Mason University Institutional Review Board.

Summary

A cross-sectional study was conducted using an online survey. The target population was registered nurses in the U.S. The inclusion criteria were a) to be a registered nurse and b) to have been working in nursing job for at least six months. Participants were recruited using social media advertisements and direct outreach on social media. Study variables were demographics/workplace characteristics, bullying, organizational betrayal and support, burnout, job satisfaction, and absenteeism. Bullying was measured using the Negative Acts Questionnaire-Revised for Nursing. Organizational betrayal and avoidant leadership types were measured using the Institutional Betrayal Questionnaire for Health (IBQ-H). Burnout was measured using the Well-Being Index (WBI). Job satisfaction was measured using a satisfaction Likert scale question. Absenteeism was measured by asking respondents how many days of work were missed in the past 12 months for illness or personal reasons. Demographic and workplace characteristics were also collected, including age, gender, race/ethnicity, workplace type, work role, years of experience in nursing, hours worked per week, and Magnet ® status of workplace.

Descriptive statistics were used to describe the sample, prevalence of bullying and prevalence of avoidant leadership types. Cut scores were used to dichotomize variables. Chi square tests were used to analyze bivariate relationships among study variables. Simultaneous and hierarchical logistic regression were used to examine associations between study variables and to control for demographic and workplace characteristics of nurses. Institutional review board approval was obtained.

CHAPTER FOUR

Summary of Results

This chapter is a summary of the results and data analysis for the specific aims.

Sample

There were 242 responses to the survey that met the inclusion criteria. The cases were examined manually for missing data and 56 cases deleted due to missing data on the IBQ-H and WBI scales. After the deletion of these cases, there was <5% item level missing data on all scales, and data appeared to be missing at random.

The sample (N=242) characteristics indicated a majority were female (n=231, 95%) and white/non-Hispanic (n=221, 91%), younger than 50 years of age (n=135, 55%), had >10 years of experience in nursing (n=130, 53%), worked full time (n=208, 86%), worked in a staff nurse role (n=154, 63%), worked in a non-Magnet facility (n=174, 72%), and worked in hospitals (n=130, 53%).

Reliability of Study Measures

All scales demonstrated fair to good reliability. The Cronbach's alpha for the NAQR-US was .84. On the IBQ-H subscales, the Cronbach's alpha for the betrayal subscale was .92, and the support subscale was .76; the Cronbach's alpha for the hostility subscale was .84, the normalization subscale was .79, and the equivocation subscale .72. The Cronbach's alpha for the WBI in this study was .78.

Results for Specific Aim 1

Specific aim 1 was to describe the prevalence of weekly/daily bullying among nurses (N=242). Scores with complete data for the NAQR-US were used to determine prevalence of bullying and examine bivariate associations between bullying and demographic and workplace characteristics. Using a cut score of 10, the prevalence of bullying on a weekly or daily basis was 31% (n=75).

Results for Specific Aim 2

Specific aim 2 was to describe associations of demographic and workplace characteristics and workplace well-being (burnout, job dissatisfaction, and absenteeism) among nurses who have experienced any bullying behaviors (N=173). Bivariate associations showed no significant associations between weekly/daily bullying and demographic/workplace characteristics.

Results for Specific Aim 3

Specific aim 3 was to explore associations of organizational betrayal and support with workplace well-being (burnout, job dissatisfaction and absenteeism) after controlling for demographic and workplace characteristics among nurses who have experienced at least one bullying behavior (N=173). After controlling for covariates in a hierarchical regression model, organizational betrayal increased the odds of burnout, OR =2.62, 95% CI [1.14,6.03], job dissatisfaction, OR =2.97, 95% CI [1.01,8.73], and absenteeism, OR= 6.11, 95% CI [2.26,16.54]. Organizational support decreased the odds of job dissatisfaction, OR= .30, 95% CI [.15,.60] and absenteeism, OR= .50, 95% CI [.25,.99].

The Hosmer and Lemeshow tests were non-significant and the model goodness-of-fit tests indicated the data were a good fit for the model. Nagelkerke pseudo R^2 was equal to .11 for burnout, .21 for job dissatisfaction, and .20 for absenteeism.

Results for Specific Aim 4

Specific aim 4 was to describe frequencies of types of avoidant leadership in response to bullying among nurses who experienced bullying behaviors (N=173). Frequencies of the avoidant leadership types indicated 76% reported experiencing at least one act of hostility (n=132), 75% reported experiencing at least one act of normalizing (n=131) and 66% reported experiencing at least one act of equivocation (n=115).

Results for Specific Aim 5

Specific aim 5 was to examine relationships between types of avoidant leadership in response to bullying and workplace well-being among nurses among nurses who experienced bullying behaviors (N=173). In chi-square tests, the three types of avoidant leadership all had significant bivariate associations with the dependent variables. Specifically, hostility had significant associations with burnout, job dissatisfaction and (X^2=7.72, df 1, p=.005) and absenteeism (X^2=8.98, df 1, p=.003). Normalizing had significant associations with burnout (X^2=11.23, df 1, p=.001), job dissatisfaction (X^2=10.61, df 1, p=.001), and absenteeism (X^2=12.27, df 1, p<.001). Equivocation had significant associations with burnout (X^2=14.82, df 1, p<001), job dissatisfaction (X^2=5.43, df 1, p=.02) and absenteeism (X^2= 8.09, df 1, p=.004). Overall, in these significant relationships, the nurses who reported experiencing the avoidant leadership type had a higher percentage of poor well-being than those who did not. Significant

differences in workplace well-being and demographic/workplace characteristics were age and burnout (X^2 =3.81, df 1, p=.05), role and job dissatisfaction (X^2 = 6.23, df 1, p=.01), and hours worked per week and absenteeism (X^2.=3.66, df 1, p=.05).

Results for Specific Aim 6

Specific aim 6 was to estimate the size and direction of associations between experiencing acts of avoidant leadership and demographic and workplace characteristics with workplace well-being among nurses among nurses who experienced bullying behaviors (N=173). Findings from the logistic regression model indicate that experiencing at least one act of equivocation was associated with three times higher odds of burnout compared to those who did not report experiencing this event, OR = 3.78, 95% CI [1.35,10.53]. Similarly, experiencing at least one act of normalizing was associated with five times higher odds of job dissatisfaction relative to those who did not experience an act of normalization, OR =5.03, 95% CI [1.16,21.72]. None of these types of avoidant leadership experiences were associated with absenteeism in the logistic regression model.

The Hosmer and Lemeshow tests were non-significant and the model goodness-of-fit tests indicated the data were a good fit for the model. Nagelkerke pseudo R^2 were .20 for burnout, .18 for job dissatisfaction, and .17 for absenteeism.

CHAPTER FIVE

Discussion

Workplace Bullying

The prevalence of weekly/daily bullying in this sample was 31% based on the NAQR-US. General comparisons can be made by examining other studies that used a similar target population and similar bullying measures. Olender (2017) reported 35% of nurses (n=156) experienced at least one bullying behavior on a weekly basis. Sauer & McCoy (2018) report 38% of nurses (n=345) experienced exposure to at least some frequency of bullying behaviors. The bullying prevalence in this study suggests bullying occurs even as U.S. nursing organizations have placed an emphasis on eliminating bullying in the work environment (American Nurses Association, 2015a). The reliability for the NAQR-US scale in this study (.78) was comparable to what has been reported (Simons et al., 2011).

Betrayal and Support

Organizational betrayal was a significant predictor of poor well-being, consistent with previous studies (Salin & Notelaers, 2017; Smith, 2017; Smith & Freyd, 2013; Trybou et al., 2016). The finding in this study appears consistent with qualitative findings in which nurses describe feeling let down by their organizational leaders (Gaffney et al., 2012).

It is somewhat unsurprising that nurses who experienced organizational betrayal were more likely to experience burnout. Betrayal likely contributes to the lack of joy in work, consistent with studies that found that nurses who reported betraying actions had less affective commitment to their workplace (Trybou et al., 2016). Betrayal could compound the myriad of factors that contribute to burnout.

Organizational support was a significant predictor of job satisfaction and absenteeism. This indicates nurses in this study who are supported in the context of bullying were more satisfied with their jobs and miss less work. The finding was consistent with other studies analyzing the relationship of organizational support and nurse job satisfaction (Kelly et al., 2011; Spence Laschinger et al., 2012; Wing et al., 2015). The findings are similar to the description of nurses that support was important in emotional healing (Gaffney et al., 2012).

Avoidant Leadership

The study findings in relation to avoidant leadership indicate that avoidant leadership types are associated with poor workplace well-being among nurses. The finding in this study supports other findings in the literature where absence of leadership and/or management through hostility eroded trust and undermined affective commitment among nurses (Gaffney et al., 2012; Jackson et al., 2013; Manning, 2016; Trybou et al., 2016). Though workplace well-being is a multifactorial issue, and one that encompasses many facets of individual and organizational characteristics (National Academy of Medicine, 2018), leadership is an important component of the work environment, and can

be instrumental in workplace engagement and wellness (Alilyyani et al., 2018; Laschinger & Fida, 2014; Manning, 2016).

Hostility was experienced by more than three-quarters of the nurses in the sample. This appears problematic because hostile leadership, also considered management by exception or aggressive management, has been associated with decreased work engagement among nurses (Manning, 2016). Hostility avoidant leadership might include punishment for reporting the bullying, which is antithetical to a culture of safety and erodes trust among nurses (Ahern, 2018). It could also include the overall workplace culture and the culture created by organizational leaders; a poor workplace culture likely leads to poor nurse and patient outcomes (Wei et al., 2018).

Normalizing workplace bullying, such as by failing to prevent it or creating an environment where it was more likely to happen, led to higher likelihood of job dissatisfaction among nurses. Normalizing bullying would logically cause nurses to feel dissatisfied, as the bullying is made to seem like a regular part of the work environment. Bullying itself has been associated with job dissatisfaction (Read & Laschinger, 2013), therefore an environment in which bullying seems common, normal, or "just the way it is here" would likely increase job dissatisfaction as well. Normalization of bullying has also been found to be associated with increased bullying (Glambek et al., 2018; Hutchinson, Vickers, et al., 2010).

Equivocation, such as acting without adequacy, regard, or care for a person's information or experiences was a significant predictor of burnout. This finding appears similar to studies where nurses express dismay and desire to leave their jobs when their

experiences are downplayed or reports of bullying are dealt with inadequately (Gaffney et al., 2012). Equivocation might create a sense that the leader does not care about the well-being of the person who was bullied or there is no validation of their experience. These experiences could signify a lack of organizational support, which has been linked to clinician burnout (National Academy of Medicine, 2018). Equivocation could also signify that there is insufficient competency to deal with the issue (Jackson et al., 2013), indicating a potential need for even stronger policies, training and support in healthcare organizations.

Strengths

The strength of this study is that it introduces new concepts – organizational betrayal and support – and addresses a research gap of avoidant leadership. The online sampling method allowed for recruitment across geographical areas, specialties, and workplaces, allowing for a more diverse sample of nurses. The distribution of several demographic factors among this study sample, including the critical aspect of workplace type, was similar to that of a nationally representative sample of nurses (Smiley et al., 2018). The inclusion of managers in the sample allowed for exploration of concepts among nurses at any level of the organization.

Limitations

There appeared to be a lack of racial diversity in the sample – nationally nurses are 83% white, while in the sample the distribution was 91% white. The subscales for avoidant leadership were developed and tested in this study and further psychometric testing of this modality is required. The sample size was small in comparison to the total

population of registered nurses in the U.S., however according to the a priori analysis was adequately powered and there were at least 15 participants per variable. Statistically, using the Nagelkerke pseudo R^2 as an estimate, the study appeared to have small but acceptable effect sizes for organizational betrayal and support (pseudo R^2 .11 for burnout, .21 for job dissatisfaction, and .20 for absenteeism) and for avoidant leadership (pseudo R^2.20 for burnout, .18 for job dissatisfaction, and .17 for absenteeism).

Future Studies

Future studies with larger samples and more controlled design can build on this study and further test organizational response as a contributor to workplace well-being. Future studies could employ wider recruitment strategies to increase diversity of the sample and increase the overall sample size, particularly to better account for contextual measures such as Magnet®, and employ more controls for burnout, job satisfaction and absenteeism (e.g. personal characteristics, work-life balance, and employer benefits). Future studies could also be designed to test for mediation to determine if organizational response is impacting the strength and association of negative work environment experiences (e.g. bullying) and workplace well-being. Future studies can explore betrayal, support, and avoidant leadership in relation to other negative experiences as well as among other populations (e.g. patients, caregivers). Future studies be conducted to further test measures of avoidant leadership.

Implications for Nursing Practice

This study offers important evidence towards improving the work environment for nurses and for improving overall patient care. Consistent with other studies, this study

found that bullying is occurring in the work environment, despite national efforts to address the problem (American Nurses Association, 2015a). Though bullying is a complex and challenging social behavior, organizational response to it could be an intervention (Gillen et al., 2016). Nurse leaders should recognize the importance of a supportive response to bullying in the work environment and face the challenge head on as opposed to avoiding it. Nurses should continue efforts to advocate for stronger organizational policies and interventions to decrease the prevalence of bullying in the workplace.

Conclusions

Organizational leaders, including nurse leaders and managers, have an important role in the prevention and mitigation of workplace bullying. Nurse leaders should promote awareness of the issue of bullying and promote strategies to prevent it, and to support nurses that experience it. Practicing nurses of all specialties and workplaces should advocate for policies to confront the negative workplace issue of bullying.

CHAPTER SIX

This chapter includes the manuscripts produced as a result of this dissertation research.

Manuscript 1

The first manuscript was published in the *Journal of Nursing Management* at the time of the dissertation defense. John Wiley & Sons, Inc., is the publisher and copyright owner. Permission was granted from the publisher to reuse the manuscript for this dissertation. The citation is:

Brewer, K. C., Oh, K. M., Kitsantas, P., & Zhao, X. (2020). Workplace bullying among nurses and organizational response: An online cross-sectional study. *Journal of Nursing Management, 28*(1), 148–156. https://doi.org/10.1111/jonm.12908

Abstract

Title: Workplace bullying among nurses and organizational response: An online cross-sectional study.

Aims: Examine prevalence of bullying among nurses and explore associations of organizational betrayal and support with well-being among nurses who experienced any bullying.

Background: Organizational support contributes to nurse well-being. Organizations have an obligation to support nurses who are bullied, and lack of support is organizational betrayal. Organizational betrayal and support after bullying could be associated with nurse well-being but are not well explored.

Methods: A cross-sectional study among nurses was conducted via online survey. Data were collected using the Negative Acts Questionnaire-Revised for Nursing, the Institutional Betrayal Questionnaire for Health, and the Well-Being Index. Job satisfaction and absenteeism were measured using single questions. Demographics were used as covariates.

Results: Prevalence of weekly/daily bullying was 31% (N=242). Among those that experienced any bullying (N=173), organizational betrayal increased odds of burnout (OR 2.62, p=.02), job dissatisfaction (OR 2.97, p=.04), and absenteeism (OR 6.11, p<.001). Organizational support decreased odds of job dissatisfaction (OR .30, p=.001) and absenteeism (OR .50, p=.04).

Conclusion: In this study, organizational betrayal increased likelihood of burnout, job dissatisfaction, and absenteeism. Support decreased likelihood of dissatisfaction and absenteeism.

Implications for Nursing Management: Further study of organizational betrayal and support can bring attention to this issue for nurse administrators.

Introduction

Clinician well-being has been linked to many important health care outcomes, including patient safety and quality of care (Salyers et al., 2016). Examination of the multiple factors that affect clinician well-being has been called a national priority by the National Academy of Medicine (Dyrbye et al., 2017).

Organizational support for clinicians can impact well-being (Brigham et al., 2018). Organizational support and betrayal (i.e. non-support) in the context of workplace bullying are important in nursing. This is because organizations have an obligation to support nurses by preventing and mitigating workplace bullying and because nurses trust their organizations to provide psychological and physical safety in the work environment (American Nurses Association, 2015a). However, there appear to be few studies which examine organizational support and betrayal in the context of workplace bullying.

The purpose of this study was to explore bullying and associations of organizational support and betrayal with well-being among nurses exposed to bullying. The variables of interest are bullying, organizational betrayal and support, and well-being (burnout, job satisfaction, and absenteeism). The findings contribute to the evidence base of nurse well-being, which is an important issue for nurses and administrators.

Background

Workplace Bullying

Workplace bullying is the prolonged exposure to negative behaviors, such as sabotage, criticism, and exclusion (Gillen et al., 2017). Bullying has harmful effects on well-being. A meta-analysis of 173 cross-sectional studies of workplace bullying

(N=77,121) found bullying was associated with mental health problems (r =.34, p<.001), burnout (r=.27, p<.001), and physical health problems (r=.21, p<.001). Bullying was associated with organizational outcomes, including intent to leave (r=.28, p<.001), job satisfaction (r= -.22, p<.001), performance, (r= -.12, p<.001) and absenteeism (r =.11, p<.001) (Nielsen & Einarsen, 2012). Though scarce cost estimates of bullying are available for the U.S., worldwide cost estimates related to medical care, lost productivity, and other organizational outcomes are around $23 billion (Gillen et al., 2017).

Bullying in Nursing

Workplace bullying is a prominent work environment issue in nursing (American Nurses Association, 2015a). Analysis of bullying indicates it has impacts on nurse well-being and other issues that impact health care quality (Hutchinson, Wilkes, et al., 2010). Among nurses, bullying has been shown to increase burnout (Allen et al., 2015), mental health symptoms such as anxiety and fatigue (Reknes et al., 2014), and intent to leave an organization (Sauer & McCoy, 2018). Bullying has also been associated with increased reports of patient adverse events (e.g. infections and falls) and decreased perceived quality of care (Laschinger, 2014).

Organizational Response

Evidence suggests that organizational support is important to nurse well-being. Studies suggest that organizational support is a critical element towards creating healthy work environments, and that healthy work environments in turn have impacts on nurse health, emotional strain, and retention (Wei, Sewell, Woody, & Rose, 2018). Organizational support includes empowering nurses in practice, which has been found to

predict lower levels of mental health symptoms in new graduate nurses (Wing et al., 2015). Magnet ® designated organizations are those that are recognized for high levels of support for nursing, and have been found to have lower levels of burnout and higher levels of job satisfaction among nurses (Kelly et al., 2011).

A lack of organizational support is betrayal. Non-supportive actions by an organization is also known as institutional betrayal, which occurs when an institution (e.g. individuals, policies and/or systems) betrays the trust of an individual within that institution. Smith & Freyd (2013) found that among college women who experienced sexual assault, betrayal by the university was associated with increased anxiety, dissociation, and trauma. Smith (2017) found that among patients who experienced a medical error, betrayal by the medical system was associated with decreased trust and increased disengagement.

Betrayal at the organizational level has also been studied as psychological contract violation. This type of betrayal was found to increase the intent to leave an organization among general employees (Salin & Notelaers, 2017). Among nurses, psychological contract violation predicted higher intent to leave and lower affective commitment to the organization (Trybou et al., 2016).

Most of the identified studies of organizational actions in the context of bullying have examined individual managers' actions and behaviors, and mostly as antecedents to bullying (Hutchinson, Wilkes, et al., 2010; Trépanier et al., 2016). There appear to be scarce quantitative studies that have measured organizational betrayal or support after

bullying and examined relationships of these factors with nurse well-being. This is an apparent research gap.

Nurse Well-Being

The focus on well-being reflects the growing threat posed by burnout and other well-being issues to clinical care (Dyrbye et al., 2017). Well-being is a multi-factorial manifestation in which nurses feel low levels of burnout and fatigue, and high levels of job engagement (Dyrbye et al., 2017). Well-being encompasses personal factors (e.g. demographics), skills and abilities (e.g. level of experience), rules and regulations (e.g. accreditation), healthcare responsibilities (e.g. clinical/administrative role, patient population), and organizational culture (e.g. support for clinicians) (National Academy of Medicine, 2018). Among the issues of clinician well-being, burnout is of concern. A meta-analysis of studies of nurses and other clinicians found that burnout had negative associations with perceived quality (r=.26, 95% CI -.29 to -.23) and with patient safety (r=.23, 95% CI -.28 to -.17) (Salyers et al., 2016). Studies have demonstrated that nurse burnout is associated with intention to leave an organization (Spence Laschinger, Leiter M, Day, & Gilin, 2009) and decreased empathy (Wilkinson et al., 2017). In addition, studies have demonstrated that nurse burnout predicted hospital-acquired infections, including urinary tract infections (β=.85, p=.02*)* and surgical site infections (β=1.58, p<.01*)* (Cimiotti, Aiken, Sloane, & Wu, 2012).

Theoretical Frameworks and Conceptual Model

An ethical framework of nursing practice was the theoretical guide for this study. Ethically, healthcare organizations have an obligation to provide a safe and healthy work

environment for nursing practice, and nurses trust their organizational leaders will provide them safety and support (American Nurses Association, 2015b). This trust includes prevention of any level of bullying and justice if it occurs (American Nurses Association, 2015a). If the trust is violated, as when an organization ignores reports of bullying or even punishes the reporter, theoretically organizational betrayal can occur.

Bullying was selected as the specific context for organizational betrayal because it is a recognized issue across many nursing work environments and because organizations have been called on to support nurses who experience any level of bullying (American Nurses Association, 2015a). It is theorized that bullying is an ongoing issue in nursing due to the need to achieve control over those of the same occupational identity (Roberts et al., 2009).

The conceptual model for this study is depicted in Figure 1, and is based on a larger model developed by the National Academy of Medicine's clinician well-being workgroup (National Academy of Medicine, 2018). In the conceptual model for the current study, organizational support or betrayal after a nurse experiences bullying are used as independent variables. The conceptual definition of betrayal and support is actions at the organizational level (i.e. administration and policies, including but not limited to the actions of individual managers) in response to bullying. Well-being is the dependent variable. The conceptual definition of well-being is thoughts, attitudes and behaviors that connote wellness at work. In this study, three metrics of well-being are used - burnout, job satisfaction, and absenteeism.

Aims

Specific aims of this study are to describe the prevalence of weekly/daily bullying among nurses (N=242) and to explore associations of organizational betrayal and organizational support with well-being (burnout, job satisfaction and absenteeism) after controlling for demographic and workplace characteristics among nurses who have experienced at least one bullying behavior (N=173).

Methods

Design & Sample

A cross-sectional study was conducted. A convenience sample was sought. The target population was registered nurses in the United States. The inclusion criteria for participation in the survey were a) registered nurse and b) worked in a nursing job for the past six months. Demographics including workplace were collected, however were not used as exclusion criteria. The convenience sample and broad inclusion criteria reflected the exploratory nature of the study.

Data Collection

Data were collected using an online survey. Recruitment occurred via advertisements on social media using strategies that have proven successful in other studies (Akers & Gordon, 2018). Advertisements ran for seven days, achieving about 4,000 views and 150 clicks. Direct recruitment was also used via social media. Data were collected in December 2018 through January 2019.

Ethical Considerations

The survey was anonymous and no identifying information about the participants was collected. The study methods were reviewed and deemed exempt from review by the

authors' Institutional Review Board. Signed consent was waived; however, participants were asked to review a consent page and select a response indicating their consent.

Measures

Demographics (i.e. individual and workplace characteristics) collected were gender, race/ethnicity, age, years of experience, role, workplace type, hours worked per week, and Magnet ® status of workplace.

Bullying. Bullying was measured using the Negative Acts Questionnaire Revised for Nursing (NAQR-US), a four-item scale that measures bullying in nursing (Simons et al., 2011). Bullying behaviors are measured using a 5-point scale (1= *never,* 2 = *now and then*, 3 = *monthly*, *4 = weekly*, 5 = *daily*). Scores range from 4 to 20, with higher scores indicating greater exposure to bullying. Scores are cumulative and in initial testing the scale had a Cronbach's alpha of .75 (Simons et al., 2011). Prevalence was measured using a score of 10 on the NAQR-US. A sum score of 10 would indicate exposure to at least two bullying behaviors on a minimum weekly basis.

Betrayal and Support. The measurement strategy for organizational betrayal and support was the Institutional Betrayal Questionnaire-Healthcare (IBQ-H) (Smith, 2017). The IBQ-H is a binary scale measuring acts by an organization and uses dichotomous yes/no scoring (Smith, 2017). The instrument was selected because it fit the conceptual definition of organizational support because it measures actions of the whole organization and not necessarily of a single individual (e.g. manager). With permission, it was slightly modified to reflect bullying. Items of betrayal include "not taking proactive steps to prevent bullying acts" and "making it difficult to report bullying acts or share concerns."

Items of support include "actively supporting you with either formal or informal resources regarding bullying" and "admitting that the institution did not adequately act to prevent bullying."

For this exploratory study, scores were dichotomized at 0 and $\geq$1, indicating either did or did not experience betrayal or support. Validity was established for a similar version of the scale (Smith & Freyd, 2013). Face and content validity were tested for this study among three experts in nursing administration and nurse health and wellness.

Burnout. Burnout was measured using the Well-Being Index (WBI) (Dyrbye, Satele, & Shanafelt, 2016). The WBI is a nine-item instrument designed to measure indicators of workplace wellness. The scale uses both dichotomous and scale items. Dichotomous items include "Have you felt burned out from your work?" and "Have you worried that your work is hardening you emotionally?" Scales used a 7-point scale (1=*very strongly agree* and 7=*very strongly disagree*), and items include statements such as "The work I do is meaningful to me." Scores range from -2 to 9 (negative scores occur because the two scale items have possible negative values). Higher scores on the WBI indicate increased risk of burnout. A cut score of 2 is recommended as an indicator of burnout. Criterion validity was established by the scale authors by comparing WBI scores with other well-being scales (Dyrbye, Johnson, Johnson, Satele, & Shanafelt, 2018).

Job satisfaction. Job satisfaction was measured using a single question asking about levels of satisfaction. The responses were at a 4-point Likert scale (1=*very satisfied* and 4=*very dissatisfied*) and scores were dichotomized as satisfied or not satisfied. This

single-question item and scoring was used in other studies of nurse well-being (Kelly et al., 2011; Stimpfel et al., 2012).

Absenteeism. Absenteeism was measured self-report of days missed work for illness/personal reasons over the past year, which is consistent with the definition of absenteeism (National Institute of Occupational Safety and Health, 2019). An estimated cut score of absenteeism was ≥3 days missed from work.

Data Analysis

Frequencies and percentages were used to describe the sample and bullying. To determine prevalence, bullying was dichotomized at a score of 10, which indicated weekly/daily bullying. Chi-square tests were utilized to examine associations between demographic and workplace characteristics and bullying (N=242).

In analyzing associations of betrayal and support with well-being, nurses who experienced at least one bullying behavior were included in the analyses (N=173). Some outcome variables were not fit to a normal distribution so dichotomous scoring and non-parametric testing were used. Chi-square tests were conducted to examine bivariate associations between variables. Hierarchical logistic regression analyses were conducted for each of the outcome variables. In the first regression model, individual demographic/workplace characteristics were entered as independent variables to examine associations with each of the well-being measures. These variables were selected for their congruence with the personal and organizational factors that might influence well-being (National Academy of Medicine, 2018). In the adjusted models, dichotomous variables of

betrayal and support (i.e. experienced at least one act and experienced none) were entered as independent variables.

SPSS version 25.0 was used for data analysis. The significance level for all analyses was set at .05.

Results

There were 242 responses to the survey that met the inclusion criteria. The cases were examined manually for missing data and 56 cases deleted due to missing data on the IBQ-H and WBI scales. After the deletion of these cases, there was <5% item level missing data on all scales, and data appeared to be missing at random.

Participant Characteristics

The sample was predominantly female, white/non-Hispanic, older than 50 years of age, had more than 20 years in nursing, worked full time, identified as a staff nurse, and worked in a non-Magnet facility. A slight majority (n=130, 53%) worked in hospitals. Of the nurses who did not work in hospitals, 9% (n=17) worked in ambulatory care, 8% (n=14) worked in educational settings, 8% (n=14) worked in long term care, 5% (n=5%) worked in a community setting, 2% (n=4) worked in an outpatient procedure center, and 11% (n=19) indicated 'other'.

Though multiple levels of demographic categories were collected in the survey, the categories were grouped for even distribution. Grouped demographic and workplace characteristics are depicted in Table 1.

Reliability for Scales

All scales demonstrated fair to good reliability. The Cronbach's alpha for the NAQR-US was .84. On the IBQ-H subscales, the Cronbach's alpha for the betrayal subscale was .92, and the support subscale was .76. The Cronbach's alpha for the WBI in this study was .78.

Bullying Results

Scores with complete data for the NAQR-US were used to determine prevalence of bullying and examine bivariate associations between bullying and demographics (N=242). Using a cut score of 10, the prevalence of bullying on a weekly or daily basis was 31% (n=75). Bivariate associations listed in Table 1 showed no significant differences.

Organizational Betrayal, Support and Well-being Results

Because hospitals potentially have more resources for bullying, it was possible that differences in organizational betrayal might exist. Additional chi square tests were conducted to analyze bivariate associations between betrayal/support and workplace types (N=173). When comparing by workplace types, no significant difference was noted among those who experienced at least one act of betrayal and those who experienced none (X^2=3.76, p=.80), nor among those who experienced at least one act of support and those who experienced none (X^2=5.04, p=.65).

Overall, among the sample, 67% (n=125) were at risk for burnout, 33% (n=58) were dissatisfied with their jobs, and 50% (n=87) reported missing at least three days of work for illness/personal reasons. Chi square tests of demographic characteristics and associations with well-being are listed in Table 2. The only significant associations with

demographic/workplace characteristics were between hours worked per week and absenteeism (p=.04), and between Magnet® status of the workplace and job satisfaction (p=.04).

Table 3 depicts logistic regression analyses. After controlling for covariates, nurses who experienced ≥1 act of betrayal were more likely to experience burnout (OR 2.62, p=.02), to be dissatisfied with their jobs (OR 2.97, p=.04), and to miss three or more days of work (OR 6.11, p<.001) than those who did not. Nurses who experienced ≥1 act of support were less likely to be dissatisfied with their jobs (OR .30, p=.001) and to miss three or more days of work (OR .50, p=.04) than those who did not.

The Hosmer and Lemeshow test indicated the model adjusting for all co-variates was not significantly different from the fit for an ideal model and was a good fit for the data (see Table 3).The classification results also indicated a strong model, with overall Nagelkerke R^2 being equal to .11 for burnout, .21 for job dissatisfaction, and .20 for absenteeism. correct classification rate ≥67% for all models; however, the effect sizes were modest, with

Discussion

This study marks one of the first noted that examined organizational betrayal in nursing. Organizational betrayal was a significant predictor of poor well-being, consistent with studies examining relationships between organization-level betrayal and poor well-being (Salin & Notelaers, 2017; Smith, 2017; Smith & Freyd, 2013; Trybou et al., 2016). It appears consistent with qualitative findings in which nurses describe feeling let down by their organizational leaders (Gaffney et al., 2012).

It is somewhat unsurprising that nurses who experienced organizational betrayal were more likely to experience burnout. Betrayal likely contributes to the lack of joy in work, consistent with studies that found that nurses who reported betraying actions had less affective commitment to their workplace (Trybou et al., 2016). Betrayal could compound the myriad of factors that contribute to burnout.

Organizational support was a significant predictor of job satisfaction and absenteeism. This indicates nurses in this study who are supported in the context of bullying were more satisfied with their jobs and miss less work. The finding was consistent with other studies analyzing the relationship of organizational support and nurse job satisfaction (Kelly et al., 2011; Spence Laschinger et al., 2012; Wing et al., 2015). The findings are similar to the description of nurses that support was important in emotional healing (Gaffney et al., 2012).

The level of burnout was consistent across groups. Job satisfaction and absenteeism had similar consistency across groups, with two exceptions. The association of hours worked and absenteeism was logical considering nurses working part-time are likely to have obligations which might necessitate missing work. The association of Magnet® status and job satisfaction has been shown in other studies.

Effect sizes (i.e. pseudo R^2) for betrayal were comparable to those seen in a study of betrayal (Smith & Freyd, 2013). It is possible that betrayal plays a smaller role in well-being than the actual negative event. Bullying is likely a larger contributor to nurse well-being, as demonstrated in prior studies (Allen et al., 2015; Nielsen & Einarsen, 2012).

The prevalence of weekly/daily bullying in this sample was 31% based on the NAQR-US. General comparisons can be made by examining other studies that used a similar target population and similar bullying measures. Olender (2017) reported 35% of nurses (n=156) experienced at least one bullying behavior on a weekly basis. Sauer & McCoy (2018) report 38% of nurses (n=345) experienced exposure to at least some frequency of bullying behaviors. The prevalence in this study suggests bullying occurs even as U.S. nursing organizations have placed an emphasis on eliminating bullying in the work environment (American Nurses Association, 2015a). The reliability for the NAQR-US scale in this study (.78) was comparable to what has been reported (Simons et al., 2011).

The strength of this study is that it introduces new concepts – organizational betrayal and support - as factors in nurse outcomes. The online sampling method allowed for recruitment across geographical areas, specialties, and workplaces, allowing for a more diverse sample of nurses. The distribution of several demographic factors among this study sample, including the critical aspect of workplace type, was similar to that of a nationally representative sample of nurses (Smiley et al., 2018). The inclusion of managers in the sample allowed for exploration of concepts among nurses at any level of the organization.

This study has limitations. Causal relationships cannot be determined and generalizability of the findings is limited. This was a convenience sample and the sample size was small in relationship to the target population. Nurses who were not on social media were potentially not recruited, and non-response could not be measured. Though

the sample was consistent with most demographic characteristics of nurses nationally, the sample appeared to lack racial/ethnic diversity. The sample uses self-report items, increasing risk of recall or response bias, and it was possible that only those that were experiencing bullying, burnout, or both, participated. The IBQ-H was thus far untested in a nursing population. Estimating absenteeism created a potential measurement issue.

Conclusion

This study explores organizational factors that could impact nurse well-being, namely workplace bullying and organizational responses to bullying. The study's measurement of betrayal and support after bullying as organizational factors is a relatively new contribution to the nursing literature. In this study, organizational betrayal and support had significant associations with well-being. These findings contribute to the evidence base that nursing work environments are important to well-being.

Implications for Nursing Management

Nurse leaders have an important role in orchestrating organizational communication and culture of safety. To confront the issue of bullying, nurse leaders should consider the organization's role in preventing bullying in the workplace, such as prevention policies. This study also introduces the concept of organizational betrayal as a work environment experience. Nurse leaders should be aware that in responding to bullying, organizational actions can be perceived as betrayal or support, and these experiences are possible contributors to nurse well-being. Well-being, especially burnout, is an important issue for the nursing profession as it is associated with retention and patient care quality.

Future studies with larger samples and more controlled design can build on this study and further test organizational response as a contributor to burnout. Future studies could employ wider recruitment strategies to increase diversity of the sample and increase the overall sample size, particularly to better account for contextual measures such as Magnet®, and employ more controls for burnout, job satisfaction and absenteeism (e.g. personal characteristics, work-life balance, and employer benefits).

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Table 1. Associations of Bullying and Individual/Workplace Characteristics among Nurses (N=242).

		Total		Bullied†		Not Bullied		
Variable		n	(%)	n	(%)	n	(%)	*p*
Gender	Female	231	(95)	72	(31)	159	(68)	.78
	Male	11	(5)	3	(27)	8	(72)	
Race	White/N-H	221	(91)	70	(31)	151	(68)	.46
	Other	21	(8)	5	(23)	16	(76)	
Age	20-50 years	135	(55)	44	(32)	91	(67)	.55
	>50 years	107	(44)	31	(29)	76	(71)	
Years of	<10 years	130	(53)	40	(30)	90	(69)	.94
experience	>10 years	112	(46)	35	(31)	77	(68)	
Role in nursing	Staff nurse	154	(63)	54	(35)	100	(64)	.07
	Manager	88	(36)	21	(23)	67	(76)	
Workplace	Hospital	130	(53)	39	(30)	91	(70)	.72
	Non-hospital	112	(46)	36	(32)	76	(67)	
Hours worked	Full time	208	(86)	69	(33)	139	(66)	.07
	Part Time	34	(14)	6	(17)	28	(82)	
Magnet ® status	Yes	65	(27)	23	(35)	42	(64)	.32
	No	174	(72)	50	(28)	124	(72)	

†Weekly or daily bullying

Table 2. Associations of Well-being and Individual/Workplace Characteristics among Nurses who Experienced Bullying (N=173).

		Burnout					Job dissatisfaction					Absenteeism				
		Yes		No			Yes		No			Yes		No		
Variables		n	(%)	n	(%)	*p*	n	(%)	n	%	*p*	n	(%)	n	(%)	*p*
Gender	Female	116	(70)	49	(29)	.29	53	(32)	112	(67)	.07	84	(50)	81	(49)	.45
	Male	7	(87)	1	(12)		5	(62)	3	(37)		3	(37)	5	(62)	
Race	White/N-H	113	(71)	46	(28)	.97	55	(34)	104	(65)	.31	78	(49)	81	(50)	.27
	Other	10	(71)	4	(28)		3	(21)	11	(78)		9	(64)	5	(37)	
Age	20-50 years	77	(76)	24	(23)	.07	34	(33)	67	(66)	.96	51	(50)	50	(49)	.94
	>50 years	46	(63)	26	(36)		24	(33)	48	(66)		36	(50)	36	(50)	
Experience	<10 years	55	(76)	17	(23)	.19	27	(37)	45	(62)	.35	36	(50)	36	(50)	.94
	>10 years	68	(67)	33	(32)		31	(30)	70	(69)		51	(50)	50	(49)	
Role	Staff nurse	103	(70)	43	(29)	.71	51	(34)	95	(65)	.36	72	(49)	74	(50)	.55
	Manager	20	(74)	7	(25)		7	(25)	20	(74)		15	(55)	12	(44)	
Workplace	Hospital	66	(68)	30	(31)	.44	37	(38)	59	(61)	.11	46	(47)	50	(52)	.48
	Non-hospital	57	(74)	20	(26)		21	(27)	56	(72)		41	(53)	36	(46)	
Work hours	Full time	107	(72)	41	(27)	.39	50	(33)	98	(66)	.86	79	(53)	69	(46)	.04*
	Part Time	16	(64)	9	(36)		8	(32)	17	(68)		8	(32)	17	(68)	
Magnet®	Yes	38	(77)	11	(22)	.23	22	(44)	27	(55)	.04*	21	(42)	28	(57)	.21
	No	85	(68)	39	(31)		36	(29)	88	(71)		66	(53)	58	(46)	

*indicates $p<.05$

Table 3. Logistic Regression Examining Associations of Betrayal and Support with Well-being among Nurses who Experienced Bullying (N=173).

			Burnout		Job dissatisfaction		Absent from work	
Step	Variables Entered		OR	[95% CI]	OR	[95% CI]	OR	[95% CI]
Step1	Gender	Female	.43	[.05-3.85]	.35	[.07-1.75]	2.92	[.61-14.14]
		Male	REF		REF		REF	
	Race/Ethnicity	White/non-Hispanic	.87	[.25-3.18]	.44	[.11-1.83]	1.34	[.40-4.50]
		Other than white/N-H	REF		REF		REF	
	Age	<50 years of age	.15	[.21-1.28]	1.32	[.52-3.34]	.97	[.41-2.26]
		>50 years of age	REF		REF		REF	
	Experience	<10 yrs. experience	1.02	[.40-2.60]	.78	[.31-1.99]	1.00	[.42-2.35]
		>10 yrs. Experience	REF		REF		REF	
	Role	Staff nurse	1.33	[.49-3.62]	.69	[.24-1.95]	1.36	[.53-3.47]
		Manager	REF		REF		REF	
	Workplace	Hospital worker	1.43	[.70-2.29]	.63	[.31-1.30]	1.03	[.53-2.01]
		Non-hospital	REF		REF		REF	
	Hours Worked	Full time	.77	[.30-1.99]	.99	[.37-2.64]	.35	[.13-.94]
		Part Time	REF		REF		REF	
	Magnet®	Yes	.58	[.25-1.34]	.49	[.23-1.06]	1.66	[.78-3.51]
		No	REF		REF		REF	
Step2		Betrayed	2.62*	[1.14-6.03]	2.97*	[1.01-8.73]	6.11*	[2.26-16.54]
		Not betrayed	REF		REF		REF	
		Supported	.70	[.34-1.46]	.30*	[.15-.60]	.50*	[.25-.99]
		Not supported	REF		REF		REF	

Notes: Hosmer and Lemeshow: (χ^2 =9.44 df=8 p=.30; χ^2 =8.39 df=8 p=.39; χ^2 =6.78 df=8 p=.56); percent correctly classified= 69%, 71%, 67%; Nagelkerke R^2= .11; .21; .20

***** p<.05

Manuscript 2

At the time of this dissertation defense, this manuscript had been submitted for publication to the *Journal of Nursing Administration.*

Abstract

Title: Avoidant leadership in response to workplace bullying and relationships with well-being among nurses

Objective: The aim of this study is to examine relationships between types of avoidant leadership in response to workplace bullying and well-being among nurses.

Background: Avoidant leadership is a problematic style of leadership in response to a workplace issue. It has been described as actions of hostility, equivocation (i.e. lack of concern), and/or normalization.

Methods: Data from a cross-sectional online survey of nurses who experienced at least one bullying behavior was used (N=173). Measures were subscales of the Institutional Betrayal Questionnaire for Health, the Well-Being Index, a job dissatisfaction scale, and days missed from work.

Results: More than 60% of nurses reported experiencing avoidant leadership. Nurses who reported experiencing avoidant leadership had a higher percentage of poor well-being than those who did not. Equivocation and normalizing avoidant leadership increased the likelihood of burnout and job dissatisfaction.

Conclusion: Nurse leaders should promote awareness that avoidant leadership might be problematic in the nursing work environment, including when managing issues of workplace bullying.

Avoidant leadership is a management style in which there is a lack of timely, and effective response to employee issues or concerns (Jackson et al., 2013). Though there are several definitions in the literature, avoidant leadership is generally considered a passive or laissez-faire style of management. It is characterized as by the inability to address workplace issues adequately, such as by giving false assurance that the problem will be dealt with, responding with no sense of urgency, or intimating that the issue is not really a concern. In more aggressive forms of avoidant leadership, leaders might even react with hostility or punish the person who reports the workplace issue (Grill et al., 2019; Manning, 2016).

Avoidant leadership is considered a problematic style of management and organizational behavior. Avoidant leadership can contribute to an unsafe work environment because workplace safety issues are not dealt with and employee trust is diminished (Grill et al., 2019). In workplaces where employees reported being bullied, avoidance of and non–response to the issue of bullying by leaders was found to increase the likelihood of continued bullying in the workplace (Glambek et al., 2018). In nursing, where bullying remains an issue (American Nurses Association, 2015), avoidant leadership in responding to bullying among nurses can diminish nurses' commitment to their work and their organization (Jackson et al., 2013). Avoidant, ineffective leadership among nurses has also been shown to negatively influence nurse engagement (Manning, 2016) and nurse job satisfaction (Bormann & Abrahamson, 2014).

A similar concept to avoidant leadership is organizational betrayal. Organizational betrayal occurs when an organization (e.g. employer) commits acts of omission or

commission which betrays a member of that organization (Smith & Freyd, 2014). In both betrayal and avoidant leadership, the organization leaders do something to defy the trust of the people within that organization, however avoidant leadership represents tangible leadership practices and a way of categorizing acts of organizational betrayal. Avoidant leadership types could be considered a sub-construct of betrayal. Organizational betrayal has been found to have associations with workplace well-being among nurses (Brewer et al., 2020), however, in this current study, organizational betrayal is viewed through the lens of avoidant leadership to test its relationships with well-being.

Conceptual Model

The conceptual model for this study posits that bullying occurs in the workplace, there is avoidant leadership in response to the bullying, and the avoidant leadership then influences nurse well-being. The relationship of concepts is depicted in Figure 1. The conceptual model is adapted from a larger framework which describes the relationships between organizational factors (including leadership styles) and clinician well-being (National Academy of Medicine, 2018), and from the findings of types of avoidant leadership in nursing in response to bullying among nurses (Jackson et al., 2013). The conceptual model in this study tests types of avoidant leadership as new concepts in relation to workplace well-being.

In this study, avoidant leadership is a concept where an organizational leader or member responds ineffectively to workplace bullying and defies trust and expectations of nurses. Avoidant leadership is conceptualized as three factors: hostility, normalizing and equivocation, (Jackson et al., 2013). Hostility is defined as antagonism towards the

person who experienced the bullying and/or prioritization of the organization over the person. Normalizing bullying is defined as making the bullying seem like an inevitable or regular aspect of the work environment. Equivocation is defined as ambivalence toward the fact that bullying is occurring and lack of concern for the person who experienced the bullying or their information.

The avoidant leadership types are then conceptually linked to nurses' workplace well-being. Workplace well-being is defined as a physical and emotional health related to one's employment (Brigham et al., 2018). In this study workplace well-being is conceptualized as three factors: burnout, job dissatisfaction and absenteeism. Burnout is defined as a lack of enjoyment and affective connection to one's work. Job dissatisfaction is defined as lack of satisfaction with one's current employment situation. Absenteeism is defined as missing work for personal reasons or illness.

Aims

The aims of this study are to 1) describe types of avoidant leadership among nurses who experience bullying at workplace, 2) examine relationships between types of avoidant leadership and workplace well-being (burnout, dissatisfaction and absenteeism) among nurses, and 3) to estimate the size and direction of associations between experiencing acts of avoidant leadership and demographic and workplace characteristics with workplace well-being among nurses.

Methods

Sample

The target population is registered nurses who experienced workplace bullying. Data from a cross-sectional online survey of nurses in the U.S. was used. The data were collected from nurses in the U.S. who at the time of the survey were working in a nursing job for the past six months. In this study, the inclusion criteria were to have experienced at least one bullying behavior at work. Exclusion criteria were to have more than two missing data items on the scales used in the survey. The data were filtered to include only those nurses who met the criteria. The survey was advertised on social media, both through paid advertisements and personal postings. The survey was housed in the Qualtrics® system. The survey methods and data storage plan were approved by the authors' Institutional Review Board.

Measures

To measure avoidant leadership types, subscales of Institutional Betrayal Questionnaire for Health (IBQ-H) were created. Though the IBQ-H was originally designed to measure institutional betrayal as a larger concept, it can be considered an adequate measure for avoidant leadership because of the similarities between betrayal and avoidant leadership. This study is the first identified to group these items as avoidant leadership and tests relationships with nurse well-being. Measuring acts of organizational betrayal as types of avoidant leadership allows for a more granular view of problematic organizational actions. The subscales created for this study were hostility, normalizing, and equivocation, and represent the types of avoidant leadership identified in the literature (Jackson et al., 2013). The subscale items were selected from the IBQ-H items which measure negative organizational response (i.e. the acts that betray the trust of the

organization member). Each item on the IBQ-H that represented a negative organizational action was reviewed and grouped into one of the subscales based on its match with the conceptual definition. The grouping of items is depicted in Figure 1. The items use dichotomous yes/no scoring. Scores ranged from 0-6 for the hostility scale and 0-3 for the equivocation and normalizing scales. Scores were summed, then dichotomized at a score of 1 (0=*did not experience any action,* ≥1 = *experienced at least one action of avoidant leadership type*). The subscales achieved moderate reliability. Reliability for the subscales is reported in Table 1. Though no other studies were identified that measured avoidant leadership as hostility, normalizing, and equivocation, the reliability of the subscales in this study appears similar to that of similar measures of avoidant leadership (Kanste et al., 2007; Manning, 2016).

Burnout was measured using the Well-Being Index (WBI). The WBI is a nine-item scale used to measure risk of workplace burnout (Dyrbye et al., 2016). Seven items use dichotomous scoring, and two use Likert scale. Because of the scoring for the two Likert scale items, negative scores are possible. The range of scores for the WBI is -2 to 9. A cut score of 2 has been identified as risk for burnout among nurses (Dyrbye et al., 2018). Scores were dichotomized in this study at the cut score of 2 (<2 = *unlikely burnout* and ≥2 = *likely burnout*). The Cronbach's alpha for the WBI scale in this study was .78

Job dissatisfaction was measured using a single question satisfaction Likert scale. Participants were asked to identify their level of satisfaction with their jobs, with responses ranging from very dissatisfied to very satisfied. Scores were dichotomized as satisfied (very satisfied and satisfied) and dissatisfied (dissatisfied and very dissatisfied).

This type of scale and scoring has been used in other studies of nurses (Stimpfel et al., 2012).

Absenteeism was measured using a single question asking participants to report days missed from work for illness or personal reasons. Limited published information on an accepted cut score for absenteeism on days missed from work among nurses was identified, so a cut score of 3 was estimated for this study based on the sample mean.

Demographic and workplace characteristics collected were gender, race, age, workplace type, role in nursing, years of experience, hours worked per week and Magnet® status of the workplace. These were measured using categorical items from the online survey.

Statistical Analysis

All demographic/workplace characteristic variables and study scale scores were dichotomized for use in statistical analyses. Descriptive statistics were used to determine demographic and workplace characteristics of the sample and to describe findings for study variables. Chi-square tests were used to determine bivariate relationships between demographic/workplace characteristics and well-being (burnout, job dissatisfaction and absenteeism) and the avoidant leadership type subscales and well-being. Simultaneous logistic regression was used to determine the size and direction of the associations between the three different types of avoidant leadership and each of the dependent measures of well-being (burnout, job dissatisfaction and absenteeism). In the logistic regression models, demographic and workplace characteristics and types of avoidant leadership (hostility, normalizing and equivocation) were entered simultaneously into

each of the three models as independent variables. Hosmer and Lemeshow tests, model fit statistics, and Nagelkerke pseudo R^2 were reviewed to determine model fit and variance.

The alpha for statistical analysis was set at .05. All analyses were conducted in SPSS version 26 (IBM, 2018).

Results

Sample

Out of the 242 total responses to the survey, there were 173 nurses who met inclusion criteria (i.e. no more than two missing items from the WBI and IBQ-H scales and had experienced at least one bullying behavior). Table 2 displays sample characteristics. We observed that most nurses were female (n=166, 96%), white (n=159, 91%) over the age of 50 years (n=101, 58%), had less than 20 years of experience (n=119, 68%), and in a staff nurse role (n=110, 63%). Workplace characteristics indicated most worked in a hospital (n=96, 55%), worked full time (n=148, 85%), and worked in a non-Magnet facility (n=122, 70%). Frequencies and percentages of subscales (hostility, normalizing, equivocation) indicated 76% of nurses experienced at least one act of hostility (n=132), 75% experienced at least one act of normalizing (n=131), and 66% experienced at least one act of equivocation (n=115, 66%) (Table 2).

Associations between avoidant leadership with burnout, job dissatisfaction and absenteeism

In chi-square tests, the three types of avoidant leadership were significantly associated with burnout, job dissatisfaction and absenteeism (Table 3). Specifically, hostility had significant associations with burnout, job dissatisfaction and (X^2=7.72, df 1,

p=.005) and absenteeism (X^2=8.98, df 1, p=.003). Normalizing had significant associations with burnout (X^2=11.23, df 1, p=.001), job dissatisfaction (X^2=10.61, df 1, p=.001), and absenteeism (X^2=12.27, df 1, p<.001). Equivocation had significant associations with burnout (X^2=14.82, df 1, p<001), job dissatisfaction (X^2=5.43, df 1, p=.02) and absenteeism (X^2= 8.09, df 1, p=.004). Overall, in these significant relationships, the nurses who reported experiencing the avoidant leadership type had a higher percentage of poor well-being than those who did not. Significant differences in workplace well-being and demographic/workplace characteristics were age and burnout (X^2 =3.81, df 1, p=.05), role and job dissatisfaction (X^2 = 6.23, df 1, p=.01), and hours worked per week and absenteeism (X^2.=3.66, df 1, p=.05).

Findings from the logistic regression models (Table 4) indicate that experiencing at least one act of equivocation was associated with three times higher odds of burnout (OR 3.78, 95% CI 1.35-10.53) compared to those who did not report experiencing this event. Similarly, experiencing at least one act of normalizing was associated with five times higher odds of job dissatisfaction (OR 5.03, 95% CI 1.16-21.72) relative to those who did not experience an act of normalization. None of these types of avoidant leadership experiences were associated with absenteeism in the logistic regression model. The Hosmer and Lemeshow tests were non-significant and the model goodness-of-fit tests indicated the data were a good fit for the model.

Discussion

The study findings indicate that avoidant leadership types are associated with poor workplace well-being among nurses. The finding in this study supports other

findings in the literature where absence of leadership and/or management through hostility eroded trust and undermined affective commitment among nurses (Gaffney et al., 2012; Jackson et al., 2013; Manning, 2016; Trybou et al., 2016). Though workplace well-being is a multifactorial issue, and one that encompasses many facets of individual and organizational characteristics (National Academy of Medicine, 2018), leadership is an important component of the work environment, and can be instrumental in workplace engagement and wellness (Alilyyani et al., 2018; H. K. S. Laschinger & Fida, 2014; Manning, 2016).

Hostility was experienced by more than three-quarters of the nurses in the sample. This appears problematic because hostile leadership, also considered management by exception or aggressive management, has been associated with decreased work engagement among nurses (Manning, 2016). Hostility avoidant leadership might include punishment for reporting the bullying, which is antithetical to a culture of safety and erodes trust among nurses (Ahern, 2018). It could also include the overall workplace culture and the culture created by organizational leaders; a poor workplace culture likely leads to poor nurse and patient outcomes (Wei et al., 2018).

Normalizing workplace bullying, such as by failing to prevent it or creating an environment where it was more likely to happen, led to higher likelihood of job dissatisfaction among nurses. Normalizing bullying would logically cause nurses to feel dissatisfied, as the bullying is made to seem like a regular part of the work environment. Bullying itself has been associated with job dissatisfaction (Read & Laschinger, 2013), therefore an environment in which bullying seems common, normal, or “just the way it is

here" would likely increase job dissatisfaction as well. Normalization of bullying has also been found to be associated with increased bullying (Glambek et al., 2018; Hutchinson, Vickers, et al., 2010).

Equivocation, such as acting without adequacy, regard, or care for a person's information or experiences was a significant predictor of burnout. This finding appears similar to studies where nurses express dismay and desire to leave their jobs when their experiences are downplayed or reports of bullying are dealt with inadequately (Gaffney et al., 2012). Equivocation might create a sense that the leader does not care about the well-being of the person who was bullied or there is no validation of their experience. These experiences could signify a lack of organizational support, which has been linked to clinician burnout (National Academy of Medicine, 2018). Equivocation could also signify that there is insufficient competency to deal with the issue (Jackson et al., 2013), indicating a potential need for even stronger policies, training and support in healthcare organizations.

Limitations and Future Study Recommendations

This study had limitations. The sample appears to lack some racial and gender diversity. The data used for this study was from a cross-sectional study design, limiting inference of causality. The sample size was small in comparison to the population of registered nurses, limiting generalizability of findings. The scales used are self-report scales, creating potential reporting or recall bias. The subscales were developed based on theory and grouping of items was subjective. The absenteeism cut score was estimated and might not adequately reflect problematic absenteeism in the workplace.

Future studies could employ longitudinal design and test interventions to determine if changes in leadership practices, implementation or strengthening of zero-tolerance policies, or other policy approaches have meaningful impacts on nurse well-being. Future studies could employ purposive sampling to allow for control and nesting of certain workplace factors, such as level of authority within the organization, units, and Magnet® status.

Implications for Practice

The high number of avoidant leadership experiences found in this study is an important finding for the nurse leader specialty. Avoidant leadership has been recognized as problematic because it erodes trust in the organization and can lead to poor work outcomes (Grill et al., 2019; Jackson et al., 2013). Though bullying can be a difficult problem to manage, it is the responsibility of the healthcare employer to create a system that promotes support for nurses and a zero tolerance of bullying (American Nurses Association, 2015a). That so many nurses experienced the opposite (i.e. they experienced avoidant as opposed to effective leadership) is indicative that there is greater need to tackle the issue of bullying in nursing.

Nurse leaders are encouraged to increase awareness of avoidant leadership and to promote leadership strategies for bullying which will support and assist nurses. This might include training and competency development for transformational leadership, which has been demonstrated to improve outcomes and potentially reduce bullying (Olender, 2017; Spence Laschinger et al., 2012). Practicing nurses should also raise awareness of the issue of avoidant leadership, and participate in efforts to advocate for

strong zero-tolerance policies against bullying and incivility in an ethical practice environment (American Nurses Association, 2015a).

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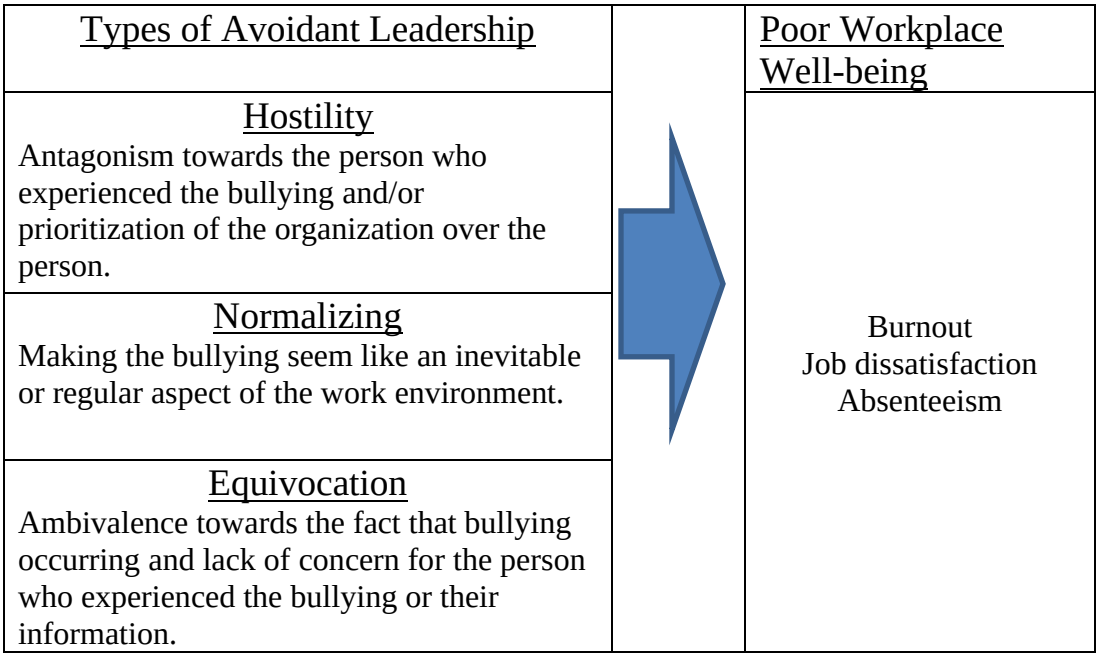


Figure 1.
Conceptual framework of types of avoidant leadership and relationships with workplace well-being.

Notes: Adapted from avoidant leadership types as described by Jackson et al., 2013. In the first column, the definition of each concept is listed, followed by the items on the IBQ-H scale that matches that definition and were grouped in the subscale. The avoidant leadership types are then conceptually linked to poor workplace well-being, which are listed in the second column.

Table 1. Reliability of subscales using Cronbach's alpha

Subscale	**Alpha**	**Number of items**
Hostility	.84	6
Normalizing	.79	3
Equivocation	.72	3

Table 2. Descriptive statistics for study variables (N=173).

Variable	**Yes n (%)**	**No n (%)**
Female	166 (96)	7 (4)
White	159 (91)	15 (9)
>50 years of age	101 (58)	72 (42)
<20 years experience	119 (68)	54 (32)
Hospital worker	95 (55)	78 (45)
Staff nurse	110 (63)	63 (37)
Full time	148 (85)	25 (15)
Magnet	51 (30)	122 (70)
Burnout	122 (70)	51 (29)
Job dissatisfaction	56 (32)	117 (67)
Absenteeism	86 (49)	87 (51)
Hostility Subscale	132 (76)	41 (23)
Normalizing Subscale	131 (75)	42 (24)
Equivocation Subscale	115 (66)	58 (33)

Note: Burnout scale scores dichotomized at a published cut score of 2. Job dissatisfaction dichotomized at 'dissatisfied' or 'very dissatisfied'. Absenteeism dichotomized at $\geq$3 days missed work in past 12 months. Avoidant leadership subscales were dichotomized at 1; score of 0 = 'no, did not experience' and score of $\geq$1 = 'yes, experienced at least one act'

Table. 3. Chi-square tests of avoidant leadership subscales with burnout, job dissatisfaction and absenteeism (N=173).

Variable	Level	Burnout n (%)		*p*	Job dissatisfaction n (%)		*p*	Absenteeism n (%)		*p*
		Yes	No		Yes	No		Yes	No	
Gender	Female Male	116 (69) 6 (85)	50 (30) 1 (14)	.36	52 (31) 4 (57)	114 (68) 3 (42)	.15	84 (50) 2 (28)	82 (49) 5 (71)	.25
Race/Ethnicity	White Other	112 (70) 10 (71)	47 (29) 4 (28)	.93	53 (33) 106 (66)	3 (21) 11 (78)	.36	77 (48) 82 (51)	9 (64) 5 (35)	.25
Age	<50 yrs >50 yrs	45 (62) 77 (76)	27 (37) 24 (23)	.05	23 (31) 33 (32)	49 (68) 68 (67)	.92	35 (48) 51 (50)	37 (51) 50 (49)	.80
Yrs. of Experience	<20 >20	80 (67) 42 (77)	39 (32) 12 (22)	.15	37 (31) 19 (35)	82 (68) 35 (64)	.59	64 (53) 22 (40)	55 (46) 32 (59)	.11
Role	Staff Other	79 (71) 43 (68)	31 (28) 20 (31)	.62	43 (39) 13 (20)	67 (60) 50 (79)	**.01**	57 (51) 29 (46)	53 (48) 34 (54)	.46
Workplace	Hospital Non-hospital	66 (68) 56 (72)	30 (31) 21 (27)	.56	35 (36) 21 (27)	61 (63) 56 (72)	.19	46 (47) 40 (51)	50 (52) 37 (48)	.59
Hours Worked	Full time Part time	106 (71) 16 (64)	42 (28) 9 (36)	.43	48 (32) 8 (32)	100 (67) 17 (68)	.96	78 (52) 8 (32)	70 (47) 17 (68)	.05
Magnet Workplace	No Yes	82 (67) 40 (78)	40 (32) 11 (21)	.14	34 (27) 22 (43)	88 (72) 29 (56)	.06	63 (51) 59 (48)	59 (48) 28 (54)	.43
Avoidant leadership										
Experienced at least one act of hostility	Yes No	99 (75) 23 (56)	33 (25) 18 (43)	**.02**	50 (37) 6 (14)	82 (62) 35 (85)	**.005**	74 (56) 12 (29)	58 (43) 29 (70)	**.003**
Experienced at least one act of normalizing	Yes No	101 (77) 21 (50)	30 (22) 21 (50)	**.001**	51 (38) 5 (11)	80 (61) 37 (88)	**.001**	75 (57) 11 (26)	56 (42) 31 (73)	**<.001**
Experienced at least one act of equivocation	Yes No	92 (80) 30 (51)	23 (20) 28 (48)	**<.001**	44 (38) 12 (20)	71 (61) 46 (79)	**.02**	66 (57) 20 (34)	49 (42) 38 (65)	**.004**

Notes**: Bolded =** $p<.05$. Results are for Chi square statistics.

Table 4. Simultaneous logistic regression results for burnout, job dissatisfaction and absenteeism (N=173).

		Burnout		Job dissatisfaction		Absent from work	
Variables Entered		OR	[95% CI]	OR	[95% CI]	OR	[95% CI]
Gender	Female	.55	[.05-5.32]	.33	[.06-1.82]	2.55	[.43-14.93]
	Male	REF		REF		REF	
Race/Ethnicity	White	1.18	[.30-4.56]	2.28	[.54-9.52]	.59	[.17-2.20]
	Other	REF		REF		REF	
Age	<50 years	.52	[.22-1.28]	1.10	[.48-2.52]	.66	[.30-1.43]
	>50 years	REF		REF		REF	
Experience	<20 yrs.	.63	[.22-1.76]	.86	[.34-2.15]	1.93	[.81-4.59]
	>20 yrs.	REF		REF		REF	
Role	Staff nurse	.85	[.36-1.99]	2.05	[.90-4.66]	1.51	[.71-3.19]
	Other	REF		REF		REF	
Workplace	Hospital	.79	[.36-1.73	1.36	[.64-2.8]	.98	[.49-1.97]
	Non-hospital	REF		REF		REF	
Hours Worked	Full time	1.18	[.43-3.27]	.99	[.36-2.69]	2.45	[.92-.53]
	Part Time	REF		REF		REF	
Magnet®	Yes	.54	[.25-1.34]	.62	[.29-1.33]	1.55	[.74-3.25]
	No	REF		REF		REF	
Experienced at least one act of hostility	Yes	3.34	[.09-1.47]	.94	[.22-3.97]	1.29	[.38-4.41]
	No	REF		REF		REF	

Experienced at least one act of normalizing	Yes	3.78	[.98-11.38]	**5.03***	[1.16-21.72]	2.63	[.81-8.53]
	No	REF		REF		REF	
Experienced at least one act of equivocation	Yes	**3.78***	[1.35-10.53]	1.26	[.46-3.42]	1.25	[.48-3.23]
	No	REF		REF		REF	

***Bolded** is $p<.05$. **Notes:** Enter method. Model statistics- Burnout: Model Likelihood ratios X^2 =26.51, *df*=11, $p=.005$, Percent correctly classified = 74%, Nagelkerke pseudo $R^2=.20$; Job dissatisfaction - Model Likelihood ratio X^2 =24.26, *df*=11, $p=.01$, Hosmer and Lemeshow test >.05, Percent correctly classified = 71%, Nagelkerke pseudo $R^2=.18$; Absenteeism- Model Likelihood ratio X^2 =24.05, *df*=11, $p=.01$, Hosmer and Lemeshow test >.05, Percent correctly classified = 66%, Nagelkerke pseudo $R^2=.17$.

APPENDIX A

Study survey

Q1
Welcome. To start, please answer the following question:

Are you a registered nurse, and have you worked in nursing in the past six months?
- o Yes (1)
- o No (2)

Q2 Study title: Examining relationships of bullying and organizational factors on well-being.

This research is being conducted to examine how bullying and organizational factors impact well-being.

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

BENEFITS
There are no benefits to you as a participant.

CONFIDENTIALITY
The data in this study will be confidential. No identifying information will be collected, and all responses will be anonymous. The data will be protected and kept secure, and only the research team will have access to the de-identified data. While it is understood that no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your transmission.

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason by simply closing the survey. 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 there are costs, replace this statement with a description of the costs for participating in the research). You must be 18 years of age or older to participate.

CONTACT
This project is being conducted by the student investigator Katherine Brewer at George Mason University. Please contact her by email (kbrewer7@masolive.gmu.edu) for questions or to report a research-related problem. The faculty adviser is Dr. Kyeung Mi Oh. For additional questions or to report a research-related problem. You may contact the George Mason University Office of Research Integrity & Assurance at 703-993-4121 if you have questions or comments regarding your rights as a participant in the project. This research has been reviewed according to George Mason University procedures governing your participation in this research.

IRBNet number:

CONSENT
Your participation in this survey conveys your consent to participate in this survey. The survey will take approximately 10 minutes to complete. If you agree to participate, and therefore consent, please click the green NEXT button at the bottom right of this page to begin the survey.

End of Block: Consent

Start of Block: Demographics

Q3 These questions pertain to you and your workplace.

Q4 With which gender do you identify?
- Male (1)
- Female (2)
- Gender other than male or female (3)

Q5 What is your race/ethnicity?
- American Indian/Alaskan Native (1)
- Asian (2)

- Black/Non-Hispanic (3)
- Hispanic (4)
- Pacific Islander/Native Hawaiian (5)
- White/Non-Hispanic (6)
- Two or more races (7)
- Prefer not to answer (8)

Q6 What is your age in years?

- 20-29 (4)
- 30-29 (5)
- 40-49 (6)
- 50-59 (7)
- 60-69 (8)
- 70 and up (9)

Q7 How many years of experience do you have in nursing?

- Less than 1 year (1)
- 1-5 years (2)
- 11-15 years (3)
- 16-20 years (4)
- More than 20 years (5)

Q8 What is your most recent role in nursing?

- Staff Nurse (1)
- Management/Administration (2)
- Educator/Faculty (3)
- Advanced Practitioner (4)
- Other (5)

Q9 Which best describes your workplace?

- Hospital (1)
- Clinic/Ambulatory Care (2)
- Outpatient Surgical or Dialysis Center (3)

- Long Term Care Facility (4)
- Academia/Educational Setting (5)
- Community-Based Care Setting (6)
- Long Term Care (7)
- Other (8)

Q10 On average, how many hours per week do you work in nursing?

- More than 40 hours per week (1)
- 30-40 hours per week (4)
- 16-29 hours per week (2)
- Less than 16 hours per week (3)

Q11 Does your workplace have Magnet® recognition status?

- Yes (1)
- No/In process of applying (2)

Q12 How many days of work have you missed in the past year due to illness or personal reasons?

_____

End of Block: Demographics

Start of Block: NAQR-US

Q13 We define bullying as a situation in which one or more individuals perceive themselves to be on the receiving end of persistent negative actions from one or more others over a period of time.

It is a situation where the target of bullying has difficulty in defending him or herself against these actions.

We will not refer to a one-off incident as bullying.

In considering this definition, have you been bullied at work?

- o No (1)
- o Yes, but only rarely. (2)
- o Yes, now and then (3)
- o Yes, several times per week. (4)
- o Yes, almost daily. (5)

Q14 The following behaviors are often seen as examples of negative behaviors in the workplace.

Over the last six months, how frequently have you experienced the following behaviors:

Q15 Someone withholding information that affects your performance.

- o Never (1)
- o Now and then (2)
- o Monthly (3)
- o Weekly (4)
- o Daily (5)

Q16 Being humiliated or ridiculed in connection with your work.

- o Never (1)
- o Now and then (2)
- o Monthly (3)
- o Weekly (4)
- o Daily (5)

Q17 Being ignored or excluded.

- o Never (1)
- o Now and then (2)
- o Monthly (3)
- o Weekly (4)
- o Daily (5)

Q18 Being exposed to an unmanageable workload.

- Never (1)
- Now and then (2)
- Monthly (3)
- Weekly (4)
- Daily (5)

Q19 Please check the appropriate box(es) below to state who you were bullied by:

- ☐ Immediate supervisor (1)
- ☐ Other managers or administrators in the organization (2)
- ☐ Other nurses (3)
- ☐ Physicians (4)
- ☐ Other co-workers (5)
- ☐ Subordinates (6)
- ☐ Patients (7)
- ☐ Students (8)
- ☐ Others customers (e.g. family of a patient) (9)
- ☐ Other (please indicate) (10)

  _____

End of Block: NAQR-US

Start of Block: IBQH

Q20
These questions ask about your organization's response to bullying. These questions may or may not call to mind certain individuals, such as a nurse manager, an administrator, a human resources representative, or your employer as a whole.

As you progress though this section, you may think about different individuals at different points of experiences of bullying at work.

In thinking about bullying experiences you described in the previous section, did your organization play a role by:

Q21 Not taking proactive steps to prevent bullying

- Yes (1)
- No (2)

Q22 Creating an environment in which bullying seemed common or normal

- Yes (1)
- No (2)

Q23 Creating an environment in which a bullying seemed more likely to occur

- Yes (1)
- No (2)

Q24 Making it difficult to report bullying or share concerns.

- Yes (1)
- No (2)

Q25 Responding inadequately to your concerns or reports of bullying.

- Yes (1)
- No (2)

Q26 Mishandling your protected personal information.

- Yes (1)
- No (2)

Q27 Covering up reports of bullying.

- Yes (1)
- No (2)

Q28 Denying your experience of bullying in some way.

- Yes (1)
- No (2)

Q29 Punishing you in some way for reporting bullying.

- Yes (1)
- No (2)

Q30 Suggesting your reports of bullying might affect the reputation of the institution.

- Yes (1)
- No (2)

Q31 Creating an environment where you no longer felt like a valued employee.

- Yes (1)
- No (2)

Q32 Creating an environment where continuing to be an employee was difficult for you.

- Yes (1)
- No (2)

Q33 Actively supporting you with either formal or informal resources for bullying.

- Yes (1)
- No (2)

Q34 Admitting that the institution did not adequately protect you from bullying.

- Yes (1)
- No (2)

Q35 Apologizing for the institution's role in what happened to you.

- Yes (1)
- No (2)

Q36 Believing your description of the bullying events.

- Yes (1)
- No (2)

Q37 Allowing you to have a say in how your report of bullying was handled.

- Yes (1)
- No (2)

Q38 Ensuring you were treated as an important member of the institution.

- Yes (1)
- No (2)

Q39 Creating an environment where bullying was safe to discuss.

- Yes (1)
- No (2)

Q40 Creating an environment where bullying was recognized as a problem.

- Yes (1)
- No (2)

End of Block: IBQH

Start of Block: WBI

Q41 The following are indicators of well-being.

During the past month...

Q42 Have you felt burned out from your work?
- Yes (1)
- No (2)

Q43 Have you worried that your work is hardening you emotionally?
- Yes (1)
- No (2)

Q44 Have you often been bothered by feeling down, depressed, or hopeless?
- Yes (1)
- No (2)

Q45 Have you fallen asleep while sitting inactive in a public place?
- Yes (1)
- No (2)

Q46 Have you felt that all things you had to do were piling up so high that you could not overcome them?

- Yes (1)

- No (2)

Q47
Have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?
- Yes (1)
- No (2)

Q48 Has your physical health interfered with your ability to do your daily work at home and/or away from home?
- Yes (1)
- No (2)

Q49 Please rate how much you agree with the following statements.

Q50 The work I do is meaningful to me
- Very strongly agree (1)
- Strongly agree (2)
- Agree (3)
- Neutral (4)
- Disagree (5)
- Strongly disagree (6)
- Very strongly disagree (7)

Q51 My work schedule leaves me enough time for my personal/family life.
- Very strongly agree (1)
- Strongly agree (2)
- Agree (3)
- Neutral (4)
- Disagree (5)

- Strongly disagree (6)
- Very strongly disagree (7)

End of Block: WBI

Start of Block: Job satisfaction

Q52 How satisfied are you with your current job?

- Very satisfied (1)
- Somewhat satisfied (2)
- Somewhat dissatisfied (3)
- Very dissatisfied (4)

End of Block: Job satisfaction

APPENDIX B

GEORGE MASON UNIVERSITY

Office of Research Development, Integrity, and Assurance

Research Hall, 4400 University Drive, MS 6D5, Fairfax, Virginia 22030
Phone: 703-993-5445; Fax: 703-993-9590

DATE:	December 13, 2018
TO:	Kyeung Mi Oh, PhD
FROM:	George Mason University IRB
Project Title:	[1356663-1] Exploring relationships of bullying, organizational response, and well-being among nurses
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
DECISION DATE:	December 13, 2018
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of New Project materials for this project. The Institutional Review Board (IRB) Office has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Please remember that all research must be conducted as described in the submitted materials.

Please note that any revision to previously approved materials must be submitted to the IRB office prior to initiation. Please use the appropriate revision forms for this procedure.

If you have any questions, please contact Kim Paul at (703) 993-4208 or kpaul4@gmu.edu. Please include your project title and reference number in all correspondence with this committee.

Please note that all research records must be retained for a minimum of five years, or as described in your submission, after the completion of the project.

Please note that department or other approvals may also be required to conduct your research.

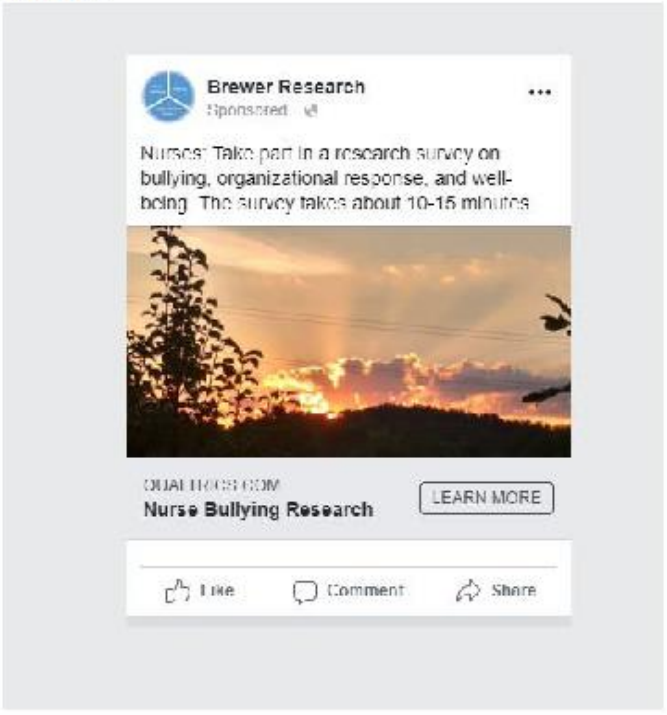
GMU IRB Standard Operating Procedures can be found here: https://rdia.gmu.edu/topics-of-interest/human-or-animal-subjects/human-subjects/human-subjects-sops/

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within George Mason University IRB's records.

Advertisement
1356663-1

Facebook promotions and Instagram language -

Nurses: Take part in a research survey on bullying, organizations, and well-being. The survey takes about 10-15 minutes.



LinkedIn ® post language - Nurses: Take part in a research survey on bullying, organizational response, and well-being. The survey takes about 10-15 minutes.

Recruitment post with IRBNet number for Facebook page:

Exploring relationships of bullying, organizational response, and well-being among nurses
135663-1

INFORMED CONSENT FORM

RESEARCH PROCEDURES
This research is being conducted to examine how bullying and organizational factors impact well-being. If you agree to participate, you will be asked to complete this online electronic survey, which should take between 10-15 minutes to complete.

RISKS
There is negligible risk for participation in this research. There could be some distress in recalling negative events at work.

BENEFITS
There are no benefits to you as a participant.

CONFIDENTIALITY
The data in this study will be kept confidential. Names and other identifiers will not be included on this survey, thus all responses will be anonymous. The data will be protected and kept secure, and only the research team will have access to the anonymous data. While it is understood that no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your transmission. The de-identified data could be used for future research without additional consent from participants

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason by simply closing the survey. 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. You must be 18 years of age or older and a registered nurse who has worked in a nursing job for the past six months to participate.

CONTACT
This project is being conducted by the student investigator Katherine Brewer at George Mason University. Please contact her by email (kbrewer7@masolive.gmu.edu) for questions or to report a research-related problem. The faculty adviser is Dr. Kyeung Mi Oh. For additional questions or to report a research-related problem. You may contact the George Mason University Institutional Review Board (IRB) Office at 703-993-4121 if you have questions or comments regarding your rights as a participant in the project.

This research, per IRB package number 135663-1, has been reviewed according to George Mason University procedures governing your participation in this research.

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