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Empowering Nurses of Minority in the Face of Incivility and Bullying: Through the Lens of Phenomenology

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Empowering Nurses of Minority in the Face of Incivility and Bullying: Through the Lens
of Phenomenology

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Abstract

Up to 85% of nurses have reported exposure to incivility in the workplace (Hunt & Marini, 2012). The often-subtle nature of incivility toward nurses in a minority population may partially explain why it remains a problem. Healthcare organizations realize the need for civility to counter the high turnover rate, staff shortages, and low job satisfaction reported by nurses, but lack understanding of how nurses of a minority population perceive incivility and bullying. This study aimed to answer the research question how do nurses with minority representation experience incivility and bullying versus empowerment in the workplace? A descriptive phenomenological design used a purposeful sample of minority registered nurses to explore how they experience these phenomena in the workplace. The participants were recruited through electronic communications with leaders of national healthcare and nursing organizations, minority nurses' associations, and word of mouth via social media in the United States. The Workplace Incivility Survey was used to identify minority nurses who have experienced incivility. Then, semi-structured interviews were collected to investigate nurses' experiences in depth. Colaizzi's Descriptive Phenomenological Method guided the data analysis. The themes identified in the analysis indicated that nurses representing the minority population have a range of unique experiences related to incivility, bullying, and empowerment. These experiences are influenced by implicit bias, microaggression, and systemic racism. Minority nurses also offered several ideas for empowerment, such as resources, tools, education, instilling confidence and power, providing mentors, and autonomy provided to nurses individually and for the organization, provide more diverse people in management positions, managerial accountability, consequences for bad

behavior, anonymity reporting, and unification throughout the organization. Findings

point toward future research for interventions and education in health care systems and

schools of nursing.

Keywords: *minority nurses, incivility, minorities in nursing, empowerment nursing,*

empowering nurses, minority nurses, bullying, phenomenology, and incivility.

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Throughout the last four years of this journey through the Ph.D. nursing program, I have shared with my students the trials and milestones. I share that I am a student too and I was once in their shoes. I also share it not only takes family support, but of those around you, including friends and colleagues to survive and to make it to your goal.

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CHAPTER ONE: INTRODUCTION

Nurses are essential for providing frontline patient care and are part of one of the largest groups of healthcare professionals in the United States (Bureau of Labor Statistics, U. S. Department of Labor, 2019). Hospitals are filled with nurses who are intent upon a purpose. Most of them entered the profession wanting to help and care for people and make a difference (Gordon & Nelson, 2005). As a discipline, nursing is one of the most valued and caring professions (Luparell, 2011). Watson (1988, 2008) developed a theory of human caring because she believed that nurses contribute to humankind through social, moral, and scientific contributions that can affect human development.

The differences between caring and incivility are blurred in nursing departments, in health care facilities, and academic institutions. The often-subtle nature of incivility may partially explain why it remains a problem. Author Sandra Thomas (2009) stated that "nurses wound each other with words, and with more subtle indicators of hostility" (p. 144). The author also noted that uncivil or demeaning treatment provokes anger, which leads to incivility (Thomas, 2009, p. 8). Uncivil behaviors in the workplace have a cumulative effect, eventually having significant consequences for stakeholders (Schilpzand, Leavitt, & Lim, 2016).

Unpacking the concept of incivility starts with its opposite, *civility*, defined as a tool for interacting with others where rules of civility are rules of morality: as civility is a moral issue and it is morally better to be civil than to be uncivil (Carter, 1998, p. xii-11). Clark and Carnosso (2008) concluded that "each individual perceives civility through his or her personal lens that is influence by culture, experience, position, and expectation" (p.14). A necessary condition of civility is the peaceful harmonization of diverse social

groups, i.e., the "existence and maintenance of intergroup empathy and mutual respect" (Bannister & O'Sullivan, 2013).

According to Hunt and Marini (2012), up to 85% of nurses have reported exposure to incivility in the workplace. Abolfazl Vagharseyyedin's (2015) analysis of workplace incivility described it as a phenomenon that has "negative outcomes for the victims, witnesses, organizations, and perpetrators themselves" (p. 123). Incivility in nursing is so prevalent (Gallo, 2012; Kaiser, 2017; Perry Black, 2016) that The Joint Commission (2016) reported: "Workplace incivility that is expressed as bullying behavior is at epidemic levels." Healthcare organizations realize the need for civility to counter the high turnover rate, staff shortages, and nurses' low job satisfaction. Understanding the inner workings and incivility dynamics among nurses representing a minority population in the workplace may provide some crucial insights to curtail it.

I propose that there is an association between civility and empowerment because both are social processes. Clark and Carnosso's (2008) operational definition of civility is "an authentic respect for others when expressing disagreement, disparity, or controversy. It involves time, presence, a willingness to engage in genuine discourse, and a sincere intention to seek common ground (p. 13);" empowerment is also characterized by positive social action (Kuokkanen & Leino-Kilpi, 2001). Empowerment has been defined as a "process of increasing personal, interpersonal, or political power so that individuals, families, and communities can take action to improve their situation" (Gutierrez, 1995 p. 229). When civil behavior is proliferated, and nurses are given resources and tools to prevent incivility, the result is decreased stress, burnout, and turnover in the workplace (Spence Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012). Empowerment plays

a significant part in providing tools and resources that allow workers to reach individual and collective goals (Kaiser, 2017). Empowerment is an "essential part of human nature and development" (p. 350), and nurses with longer work histories have a more empowered approach to work than those with shorter work histories (Kuokkanen et al., 2014, p. 354). Nurses who have experienced empowerment are more likely to be invested in the organization's success if they are actively engaged and have a level of organizational support. In turn, this investment may lead to a chain effect and create momentum for supportive experiences in the organization (Clark, Olender, Kenski, & Cardoni, 2013).

Empowerment has three main components: it is present in the workplace, individuals must believe in their ability to be empowered, and power exists in caring for the patient (Manojlovich, 2007). In a qualitative study by Lunardi et al. (2007), the word power was completely absent from the dialogue of nurses who were interviewed about the situations they faced in their day-to-day work. In essence, the nurses did not recognize the power relations in which they were immersed. Extant literature that examines research on empowerment will be described in Chapter Two.

Purpose and Research Questions

Research is needed to shed light on nursing incivility, bullying, and empowerment, expose the intricacies of these phenomena and give a voice to nurses who have minority representation. The purpose of this study is to explore how nurses who represent minorities share their lived experiences of incivility, bullying, and empowerment in the workplace. The following questions helped to establish the research agenda:

1. How do minority nurses describe or explain their experiences with incivility and bullying in the workplace?

2. How do nurses with minority representation experience empowerment in the workplace?

Methodology

A diverse workforce is vital for healthcare, and as such, nurses with a minority representation need to be supported, listened to, and actively retained. The empowerment of people representing the minority population of nurses is significant for all healthcare, but the extent to which they are empowered may not be fully appreciated. This study uses descriptive phenomenology as its chosen methodology to convey the voices of the nurses interviewed. Edmund Husserl (1859-1938), a German mathematician, developed this type of qualitative research phenomenology, "where every day conscious experiences were described while preconceived opinions were set aside or bracketed" (Dahlberg, Drew, & Nystrom, 2008 as cited in Reiners, 2012, p. 1). The philosophical underpinnings of Husserlian descriptive phenomenology are that of "lived, human experience, moreover the rich, complex unspoken meanings associated with being and experiencing shapes an individual's understanding of their life-world" (Christenson, Welch & Barr, 2018). This methodology provides a better understanding of environmentally influenced phenomena, such as incivility, bullying, and empowerment in nursing.

Given the nature of the research questions, the experiences of incivility, bullying, and empowerment are equally salient. Interviewing nurses may lead to deeper understanding, but also might reveal other opportunities for empowerment. Thus, I hope the study findings will reveal what minority nurses interpret as empowerment, and lead to

possible solutions for improving the work environment, increasing inclusion, and helping administrators to increase empowerment in their facility (DeVivo, Griffin, Donahue & Fitzpatrick, 2013; Marriott-Statham, Mackay, Brennan & Mackay, 2018).

The Role of the Researcher

As a child, I observed discrimination and racism with my family and in the community; these experiences were in response to my two biracial stepbrothers on both sides of the family. The discrimination and racism I witnessed shaped me as a person and certainly as a nurse. As a nurse, I have heard minority nursing students and colleagues' comment and recall discrimination and racist remarks made in the workplace.

Throughout my nursing career, I have encountered various incivilities and bullying. My experiences vary in intensity, and my position or role played a part in these experiences. I have also experienced empowerment by supportive leaders, peers, and patient experiences as a nurse.

The purpose of my research focuses on minority nurses, which means any nurse who is non-White. Despite reading much research on incivility and bullying, I found extraordinarily little information on minority nurses, mainly just mentioned as a small percentage in the demographics. I wanted to focus on nurses representing the minority population to hear their incivility and bullying stories from a raw perspective.

I chose to study empowerment also because while incivility and bullying are lived experiences by these nurses representing minorities, have they also experienced empowerment? By empowerment, I want to know what their experiences are, and what they involve. I developed questions about context, such as: what were the circumstances, where did these incidents occur, and by whom did the nurses feel empowered? By

"seeing" these minority nurses' experiences, we will get a look into their lives and what has suppressed them. My aim for this topic is to contribute to nursing by providing essential insights from nurses who have lived the experience to learn from them. I can see through my research thus far that this topic can evolve to other research opportunities. I hope to bring light to the negative topic of incivility and bullying by drawing attention to instances of empowerment.

As a qualitative researcher, I had an "emic perspective" and intended to be directly involved and actively participate throughout the study (Terrell, 2016). I realized that I could transfer my feeling to the participants because of my experiences. To prevent bias, bracketing was employed so that I could focus directly on what was happening. Bracketing means to "suspend our judgement and 'empty our minds' of any preconceived notions or ideas when we collect and analyze our data" (Terrell, 2016, p. 151). The quality standards of trustworthiness, credibility, and dependability in my research were achieved by being transparent about my role and my analytic process, conducting the analysis with an analytic group, and keeping a reflective journal during the research process (Bloomberg & Volpe, 2019).

Procedures

The first part of the procedure was to send a workplace incivility survey with a Likert scale and demographic survey to potential participants. The surveys acted as a screen to determine if participants were positive for workplace incivility and a minority. After the participants "tested positive" for incivility, they were sent an invitation to interview. The participant could choose to interview either face-to-face, either physically or via Skype, Zoom, or by phone, email, texting, or mail formats. If the interview was

verbal via face-to-face or by phone, the interview was recorded for transcribing purposes.

It was the intention of this study to provide information on the workplace environment for nurses representing the minority population in their field. Specific practice areas were revealed, and the duration of time as a nurse and other demographics were compared to their recollection of events as they told their story.

More details about the study design are found in Chapter Three.

The Framework of the Study

A theory investigated as a framework for this study was the Critical Race Theory (CRT). The CRT was built on a race-conscious framework and was developed from the critical theory. The critical theory was defined as "an attempt to understand oppressive aspects of society in order to generate societal and individual transformation" (Tierney, 1993, p. 4). The CRT framework fits for this study because it is designed to target "the subtle and systemic ways racism currently operates above and beyond any overly racist expressions" (Crenshaw, Gotanda, Peller, & Thomas, 1995, p. 223). The goals of the CRT are to recognize the movement of anti-racial motivation to identify, understand, and undo the root causes of racial hierarchies (Crenshaw, Gotanda, Peller, & Thomas, 1995, p. 228).

Significance

The literature on incivility leaves few doubts about the validity and frequency by which nurses experience this phenomenon. Incivility has a significant impact on the nursing profession and patient care through the dwindling population of nurses. Nurses who suffer from incivility seldom report their experiences. Moreover, when nurses do report incidents of incivility, action is seldom taken. In turn, it harms the nurse's self-

esteem, undermines confidence in patient care decision making, and correlates with an unhealthy work environment (Kieft, Brouwer, Francke, & Delnoij, 2014).

Assumptions

The assumptions for this study were:

1. Nurses representing the minority population will have more incivility and bullying than experiences of empowerment.

2. Any empowerment experiences the nurses might have had were because another person cared about them.

3. The nurses' responses to the inquiry were honest, and their perceptions valid.

4. A targeted pool of participants was needed due to minority nurses making up a tiny percentage of the nurse population.

Definition of Terms

The following terms are defined to help the reader understand the context of each term for this study:

Bullying: A form of aggressive behavior-designed to hurt another (Smith, 2016). The Centers for Disease Control and Prevention (CDC) and the U.S. Department of Education gives a 'uniform' definition of bullying, which can be applied to nursing.

> "any unwanted aggressive behavior(s)…that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated; may inflict harm or distress on the targeted [person], including physical, psychological, social, or educational harm" (Gladden, Vivolvo-Kantor, Hamburger, & Lumpkin, 2014).

Empowerment: "The process of increasing personal, interpersonal, or political power so that individuals, families, and communities can take action to improve their situation" (Gutierrez, 1995 p. 229).

Husserlian Descriptive Phenomenology: The philosophical underpinnings of Husserlian phenomenology are that of the lived, human experience, moreover the rich, complex unspoken meanings associated with being and experiencing shapes an individual's understanding of their life-world" (Christensen, Welch & Barr, 2018).

Incivility: Behaviors that reveal disrespect and promote conflict while increasing stress among individuals, including disregard and insolence for others, causing an atmosphere of disrespect, conflict, and dissent (Clark, 2008; 2013).

Implicit Bias: Tendency, unreasonable judgment or prejudice between a "group or category attribute, such as being Black, and a negative evaluation (implicit prejudice) or another category attribute, such as being violent (implicit stereotype)" (Holroyd & Sweetman, (2016) as cited in FitzGerald & Hurst, 2017).

Lived experience: Those who have experienced phenomena can communicate them to the outside world, thus providing an understanding of experience from those who have lived it (Mapp, 2008).

Microaggression: An observed minor or subtle behavior or verbalization, such that initially the behavior appears non-harmful, but may lead to more harmful or damaging action (McTernan, 2018).

Minority: An ethnic person of color and who is defined by the United States Census Bureau as non-White, including Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian, or Other Pacific Islander (United States Census Bureau,

2020). While the term "*minority* has been equated with the label of being less than, oppressed, and deficient in comparison with the majority, i.e., Whites," (American Psychological Association (APA), 2020, p. 145), for this research the term minority is designated as a word for representation and inclusive of all minority groups, as guided by the word choice for the United States Census Bureau, 2020. It is acknowledged that there are other minority groups such as sexual orientation, gender status, and disability status, though these minority groups were not the focus of this study.

Morality: "Identifies properties that constitute moral systems as a natural kind and copied, a moral system has rules, psychological states, and modes of character development that performs the function of enabling mutually beneficial social cooperation" (Luco, 2014).

Racial Microaggression: According to Kohli and Solórzano (2012), racial microaggressions consist of multifaceted factors:

- Subtle verbal and non-verbal insults/assaults directed toward People of Color are often carried out automatically or unconsciously.

- Layered insults/assaults, based on race, gender, class, sexuality, language, immigration status, phenotype, accent, or name.

- Cumulative insults/assaults that take their toll on People of Color. In isolation, racial microaggressions may not have much meaning or impact; however, as repeated slights, the effect can be profound.

Systemic Racism: "Covert or everyday forms" of racism to keep those "at the racial margins in their place" (Kohli, & Solórzano, 2012).

White privilege: "Having a collection of benefits based on belonging to a group perceived to be White, when the same or similar benefits are denied to members of other groups, not because of one's individual accomplishments or actions" (Johnson, 2001, p. 23 as cited in Potapchuk, Leiderman, Bivens, & Major, 2005, p. 5).

Workplace incivility: "Low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect" (Andersson & Pearson, 1999).

Summary

Researchers have been examining why incivility and bullying are prevalent in nursing. 60% of registered nurses work in state, local, and private facilities (Bureau of Labor Statistics, U. S. Department of Labor 2018). Employment for nursing is projected to grow faster than the average for all occupations, up 12 percent from 2018 to 2028. A number of reasons for the growth include the need for nurses to deliver preventive care, increasing rates of chronic conditions, such as diabetes and obesity, a demand for healthcare services from the baby-boom population living longer than previous generations, and replacing workers who retire (Bureau of Labor Statistics, U. S. Department of Labor, 2018). With a greater focus on losing the nursing workforce to retirement and retention issues, the question asked in this study was how minority nurses perceive their experiences of empowering events compared to incivility and bullying through their perception as they live it? It was expected that by identifying the definitions of incivility, bullying, and empowerment as they relate to the nurses in the workplace, their stories could be told and recorded to understand the phenomenon.

Four more chapters follow Chapter One. Chapter Two is a comprehensive review of literature on incivility, bullying, and empowerment in nurses of minority. In Chapter

Three, the topics discussed include the research design and how the study was conducted.

Chapter Four presents the findings, and Chapter Five provides discussion and conclusion

of the study.

CHAPTER TWO: REVIEW OF LITERATURE

This chapter discusses the literature on nursing incivility, bullying, and empowerment for minority nurses. Multiple sources and types of incivility are identified in the literature: student-to-faculty, student-to-student, nurse-to-nurse, physician-to-nurse, nurse-to-leadership, leadership-to-nurse, faculty-to-student, nurse-to-graduate nurse or "new nurse and faculty-to-faculty" with students witnessing faculty incivility in institutions (Peters, 2014; Andersson & Pearsson, 1999).

A comprehensive literature review was conducted using the timeframe within the past five years (2014-2019) to ensure current and timely research. Sentinel and empirical works published earlier than the five-year range were included in the literature review process if they described the topic and provided useful explanations. The literature review was conducted in consultation with a University of Missouri-St. Louis research librarian, using several scientific databases such as the Cumulative Index for Nursing and Allied Health (CINAHL), Google Scholar, Medline, Ovid, ProQuest, PubMed, ScienceDirect, Wiley Online Library, and a search for books on the topic of incivility, bullying, and empowerment of nurses.

The inclusion criteria were published between 2014-2019 unless sentinel or empirical works were discovered. The use of the English language was required and articles with editorials or opinion papers were excluded. The initial search identified 88 articles with 32 articles applicable to the study. The articles were evaluated for their topic, design, content, data collection and analysis, population, sampling, size, methods, and instruments used.

The search consisted of peer-reviewed articles and books using multiple keywords and terms. Keywords were: *civility, nursing incivility, nurse bullying, hierarchical incivility, minority nurses, nursing minorities and incivility and bullying, empowerment in nursing, culture care theory, social learning theory, empowerment theory, modeling incivility, modeling behaviors in nursing, peer incivility, culture of nursing, nursing culture and incivility,* and *cost of incivility.* Due to the lack of literature on *incivility* and *bullying* in comparison *to empowerment* in nursing, the term *incivility* was replaced with other related terms such as *workplace bullying*, *lateral violence in nursing, bad behaviors in nursing,* and *medical profession aggression*. The search found no studies on nursing incivility, bullying, and empowerment, using a comparison of experiences and perspectives of nurses who represented minority populations.

Organization of Review

The articles under review were grouped into seven themes focusing on incivility, bullying, and empowerment. The seven themes were named Nursing: A Profession of Caring, Organizations and Associations of Nursing, Minority Nurses, Hierarchical Relationships, Leadership, and Modeling in Nursing, Power and Empowerment, Costs of Incivility, and Phenomenology.

The first theme in the literature review was "Nursing: A Profession of Caring." Smith and Liehr (2018) shared that "Caring is described as a moral imperative having a service identity" (p. 20). The focus of caring is part of the human health experience, and research hopes to facilitate change in the human experience (Smith & Liehr, 2018). There may be particular personality factors associated with caring that are important to understand and consider if incivility and bullying are partially determined by personality

type.

The second theme, "Organizations and Associations of Nursing," addressed how organizations and associations of nursing approach incivility and bullying. This factor explains how impactful the experience of incivility and bullying is in the nurse's work-life and how organizations and associations of nursing are counteracting it. The supportive nature of these entities provides acknowledgment and assistance for nurses in the workplace in instances of incivility and bullying. As referred to in Chapter One, Abolfazl Vagharseyyedin's (2015) analysis of workplace incivility described it as a phenomenon that has "negative outcomes for the victims, witnesses, organizations, and perpetrators themselves" (p. 123). Health organizations realize the need for civility to counter the high turnover rate, staff shortages, and low job satisfaction reported by nurses.

The third theme of "Minority Nurses" relates to the focus on nurses who represent the minority population. Exploring the interpersonal relationships and influences of nurses who represent a minority may provide new insights into the phenomena in the workplace setting. This study investigated whether incivility and bullying in the workplace for nurses are related to ethnicity and race, whether they are on the rise or decline, and if nurses can empower one another.

The fourth theme covered "Hierarchical Relationships and Modeling in Nursing." The relationships included nursing ranks, interdisciplinary medical professionals, leadership, and modeling within the healthcare organization. According to Daiski (2004), the hierarchical properties within nursing organizations also "replicate a traditional patriarchal structure, and through this framework, marked power differentials within

nurses' ranks came into being" (p. 44).

The fifth theme was "Power and Empowerment" in nursing. The review of the literature not only revealed a rise in nurse-to-nurse incivility, but also illuminated the role of empowerment between peers. Manojlovich (2007) stated that when nurses are powerless, they are ineffective in their work, less satisfied with their jobs, and will burn out, becoming depersonalized. When nurses are empowered they are "highly motivated and able to empower others by sharing the sources of power" (Laschinger & Havens, 1996, p. 28 as cited in Manojlovich, 2007, p. 4).

The sixth theme was named "Costs of Incivility." This theme was about the costs of incivility and bullying to minority nurses, employers, and their patients. I hoped to gain a degree of historical and conceptual cost context for this study through the exploration of literature. Losses due to incivility are due to lower productivity among direct care staff (Hutton & Gates, 2008).

The seventh theme was the method of the study of phenomenology. If any, very few phenomenological studies have explored the lived experiences of incivility and bullying in minority nurses. First-person accounts of incivility and bullying, as experienced by minority nurses, allow the study of the social, political, and cultural circumstances that influence behavior (Gallo, 2012). Data gathered from the phenomenological research may help establish an environment free of incivility (Gallo, 2012).

After the seven themes were identified in the literature, common theories in the research were identified, focusing on Kanter's Theory of Structural Empowerment. In the study's conclusion, I identified the Critical Race Theory as the theoretical underpinning

for the study. Chapter Two concludes by summarizing the scarcity of literature about incivility, bullying, and empowerment among minority nurses, the implications for further research, and the anticipated impact on nursing as a profession.

Nursing: A Profession of Caring

Historically, nursing has been a female-dominated profession overseen by mostly male medical professionals (Palmer & Short, 2014). As this nursing profession structure became established, the power imbalance created a self-perpetuating culture (Cleary, West, Arthur, Kornhaber, & Hungerford, 2019; Baillien, Nevens, De Willte, & De Cuyer, 2009). The power imbalance is about more than just gender interactions and parent-child relationships between colleagues; it is also about the nursing culture and perceptions (Cleary et al., 2019). The nursing profession has been associated with caring for patients beginning with Florence Nightingale, the ambassador for nurses, serving patients in the Crimean War. Nursing's foundation relies on patient-centered care, with nurturing and caring as the cornerstones of the nursing profession. Caring remains the inner core or the "essence" of nursing (Andersson et al., 2015). In a phenomenological study, Andersson et al. (2015) described nurses' conceptions of caring as the [context] within the environment contributing to safer and better-quality care for patients.

Bagdonaite-Stelmokiene, Zydziunaite, Suominen, and Astedt-Kurki (2016) described caring as a way of thinking and collaborating with others for the patients' well-being. Another qualitative study examining how nursing applicants view the nursing profession revealed that as nurses work in multi-professional teams, nurses' roles were described as caring (Glerean, Hupli, Talman, & Haavisto, 2019). See Table 2.2 *Nursing: A Profession of Caring*, in Appendix A, as it identifies the sources used related to nursing

as a profession of caring.

The definition of *nursing* and *caring* are interchangeable in the Western or United States culture (Lachman, 2012). The culture of nursing, or the way a nurse is introduced into the world of nursing and the socialization of nursing, "plays a role in interpreting what it means to care" (Benner, Hooper-Kyriakidis, & Stannard, 2011, p. 591). Caring and nursing go hand in hand because, "caring behaviors are affected by attitudes, plans, and the experiences of nursing students about the profession" (Gözütok Konuk & Tanyer, 2019, p. 196). Nurse-to-nurse incivility is contrary to this principle of caring and nurturing behavior. The nursing profession is viewed as one of the most valued and honorable jobs in which professionalism and altruistic values reign. The National League for Nursing (NLN, 2010) defined a nurse's professional identity with the moral values of "caring, diversity, ethics, integrity, excellence, holism, and patient-centeredness" (NLN, 2010). The predominant meaning of caring is akin to concerns for others, including the maintenance, protection, emotions, and concerns for one other (Bailey, 2009). If professionalism and ethical values are at the foundation of nursing, then incivility in nursing should not exist in the workplace.

Organizations and Associations of Nursing

When referring to nurses who represent the minority population, scant research has examined the prevalence of incivility, bullying, empowerment, and organizations and associations' involvement. Evidently, organizations and associations differ in their support of minority nurses. Historically, policy leaders within these organizations and associations have sought to define the problems of incivility and bullying and shape the work environment toward improved conditions.

In 2003, the Institute of Medicine (IOM) released an article titled, "*Keeping Patients Safe: Transforming the Work Environment of Nurses,*" which focused on endeavors to support the nursing work environment. In 2008, the Joint Commission, a private nonprofit organization that is the leading global source for accreditation standards in health care organizations, released a statement about incivility and its implications for nursing. The statement was released July 9, 2009 in Issue 40 for *Behaviors that Undermine a Culture of Safety*.

> Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction, and prevent adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team (The Joint Commission, 2008).

In 2016, the Joint Commission released an article titled "*Bullying has No Place in Health Care.*" The article stated that workplace and bullying behavior was at epidemic levels (The Joint Commission, 2016). The Occupational Safety and Health Administration (OSHA) noted that 21% of registered nurses reported being physically assaulted, and over 50% had been verbally abused in a 12-month time span. The Joint Commission identified types of bullying as "intimidation, harassment, victimization, aggression, emotional abuse, and psychological harassment or mistreatment" (2016).

That same year, the IOM released an update to their report that included an expanded effort to promote opportunities, programs with interprofessional collaboration to support nurses in their development, leadership, and collaborative practices. The new direction maintained the importance of the work environment while broadening its coalition (Altman et al., 2016).

Around the same time era, a study by Laschinger, Cummings, Wong, and Grau (2014) resulted in the discovery that the role of positive leadership in organizations empowers nurses and discourages workplace incivility, burnout, and job satisfaction. Leadership skills such as empathy, listening, and responding to concerns would help create an empowering environment and decrease burnout and workplace incivility (Laschinger et al., 2014, p. 13).

The consequences of nursing incivility are severe and costly, as reflected by the specific statements in the American Nurses Association (ANA) Code of Ethics, aimed at addressing incivility. Although incivility among nurses is well-recorded, nurses must be empowered to model the ethical conduct outlined in the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015).

Torkelson, Holm, Backstrom, and Schad (2016), determined the culture of incivility in the organization carries implications for future practice. In future practice, the focus should be on the perception of the instigator, to gain insight about workplace incivility. The Torkelson et al. (2016) study was critical because it looked at incivility by supervisors and coworkers. Low social support from coworkers or peers, the nursing profession's demands, and organizational change were all related to instigated incivility in the workplace (Torkelson et al., 2016).

According to Glerean et al., (2019), how nurses perceive nurses, versus how patients perceive nurses, are different. The study was important because it displayed how the culture of incivility in an organization can impact nursing care. The study findings noted that the collaboration between nursing organizations needs to increase to strengthen the image of nursing (Glerean et al., 2019).

Brewer, Oh, Kisantas, and Zhao (2020) determined that organizational factors impact nurses through betrayal or support and significantly affect their well-being. Organization and association involvement are relevant to the experiences of incivility, bullying, and empowerment among minority nurses because organizations are obligated to support nurses and ensure safety (Brewer et al., 2020). Likewise, organizations should provide prevention and mitigation of workplace bullying (p. 149). A cross-sectional study was conducted using a convenience sample of 242 registered nurses in the United States, using the Negative Acts Questionnaire-Revised for Nursing (NAQR-US) by Simons, Stark, and DeMarco (2011) to measure bullying, the Betrayal Questionnaire-Healthcare (IBQ-H), a binary scale measuring acts by an organization (Smith, 2017); and the Well-Being Index (WBI) measuring burnout (Dyrbye, Satele, & Shanafelt, 2016). The study was unique because it focused on how work environments are essential to the nurse's well-being and noted that incivility and bullying are more prevalent in medical organizations due to their size and resources (Brewer et al., 2020). The importance of the Brewer et al. (2020) study was that it was the first study of its kind to examine organizational betrayal in nursing. The authors listed the strength of the study as introducing new concepts, which were the organizational impact of betrayal and support as factors causally related to nursing outcomes. Another strength was using an online

sampling method, which provided a wide geographical area, and included diverse workplaces and specialties of nursing in the United States (Brewer et al., 2020). The findings of this study concluded that specific types of nursing work environments are of central importance to maintain nurses' well-being (Brewer et al., 2020). Table 2.3 *Organizations and Associations of Nursing* describes characteristics of studies that relate to nursing and how the organization can facilitate a positive workplace.

Minority Nurses

The literature on incivility leaves few doubts about the validity and frequency of nurses experiencing this phenomenon. Minority nurses are impacted by incivility and bullying, but the literature lacks minority nurse reporting due to the ratio of minority nurses to White or Caucasian nurses in the United States. Minority nurses are often only mentioned in studies as a small percentage in the demographics section. Nurses who suffer from incivility seldom report their experiences. Moreover, when nurses do report incidents of incivility, action is rarely taken. As mentioned in Chapter One, when reports are ignored, it is disempowering to the nurse's esteem, undermines confidence in patient care decision making, and correlates with an unhealthy work environment (Kieft et al., 2014).

A study by Alshehry et al. (2019) used a descriptive, cross-sectional design to sample 378 nurses in two government hospitals located in Saudi Arabia. The aim was to examine workplace incivility of nurses and study its influence on their professional quality of life (ProQOL) (Alshehry et al., 2019). The descriptive analysis revealed there was a perceived association of incivility with the nurses' demographics or location in Saudi Arabia, and the results showed the Saudi nurses had good ProQOL. In this study,

the selection bias was high because only two public hospitals were included, and other research designs were recommended to decrease bias and help to determine the true cause and effect of the related variables of the study. Overall, the study made recommendations relevant to current clinical practice, including the promotion of workplace intervention programs such as "conflict management, collaborative team efforts, internal training, coaching, and open communication and feedback" to improve workplace culture (Alshehry et al., 2019, p. 2562).

Cases of incivility and bullying are prevalent in nursing. Beard and Julion (2016) examined the narratives of 23 African American nursing faculty members to explore if racial discrimination, a previously identified challenge in the profession, continued in academic nursing settings. The study used the term "microaggression" to designate slights and other subtle discriminatory or racist acts, intentional or inadvertent, directed at a minority individual (Beard & Julion, 2016). The study aimed to see if racist barriers contribute to the lack of African American faculty representation in academia. An interview guide was sent by email to 127 faculty members who were members of the Association of Black Nursing Faculty. Additional faculty were presented with an interview guide, which was prepared by the National League for Nursing and the National Black Nurses Association. The goal was to obtain a sample of participants who represented diverse academic members.

After the questionnaires were returned via email, the data was thematically analyzed based on the eight interview questions. The 23 participants came from 17 states in the United States. A strength of the study was how the narrative analysis was integrated into the participants' stories across their timelines such as in the past (how they

entered into academia), present (what was going on during their time in academia, and the future (did they leave, stay or were still employed and what influenced their decision, Beard & Julion, 2016). All participants had the same reason for going into academia: for the love of teaching and the chance to make a difference in the lives of students. Through the findings of the study, the recommendations were a provision of workshops to allow for the creation of personal narratives, administration recognition of unique challenges faced by minority faculty, mentorship, and increased transparency in policies (Beard & Julion, 2016).

Exclusion of diversity in nursing was one of the focal points of a study by Schmidt, MacWilliams, and Neal-Boylan (2017). Exclusionary behaviors, such as incivility and bullying, can discriminate against and isolate minority groups and individuals. The focus should be on inclusion, which encourages diversity. The study offered a code of conduct for nursing schools and facilities, along with modeling. Table 2.4 *Minorities and Incivility in Nursing* in Appendix A describes study characteristics that relate to minority nurses and their workplace experiences, exposure to microaggression and achieving positive patient experiences.

Hierarchical Relationships, Leadership, and Modeling in Nursing

Research shows that workplace incivility is widespread in the medical field, but also exists in business, organizations, and academia (Clark & Spring, 2007; Cortina, Magley, Williams, & Langhout, 2001; Luparell, 2011; Pearson, Andersson, Pearson, & Porath, 2000; Pearson & Porath, 2005; Schilpzand, De Pater, Erez, 2014). An escalation in workplace incivility in the medical field has persisted, and stems largely from nursing (Pattani et al., 2018). Mistreatment from incivility results in "counterproductive work

behavior, that has many implications for the hospital employee, the organization, and patient care" (Hamblin et al., 2015, p. 2465).

For a workplace such as a business or organization, incivility is linked to both instigated incivility and adverse outcomes "in the form of reduced well-being, job satisfaction, turnover intentions, and sleeping problems" (Holm, Torkelson, & Backstrom, 2015, p. 8). "Instigated incivility" was a named phenomenon, described as workers witnessing coworkers' incivility toward others (Holm et al., 2015). When incivility exists in organizations, the climate and morale are diminished, which costs the organization productivity, time, and money (Felblinger, 2008).

Faculty who challenge other faculty knowledge was the most frequently observed uncivil act in a study about incivility in nursing education (Clark & Springer, 2007, p. 13). The second most frequent uncivil behavior was "taunts and disrespect to students in front of other students" (Clark & Springer, 2007, p. 13). The study used the Incivility Nursing Education survey to examine incivility in nursing education from the view of faculty and students. The study examined the hierarchical properties involved in the different roles in nursing education that, through uncivil behavior, contribute to the greater tolerance of incivility (Clark & Springer, 2007).

Another study focused on how differences in the way incivility was experienced effect thinking and behaviors following uncivil treatment. The study by Schilpzand et al. (2016) used a controlled experimental design within a team task environment with 289 participants. The implications for this study were that "work teams including managers could examine their interpersonal communications and interactions for tone and intent while team members that are perceived to be uncivil [should] be held accountable for

their actions" (Schilpzand Leavitt et al., 2016, p. 42). Organizations and leadership could build civil exchange reminders and prompts to encourage civil interactions and communications (Schilpzand et al., 2016).

The American Association of Colleges of Nursing (AACN) stated a need for higher degrees in nursing and reported that nurses with a lower level of degree are undereducated to meet the critical demands and needs of patients in the current healthcare system (AACN, 2010). When comparing the different degree levels in nursing, the level in the organization can factor into the behaviors among colleagues (Kennedy & Anderson, 2017). The power relationship between the levels might influence the interpretation of incivility between professionals in the workplace with observer responses viewed as assertive and confrontational to the perpetrator, avoidant, downplaying the transgression, or compassionate, offering support to the target (Hershcovis et al., 2017).

Leadership

Leaders play a crucial role in establishing a quality work environment by setting an example for standards of behavior and providing resources to employees so they can function well (Laschinger, Wong, Cummings, & Grau, 2014). Positive leadership puts a focus on training and mentoring people in leadership positions, teaching them how to utilize an employee's strengths and positive contributions to the organization (Nel, Stander & Latif 2015). Leaders are also role models because their actions and roles communicate messages as to what is considered acceptable behavior (Kaiser, 2017). Through empowering leadership, employees are encouraged to participate in decision making, which results in teamwork and a team-based commitment (Cai, Yahua Cai, Sun,

& Ma, 2018). Ideally, an effective leader can demonstrate that empowerment is a motivational process rather than a delegation of power (Park, Kim, Yoon, & Joo, 2016). Ineffective leadership is observed when an administrator's involvement either has a part, causes incivility, or displays complicit behavior by not taking appropriate steps to address and remedy complaints and conflict (King & Piotrowski, 2015).

Arslan Yürümezoğlu, Kocaman, and Mert Haydari̇, (2018) tested a theoretical model of the relationships between nurses' perceptions of structural empowerment, leadership, and peer incivility, focusing on what the intent was with respect to leaving the organization or the nursing profession. They used a cross-sectional, correlational study with a sample size of 574 nurses. The data was gathered using a generic demographic and work characteristic survey form and face-to-face interviews. The study found that the key to an empowering work environment was a nurse manager with leadership characteristics and a relationship-oriented understanding, who supported nurses and provided resources for nurses to access that gave them opportunities for development and promotion (Arslan Yürümezoğlu, Kocaman & Mert Haydari̇, 2018).

An empirical study by Park, Kim, Yoon, and Joo (2017) investigated the effect of empowering leadership on employees' psychological well-being and job engagement. The sample was comprised of 285 participants and used a structural equation modeling to estimate the fit of the hypothesized model to the data. The theoretical implications indicated that empowering leadership was essential to enhance employees' mental well-being and positive psychological capital (Park et al., 2017). Table 2.5: *Hierarchical and Leadership Relationships in Nursing,* in Appendix A, displays the articles pertaining to leadership and relation to rank and hierarchy in the workplace.

Modeling

Nurse faculty role-modeling in an unsupportive and hostile environment will influence student nurses in a negative manner (Sanner-Stiehr & Ward-Smith, 2017). Research on the 'incivility spiral' (Andersson & Pearson, 1999) illustrated how the power of observing and modeling could breed perpetuating behaviors in the work environment. Similarly, Bandura's Social Learning Theory (1977) suggested that individuals model behaviors that they have observed from leadership. In essence, if nurses see uncivil leader behaviors, they will likely behave in the same way.

Labrague, McEnroe-Petitte, Papathanasiou, Edet, and Arulappan, (2015) studied 586 nursing student questionnaire responses and discovered the quality of the learning environment was important because nursing students were influenced and modeled the behavior of their nursing instructors. The overall premise of this study was that "instructors' caring behaviors influence nursing students' caring behaviors positively" (Labrague et al., 2015, p. 344).

In another study by Rad, Ildarabadi, Moharreri, and Moonaghi (2014), a quantitative content analysis was used to study open questionnaires of 540 students and 100 educators. The top three things students complained about educators were wasting class time, distraction, incompetence, and poor class management. For educators, the biggest complaints about students were disrespect toward instructors, class order, and humiliating fellow classmates (Rad et al., 2014). The study revealed that incivility was present in the academic environment, and disruptions due to incivility could influence future behavior.

A study on role modeling examined the perceptions and experiences of nursing students and instructors using semi-structured interviews and a qualitative content analysis approach. In the study by Nouri, Alhani, and Ahmadizadeh (2013) in Tehran, Iran, the authors discovered three main themes from the data: promoting intellectual development, spiritual development, and emotional development. The study focused on how, in the Iranian culture, a role model in the clinical environment should be given more attention because of its value in nursing education (Nouri et al., 2013). Table 2.6: *Modeling in Nursing*, in Appendix A, displays how good and bad behavior in the workplace can affect the behavior of nursing students and other nurses.

Power and Empowerment

The terms power and empowerment are linked to incivility in nursing in many ways. Incivility in the nursing culture evokes feelings of powerlessness. It leads to a new generation of nurse-to-nurse aggressors who feel pressured to assimilate to the current nursing culture to avoid becoming victims themselves (Baillien et al., 2009). Contributing factors to the loss of power in a nursing department include hierarchical management, change through restructuring or downsizing of the organization, employees who are not empowered, tolerance of bad behavior, failure to enforce policies to negate incivility, and lack of support and collaboration by seasoned or more experienced nurses (Sauer, 2012). Gonthier & Morrissey, (2002), in their book, *Rude Awakenings: Overcoming the Civility Crisis in the Workplace*, states "Civility is being mindful of the dignity of the human being in your sphere at all times. Civility is not so much about niceties as it is about the way we live our lives overall and the way we treat other people" (Gonthier & Morrissey,

2002). To achieve such goals in the workplace, nurses must first support each other, and identifying ways to do this is just the beginning.

Empowerment is the process of helping disadvantaged people strengthen their "personal and political power by taking charge of their lives" (Compton & Hoffman, 2013). The key to influencing employee engagement and empowerment, as proposed by authors Zhang and Bartol (2010), is to enhance the meaningfulness of work by helping employees understand the significance of their contribution to general organizational effectiveness. Other ways to improve an institution's efficiency are by conveying confidence in employees' competence, performance, and providing autonomy (Zhang & Bartol, 2010). Ugwu, Onyishi, and Rodriguez-Sanchez (2014) asserted that the direct impact of empowerment on work engagement could fuse trust and commitment in such a way that employees would share in organizational trust.

A longitudinal study of 191 nurses applied the authentic leadership and structural empowerment theories to show how leaders could positively influence new graduate nurses' health and retain them in the workplace (Read & Laschinger, 2015). The study took place in Ontario, Canada, and the participants were nurses working in either critical care or medical-surgical areas. Social capital in the study referred to the quality of positive relationships between coworkers and peers. Read and Laschinger (2015) found that "organizational conditions in nursing work environments have positive effects on new graduate nurses' career experiences" (p. 1612). Table 2.7: *Power and Empowerment*, in Appendix A summarizes the literature on organizational power and its effects on nurses' behaviors and experiences.

Costs of Incivility

The cost of incivility to the organization includes the impact on the individual as well as witnessed workplace incivility. Those who observe their co-workers experiencing workplace incivility report negative responses and attitudes toward the organization (Miner & Eischeid, 2012). Research has highlighted the problems of incivility related to its prevalence in the individual and organization; however, it is also essential to examine the characteristics of the perpetrator's motives and actions toward the victim (Anderson & Pearson, 1999; Pearson & Porath, 2005; Einarsen, 2011).

Porath and Pearson's (2010) article, "*The Cost of Bad Behavior"* summarized a decade of research on workplace incivility. They noted that when employees misbehave toward one another, not only do the individuals suffer, but "teams lose time, effort, energy, focus, creativity, loyalty, and commitment in the workplace" (Porath & Pearson, 2010, p. 64). The authors defined incivility as "the exchange of seemingly inconsequential inconsiderate words and deeds that violate conventional norms of workplace conduct" (Porath & Pearson, 2010, p. 64). The article is unique because it promoted the teaching of civility after it was discovered that employees and professionals don't understand the meaning of civility or how to be civil. The understanding is, if the individuals are not aware of what is considered uncivil, they won't know any better, but training will make the difference.

The perpetuation of workplace incivility is a significant organizational cost associated with experiencing incivility among peers (Torkelson et al., 2016). The cost of training new nurses and dissatisfaction in the work environment has been reported as a significant reason for leaving (Kutney-Lee, Wu, Sloane, & Aiken, 2013). "Substantial

high costs of workplace incivility occur when uncivil incidents are overlooked, the target suffers, the instigator thrives, and the organization loses" (Pearson, Andersson, & Porath, 2000). The impact of incivility puts detrimental stresses on the individual and organization. Workers exposed to incivility in the workplace contend with a reduced ability to focus, lack of motivation, decreased self-confidence, and a sense of helplessness (Baillien, Neyens, Witte, & Cuyper, 2009).

The actual financial cost to facilities and loss of employees was the topic of the study "*Workplace Incivility and Productivity Losses Among Direct Care Staff*" by Hutton and Gates (2008). The study sample included 184 participants consisting of registered nurses and nursing assistants in a large midwestern hospital. This study confirmed that workplace incivility from patients and management appeared to have the most significant impact on employees' productivity. The total losses in productivity from incivility in this sample was an estimated $264,847.34 annually (Hutton & Gates, 2008). Table 2.8: *Costs of Incivility*, in Appendix A, displays studies about how incivility can trickle down and lead to dissatisfaction and the nurse leaving the workplace.

Theoretical and Conceptual Frameworks

Theories frame the research and guide future research opportunities. Common theories were utilized by various authors in the literature regarding the impact of nursing incivility, bullying, and empowerment. Theoretical underpinnings found in the review of literature were identified as learned behaviors and empowerment. Two theoretical frameworks were considered for the study initially: Kanter's Theory of Structural Empowerment and Bandura's Social Learning Theory (SLT). A philosophical similarity within these theories was the emphasis on the environment for achieving a nurturing,

positive atmosphere conducive to learning. After the study was completed, the two theories did not fit as frameworks.

Bandura's Social Learning Theory

Albert Bandura is the theorist behind the SLT and held that individuals learn by what they see whether it be attitudes or behaviors (Bandura, 1977). The SLT explains behavior as a dynamic, give-and-take model in which individual perception, environmental factors, and behavior constantly intermingle (Butts & Rich, 2015). Such observation of the behavior of others leads to the modeling of those same behaviors, which can lead to positive or negative consequences. In terms of nursing incivility, new nurses observe and mimic the interactions of more senior nurses, including how senior nurses handle situations.

According to Bandura (1977, p. 22), "Most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions, this coded information serves as a guide for action." The SLT focuses on how human behavior is learned through observation through the means of modeling. From the observation of others, by example, people learn what to do and how to react. The SLT modeling "influences principally through the reference of the activity that is repeatedly observed" (Bandura, 1977, p. 25-26). "Motivation remains a primary factor in how behavior is determined and maintained," and in some instances, bad behavior such as incivility, is rooted in [patterns of] thinking (Bandura, 1977, p. 161).

To this end, if the behaviors being observed demonstrate that unacceptable behavior goes uncorrected, health care providers will invariably continue to exhibit that

behavior, and it will be observed and imitated by others (Lynette, Echevarria, Sun, & Ryan, 2016). Further, incivility can result from this event being replicated by other health care providers in the unit and throughout the organization, hurting peers and patients alike. The expansion of incivility through modeled behavior is described as 'spreading among the social milieu' (Lynette et al., 2016).

Kanter's Theory of Structural Empowerment

Rosabeth Moss Kanter's Theory of Structural Empowerment (1993) details the nature and effects of the distribution of power and powerlessness and provides a framework for understanding how to empower workplaces and employees. The theory is unique, considering its potential to positively impact the workplace by creating value in the work environment. The theory aims to promote the socio-political liberation of marginalized groups (Hipolito-Delgado & Lee, 2007). The Theory of Structural Empowerment is born in efforts to transform the way educators view the poor and marginalized (Freire, 1971). Hipolito-Delgado and Lee (2007) focused on the personal level of empowerment: if the individual was empowered to be effective in the community and take action, the activities of that person would lead to a shared environment, thus influencing the community to take action to advocate for change (Hipolito-Delgado & Lee, 2007).

The term *empowerment* has historically been used to describe power in the workplace, as in "the ability to mobilize information, resources, and support to get things done in an organization" (Kanter, 1993). Kanter's theory suggests that the characteristics of the situation can either constrain or encourage optimal employee performance (Kanter, 1993). Managers aim to empower their employees to increase their ability to accomplish

their work in a meaningful way (Kanter,1993). Empowerment is promoted in the workplace by providing employees with resources, such as information, support, and opportunities to learn and grow (Kanter, 1993).

Another aspect of the Theory of Structural Empowerment concerns nurses' empowerment of patients. Nyatanga and Dann (2002) suggested that nurses cannot effectively empower patients because nurses are themselves an oppressed group. In effect, Nyatanga and Dann (2002) asked whether one oppressed group can support the empowerment of another oppressed group while remaining oppressed themselves. Nyatanga and Dann (2002) also suggested that the hierarchical nature of the nursing profession makes it impossible to empower patients, who are viewed as lower than the nurse. The literature focuses on the language used by nurses, particularly the term *patient* as a barrier to their empowerment (Nyatanga, & Dann, 2002). This study is unique because it showed that nurses often relate in a distant and fragmented manner to their patients, and that this behavior is the product of choices made by nurses to withdraw and not cope with the realities of their workplaces, thus resulting in incivility (Barlem, Lunardi, Lunardi, Tomaschewski-Barlem, & da Silveira, 2013). By not dealing with the realities of their workplaces, nurses perceive their relationship with one another in terms of a struggle, a challenge, and may feel a need to follow another course of action (Barlem et al., 2013).

Inherent in the process of linking nursing incivility to empowerment in the workplace is recognizing the interrelationships between positive modeling and behavior in reaction to uncivil behavior. This link is a conceptual connection between a) how people model behavior towards others, thus influencing their actions, and b) utilizing

empowerment and resiliency in their responses. Structuring the empowering conditions in the work setting can help to increase the sense of personal and psychological empowerment, as well as feelings of self-determination and competence, thus resulting in positive work outcomes (Spence Laschinger, Gilbert, Smith, & Leslie, 2010).

Identifying a relationship between nurses' perceived realities in their workplaces and challenges, it is necessary to reduce incivility, empower working nurses, and give them a voice. The consequences of incivility among nurses have a direct impact on patient outcomes, with nursing absences and resignations affecting direct patient care. The cycle of incivility is unending, putting more pressure on those nurses who remain in the workplace. As such, changing the relationship dynamics among these nurses might reduce their tendency to perpetuate incivility.

The conditions necessary for empowerment are as follows: an opportunity for advancement, access to data/information, access to support, access to resources, formal power, and informal power (DiNapoli, O'Flaherty, Musil, Clavelle, & Fitzpatrick, 2016; Kanter, 1993; Wagner et al., 2010). Formal power is defined as "power that accompanies high visibility jobs and requires a primary focus on independent decision making and autonomy" (Wagner et al., 2010). Informal power is defined as "building relationships and alliances with colleagues" (Kanter, 1993; Wagner et al., 2010).

My study's phenomenological focus is to record the employee's perception of the actual conditions and what takes place in the work environment (Kanter, 1993). Autonomy plays a large part in the function and versatility of nurses in the workplace, and empowerment gives employees permission and the ability to make decisions and act autonomously for the organization (Kanter, 1993).

Theoretical Model

A model of nurse empowerment was derived from Kanter's Theory of Structural Empowerment, which suggests that empowering working conditions increase the feelings of psychological empowerment in nurses. The dynamic empowerment model displays how inspiration, psychological comfort, and problem-solving influence professionalism (Clark & Davis Kenaley, 2011). Kanter's Theory of Structural Empowerment elevates psychological and structural empowerment in nurses, resulting in satisfaction in the work environment, better health outcomes for patients, resources, support, and learning opportunities (Spence Laschinger et al., 2010; Shanta & Eliason, 2014).

Another study by Wing, Regan, and Spence Laschinger (2015), also followed the model based on Kanter's Theory of Structural Empowerment to investigate the relationship between new graduate nurses' perceptions of incivility in the workplace, mental health symptoms, and structural empowerment. A predictive, non-experimental design was used in this study of 394 new graduate nurses, and the study determined that the introduction of empowering structures into the working environment can lead to a reduction of workplace incivility and positively impact the mental health status of new graduate nurses (Wing et al., 2015).

The empowerment model in Table 2.1 presented by Worrell et al. (1996), displays the four elements of empowerment to show the interpersonal process and outcomes for nursing students. The authors used the SLT for their look into empowerment to teach strategies that would positively change student behavior (Worrell et al., 1996). The Table 2.1 in Appendix A displays the empowerment model (Worrell et al., 1996), which lays out the study's strategies.

Critical Race Theory

In my study, the Critical Race Theory (CRT) was thought to be relevant for nurses who represent the minority population and their experiences of incivility, bullying, and empowerment because CRT highlights oppressive topics such as race and racism and "heightens awareness about racism and educational inequity" (Kohli & Solórzano, 2012, p. 445). The utility of the CRT theory is that it "asserts that racism is an ordinary, everyday occurrence for people of Color…deeply embedded and its structural functions effect our ways of thinking and are often invisible" (Abrams & Moio, 2009, p. 251). The CRT was observed and developed as the theoretical frame after the study was completed. The nurses in my study's responses aligned with the tenets of the CRT. The CRT was applied at the conclusion of the study as the other theories discovered in the literature review did not fit.

Instruments Measuring Incivility and Bullying in the Workplace

Instruments are important tools to use in the study of incivility and bullying, measuring the problem of incivility in various workplace areas such as medical facilities and academic organizations. By measuring the impact of nurse incivility and bullying, we can promote change by developing strategies and interventions to improve the workplace, enhance teaching and learning experiences, and change the culture in nursing practice (Clark, Barbosa-Leiker, Gill & Nguyen, 2015). Table 2.9: *Measures*, in Appendix A, summarizes research instruments and measures of incivility and empowerment in the workplace. As mentioned previously, the (WIS) was selected as a screening tool and is described in this section. However, it is acknowledged that other study designs might incorporate the use of additional instruments and for differing purposes.

Clark, Sattler, and Barbosa-Leiker (2018) developed and tested the Workplace Incivility Index (WCI). The WCI is a 20-item instrument used to measure perceptions of workplace civility among individuals and groups within work environments. Three hundred ninety-three nurse faculty and practice-based nurses participated in the study at an international nursing conference with all responses collected anonymously. A factor analysis established its validity and reliability for use among individuals and groups in work environments.

Another study by Liao, Qin, He, and Guo (2015) tested a new instrument, the Nurse Collaboration Behavior Scale (NNCBS). The scale is a 46-item nurse-to-nurse collaboration scale, and 202 nurses participated in the study from the International Department of Services. An exploratory factor analysis established reliability with a Cronbach coefficient of 0.929. One limitation was the single site used for data collection, a large hospital located in Beijing; results may vary in other areas (Liao et al., 2015).

A tool used to describe and validate uncivil behavior in the clinical nursing environment (UBCNE) by Anthony, Yastik, MacDonald, and Marshall (2014), measures nursing students' experiences with incivility in the clinical learning setting. The study used 118 nursing students who completed the 20-item Likert type scale UBCNE instrument. The UBCNE was developed by two of the authors after a review of the literature and conducting focus groups. The site for the study was a large, private, midwestern school of nursing. The UBCNE was shown to have good reliability with a Cronbach's alpha of = 0.93. Still, the researchers reported limitations such as the participants' self-reporting of the UBCNE and the use of only one school and degree program of nursing. For future recommendations, the authors suggested using several

schools of associate and baccalaureate degrees. Overall, the UBSNE has the potential to help educators and nurse managers develop interventions to improve relationships and provide quality of care (Anthony et al., 2014).

The Psychological Empowerment Instrument for Brazilian nurses (PEI-Br) consisted of 12 items to measure the psychological empowerment in the work environment (Schumaher, Milani & Alexandre, 2019). The study included 219 Brazilian nurses and used factor analysis to evaluate the instrument's validity. The study concluded that the PEI-BR was reliable and can be used appropriately to assess nurses' psychological empowerment level (Schumaher, Milani & Alexandre, 2019).

The Workplace Incivility Survey (WIS) was created by Cortina, Magley, Williams, and Langhout (2001) to measure workplace incivility. The WIS was an instrument used to examine the incidence, targets, instigators, and incivility impact in 1,180 employees. The critical component of the WIS was to measure the frequency of incivility as "disrespectful, rude, or condescending behaviors from superiors and coworkers" in the last five years (Cortina et al., 2001, p 68). More details about the WIS are found in Chapter Three.

The Reasons for Incivility and Bullying

One of the most cited reasons for the occurrence of incivilities is resistance to change (Clark, 2013)."The cause and purpose of the perpetrator's behavior are typically unclear as some incivility is unintentional, the result of ignorance or oversight on the part of the instigator" (Marchiondo, Marchiondo, & Lasiter, 2010). Behaviors that lead to aggressive responses can be identified as personal attacks, setting a co-worker up to fail, making rude remarks, resisting change, and failing to communicate (Clark, Olender,

Kenski, & Cardoni, 2013). Examples of incivility are giving the silent treatment, micromanagement, constant criticism, treating like a child, gossip, exclusion, intimidation, patronizing behavior, belittling others' work, and taking credit for others' work (Peters, 2014; Wright & Hill, 2015).

The role of digital technology also plays a role in incivility and bullying behaviors, such as emails taken out of context. If emails are taken out of context or if the response is immediate, it illustrates that the incivility of the initial email and the way it is presented influences the civility of one's reaction, thus demonstrating the potential for incivility exchange and escalation, as described by Andersson, and Pearson (1999). Digital technology relates to 'cyberincivility,' which is defined as the "direct and indirect interpersonal violation involving disrespectful, insensitive, or disruptive behavior of an individual in an electronic environment that interferes with another person's personal, professional, or social well-being" (De Gagne, Choi, Ledbetter, Kang, & Clark, 2016). Using technology as a communication tool to "harass, intimidate, threaten, or otherwise harm others (De Gagne et al., 2016, p. 239, as cited in Hinduja & Patchin, 2010, p. 21). De Gagne et al. (2018) highlight the importance of civil online communication, also known as "cybercivility" by promoting it in health professional education prior to working in the health care field. By training cybercivility to educators, cyberincivility would be understood, and such training would "empower them to excel in their roles" (De Gagne Yamane, & Conklin, 2016, p. 138).

Needs Identified in the Literature

No studies were found that address phenomenological approaches to examine minority nurses' experiences incivility, bullying, and empowerment, nor do studies

address interventions or prevention strategies for incivility and bullying among this population. There is a need for a longitudinal study, due to possible inflated responses i.e., socially desirable attitudes and self-reporting. Also, there is a need for larger sample sizes, studies in different environments, and consideration of other roles in the work environment that could contribute to a positive impact on work engagement and promote empowerment (Ugwu, Onyishi, & Rodriguez-Sanchez, 2014; Schumaher, Milani & Alexandre, 2019).

Summary

"Civility is a code of superficial behaviors necessary to enable diverse populations to coexist in harmony, yet the enactment of civility depends upon the awareness of others informed by more meaningful social interaction" (Bannister & O'Sullivan, 2013, p. 95). Nursing incivility and bullying are concepts that are all too familiar in nursing culture. Studies estimate that approximately 80% of nurses have experienced bullying or incivility at work (Elmblad, Kodjebacheva, & Lebeck, 2014). Although the literature displays how common incivility and bullying are, scarcities exist in understanding minority nurses and their experiences. With these experiences, the question arises if any experiences of empowerment also occur? The reason to research these topics is to get the perspective and listen to minority nurses as they compare these negative and positive occurrences. Certainly, incivility and bullying are costly in multiple ways to the facility and organizations in which nurses of minority work, but these experiences are also personal and could determine if they will stay at their employers or leave. The repercussions and the aftermath result in issues with employee retention, additional costs, and a bad reputation for the institution.

Considering the body of literature on incivility, bullying, and empowerment in nursing, it is evident that it lacks a focus on minority nurses. The concept of incivility appears synonymous with bullying in the research, as the literature evolved from describing incivility as "subtle" to bullying, which is much more aggressive if the incidence of the first uncivil act was not stopped. The literature on empowerment lacks the inclusion of minority nurses, other than in the small percentage listed in the literature's demographic. The paucity of extant literature supports the need for the study in order to understand the experiences of minority nurses.

CHAPTER THREE: METHODS

This study aimed to answer the question: how do nurses with minority representation in healthcare experience incivility and bullying versus empowerment in the workplace? A significant part of answering this question involves discovering what these concepts mean to them. Due to the study's primary focus on the lived experiences of the study participants, a phenomenological study was considered the most logical to answer the research question. The objective of the study was to focus on what participants had in common, which were their shared, lived experiences (Creswell, 1998).

The purpose of this study was to explore how nurses who represent minorities share their lived experiences of incivility and bullying in comparison to empowerment in the workplace. The research questions were:

- How do minority nurses describe or explain their experiences with incivility and bullying in the workplace?

- How do nurses with minority representation experience empowerment in the workplace?

Research Design

To answer the research questions, a descriptive phenomenological method was chosen as the best qualitative design to study the human experience of nurse incivility, bullying, and empowerment in the workplace. The phenomenology allowed the raw perceptions of the minority nurses to be observed. To remain true to the methodology, I tried to remain unbiased, and bracketed the experience to look objectively at the information the participants were giving. I employed a descriptive phenomenological approach using Colaizzi's (1978) method for data analysis.

Qualitative research is defined as "the understanding of how people interpret their experiences, construct their worlds, and what meaning they attribute to their experiences" (Merriam, & Tisdell, 2016, p. 6). Qualitative methods encompass four characteristics. The first characteristic is the analysis of forms of data, from verbal expression and a natural language that goes beyond assumptions or beliefs a researcher might have before the data were collected, and which produces new thoughts, theories, and understanding of the phenomenon (Levitt, 2020). The second characteristic involves developing an initial meaning of the analyzed data, and then through re-examination, new data and understanding may develop (Levitt, 2020). The third characteristic involves the qualitative researcher clarifying the time, place, culture, and the dynamics so other researchers can apply the findings to their research (Levitt, 2020). The fourth characteristic of qualitative methods involves my interpretation of the data. Engagement in self-reflection was a necessary part of interpretation of the data. I examined my perceptions of the data, and how they might influence the research. I was cautious, so as to not unduly influence the outcome of the study (Levitt, 2020).

Phenomenology

Phenomenology is the study of consciousness from the perspective of human participants and their experiences. In descriptive phenomenology, the structure has a psychological component, which is the focus, and the objective is to describe the psychological structures involved in a phenomenon from the perspective of the individual experiencing it (Giorgi, 2012). Based on Husserl's philosophical work, phenomenology is understanding the participants' lived experiences (Chan, Fung, & Chien, 2013). Phenomenology was an ideal method to explore the experiences of incivility, bullying,

and empowerment in the minority nurse population because, as a "research method, the processes are rigorous and systematic, and provide insights that contribute to conceptual clarity and theoretical thinking" (Chinn & Kramer, 2015, p. 221). The focus is on the "appearance of things opposed to the things themselves" (McEwen & Willis, 2014). *Understanding* was the goal of this methodology to recognize the connection between the participants' perspectives and experiences (McEwen & Wills, 2014).

The descriptive phenomenological method was selected from among alternatives to understand the perceptions of minority nurses and their experiences of incivility, bullying, and empowerment in the workplace. Clark and Springer's (2007) research illustrated the suitability of this methodology. By using phenomenology to examine students' perceptions of faculty incivility, three main themes were identified: faculty incivility as demeaning and belittling, unfair treatment of students and subjectivity, and pressuring the students to conform to unreasonable faculty demands (Clark & Springer, 2007). Students expressed feeling powerless to address the problems and identified abuse of power and faculty arrogance as central factors of nursing faculty incivility. The study was valuable for its implications in nursing as there are not many phenomenological studies on incivility and bullying in nursing. It was important to ask the nurses to tell their story of any instance in which they encountered incivility and bullying in the last five years per the WIS, to provide current experiences. By using a descriptive phenomenology, I can account for the phenomenon via the person's description (Englander, 2012).

Bracketing

A reduction or bracketing is an important component of descriptive phenomenology. In phenomenology, I focused on the practice or "Epoche" (Husserl, 1930; Giorgi, 2009), or bracketing, by putting away previous notions or a priori assumptions while conducting the research. Bracketing is used in descriptive phenomenology as a way for me to "bracket" my own experiences so that I didn't "influence the participant's understanding of the phenomenon" (Chan, Fung, & Chien, 2013, p. 1). Using descriptive phenomenology, I described the phenomenon under study and bracketed my biases (Reiners, 2012).

As part of the data analysis using Colaizzi's (1978) seven-step method, to flesh out the essence of incivility phenomena, bracketing is a crucial part of the process before and during the data collection, as well as during and after analysis. I chose the Colaizzi method because of the use of bracketing bias and the follow-up with the participants to confirm accuracy of the transcribed data. My bias was revealed in the "role of the researcher" in Chapter One in relation to incivility, bullying, and empowerment in nursing minorities. "Based on Husserl's descriptive phenomenological philosophy the "intentionality" of the nurses' perspectives of their experiences and the researchers' bracketed engagement guided their feelings" (Reiners, 2012).

Reflexivity

Developing reflexivity involved becoming more self-aware while listening. By bracketing bias and personal experience, I was able to keep open awareness, for the sake of phenomenological inquiry, and provided therapeutic listening (Lee & Prior, 2013). Colaizzi (1978) stated that without a little personal interest on the part of the researcher,

the study may never by started or completed. Reflecting on my role as the researcher, past experiences growing up in a multicultural family and in a rural area not exposed to various ethnicities were examined as a possible bias to bracket in this study. I also bracketed the personal experiences I had as a registered nurse involving incivility and bullying. These experiences and associated feelings were kept in short notes and in audible form in order to keep the essence of the phenomenon free from influencing the study.

To lay out the process used in this study, I used bracketing, by way of reflexivity. Beginning with using subjective awareness, I attempted to put aside personal experiences, feelings, and preconceptions (Ahern, 1999). Through reflexive journaling and recording my voice and listening to audibles of my dictation, I was recording my examination of values and interests that may have impinged on the research (Porter, 1993 as cited in Ahern, 1999, p. 408). According to Ahern (1999), p. 408-409, the author labels the process that would enhance reflexivity and my ability to bracket: identify interests, personal issues, and assumptions in the undertaking of the study; clarify personal values and acknowledge areas that are subjective; identify potential role conflict; identify gatekeepers' interests to maintain neutrality (in this study gatekeepers were my dissertation committee); recognize feelings that indicate lack of neutrality, such as seeking feelings that feel good or avoiding feelings that feel bad; if recognized, then revisit reflexive notes and recordings to gain insight of the feelings; identify new or surprising data in the collection or analysis; compare the data collection and analysis with the dissertation committee; identify blocks in the research process and reframe them; reflect on the study and process, questioning fairness of participant reporting, and if there

is a bias or agreement leaning toward one participant or others that may skew the reporting (Ahern, 1999, p. 408-409).

Based on the scarcity in the literature about incivility, bullying, and empowerment experiences by minority nurses, a descriptive phenomenological questioning was used to invite the participants to speak and tell their stories, using an interview guide to keep the interview on track. Prompting was used for the participants to elaborate or to start and end the interview. As part of the purposive sampling for the study, the participants already had a definition of incivility given prior to the WIS to screen for incivility experiences in the workplace and had volunteered and consented to the study. Hence, the participants knew before the interview what incivility was. In Appendix K: Semi-structured Interview Questions served as an interview guide.

Protection of Human Subjects

The University of Missouri-St. Louis Institutional Review Board (IRB) reviewed and approved the research study prior to data collection, signifying that criterion for the protection of the human participants was met and followed federal regulations (Appendix F). Participants were informed to bring any concerns about rights as research subjects to the chair of the Institutional Review Board at the University of Missouri-St. Louis. Informed consent was obtained from each participant. Full disclosure and comprehensive explanation of the purpose of the study was stated in an email letter to the prospects. The letter also informed participants of confidentiality in reporting, disclosing data, and the option to be removed from the research prior to submitting the survey.

Risks

Risk associated with this research included discomfort sharing experiences of incivility and bullying in the workplace. There could have been subjective discomfort in sharing personal and sensitive information. If participants became significantly uncomfortable with being interviewed, they could elect to stop participating in the study at any time. There was a potential for a breach of confidentiality using email or other researchers reading or viewing the recordings. Confidentiality was strictly maintained during and after the study, and participants were informed they would remain anonymous during and after the study concludes. Deciding not to participate or choosing to leave the project prior to completion would not result in any penalties.

The nursing associations, University of Missouri-St. Louis, and I as the researcher are committed to maintaining strict confidentiality and anonymity. Study approval was acquired from the University of Missouri-St. Louis and the nursing associations. The survey and its results would not reveal any personal information that could be traced to the participant and/or location. Results of the survey were transferred directly to a digital spreadsheet to compile answers and questions. All survey information and data related to answers are stored on a computer in a locked office. The data was used solely for educational purposes to benefit nurses. There was a dissertation paper written at the conclusion of the study in fulfillment for my doctoral degree.

Participants were told that I would do everything I could do to protect privacy. All interviews recorded through participant choice of face-to-face, Zoom, Skype, or cell phone were kept confidential on my password-protected computer. The interviews were transcribed, and participants were given alphabetical pseudonyms of random female

names before the data analysis to protect personal identity. Any information in the recordings or videos was kept on a password-protected computer.

During transcription, names were replaced with alphabetical pseudonym corresponding with the number of participant before the analytic committee viewed the transcription. Data includes emails, correspondence, phone numbers, recordings, and files; all was preserved in locked storage and under a password-protected computer. An email address not linked to the participant's organization or association address was requested at the end of the WIS to provide confidentiality and anonymity in correspondence.

As part of this effort, participant identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to the disclosure of participant data as well as any other information collected by me.

Participation in this doctoral study was voluntary. Participants were instructed that they have the right not to participate or to leave the study at any time. Deciding not to participate or choosing to leave the study prior to completion would not result in any penalty. No response would be retained if they decided to leave the study and confidentiality and anonymity is a priority.

Procedure

Permission was obtained to use Dr. Cortina's WIS instrument (Appendix C). Data from the initial survey was collected using SurveyMonkey Inc. (2020), an electronic web-based instrument. SurveyMonkey Inc. (2020), offers the services of anonymous data

collection and secure servers. All emails were sent by me after the nursing association or organization gave permission to send the email, and other means of recruitment consisted of using social media for potential participants. The email introduced the study and gave my contact information. Qualtrics Survey Software (Qualtrics, Provo, UT, 2019) was used for the initial consent for the respondent to agree to take the survey. The Qualtrics Survey Software link was sent via email with the introduction letter. The SurveyMonkey Inc. link was embedded in the Qualtrics Survey Software consent. If participation was desired, the participant was given instructions to click on the survey link and complete the survey. By clicking on the link, they consented by clicking "Yes" or "No" to participate in the survey for demographics and the Workplace Incivility Survey.

An email describing the study and request to participate was sent to organizations such as hospitals, clinics, and nursing programs and associations in the United States. A snowballing method was also used to recruit participants by word of mouth and emails provided link to the survey that was distributed to potential subjects, who then volunteered for the study and contacted me.

Social media was used as another recruitment tool using the word of mouth to create interest in the study. Media such as Facebook, LinkedIn, Tumblr, and Twitter reaching out to over 50 potential minority nurse participants. The process followed the same format if there was interest by a volunteer participant; the respondent was then sent the same email explaining the survey and interview process. Out of all of the organizations and associations, the Arizona Nursing Association, Asian American/Pacific Islander Nurses Association, Association of Medical Professionals with Hearing Losses, Black Nurses Rock (chapters), Chi Eta Phi Sorority, Inc. (and its chapters/regions),

International Society of Psychiatric and Mental Health Nurses, Native American Nurses Association of Arizona, Organization for Associate Degree Nursing, and Philippine Nurses Association of America agreed to post to their members. In some of the large associations, their chapters sent the study to their members or posted in their newsletter, while several organizations and associations did not respond to emails or voicemails. See Appendix N for a list of Organizations and Associations of Nursing contacted for the study.

After careful consideration and lack of responses to the study, it was decided to offer an incentive for completion of the interview portion of the study. A modification was approved from the IRB to allow for the addition of the incentive. An offer for a $20 e-gift card was included in the introductory email in reciprocation of a completed interview. Once the written consent and interview was completed, the participant was sent the $20 e-gift card by me via their email address submitted in the initial survey, as a contact for the interview written consent. The e-gift card was also sent to all participants who had already participated in the study. The anticipated benefits for participants were to help nurses improve the workplace for minority registered nurses and provide education, knowledge, and give a voice to minority nurses based on their experiences of incivility, bullying, and empowerment in the workplace.

After approval by selected organizations and associations, the initial email and survey were sent out to potential participants. In schools of nursing, email addresses could be obtained directly from the posted directory on their organization's websites and emails were sent to directors of the schools to forward to faculty representing minorities. The demographic data (Appendix E) was collected first, followed by the WIS.

Respondents were also made aware they could discontinue participation in the survey at any time before submitting the survey. After the survey was completed, the respondents who were identified as positive for incivility in the workplace, by scoring four and above on the WIS, were sent an invitation to arrange an interview through personal contact. The respondents were able to self-schedule a date and time for the interview. The interviews were semi-structured, individual interviews, lasting approximately up to an hour. The respondents were given an option to choose the style of interview and how the recorded interviews were individually conducted (via Skype or Zoom conferences, cell phone conversations, cell phone texting, email, or letters through the United States Postal Service). After the interviews were completed, the audio recorded and documented interviews were transcribed, anonymized, and content was analyzed by the members of the Data Analysis team and me, which consisted of the dissertation committee members and graduate students.

The following guidelines were sent to the participants to outline the steps of the study.

Steps for the Study:

It was planned that the study would be conducted within a two-week time period as follows:

1. Participant would receive an initial letter of invitation to the study.

2. At the end of the letter, a link to a 10-minute demographic and Workplace Incivility Survey (WIS) was attached. By clicking on the consent link, the participant consented to take the survey, and this was explained in the invitation letter and listed at the top of the survey. The survey was used as a screener to test participants for workplace incivility.

3.   If the participant tested positive for incivility in the workplace, he/she was contacted by the email that was submitted in the survey for contact. In the survey it was recommended to not use an employer or facility email. After personal contact through email a one-hour interview was arranged at the participant's convenience, and a signed consent form to participate in the study provided the researcher with permission to proceed.

4.   The date, time, and kind of interview were selected per participant preference (participants selected choices in the first survey of face-to-face, Skype, Zoom, cell phone, cell phone texting, email, or by the United States Postal Service mail for the interview). Face-to-face, Skype, Zoom, or cell phone interviews were recorded or videotaped for transcription purposes for the study.

5.   After the written consent and interview was completed, a monetary $20 e-gift card was sent to the provided email address for completing the interview.

6.   The last contact was through email with the conclusion of the study. As part of the data analysis method, the participant was offered the chance to confirm the transcription and conclusion of the study.

7.   All emails and interviews recorded audio or videos are stored per IRB regulations in case of audit. Any information in the recordings or video will be kept on a password-protected computer by the Principal Researcher until the time period is complete. After five years, the participant's information, recordings, or videos will be deleted. During transcription, the Principal

Researcher gave each participant a pseudonym such as "Respondent one" and "Respondent two," and so forth before the analytic committee viewed the transcription.

8. Participants were informed that if they were to become significantly uncomfortable with being interviewed, they could elect to stop participating in the study at any time. Additionally, I communicated that I would take every precaution to safeguard privacy, and that data was considered confidential. If participants decided to participate, they were free to withdraw at any time. There were no alternative procedures for the study.

Sampling and Sample

Population

The population screened with the WIS (Appendix D) compromised part-time and full-time minority nurses working in clinical or non-clinical environments, including academic nursing programs located in the United States. Participation was voluntary, and the survey was administered by SurveyMonkey Inc. with a link via email.

Sampling

One of the most fundamental aspects of planning the research was selecting the population through purposive sampling. Purposive sampling in phenomenological research is recommended in the book by Merriam and Tisdell (2016), *Qualitative Research: A Guide to Design and Implementation*, as this kind of sampling demonstrates that I wanted to "discover, understand, and gain insight and therefore select a sample from which the most can be learned" (Merriam & Tisdell, 2016, p. 77). Using purposive sampling, 15 participants were selected to encourage in-depth reflection of the transcripts

versus the risk of too many transcripts in which shallow reflection can occur (Van Manen, 2016). Suggestions for the number of participants for phenomenological studies include recommendations by Creswell (1998) of 5 to 25 participants and Morse (1994) of six or more.

Although qualitative studies generally look for characteristics or themes that are repetitive, in this qualitative study, using descriptive phenomenology, I looked for what was different and singular, plus relaying themes. The term 'saturation' is not part of the phenomenological method. However, respondents were added if they met the positive screening for the study as the number of participants could not be predicted based on the method used. In part, due to the limitations of the research attributed to the viral pandemic of Covid-19 affecting the world during the time of the study many nurses were working outside of their regular hours or called to work in unusual circumstances, affecting the response of participants for this study.

The inclusion criteria are delineated, and the sample was based on comparable phenomenological studies, where it was not generalizable to the greater population. Instead, the objective was to expose what could be "representative of the phenomenon of interest" (Englander, 2012). In this case, the aim was for the study to be a phenomenologically true, comprehensive description of minority nurses who described their lived experiences of incivility, bullying, and empowerment in the workplace. It is important to note that the population of minority nurses was chosen because of the small percentage of minority nurses in the field of nursing compared to the majority of White female nurses. Purposive sampling allowed participants' voices to be heard, who were either living the experience of incivility, between ranks in the workplace or had lived

with the experience in their past. The focus of phenomenology applies the dimension of the present and past experiences and gives a voice to the participants (Van Manen, 2016).

Only registered nurses representing a minority population were invited into the study. The delimitation of minorities was non-White nurses, as defined by the United States Census as minority. Demographic data were collected to determine the representation of the sample to the population. The advantage of purposive sampling was the accessibility to minority nurses, and the disadvantage was predicting a small sample of responses. The participants were active registered nurses working in the United States, who spoke English, and were over the age of 18 years of age.

Demographics

The demographics collected were gender, age, state, race/ethnicity, country of birth, English as the first language, years in current position, if they were a registered nurse, employment status, job description, years as a nurse, degree, intention to leave employer, time frame and reason, preference of interview and marital status. The survey also included the Workplace Incivility Survey (WIS) for participants to complete. Serving as a screener, the WIS determined if the participant scored a four or higher to go forward with the interview. A total of 78 participants took the initial survey, with 14 participants who were disqualified due to their ethnicity as White, not a registered nurse, or did not complete the survey and 16 who did not experience incivility. Forty-eight participants screened positive for incivility in the workplace to qualify for an interview.

Stakeholders

The findings in this research study benefits nurses at all levels, and institutions that employ them in the positions of leadership to identify, acknowledge, and negate

uncivil practices that affect minority nurses. Workplace incivility also affects the outside

stakeholders of an organization too, such as consumers or patients. The targets of the

workplace incivility may vent and display their dissatisfaction with their situation to the

consumers and complain to consumers about what occurred, or consumers may simply

observe the behavior (Gonthier, & Morrissey, 2002). Key stakeholders in this study

included individuals who work in or receive care in health care facilities such as hospitals

and the nurses who provide patient care.

Instrument

Instruments are essential tools to use in the study of incivility in nursing. For this

study, the Workplace Incivility Survey (WIS) was an instrument used to measure nurses'

personal experiences of incivility and bullying in the workplace (Cortina et al., 2013, p.

1586). In this phenomenological study, the WIS was used as a screen to determine what

nurses would be candidates for participation in the study. The WIS measured the

frequency of the participants' experiences of disrespectful, rude, or condescending

behaviors from supervisors or coworkers within the previous six months (Cortina et al.,

2001).

The WIS was created to minimize response bias and address "interpersonal

mistreatment in the workplace" (Cortina et al., 2001). In the very first study using the

WIS by Cortina et al. (2001), seven incivility items were summed into the WIS in a five-

point Likert scale format to measure the frequency of uncivil behaviors in the past five

years in the workplace. The study concluded that the WIS had an alpha coefficient of .89,

a highly reliable and cohesive instrument (Cortina et al., 2001). Results of high scores on

the WIS represent high levels of incivility.

Dr. Cortina gave permission to use the WIS on March 30, 2020 (Appendix C) for this phenomenological study. There is a revised 12-item version of the WIS available from Cortina et al. (2011), but because the original was used only as a screening tool to see if participants have experienced incivility in the workplace, the revised version was not needed.

The instrument is designed to be administered in any workplace. The questionnaire design of the instrument allowed for self-administration. The nurses were given a brief description of incivility before taking the survey as part of the email introduction (Appendix B). The introduction to incivility is to ensure the participants understood the concept of incivility before completing the survey. The demographics and WIS were completed online. Participants had two weeks to complete the electronic survey. After the survey was emailed to the participants, a reminder email was sent out at week one and week two.

Limitations of the WIS were using a single source scale with self-reporting data, which could provide the potential to drive significant results (Cortina et al., 2001). The WIS was used solely as a screen in this study to determine if the participant had experienced incivility or form of bullying by their responses and to gather initial demographic data to describe nurses of minority. Based on these criteria of revealing they were victims of incivility or bullying in the workplace, and representing the minority population of nurses, the respondents were interviewed for the study.

The Researcher as Instrument

Another instrument is that of the Principal Researcher. According to Richards and Morse (2013), in qualitative research the skills required "ensure quality and scope of

data, the interpretation of the results, and the creation of the theory" (p. 216). My skills as

a researcher are needed because I am an instrument, requiring preparation in qualitative

methods prior to beginning research (Richards & Morse, 2013). Conditions that could

affect me arise from my personal background, motives for conducting the research, and

the filters that could easily filter my understanding (Yin, 2016, p. 130). In this study a

prominent difference between the participants of the study and me is although they are all

registered nurses, the race and ethnicity do not match (Yin, 2016, p. 130). The

participants are diverse and come from different backgrounds, making them not only

different from each other, but different from me who is White. Although White, I have a

multiracial family, and as an instrument, rely on tools such as bracketing, reflexivity, and

revealing my role for transparency and self-awareness throughout the study.

Interviews

I used in-depth semi-structured, open-ended interviews conducted via participant

preference as another tool for gathering data. Options for the interview consisted of face-

to-face via Skype, Zoom, cellular phone, email, cellular phone text, or USPS mail, and

the interview was recorded or documented based on the participant's preference. The

interview preference and open-ended questions allowed multiple options for responding

(Creswell & Plano Clark, 2011). An interview guide was used while conducting a

qualitative interview and included prompts or reminders for the interviewer but was not a

strict or formal process; see Appendix K (Yin, 2016).

The interviews were per individual choice of style, including Skype or Zoom

conferences, cell phone conversations, cell phone texting, email, or letters through the

United States Postal Service (USPS). Several of the 15 final participants changed their

minds about their preference of style of the interview during the study, but in the end, there were seven completed by email, two by cell phone, and six by Zoom. The 15 final participants were recruited over a period of 10 weeks through nursing associations, organizations, social media, and word of mouth. I used the interview guide, and a transcript was made using Otter. ai Service. I reviewed the written transcripts for accuracy by comparing to the recorded interviews.

Initial analysis

The steps in the analysis were followed closely. The process of data analysis involved reading, re-reading, listening, re-listening, taking notes, and transcribing notes to assist with visual themes and themes that emerged from the interviews. Another method I used was to record my voice in an audible form while reading the interview, as to listen to it repeatedly for significant statements from the transcripts that causally related to the phenomenon. The meanings were formulated out of each statement and constant reference to the original transcript to stay true to what was revealed. Interpretations and delivery of the transcribed interviews were discussed with the data analysis committee, which consisted of the dissertation committee and three graduate students. The committee met once to twice weekly to discuss the data gathered from the interviews.

After clusters and themes were developed, they were validated with the original transcript several times to look for repeated cycles and conclusions for the report. The results were gathered together with the results of the data analysis, given to participants to review, to assure that it represents their experience, and as a measure of validity and credibility of the research findings (Colaizzi, 1978).

Data Analysis

The framework for the data analysis described the perceptions and the respondents' life experiences of incivility, bullying, and empowerment. Verbatim transcripts from the interviews were uploaded onto a qualitative software analysis program called MAXQDA 2020 (VERBI Software, 2019). This computer software program offers the ability to organize and label the transcribed sections for the data analysis committee to review. I looked for themes that emerged from the data using Colaizzi's Seven-Step Method. Essentially, themes were gathered by grouping like words, feelings, and statements together. The themes were identified and described meaningfully with each transcript from each interview.

Colaizzi's Seven-Step Method

The descriptive phenomenological method and analysis procedure was used to analyze the study data as described by Colaizzi, (1978) and Giorgi (1985). For data analysis, Colaizzi's seven-step descriptive phenomenological method was used. This method was chosen because of its rigor in phenomenological studies. Using interviews as data sources, a descriptive phenomenology was used to identify empowerment attributes and negative attributes to the circumstances as identified by the participant. Using phenomenology to explore the lived experiences of the participants in this study established a foundation to explore the experience of empowerment and negativity experienced by self or peers.

Colaizzi's method was appealing because by using descriptive phenomenology, the "concern is revealing the 'essence' or 'essential structure' of the phenomenon under investigation (Morrow, Rodriguez, & King, 2015). Using the descriptive phenomenology

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method involves asking people to describe situations instead of creating a scenario in a laboratory to test a situation (Yin, 2016; Giorgi, 1985). The goal of phenomenology is to understand the meaning the conscious individual has developed from their experience (Willis, 2007).

Step One

The first step in Colaizzi's descriptive phenomenological method was familiarization with the data. For this study, reading the interviews, then typing the interview transcripts assisted me in becoming familiar with participants' recall of their experiences. I also recorded the interviews by email with my own voice to re-listen to the transcript over and over. Besides becoming familiar with the data from the interviews, it was important to recognize the flexible scheduling and semi-structured interviews as a way to gather the data. As the interviewer, I allowed context-sensitivity and conversational flexibility for the semi-structured questions (Denzin & Lincoln, 2018). The semi-structured questioning allowed the participant to divulge their experience and the "essence" they wanted to get across.

My understanding of the interviewing and analysis phases was that they were not to get to know the person, but to become more familiar with the phenomena. I interviewed each person to gain a description of their lived experience, and I found this to be an important distinction while working with the information for analysis. In phenomenological research, the participant is important, but the phenomena described are just as important (Englander, 2016).

Step Two

In step two, I identified all statements in the accounts that were of direct relevance to the phenomenon (empowerment and negativity) during and after their traumatic event. In this step, the significant statements were identified relating to the inquiry in the research questions. The style of the interview allowed the participant to elaborate on the interview questions and facilitated the telling of the story in an unstructured way. After the participant's story was told, I expanded on some of the points the participant made in the interview as a confirmation; in this way, the statements made by the participant pertain directly to the main phenomenon.

Step Three

The meanings relevant to the phenomenon of empowerment and negativity, during and after a traumatic event, were highlighted. In this step, I completed "bracketing" to reflect and prevent bias in the identification and formulation of meanings in the data. Bracketing was defined by Yin (2016), as "trying to set aside the researcher's beliefs, values, predispositions, and prior assumptions in designing, conducting, and analyzing a qualitative study" (p. 333). Bracketing was completed prior to the study by listing my assumptions before the interviews were completed and during the process of data analysis as a criterion in Colaizzi's seven-step method. I tried to use bracketing to reduce bias. Reducing bias is referred to by other researchers as forgoing rigid ideas about objectivity, retaining rigor, and controlling bias in qualitative research (Denzin & Lincoln, 2018; Cohen, Kahn, & Steeves, 2000).

Step Four

In step four, I put the identified meanings into themes that were most common in the interview. The themes identified in the interview as *sentiments* were positive or negative feelings identified in the interviews and common words used throughout the interviews. These sentiments or feelings were relevant to the phenomenon of identifying positive and negative references in the script. This fourth step required grouping the participants' feelings and reformulating statements into thematic clusters. This process of clustering the statements, displayed the feelings and character of the participant in their recount of their experience. The formulated meanings were then placed into themes and were identified.

Steps Five

Step five began by developing an exhaustive description that was full and inclusive of the phenomena, and included all themes captured in step four (Morrow et al., 2018). In step five, the sentiments and the display of emotion create the rich story told by the participant. Detailed descriptions were written including statements, formulated meanings, and themes. The themes and interpretations were supported by the raw data from the interviews of the participants, following the descriptive explanation of the findings from the interviews.

Step Six

Step six produces the fundamental structure that condenses the material to a shorter statement that captures the aspects of the phenomena (Morrow et al., 2018). The detailed description of what occurred was written into a narrative that identified the

phenomenon investigated. This step was validated by a member of the data analysis group for the study and colleagues who have experience in phenomenological research.

Step Seven

The final step in Colaizzi's seven-step descriptive phenomenological method was to seek verification of the fundamental structure to see if it captured the participant experience (Morrow et al., 2015). By seeking verification, it means to return to the participants for verification. Much deliberation was involved between Colaizzi's method and author Giorgi (2006), who argued Colaizzi's method as meaning "the researcher and participant inevitably have different perspectives." I as the researcher was using the phenomenological method and the participant perspective, who through pure phenomenology, has a "natural attitude" (Giorgi, 2006). Step seven involves "member checking" in which I reconnected with the participants and requested them to validate the findings. Three participants responded to the member checking query and did not request or offer any changes to the findings or transcription excerpts. The third participant did not offer any changes to the findings or transcription excerpts but gave an overview of her thought about the findings. Her contributions about the findings are included in Chapter Four.

Limitations

The response rate was predicted to be small due to the pandemic of the virus Covid-19 2020. The unusual circumstances surrounding the healthcare field that had a direct impact on nurses were predicted to lead to a lack of responses to the study. Nurses were called away from their normal specialties, were working odd hours and shifts, and

might not have the time or even the desire to participate in a research study during the crisis.

Another consideration for lack of response rate was due to the Black Lives Matter protests in reaction to the murder of George Floyd on May 5th, 2020, a Black man who was murdered by a police officer and several accomplice police officers while being filmed in public. One response by a potential candidate stated she was too tired from working with Covid-19 patients and protesting. and another responded she was too stressed out to participate at this time. It is fair to mention that both potential participants were not of Black ethnicity, but of other minorities. Another participant who participated in the survey but did not complete the survey replied that she did not complete the survey because she had been retired for more than 15 years, but thought the study was especially important, and she wanted to contribute. The Workplace Incivility Survey which was used as a screen for experiences of incivility, had the requirement for inclusion of experiences in the last five years.

Both history-making events, the Covid-19 pandemic and protesting, impacted potential minority nurses in unknown ways. All ways of recruitment were utilized and diligently pursued to attempt to get volunteers for the study. Recruitment was through social media, organizations, and associations of nursing and word of mouth. Obstacles consisted of financial and time constraints; when organizations and associations replied, most of them required a substantial fee to post the recruitment letter and survey in various lengths of times, one week to three months based on when their newsletters were released. Others posted for free and supported the study.

The data collection using a self-report method was considered a limitation; the instrument WIS was used to screen potential participants for voluntary participation (Clark et al., 2015). The self-reporting could be skewed based on the biases the participants may have had from other experiences outside of what was to be considered incivility, bullying, and empowerment in the workplace. As an example, within the different areas of nursing, in academia, the student involvement with nurse faculty may contribute to other kinds of incivility, such as faculty-to-faculty discourse and communication. Another issue with self-reporting was that reporting of incivility and bullying could be based on one incident or multiple as recorded by several nurses located in the same institution, resulting in a skewed view of what occurred (Clark et al., 2015).

There were few studies that addressed "fear of retaliation," revenge, or the use of the responses from the studies to track faculty responses and reporting back to their institution (Casale, 2017, p. 180). The contradictory focal point of this limitation for fear of retaliation was unique to the response that incivility has on nurse-to-nurse relationships, incautiousness filling out surveys on incivility, because of incivility and retaliation from other faculty or leadership.

Previous research on incivility focused on single sites for data collection; this was a limitation because participants tended to have similar experiences. For example, in the academic setting, most research uses only one or two academic institutions and not enough diversity of faculty (Lasiter, Marchiondo, & Marchiondo, 2012; Del Prato, 2013; Clark et al., 2015). Although the diversity aspect of this phenomenological study directly answered the diversity question, and the small sample served the method of the study, the

number of participants and institutions needs to be broadened in future qualitative studies.

After reaching out to the participants who took the initial demographic and WIS survey, the participants were asked if they would reply as to the reason for not participating in the interview and were reassured it was for research purposes with the consent still applying for confidentiality and anonymity. A limited amount of literature exists, focused on minority nurses' perceptions of incivility, bullying, and empowerment. Further research is needed based on the limitations and potential impact on nurses of minority.

Summary

Chapter Three described the process for obtaining IRB approval and safeguarding participant confidentiality and anonymity in the study. I discussed the research methodology used in this qualitative study, which is a descriptive phenomenological research design. I included information on the data collection processes, as well as data analyses, which included identifying themes from answers of minority nurses who have experienced incivility, bullying, and empowerment in the workplace.

The population and sample for the research were identified, and the data collection process and research instruments were explained. Suggestions for future research would necessitate interviewing more minority nurses. By interviewing more participants, more themes may emerge by gathering additional experiences. Another possibility is to extend the research to add another minority in the nursing field such as Caucasian male nurses, because they also make up only a small percentage of nurses in comparison to Caucasian females that dominate the profession.

A suggestion to use a mixed method approach could identify specific resources or tools nurses could use to develop interventions and promote empowerment in the workplace. Another suggestion for further research is to use a grounded theory method to explore how this population of nurses cope with incivility and bullying over time, extending the history of the experience of the minority nurse throughout their career. Information resulting from further research may expose features in different environments that would tamper down incivility and bullying and increase the possibilities for empowering nurses.

In the next chapter, I provide the results of my research findings and analysis of 15 interviews with current minority nurses experiencing incivility, bullying and empowerment in the work environment.

CHAPTER FOUR: RESULTS

This chapter presents my research findings and analysis of the 15 interviews with currently employed minority nurses, with the word minority defined by the United States census as non-White. This study addresses minority nurses' experiences to bring their voices to the forefront by documenting their exposure to incivility, and bullying in the workplace, then comparing each of these phenomena to their empowerment experiences. As each participant shared their unique story, knowledge emerged in themes (Denzin & Lincoln, 2018, p. 222) and they appeared progressively from the interviews and data analysis through the use of Colaizzi's (1978) seven-step method. The findings exposed significant implications for nursing from a diverse sample of the minority nurse population, not only identified through their ethnicity, but also their age, position, years as a nurse, and degree.

Overview of Purpose and Questions

This study aimed to explore how nurses who are members of minority groups share their lived experiences of incivility, bullying, and empowerment in the workplace. Incivility, as defined and provided in the initial survey that screened for experienced uncivil behavior, was defined as "characteristically rude and discourteous, displaying a lack of regard for others" (Andersson & Pearson, 1999, p. 457).

The research questions guiding this study were:

- How do minority nurses describe or explain their experiences with incivility and bullying in the workplace?

- How do minority nurses experience empowerment in the workplace?

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The process of examining minority nurse experiences with incivility, bullying, and empowerment in the workplace included conducting a literature review, administering a survey, interviewing participants using a semi-structured interview guide, and analyzing the data according to a descriptive phenomenology methodology that was explained in Chapter Three. The findings were generated by identifying overarching themes pressed into each experience by the voice of the nurse.

For the purpose of the research, I identified my assumptions prior to starting the study to bring forth any preconceived notions I had before data collection. Assumptions are discussed again in Chapter Five. Throughout the Institutional Review Board (IRB) process and writing my role as the researcher, I was able to expose areas where I may have had bias, prior to the interview with the first participant. I set aside any preconceived thoughts, assumptions, and feelings, so my assumptions wouldn't shape the data collection (Hamill & Sinclair, 2010). By "setting aside" my feelings and experiences, it assisted me in identifying what was important for understanding what I believed to be true and what the participants experienced. According to Hamill and Sinclair (2010), "by bracketing the researcher does not influence the [participant] understanding of the phenomenon. Thus, it is their reality" (p. 2).

I also met with the data analysis team composed of the dissertation chair and one graduate student. The team was occasionally joined by other members of the dissertation committee and graduate students. Meetings occurred once or twice weekly to discuss each interview, go over new interviews, and help create comparative narratives.

In addition to meeting with the data analysis team, I used the computer program MAXQDA to sort the qualitative data for themes of negative and positive connotations,

to isolate the verbiage used in the description of the phenomena. This, in conjunction with the semi-structured interviews, bracketing, team data analysis, and re-examination of the interview content through Colaizzi's seven-step method, supports the rigor and validity of the study. At the end of the data collection and examination of the results, as part of Colaizzi's final step, the participants were sent the transcripts and study findings, in a procedure called member checking. Member checking "is not to 'check data' but rather continue with the analysis at a higher, more abstract position in the analysis" (Denzin & Lincoln, 2018, p. 812).

All fifteen participants were asked to provide feedback as part of step seven of Colaizzi's final step for the analysis process. Three participants replied by email in response to the request for member checking of the transcripts and conclusion of the study. Eva replied through email communication "I reviewed the attachment and found it to be accurate. Good luck as you move forward with this. You've done great work" (Eva, line 2). Molly, another participant replied, "Yes, it's correct and accurate" (Molly, lines 1-2). The third participant Francis did not give any changes either but did contribute definitions of implicit bias, microaggression, and systemic racism. Francis' replies are listed under each definition in this chapter.

Participants

The participant sample consisted of 15 minority nurses, who were given pseudonyms to protect their identity: Angela, Beatrice, Carly, Darlene, Eva, Francis, Georgia, Hailey, Inga, Jackie, Keisha, Layla, Molly, Nora, and Olivia. The names were chosen based on alphabetical order to maintain the order of interviews and were not based on any real person. The participants' ages ranged from 24-64 years in age. All 15

were female. The participants were from a wide demographic area, including states from the regions of Northwest, Pacific Northwest, Midwest, Northeastern, and North Pacific U.S. territories. They held a variety of degrees, including ASN, BSN, MSN, post-master's certificate, and a doctorate in nursing. The difference in ethnicities was important for diversity, with participants identifying as American Indian, Asian/Pacific Islander, Black or African American, and Middle Eastern.
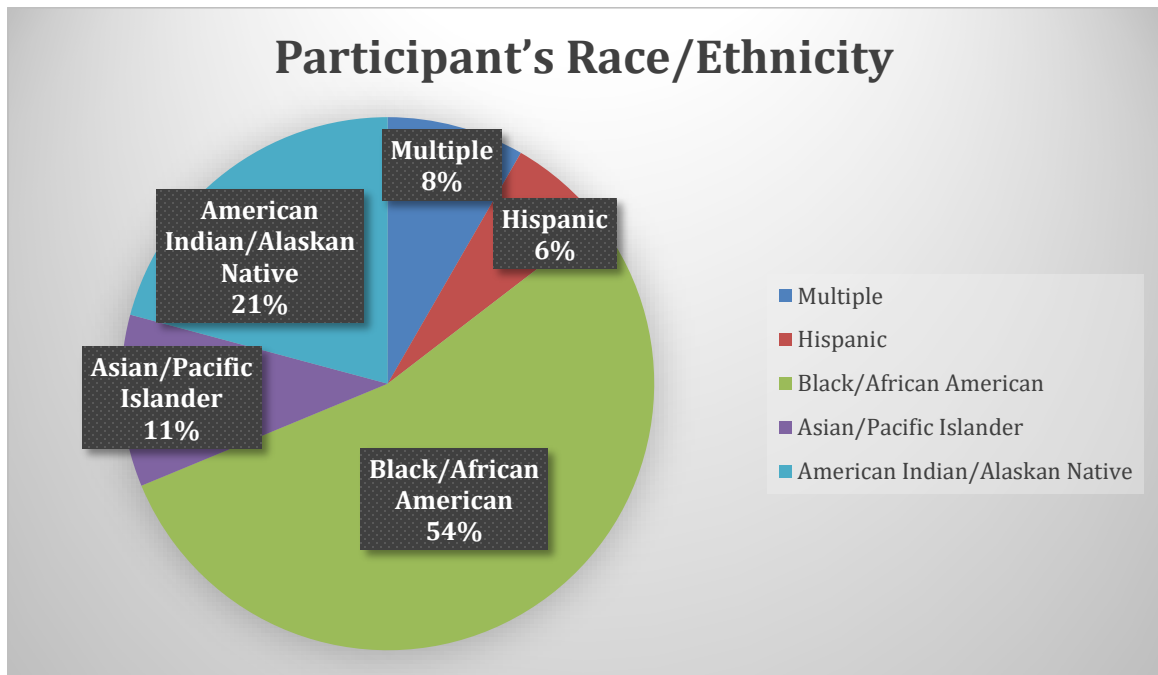
Figure 4.1: Participant Race/Ethnicity

Positions held were leadership, academic, hospital coordinators, FNP/DNP, case manager, staff nurse, and private duty nursing, with years as nurses ranging from two to fifty years, with the most common being 11 to 15 years as a nurse. There was a range of educational degree level and various specific practice settings among the sample.

Tables 4.1, 4.2, and 4.3 display characteristics of all 79 participants who took the initial demographics and/or incivility screener. The tables are divided into each group of participant who qualified, did not experience or screened negative for incivility, and those

who did not qualify. The next section of demographic survey asked the participants why they intend to leave their employer, if they choose to leave. The results proved a variety of reasons with the top reason as retirement or promotion and higher degree attained. It was discovered that the nurses did leave prior positions because of maltreatment, but most of the participants were relatively happy in their current position. The 15 interviewed nurses listed the reason for leaving their jobs as retirement (five nurses), better job/pay (two nurses), moving (two nurses), graduating with a higher degree (one nurse), promotion/growth (two nurses), different type of work (two nurses), and not leaving (two nurses). (Note that the 15 interview participants' reasons for leaving is embedded within Table 4.1).

Table 4.1

48 Qualified Participants: Time before leaving current job and reason for leaving

When leaving	Better job/pay	Different type of work	Moving	Growth	Bad Work Environment	Promotion Job/Degree	Retire	Not leaving
0-3mths		1			1	1	1	1
4-6mths	1	1	1					
7-12mths	1	1			1			
1-3yrs	4		4		2	3	4	
4-6yrs			1	2			3	
7-10yrs							2	2
10-15yrs							2	
16-20yrs							4	
21yrs+							1	3

Table 4.2

17 Participants Who Did Not Experience Incivility: Time before leaving current job and reason for leaving

When leaving	Better job/pay	Different type of work	Moving	Growth	Bad Work Environment	Promotion Job/Degree	Retire	Not leaving
0-3mths								
4-6mths						1	1	
7-12mths					1			
1-3yrs	1				1	1	2	
4-6yrs	1							1
7-10yrs								1
10-15yrs								
16-20yrs							1	
21yrs+							3	2

Table 4.3

14 Participants Who Did Not Qualify for the Study: Time before leaving current job and reason for leaving

When leaving	Better job/pay	Different type of work	Moving	Growth	Bad Work Environment	Promotion Job/Degree	Retire	Not leaving
0-3mths				1			1	
4-6mths								
7-12mths								
1-3yrs	1				1	1	1	
4-6yrs			1			2	1	
7-10yrs							1	
10-15yrs								1
16-20yrs								
21yrs+	1							1

A total of 48 qualified participants took initial surveys remotely or online. The interviews were per the participant's choice of style, including Skype or Zoom conferences, cell phone conversations, cell phone texting, email, or letters through the United States Postal Service (USPS). Several of the 15 final participants changed their minds about their preference of style of the interview during the study, but in the end, there were seven completed by email, two by cell phone, and six by Zoom. The 15 final participants were recruited over a period of 10 weeks through nursing associations, organizations, social media, and word of mouth.

Overarching Themes

Using Colaizzi's method, five overarching themes surfaced: *I Am Valued and Enough, Oppression Beyond My Control*, *"Mean Girl" Culture in Nursing, Resilience in the Face of Incivility and Bullying*, and *Taking Control with Empowerment: What Organizations and Nurses Can Do*. The findings support how individuals understood, reacted, and lived through their experiences, with some participants using the term *survive* as a description of making it through. Georgia stated, "There's a lot to be learned from negative experiences, if you survive them" (Georgia, line 30). Participants

expressed strong emotions during the interview process, and my goal was to relay how powerful and influential these experiences were on these individuals. A lot of strong emotions, long pauses, and careful consideration went into what they said and how they would respond to the questions for this study. The few experiences they shared are just the tip of the iceberg in comparison to what they experience daily, and the few examples they presented display what they have endured in their careers as nurses. There was no restraint and no shortage of bravery in sharing their lived experiences. Jackie eloquently stated this as she cried, "The reality is that if you speak up, you could ruin your career and there are already not a lot of us anyway" (Jackie, line 19:26-19:33).

Labels and Identifiers

The themes were not always labeled and, in most cases, occurred without the participants identifying their experiences as such. As an example, the word "oppression" was not labeled by the participants; however, Paulo Freire (1971) stated a simple reason for oppressed group behaviors is that dominated people feel undervalued in a culture where the mighty raise their attributes as the valued ones. Oppressed behavior is frequently found in nurses and is related to decreased nurse self-advocacy and negative aspects of the workplace environment (Roberts, DeMarco, & Griffin, 2009). These explanations support the terminology utilized by the participants in the study.

Participants were exposed to the definition of incivility, as stated in the initial survey, to ensure they knew what incivility was prior to taking the survey, along with the specific survey questions. The aim of the question "What is your understanding of incivility and bullying in the workplace?" was to ensure the participant was going into the interview with their interpretation stated at the beginning. Table 4.5 in Appendix A

displays each participant's response to question one, to identify their interpretation of what incivility and bullying in the workplace is.

I Am Valued and Enough

The first theme that quickly became the most commonly used words and feelings throughout the participants interviews were the words *value* and *enough*. The participants in this study shared their experiences of incivility and bullying behaviors, stressing that they feel devalued and never enough. Viewing their interpretation and understanding of incivility and bullying in the workplace allows an examination of what they have lived through. What nurses ideally should do for one another, and what really happens, are the opposite.

Participants shared examples of their lack of value and worth. Angela stated, "I shouldn't have to prove to my peers that I am enough and that I do a good job" (Angela, line 35). Darlene stated, "I don't feel valued. I am being humiliated and I am being pushed to resign or to be fired. These behaviors also can negatively affect my work performance, as this is stressful" (Darlene, line 14). She also referenced that under the current system in her workplace unless you participate in committees and take on several roles, "if you don't participate or your participation is not valued or welcomed…it is going to look like you don't deserve certain promotions or titles" (Darlene, line 40).

Carly expressed her feelings when in the workplace administrators did not support faculty in their time of need as "betrayed, not good enough, inadequate" (Carly, lines 21-22). Hailey stated in reference to telling other minority nurses if they were bullied, "Don't ever let anyone try to tell you you're not good enough or define who you are" (Hailey, line 28:09).

Oppression Beyond My Control

The second theme was not as evident, and the word *oppression* was not verbalized, but throughout the interviews, the participants repeatedly voiced they were denied acknowledgment, promotion, given a raise, praised, or awarded. Darlene recommended, "If you don't get promotions…and you are passed on certain roles or titles, don't despair and try to take some training, or certifications and look for other places that will recognize your value" (Darlene, line 36). Another participant stated, in response to what organizations can do to stop systemic racism, "Treat everybody the same…for job positions, opportunities, and raises…things need to change" (Molly, lines 25:50-26:14).

Participants also reported they worked nights because minorities tend to work nights to stay away from the day shift administrators and managers. Hailey stated, "All of the jobs that I've had as a young nurse, all the way to now unfortunately, I have been the only minority, meaning that I have only been one in a few unless you work midnights and that's where all of the color, women of Color work" (Hailey, lines 24:04-24:21). Olivia also supported this statement "Minority staff all work nights to avoid harassment by management" (Olivia, line 4).

Others indicated power or lack of power to make decisions, as Inga stated, "I feel as if I don't have any power" (Inga, line 9). When Inga was asked how she felt when she was bullied and what advice she would give others, she stated, "I wouldn't have much to say. I feel defeated. I am truly tired of fighting for equality that should be already established" (Inga, line 19). Another way oppression presents itself in the interviews are ideas by the participants presented in the workplace that are not heard: "Situations in

which I am not, my ideas are not heard, or my ideas are rejected until someone else presents the idea and then it's accepted and so it's very disheartening and frustrating in a leadership role, because it causes you to feel like people are trying to hold you down" (Keisha, lines 07:12-07:35).

Keisha recalled a significant account of bullying which displays oppression and humiliation. "In front of physicians and administrators at a manager meeting we were sitting at round tables…with probably 100 managers there…the walls were TV screens that were showing images of what the presentation was, where I mean were 'huge.'" Keisha was sitting by a man who was an administrator, and he asked the presenter a question. The presenter said to him, 'Um, did you not see the question? and he goes, 'Oh yeah, I just had trouble seeing over this lady's lovely hairdo.'" Keisha described this as making her feel very bullied, and she wanted to leave. People around her said, "I'm so sorry, I'm so sorry…but you know, I just sit there and try not to bust out crying, you know I'm in the middle of this thing with all of the hospital administrators in the room and I'm one of maybe three Black people in the room" (Keisha, lines 14:34-17:18).

Jackie reported a dialogue about racism that she has experienced with her White counterparts:

> "Racist remarks by nurses on unit-they're sick and tired of Black people talking about racism, because their grandma was Jewish, and they know what it's like and everybody has problems. Other instances were mentioned of where inappropriate conduct by White nurses playing 'gangster rap' at the nurse's station where patients could hear (Jackie, lines 08:51-09:04). Most minority nurses leave within the year" (Jackie, line 10:25).

"Mean Girl" Culture in Nursing

The third theme was labeled "mean girls culture in nursing." A few participants used this exact phrase to describe nurses who were bullying. For example, in reference to her treatment as a Black faculty member, Layla stated, "As an educator, as a Black woman, you know, sometimes I thought it was because I was Black, power being what it was, because they were just 'mean girls' you know, every job has 'mean girls'" (Layla, lines 00:45:02-00:45:25). She also gave an example of this upon reflecting on her own perception.

> "You have the way the message was given to you by the messenger, and then you had the receiver of the message, so you can have one messenger but 10 different receivers and we all were made the same, but see it in a different way, just based on life experiences and you know, those things that kind of influence our perception" (Layla, lines 00:45:36-00:45:53).

Another nurse, Jackie, also mentioned "mean girl culture." "When you have a mean girl culture in nursing or just a mean girl…when you have that type of culture in nursing, it's detrimental" (Jackie, lines 10:53-11:06). This theme "mean girl culture in nursing" became evident as participants described the work environment and typical workday. The majority of the participants reported they worked in a female-dominated environment. Nine said female-dominated, one said male-dominated, and the others were labeled as co-ed or vary based on where they worked. Another significant element of the study was that 14 out of 15 participants in the study were the only minority nurse or one of very few in their workplace and often the only one of their ethnicity.

Resilience in the Face of Incivility and Bullying

Despite the negative experiences documented in the study, participants also gave indications and reported feelings of resilience, support, defiance, self-development, and reflection as a result of their experiences. Examples of resilience are given throughout the interviews.

When asked about her feelings of being bullied, Olivia stated, "My supervisor's ignorance was not going to break me. I refused to quit until I was ready" (Olivia, line 5), and in her reply as to what her understanding of empowerment in the workplace was, she said, "Confidence in your skills and talent, so much confidence that a bully would not even try to intimidate you. You are not weak and not perceived as weak" (Olivia, line 6). A significant statement Olivia made was in response to what made her empowered: "I had the skills; I have the license and I do not need to be pushed around and I will not stand for it anymore. I turned in my notice and left four weeks later. That is was when I felt empowered" (Olivia, line 7).

Nora made interesting statements regarding how others experience bullying and empowerment. "I'd want to know what their perception was and what the situation was…a lot of it doesn't have to do with Color. It has to do with how people treat other people…and it kind of made me do a lot of self-reflection" (Nora, line 142). Georgia also took a self-reflective attitude when she worked with other minorities: "I try to examine my words, tone, and body language to see if I have done or said anything that may be perceived as offensive; if so, I apologize" (Georgia, line 11).

Jackie adopted a more aggressive response because of the recurring behaviors over the years. "You bite me, I bite back. I'm not going to put up with your crap, I don't

care who you are. You know, I think that's why I survived for four years there" (Jackie, lines 10:15-10:20).

Taking Control of Empowerment: What Can Organizations and Nurses Do?

In this study, the focus is on the lived experiences of minority nurses in regard to incivility, bullying, and empowerment. Questions about what organizations and nurses can do about empowerment and systemic racism provided an opportunity for participants to offer significant contributions, giving solutions that have the potential to move nursing forward. In Table 4.6 in Appendix A, some of the participants did not reply to the additional questions posed after their initial interview about systemic racism and what they think their organization can do to stop it. The participants who did respond, offered ideas to promote change and stop systemic racism. It appears from the findings that when incivility and bullying are greater, there is a decrease in empowerment, and vice versa. These findings lead to important implications for the profession. Figure 2 is a graphic illustration of a scale, showing with increased incivility/bullying experiences, there is a decrease of empowerment experiences.
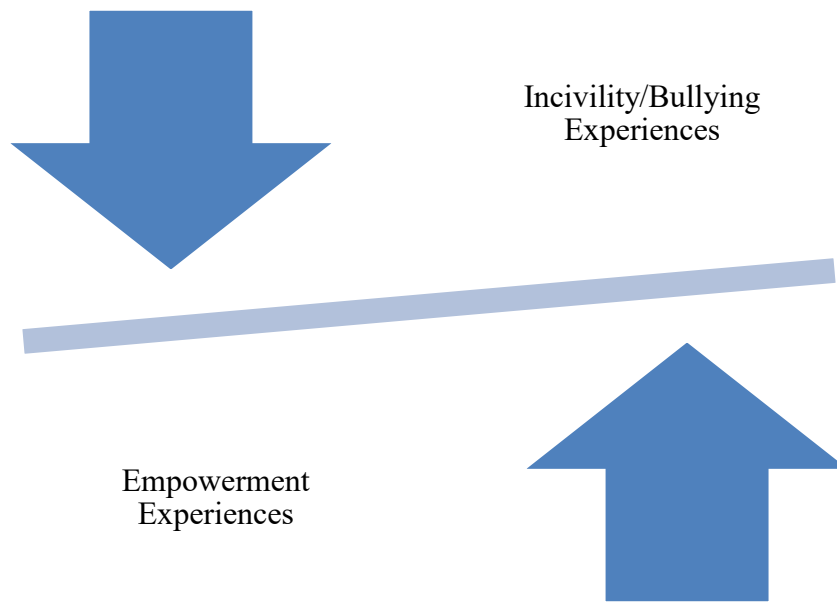
Figure 4.2: Incivility/Bullying and Empowerment Scale

Essences

The five themes help to answer the first research question, "How do minority nurses describe or explain their experiences with incivility and bullying in the workplace?" To answer this question, I made sure to be cognizant of the phenomenological lens guiding the study. In the interviews, as the researcher, I had to be flexible, comfortable, attentive, and reflective while listening to the participants' powerful stories while ensuring I wasn't adding my own presuppositions in place of their recollections. The following 15 interview statements give in-depth insight showing the essence of the nurses' experiences. The essence of each statement reflects relevant narratives and how they "are used to contextualize and clarify themes from the interview data during the process of writing and rewriting (Cohen, Kahn, & Steeves, 2000, p. 82).

The results of the study inform an understanding of the "essence" of the minority nurse experiencing incivility and bullying in the workplace as guided by the first research

question. Essence in phenomenology is defined as the structure that illuminates "essential characteristics of the phenomenon without which it would not be that phenomenon" (Dahlberg, 2006, p. 11). The following key narrative excerpts obtained from the fifteen interviews give a brief look into each interviewee's perspective.

Participant Angela described events of incivility and bullying, giving several examples which can be described as no single event, but an accumulation of several over time: "Their opinion that I lack qualification to teach certain skills based on my current specialty within in the nursing field" (Angela, line 8) when in this case Angela reported she was hired to teach in this position. She also reported occurrences of "defensiveness and passive-aggressive comments when I initiate communication for any clarifications regarding the course when expectations were either not communicated or not clear" (Angela, line 12).

Beatrice had a different outlook on her incivility and bullying experiences as she was only the second female and the only nurse hired as a director in a male-dominated company. "I never felt like they bullied me, but I just felt like it as a whole, that we were not given the same opportunity" (Beatrice, line 17).

Carly, the third participant, described her experiences with incivility and bullying as

"when the president and VP of the school lied to cover themselves blaming faculty. We had a low passing rate that put our school on probation. The admin blamed faculty, faculty blamed each other…it was a mess…Later during a meeting with a recording for the board to hear, the VP said the president sent an

invite to meet with faculty. I said, 'No she didn't.' He insisted I was wrong and tried to 'bully' me to say that my recollection was lacking" (Carly, line 9).

Darlene also shared similarities with Angela, experiencing multiple accumulative events, "The same person who acts like they do not see me or do not know what I do, will speak to the student I am training even though the student is obviously new there and I have been working there in the unit for years" (Darlene, line 11). Darlene described another instance: "Supervisor gives me the silent treatment and refuses to greet or talk to me for months when I complain about something…that does not seem to happen to anyone else, though disagreements of opinions happen with other staff members" (Darlene, line 12).

Eva described an event related to an older White male who worked in the same office building as Eva.

"He was obsessed with knowing my whereabouts…He would appear at locations where I said I would be, and I assume he was checking on me to catch me doing something wrong. It took more than a year for this to relax. I really felt paranoid and harassed during this time" (Eva, line 10). Along with this occurrence, Eva stated she worked with older females in the office who would make "inappropriate remarks about Black people as it related to stereotypes in the office" (Eva, line 9).

Francis experienced a dramatic bullying event with a White nurse she worked with.

"…a fellow teammate and registered nurse consistently spoke ill of me when I took a day off or while [I was] on vacation. A manager from another department

shared with me that she was telling other managers and anyone else in the office about my work ethics. I filed a complaint with HR and after the investigation, they, HR and my direct manager, apologized and said her behavior was unacceptable and she would be placed on probation. When I resigned, due to that was not acceptable to me, they asked if I would stay and inquired why I was resigning after they had placed her on probation…this is an issue of defamation of character" (Francis, line 9).

Francis went on to state this same nurse told "anyone around that she had a concealed and carry and brought her gun to work every day, keeping it under the front seat of her car. What purpose did she have to consistently make that statement" (Francis, line 10)?

Georgia had an experience where she attempted to advocate and educate her workgroup.

"I have been privy to conversations from others in my work group referring to staff, who are typically of a minority group, speaking negatively about [other] staff, making comments such as they want to be 'spoon fed' and other derogatory statements that I found offensive…I did a presentation to my work group on cultural diversity and sensitivity that was not well-received. There were comments made in the discussion after the presentation that they felt that they had it just as hard as minorities but were able to do for themselves and did not have things 'handed' to them" (Georgia, lines 8-9).

Hailey spoke of her position in an academic environment where she was hired as a director but was not treated like one.

"In my first meeting in my new role, faculty told me what I was going to do, and no more, and that was all, and anything they needed from me would be X. Other than I was to say nothing and that was the start…about nine months later, we had a meeting with the Union, and it caught me totally blindsided when the faculty said that I and another director…were bullying" (Hailey, 02:42-03:39).

Hailey added that as a result of retaliation, she was excluded from the directors' meetings after several other events. "I am not invited to all of the directors' meeting, and it's so unfortunate because I'm the only Black director there" (Hailey, 11:33).

Inga stated, "Staff made jokes about education obtained, constant microaggressions made, punished and isolated because I spoke out, no consequences for behavior, expected to accept abuse and keep quiet" (Inga, line 3). Jackie remembered several instances of where she would stand up for herself when others would start rumors, and would speak up,

"then I'd be in the management office…the story got juicy, juicy, juicy, you know, and I got to a point where I just called it out" (Jackie 04:48-05:58).

This progressed, as Jackie would see nurses show favoritism with their friends.

"It's a Cool Kids Club, even the assignments. You get on the floor like fine you get to catch babies…we're supposed to rotate so you can be abreast of everything. But they would just pick their little favorites to do baby catching, to do triage, to do things like that, even going home early" (Jackie, 07:47-08:03).

Jackie then went on to explain how by standing up for herself and others, she was titled "usual Jackie fashion," as in meaning she was known for "if you said something to her, she was going to say something back" (Jackie, 8:25).

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Keisha had experiences of incivility and bullying with a physician. Keisha spoke of several instances of bad behavior by the physician and one specific event was very impactful. Part of Keisha's job as a director of several outpatient clinics was to "make sure things are in order and that the environment of care is up to standards" (Keisha, 4:06). In keeping with the health standards and protocols for The Joint Commission and OSHA, she attempted to educate a physician about the protocols. "He became very agitated and told me that I better get them what he needs and do what he needs me to do because they need him a lot more than they need me" (Keisha, 04:56-05:13).

Layla worked in an academic environment and recalled an incident where the faculty (who had substantial longevity at the organization) were creating test questions in a meeting.

"You know, we would sit there and do test question design after design on questions and again, you know, you still have people learning this whole process so, you know, it just doesn't make someone feel welcome, you totally just take the breath out of them" (Layla, 00:10:09-00:10:27).

Layla was referencing faculty looking at her potential test questions and criticizing them. Layla also advocates for students where she works as the other faculty don't have an open-door policy.

"If your professor is not going to have an open-door policy you just don't connect with them. That is how a lot of students do not make it through nursing school, you know, they suffer in silence. They don't get the help they need" (Layla, 00:11:50).

Molly described her experience in the military as a senior officer. Her Battalion leader came down to Molly's company and questioned Molly about her job in front of her commanding officer, and when Molly went to her higher Brigade leader, her Battalion leader told her, "I was also unprofessional…and then they relieved her but they didn't know it was a big problem until they went around to seven other commands and found out this was something she had a history of" (Molly, line 03:29-03:44). Molly's Brigade leader then told Molly, "she didn't have time to waste on a senior officer." This occurrence resulted in Molly leaving the military.

Nora described her experiences when "a younger nurse would "demean us [in] verbal and nonverbal ways and was very aggressive, like rolling her eyes and starting rumors and you know just being hateful for no reason." Nora stated the experience made her angry. "It made me question myself a lot, like am I doing the right thing? It made me question my judgment…it just made me feel inadequate and unappreciated" (Nora, lines 24-28).

The final interview was with Olivia. Olivia described her experiences when she started as a new nurse, "difficult unit supervisors who would hunt new nurses for sport. This was beyond the sink or swim we were prepared to handle in school; they were deliberately trying to cause problems for new nurses" (Olivia, line 4). "Some days I would like to go back to LTC, but I am not tormented by older nurses here who want me to sink" (Olivia, line 2).

The second research question was, "How do minority nurses experience empowerment in the workplace?" Participants' answers varied from not identifying with the experience of empowerment in their workplace, to feel they are empowered within

themselves, to special mentors or the organization itself attempting to make them feel empowered. I deem this second question important when looking at the outcomes of the study because the participants gave rich, considerate ideas and recommendations regarding their understanding of empowerment in the workplace. This provides organizations and nurses with ideas of what minority nurses need and think would help them be empowered individually and in the workplace. A common theme in the responses for empowerment was providing the resources, tools, knowledge, and confidence, along with the autonomy to instill power in nurses individually. Table 4.4 (Appendix A) displays answers to the question what would increase empowerment in the workplace for them.

<div align="center">

Definitions

</div>

Their interviews revealed key phrases that summed up their experience and definitions that were brought forth out in the interviews. A significant realization discovered in the recollections of the participants are the descriptions of their experiences without their knowledge of the label or terms used in the literature and/or media such as implicit bias, microaggression, and systemic racism. The terms implicit bias, microaggression, and systemic racism were found to be directly related to the incivility and bullying the nurses experienced. Although a few participants did tie their experiences to the definitions, most of the participants did not. Once it was identified that the majority of the participants experienced these phenomena, I labeled and inserted the definitions of these terms for the readers, and to give a name to what the participants experienced.

An additional term I added to the study was *White privilege*. The term *White privilege* was not used by the participants, but by me as the researcher to describe myself

as a White nurse not experiencing what the participants have experienced because of my whiteness. White privilege is defined as "the benefits and unfair advantage accorded to whiteness, but rather focuses on the disadvantages of non-Whites" (Jones et al., 2008 as cited in Kwate & Goodman, 2014, p. 151). An old quote sums up the relationship of what it is like to be White. 'He was born on third base, as though he hit a triple;' this quote explains the contradiction for those who are White and the extent to which they fail to see their own accumulated privileges and their influence on worldviews and actions" (Potapchuk et al., 2005, p. 4). I included my White privilege as a limitation to the study, because although I may think I understand the experiences of the participants as related to experiences with my family, as a White person I could never feel or interpret what that is like on a daily basis.

The addition of the terminology described and used by the participants in the interviews gradually led to two changes to the interview questions. The changes reflected the direction the participants went with the questions and were molded to their answers in an attempt to try and explain the topics and to add a comparison to experiences. The first change was to say to the interviewees, "Reflecting on the interview questions for the study Empowering Minority Nurses in the Face of Incivility and Bullying, I have a couple of more questions." The first addition to the questions was to ask in the interview, "Do you feel that because you are a minority nurse your experiences of incivility and/or bullying, or empowerment are related to how you were treated? Please elaborate." The question was designed to be asked in any interview style, verbally, or in written form. I debated on how to ask this question without offending the participants and asked a fellow nurse who is Black to see if she would reword it. The nurse did not provide changes and

stated the question "is what it is," meaning she did not see any other way to ask the question. The question was added because nurses were leaving out their experiences as perceived by a minority nurse.

During the recruiting process and interviews, I discovered the term *minority* seemed to provoke an emotional response from participants. The United States census definition of *minority* was non-White; it was assumed to be an inclusive term of all minorities. However, participants told me it was offensive. I found that it was important to explain the purpose of the term *minority*, and there was no intention to offend any person who fell under this definition.

I learned from participants using a label such as *Person of Color* was preferred over the use of Government terms of African American. The same was for the label of American Indian participants who preferred the term *Native American* or *Native* to describe their identity versus American Indian. Historically, different labels were used in cultural conversation, and in the year 2020 is reflective of what is going on in the United States with diversity and inclusion awareness.

After a few more interviews, other questions were added for clarification as recommended by the data analysis committee:

1. "If it is related to your ethnicity or minority representation, if given the chance, what would you say to other minority nurses in the same situation?"

2. "From your experience as a nurse, do you feel minority nurses are treated equivalently in the workplace?"

3. "The term systemic racism has been used to describe experiences by other participants. From your understanding of systemic racism, do you feel your

experiences of incivility and/or bullying are related to your status as a minority

nurse?"

4. "If you understand systemic racism as related to your experiences, what do you

think your organization and we as nurses can do to stop it?"

Implicit Bias. Implicit bias often occurs subconsciously, influencing "health

professionals without their knowledge despite their best intention" (Sukhera, Watling, &

Gonzalez, 2020). Implicit biases are defined as bias between a "group or category

attribute, such as being Black, and a negative evaluation (implicit prejudice) or another

category attribute, such as being violent (implicit stereotype)" (Holroyd & Sweetman as

cited in FitzGerald & Hurst, 2017, p. 2). Respondent Angela used the terminology of

"implicit bias" as a possible reason for her treatment. "I feel as though if my minority

status played a part in my treatment, it is often because of underlying implicit bias and

not necessarily blatant racism or discrimination" (Angela, line 4).

Another participant reported she has experienced what she described as "hidden

racism" (Molly, line 24:31). Hailey referred to implicit bias as possibly coming from

herself:

 "This is very hurtful to say this, but I really feel this to be true, and I think it could be

implicit bias on my end, but it's my experience." She went on to explain, "When a White

nurse or faculty screams or hollers, it's just being upset, but when a person of Color

screams or hollers, it is [seen as] crazy, outraged, and unprofessional. We, as a society,

need to work on it" (Hailey, lines 14:49-15:20). Eva mentioned a focus on her hair by

others as under implicit bias, as a coworker was infatuated with her hair: "During these

past three years, I believe we've had more than a dozen 'talks' about my hair. Why I

wear it like this, styles, how long it is, etc.…it is like I need to do things with my hair that she can approve of" (Eva, line 9).

Other examples consisted of questioning the participant's position, title, or degree level. "I have been employed since 2016 in the emergency room. The response I received from my fellow co-workers was 'you have your master's degree'" (Francis, line 11)? Inga also reported a similar experience "staff made jokes about my education obtained" (Inga, line 3). Participant Eva, in her response for feedback after conclusion of the study, offered this definition of implicit bias: "differences in approach and acceptance to addressing negative nonprofessional behaviors dress, appearance, or level of education" (Francis, line 4).

Microaggression. Microaggression is defined as [behaviors that starts out as] "minor or subtle, such that individually the behaviors seem innocuous" (Wong, Derthick, David, Saw, & Okazaki, 2014, p. 182 cited in McTernan, 2018, p. 264). Another type of microaggression branches out to racial and ethnic identities that affect and target minorities. According to Kohli and Solórzano (2012), racial microaggressions consist of multifaceted factors such as:

- Subtle insults or assaults directed toward people of Color that are carried out unconsciously and automatically, in verbal and non-verbal forms.

- Association of a person's race, gender, class, sexuality, language, immigration status, phenotype, accent, or name as with layered insults and assaults.

- Accumulation of treatment takes its toll on people of Color. Isolated microaggressions are not as impactful as repeated slights making the insults and assaults profound over time. (Kohli & Solórzano, 2012, p. 447)

Inga (line 6), mentioned: "constant microaggressions were made, punished and isolated because I spoke out." Inga labeled the occurrence, but other participants who experienced microaggressions did not. Darlene (line 8-12) indicated, there were repeated bad behaviors of exclusion, lack of acknowledgment, ignoring, refusal to communicate, and supervisors and coworkers pretending "they don't see me" extending over months until reported. Participant Jackie reported several instances of constant exposure to racist remarks that blend implicit bias, microaggression, and systemic racism. Jackie's examples are of constant, daily remarks by colleagues and staff, a professional speaker in front of 25 people referenced the news where people were shot as "that kind of stuff happens in the ghetto," and Jackie noticing she was the only minority (Jackie, line 22:22-22:49). A coworker and making references to "Keesha in room seven…or we got Shanaynay back in" when patients were Black laboring women, and those were not their names (Jackie, line 23:05-23:18). Colleagues questioned how she can afford cars or her home when they don't ask others who are not minorities the same questions (Jackie, line 23:29-23:44). In a follow up email after the study concluded Francis stated she interprets microaggression as when "speaking up causes conflict and isolation, inappropriate nicknames for patients of Color, joking inappropriately about patients of Color" (Francis, line 4).

Systemic Racism. The term *systemic racism,* as defined by Kohli and Solórzano (2012), is "covert or everyday forms" of racism to keep those "at the racial margins in their place" (p. 447). This term was repeatedly identified by nurses sharing their stories of incivility and bullying that occurred in their workplace. One of the most common responses identified in the study concerning systemic racism was the lack of promotions,

raises, and awards, and even not allowing minority nurses to move to a different department.

Some of these experiences were identified by the participants as bullying and used to describe events of incivility and bullying that occurred.

"If a Black nurse wants to go to ICU, they would allow a White nurse to go first. I'm not for sure, why you grab them when they graduated from the same school and had the same amount of work experience" (Hailey, line 31:33-31:45).

Hailey also spoke of how in a current position, "I will get less hours working adjunct than my White counterpart" (line 32:09).

Keisha stated it this way, "A minority nurse who is a much better nurse, who is you know, works harder, is more consistent, more dependable and all these things will be passed over for promotions and things like that where others are promoted or written up for awards" (Keisha, line 25:57-26:27). Layla gave an example that was in reference to minority nursing students. "The professors would speak to them, you know when he asked a question to them it would feel, kind of…it just made me cringe. Just to see how students were, you know, sometimes treated" (Layla, line 00:44:46-00:45:02). When asked if she was treated equally, Layla stated, "No, we're not treated equal…not treated equal when it comes to being interviewed for a position" line 00:50:11-00:50:25). "When I now introduce myself as Dr. (XX) then I get a different look like, 'Oh she has a doc'…when I have to use my title then I get more respect and I shouldn't have to do that"(Layla, line 00:54:39-00:54:56).

One of the most influential and impactful statements that a participant made was related to giving up her position due to the bullying she received in the military. "I gave

up my career; I left the army" (Molly, line 07:24-07:33). When an investigation by

company commanders was issued, the other commanders were experiencing the same

thing. "She finally listened…and she apologized, but "it was too late; I had already

dropped my papers to get out because I didn't feel I had no support" (Molly, line 08:37-

09:03).

The Racial Continuum of Incivility and Bullying Behaviors

As part of a visual to see the racial continuum as described by the participants, I

created the diagram of The Racial Continuum of Incivility and Bullying Behaviors, to

display the progression of incivility and bullying leading to a hostile work environment,

The Racial Continuum of Incivility and Bullying Behaviors likens to Clark et al. (2015)

Continuum of Incivility as it displays the less to progressive behavior range from less civil

to aggressive and potentially violent behaviors. The Racial Continuum of Incivility and

Bullying Behaviors I created included the insertion of implicit bias, microaggression, and

systemic racism as the difference that minority nurses face. Implicit bias tended to start

with uncivil slights and then progressed to microaggressions as bullying behaviors, then

to full systemic racism.

The Racial Continuum of Incivility and Bullying Behaviors

| Implicit Bias | Microaggression | Systemic Racism |

| Incivility Behaviors | Acceleration or Intervention | Bullying Behaviors | Acceleration or Intervention | Hostile Work Environment |
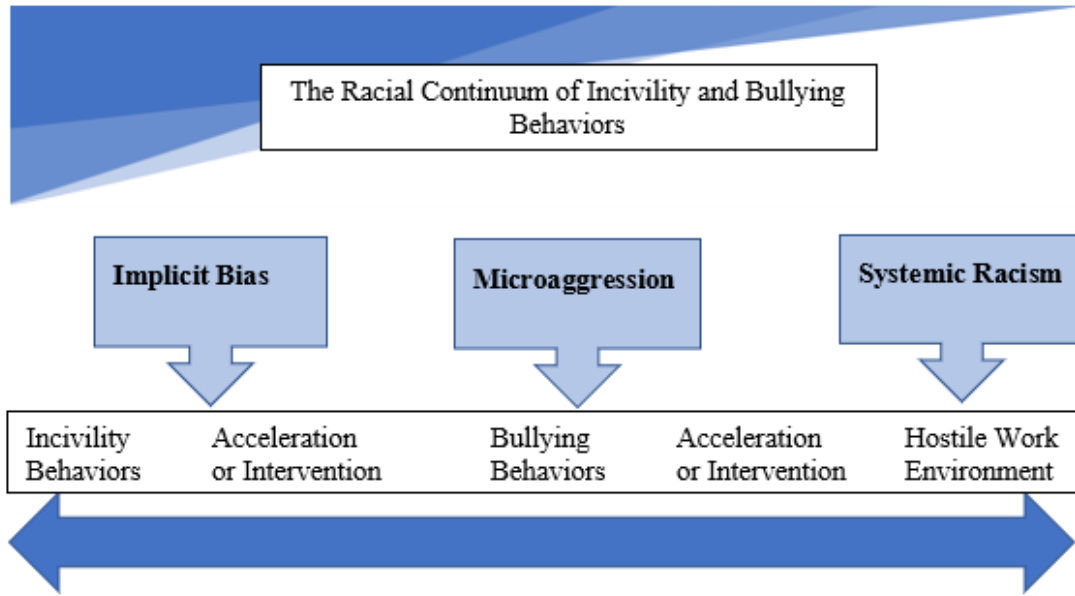
Figure 4.3: The Racial Continuum of Incivility and Bullying Behaviors

(Floyd, 2020)

The perspective of Francis, illustrates the racial continuum of incivility and bullying behaviors as she states

> "We are expected to take the grunt jobs, the worse patients, the heaviest
>
> loads, and work short without a PCT and if our White counterpart has to
>
> do any grunt work or work short then suddenly staff is increased and ratios
>
> are adjusted in fact she/he is rewarded for speaking up about something
>
> we've been reporting for years. We are judged for where we live, grew up,
>
> the color, texture of our hair, or the style in which we wear our hair, our
>
> tone of voice, the expression on our face and tested mentally, physically,
>
> emotionally, and spiritually beyond measure as if we are not human and
>
> more than less plantation slaves" (Francis, lines 6-9).

What appeared to me as the researcher were the opportunities for de-escalation and/or intervention in each story, as told by the participants. Instead, in each interview, participants recalled acceleration and escalation of less uncivil experiences, sometimes leading to hostile work environments. Keisha stated it well: "What makes it systemic [racism] is the fact that it's embedded in the culture; it's embedded in the promotions…in who gets the attention, who has higher level administrator jobs" (Keisha, line 28:04-28:28). Olivia supported this, as through her understanding of systemic racism and management, "the system is stacked against the minority nurse…Management is friends, they may not all feel that way over minorities, but also, are they willing to rock their friendship boat by speaking up?" (Olivia, line 20)

Essences as Continuous Experience(s) of the World

Significant statements were also made by the participants throughout the interviews, so much so, that I felt they deserved their own section. The statements showcase the essence of how the participants feel and, in some cases, summarize what they want to say. The "essence" is conceived as a continuous experience of the world, and this involves intention. Intention "makes clear that when the phenomenon presents itself as something, it presents its essence…seeing their meanings…in one way or the other" (Dahlberg, 2006, p. 12). Some of the statements were offered by the participants after the interview was over. If anything, I want to convey the significant elements and substance of what they said pertaining to incivility, bullying, and empowerment.

When talking about other minorities, Nora reported some of them indicated they had not experienced incivility and bullying. "It's like you've been very fortunate and lived or worked in a great place because it's out there and it's alive" (Nora, line 237).

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Comparing experiences of incivility, bullying, and empowerment, Carly said what stuck out to her was "how easy it is for one to do it. Do it subtly but can make a big impact" (Carly, line 28).

During her interview, Molly answered she wanted to be "politically correct" (Molly, line 10:10) when she answered the question about how she felt about the comparisons of incivility and bullying. In response, I wanted to make sure she felt safe and did not have to guard herself against her feelings, telling her, "You don't have to be politically correct, you're in a safe environment, you can say whatever you want to say" (Principal Researcher, Molly's interview, line 10:15). Molly then went on to explain her strong feelings: "I was thinking about homicide" because of the treatment by her tormentor, causing her to quit her career in the military. Molly did not intend to commit homicide; she was expressing how strongly she felt at that time. Her resolve in this situation was soft and nurturing; when asked what would increase empowerment for her, she wanted to communicate, "Put her at ease. What was going on and what she would have liked to have done" (Molly, lines 12:40-12:43)

Keisha mentioned again after the interview was over how scarring her experience was with the administrator humiliating her in front of the conference.

"And just to add to the comment I made about the hairdo, it was very insulting…it's one thing to compliment someone if you want to say something about my hair. You can say it looks nice, or you cannot say anything at all, but to treat you like an animal. Can I touch your hair? Why? It's like, no, I mean seriously, if you don't know me, if you're not a friend of mine-my friends can touch my hair, even if you're White, you know because we have a relationship;

we touch one another, you know, but if you're a stranger to me and you're asking

me, can you touch my hair because you want to treat me like a barn animal…"

(Keisha, lines 34:07-35:56).

Keisha's experience involving the comments made about her hair was one of the

most profound interviews in the study for me, as it required reflection and use of

bracketing to encase similar family experiences with regard to my brothers' hair growing

up. Recollections of my brothers, who were also "petted" and comments made by family

and strangers about their hair, along with the feelings of my brother had being "petted"

by people, making him feel like a dog. Keisha's experience struck a chord with me, and

her passion for the topic was not unnoticed.

Conclusion

The purpose of this study was to explore how nurses who represent minorities

share their lived experiences of empowerment in comparison to incivility and bullying in

the workplace. Fifteen minority nurses, with ethnicities of American Indian,

Asian/Pacific Islander, Black or African American, and Middle Eastern, participated in

15 interviews. The range of ethnicities provides support that the study was diverse due to

a broad recruitment strategy and communications to diverse minority nursing

associations, organizations, social media, and word of mouth. The interviews took place

over a period of 10 weeks, and each ranged in length from 35 minutes to almost two

hours for the seven recorded Zoom and cell phone interviews, and the remaining eight

were via email with several participants changing their interview style prior to the

interview.

Many of their experiences were an accumulation of events of incivility and bullying over time, and many shared very hurtful stories that brought up mixed emotions during the interview. Their descriptions helped to highlight incidences of implicit bias, microaggressions, and systemic racism, which blended with their incivility, bullying, and sometimes hostile work environments. The fact that the nurses were of different ethnicities than the majority of White female nurses in the United States separates their experiences. The purpose of this study was to also put their voices in the forefront so they could be heard over the majority of White female nurses. The fact that they are a minority does not mean that many White female or male nurses don't also experience incivility and bullying; it supports the need for change. I was honored and counted it a privilege to interview the participants, and I'm grateful and appreciative to them for sharing their experiences. My hope is to speak the truth about their experiences. In an effort to create change and support future studies on this topic, I hope to show that regardless of one's ethnicity, minority voices need to keep being pushed to the forefront. We must hear them in order to create and support change.

CHAPTER FIVE: DISCUSSION

This qualitative study aimed to explore how minority nurses share their lived experiences of incivility, bullying and empowerment in the workplace. Through this research, descriptions detailing the events that impacted the lives of the 15 minority nurses surfaced. Understanding the essences of the phenomena were discovered using the following questions, "How do minority nurses describe or explain their experiences with incivility and bullying in the workplace?" and "How do minority nurses experience empowerment in the workplace?" The philosophical framework of phenomenology guided the entire study, and the methodological framework selected for this research was descriptive phenomenology. Colaizzi's (1978) seven-step method of descriptive phenomenological analysis was used to analyze the information.

Chapter Five presents an overview of the findings that emerged from the data. These findings were discussed through the descriptive phenomenological lens and included discussing the major themes revealed by the study findings. Assumptions of the Principal Researcher were bracketed prior to the study. Ongoing reflection and bracketing before, during, and after the data collection, allowed for guarding the study findings.

The assumptions for this study were:

1. Nurses representing the minority population will experience more incivility and bullying than experiences of empowerment.

2. Any empowerment experiences the nurses might have had were because another person cared about them.

3. The nurses' responses to the inquiry were honest, and their perceptions valid.

4. A targeted pool of participants was needed due to minority nurses making up a very small percentage of the nurse population.

Procedures

The 15 participants were of a diverse participant pool. The study allowed for recruitment from nursing associations, organizations, social media, and word of mouth. This broad recruitment strategy allowed for recruiting from all over the United States and from different ethnicities to support the study's diversity and inclusion of all minorities. The term *minority*, as defined by the United States Census, includes all minorities and excludes White or Caucasian people. Recruitment consisted of sending and posting an introductory letter regarding the study with the survey link attached to minority associations and organizations' emails, and social media. Additional emails, postings, and phone calls were then made to follow-up on the emails and postings after two weeks if there was no reply.

The 15 minority nurses interviewed for the study completed the initial demographic and Workplace Incivility Survey (WIS). The WIS measured the extent of the participants' workplace incivility, and a score of four or above was positive for experiencing incivility in the workplace. If they scored four or above on the WIS, the participants were then contacted for an interview, per their preference for interview style, which they chose during the survey. After written consent was signed, the participant was asked through email or phone conversation, about preference to arrange an interview. At this point, several participants changed the route of the interview per their convenience. For example, one who initially chose email as a style of the interview then emailed back they would prefer a phone call. I honored what the participants' preferences were for each interview. Providing flexibility in interview style and participant recruitment route,

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allowed me to cater to the individual participant's needs and, therefore, retain the participant for the study.

The perspective of the individuals' experiences made them the experts on the phenomena of incivility, bullying, and empowerment in the workplace. I interviewed the participants about their experiences using a semi-structured interview style with open-ended questions. The semi-structured interview questions allowed the participants to answer each question consecutively, stay on target, and yield rich descriptions of the topics.

I transcribed the completed interviews using MAXQDA 2020 and Otter.ai 2020 software by Liang and Fu (2016). The data generated insight into the phenomena experienced by the 15 minority nurses. Analysis of the 15 participants' responses revealed three definitions in their experiences as minority nurses. Implicit bias, microaggression, and systemic racism were identified by the participants and then defined as their interviews revealed more participants had experienced these issues. After the terms used were defined and explained, five themes emerged and developed into an exhaustive description of the phenomena.

Overview of Findings

Themes emerged from the data through a complete analysis of the data by the data analysis team and me. Using Colaizzi's (1978) seven-step method as part of the descriptive phenomenological analysis allowed positive and negative connotations to emerge in the interview transcripts. The data collection was read and re-read many times, in conjunction with recording the interviews and reading the transcripts to understand the meaning behind the statements and locate significant statements from the participants. I

primarily analyzed the data; however, the data analysis team met once or twice a week to discuss and analyze the data collected. The data analysis team and I created narratives of each participant interview to compare the interpretation and relay data. The purpose of the data analysis team was to add rigor to the study. After an exhaustive analysis was completed through the organization and discussion of the findings, themes emerged from the study.

Five Themes

The exploration of these phenomena uncovered experiences with situations defined by the participants as implicit bias, microaggression, and systemic racism, leading to five overarching themes. The themes revealed through the data analysis, from the 15 participants' lifeworld experiences, were: *I Am Valued and Enough, Oppression Beyond My Control*, *"Mean Girl" Culture in Nursing*, *Resilience in the Face of Incivility and Bullying*, and *Taking Control with Empowerment: What Organizations and Nurses Can Do.*

The first theme revealed, *I am Valued and Enough,* emerged in the participant's stating they were devalued and wanted to feel valued. Several mentions of lack of worth and proving of self to show they are enough and worthy surfaced in this first theme. The second theme of *Oppression Beyond My Control* encompassed the participant's' feelings about their treatment because of their ethnicity. The word *oppression* was not used, but by definition, the term described the phenomenon the participants perceived. The third theme, *"Mean Girl" Culture in Nursing* was created by the participants using the verbiage "mean girls or mean girls club" to describe a nursing culture of cliques and maltreatment by groups of nurses toward minority nurses.

The fourth theme, *Resilience in the Face of Incivility and Bullying,* revealed the spirit of the participants when faced with adversity and condemnation. While some participants expressed feelings of defeat, others were defiant, strong, and determined to be the best nurse they could be. The final fifth theme that surfaced was *Taking Control with Empowerment: What Organizations and Nurses Can Do*. This theme of empowerment revealed the 15 participants' perceptions of empowerment in the workplace and individually. A comparison in the interviews revealed what was happening in the workplace compared to what participants perceived should happen to increase empowerment and decrease incivility and bullying. These themes relay significant data to support potential changes in organizations and as nurses.

As part of the final step in Colaizzi's (1978) seven-step method, the 15 participants participated in the validation of the findings. Three participants replied with no changes suggested. It is important to reiterate that in this study, the voices of minority nurses contribute to studies of nursing; however, the lack of minority nurses in comparison to the majority of White female nurses in the field means their voices are not at the forefront and therefore are not heard. This study gave the participants a chance and a choice to put their voices at the forefront, and their experiences and perceptions were indeed different.

<h3 style="text-align:center">Researcher Assumptions</h3>

At the beginning of the study in Chapter One, I presented four assumptions. The study's findings supported all four assumptions. The first assumption I had was, "Nurses representing the minority population will have more incivility and bullying than experiences of empowerment." The assumption that minority nurses experience more

incivility and bullying than empowerment experiences was supported in the study. Out of the 15 participants, four explained they did not feel empowered or did not have empowerment experiences. Four other participants stated they feel empowered by themselves and their actions. Five participants said others made them feel empowered through mentorship, supervision, and support. The other two participants referred to the organization as providing empowerment through opportunities given and "supportive regulations for reporting bullying and hostile behavior causing behaviors to cease, but only if supported by management" (Darlene, line 3). Fewer nurses experienced empowerment than incivility and bullying.

The second assumption, "Any empowerment experiences the nurses might have had were because another person cared about them," was supported by five participants. They primarily listed mentors as providing empowerment experiences. Carly stated, "A positive supervisor [gave] me the benefit of the doubt, trusting, believing in self value, and worthiness" (Carly, line 6). Others listed people in leadership and supervisory positions who gave them a sense of empowerment in the workplace.

The third assumption was, "The nurses' responses to the inquiry were honest and their perceptions valid." It is slightly more difficult to determine whether this assumption was validated by the findings. I can say that as the nurses expressed their recollections of events of incivility, bullying, and empowerment, some were very passionate about their experiences. Powerful emotions and retelling of events brought up mixed emotions in the participants, and I can attest the participants' perceptions and recollections were truthful.

The admission of some of the participants' own biases and considerations regarding their perceptions of what they experienced through their self-reflections and

awareness supports honest and valid perceptions. "You have a melting pot there, where you had your White nurses…but just like with any other race, you know, you have races that lookout for more of their own…Filipino nurses would look out for more of their own Filipino nurses, that's just the way it's always been" (Layla, lines 00:41:01-00:41:27). Hailey stated, "When my boss is not a woman of Color, but she still was bullied, because I saw it with my own eyes, and then it would kind of spill a little bit over to me" (Hailey, lines 16:06-16:15). Georgia explained what she does for self-awareness, "when dealing with other minorities, I try to examine my words, tone, and body language to see if I have done or said something that may be perceived as offensive" (Georgia, line 11).

The final assumption was, "A targeted pool of participants was needed due to nurses of minority making up a very small percentage of the nurse population." I can attest that although the recruitment strategy to recruit broadly to attempt to gather participants was exhaustive, recruitment was very difficult. The target goal for the study was for 15 minority nurses. The goal was met, and the assumption was proven true that many participants were needed for this descriptive phenomenology study.

Discussion

The Covid-19 pandemic was a major factor, with nurses working out of their normal shifts and facilities. Protesting and social unrest also served as significant factors. Two participants stated, in reply to me on social media, they were too exhausted from working out of their specialty, as they were moved to different floors because of furloughs and Covid-19 patients. In addition to this change, the same two participants stated they were protesting and organizing, making them too busy to participant in the study. Another participant emailed me and stated she was not following through with the

interview because she was too traumatized and remembering everything that happened with her was too painful. She did not feel protected if she took part in the study. It was a common discussion to have about protection with participants, and I went to great lengths to reassure participants their physical faces, names, and workplaces would not be exposed in the study to avoid potential retaliation.

When looking at theories for this study, I struggled to make one theory fit what the participants were revealing. For one, even though my topic is inclusive of all minority nurses, I did not know if forms of racism would surface. In the beginning of the study, the research questions did not ask specifically if race played a role in their incivility and bullying experiences. When the questions were modified after a participant mentioned the term implicit bias, the questions were altered and then experiences prejudice and racism surfaced.

The lens of the study was through phenomenology and I had to wait to gather all of the perspectives and essences of each participant to see what theory, if any, surfaced. Critical theory emerged as a possibility, with the term critical as "implies analysis that moves beyond the surface and beyond what is usually assumed" (Chinn & Kramer, 2015, p. 70). This theory "analyzes the roots and consequences of social inequities and injustices that privilege one group over another" (Carnegie & Kiger, 2009, as cited in Chinn & Kramer, 2015, p. 71). The critical theory increased my interest as I looked further into my study and noticed the glaring power imbalance between the minority nurse and the White majority of female nurses, organizations, and associations of nursing. The critical theory in research "seeks to make these dynamics visible so that people can challenge power relations" (Merriam & Tisdell, 2016, p. 61). The more I read

on critical theory, the more is fit the study. With the addition of definitions by the participants of implicit bias, microaggression, and systemic racism all linked to their incivility and bullying experiences, the Critical Race Theory (CRT) seemed to be the perfect fit.

Denzin & Lincoln (2018) describe CRT as the "Voice from the margins demonstrate the range of knowledges, perspectives, languages, and ways of being that should become foundational to our actions, that should become the new center" (p. 86). One thing in this study I made sure to include was that minority nurses have a voice; it takes all of us to move it to the forefront to hear it. One participant, before agreeing to participate, made sure that I knew she was volunteering for the study and that I was lucky to have her. The participant was leery because I was White, and I had to explain to her my purpose and that her voice would be heard unfiltered. As the researcher and as a White nurse I must "'join with' and 'learn from' rather than 'speak for' or intervene into" (Denzin & Lincoln, 2018, p. 86). The CRT fits well as the framework for this study because it also can be used for future studies, if research is pursued using other minorities such as LGBTQ, as suggested by a few of the participants in this study. Future inquiry might ask the same questions but change the participation requirements to see if their LGBTQ identity and experiences compare to the non-White minority nurse answers in this study.

Future Research

To an observer, a working nurse appears to be someone caring and capable of caring for patients. This study revealed several occurrences of White individuals misinterpreting the role of the nurse because the nurse was a minority. Reports surfaced

of nurses being mistaken for dietary workers, or aides because of their skin color. There were also instances of inappropriate, derogatory conversations about minority staff members by other nurses and questioning the rank or level of degree the minority nurse had achieved. The individual questioning was surprised the minority nurse had a higher degree. Being blocked from promotions and failing to receive awards were the most eye-opening and alarming to me. These kinds of observations and experiences by the participants separate them from the experiences of White nurses. This kind of maltreatment is sometimes experienced daily and not just by a few random minority nurses. There is a literal white elephant in the room that is ignored in the Year of the Nurse 2020 and has yet to be seen and dealt with. Minority nurses are currently dealing with this kind of treatment, and there is a permissiveness in the organizations in which they work that allows it to continue.

Although there are few studies about incivility, bullying, and empowerment among minority nurses, there remains a potential for future studies. The participants mentioned several ideas for future studies outside of the interview questioning, including the need for more studies. One topic that was continuously brought up was the need for inclusion of the male nurse population. Only four males took my initial survey, but just one qualified to do the interview and did not follow through. A study focusing just on male nurses of all ethnicities was recommended because, as a gender, they are a small minority. Another subgroup of nurses mentioned was the LGTBQ group asking the same questions in a social media forum. A couple of people who stated they were in this subgroup asked if I would do a study on LGTBQ nurses.

I agree these potential topics would be valid for comparison with the current study findings, in relation to a group of nurses who are not in the majority of White female nurses. The findings in this study support a need for other minority groups to be researched. In this current study, the minority nurse perspective is different from that of their White female counterparts. As each interview unfolded, the data revealed in the participants' answers led to additional questions as the definitions of implicit bias, microaggression, and systemic racism were revealed. Further research about incivility and bullying and how they impact empowerment would help open the conversation on this important field of inquiry.

Limitations

There were several limitations to the study. Although it was anticipated that a variety of ethnic groups would be represented in the sample achieved, the study lacked male representation. Another limitation is using a qualitative approach, where a more selective, rigorous methodology, such as a mixed method, might have provided a better look at the topic. As the researcher and an instrument in qualitative research, questioning and probing in the interview process during data collection and analysis may have resulted in variations in my approach to the study, neglecting the possibility of replication for other nurse scientists. I also want to list as a limitation my ethnicity as a Caucasian female or White privilege. Although I listed my family as multiracial in the role of the researcher in Chapter One, I still have the White privilege viewpoint. I have not experienced the same things as a minority nurse, although I have witnessed similar experiences within my family. White privilege included an "unfair advantage including benefit of doubt, high expectations, trust, laxity in rule enforcement, and day-to-day

breaks that Whites either see as luck or fail to notice at all" (Jones et al., 2008 as cited in Kwate & Goodman, 2014, p. 151). In this study, it seemed the individuals involved in the experiences of the minority nurses failed to notice or acknowledge their behaviors of incivility and bullying at all.

Recommendations for Practice

Nurses and organizations must be educated about minority nurses' treatment and become aware of incivility and bullying, asking what they can do as organizations to increase empowerment in the workplace. The participants stated what they want for themselves individually. The participants are nurses, most of whom are at their prime of experiences and knowledge, with a great deal to give to their organizations. A top recommendation was for organizations and those in leadership to listen. More education is needed for cultural sensitivity and awareness. There should be no tolerance for bullying behavior. Increased empowerment, promotions, mentors, and supervisory check-ins should be used to support nurses in the field. Fair hiring practices must be implemented for minority nurses. For example, if an organization is hiring for one position and seven people apply, look at all of their requirements, and look at their ethnicity, make sure self-awareness exists, and no bias is going into the process. If the participants in this study can acknowledge times when they may have biased thoughts and responses, certainly trained leadership can do this as well.

A final recommendation is to increase the hiring pool of applicants to recruit more minority nurses. A comment frequently repeated in the study was "there is no one who looks like me," meaning there are no other minorities and no one who can understand what they go through. "On my unit, a lot of us didn't stick around very long because just

the nature of how the environment was…there were never more than three that look like me and there was maybe two Hispanic OB techs and one Black OB tech, and that was it, so there were just five of us on day and night shift" (Jackie, lines 04:08-04:22). Darlene stated, "I would think if half of the staff looked like me, I would find someone more willing to help me (Darlene, line 32). Jackie stated, "If you don't recognize the issues, then you have minimal to no representation of people that are experiencing some of the cancers of the issue" (Jackie, lines 01:55-02:00).

Summary

This chapter presented the conclusions of this study and discussed its implications for nurses and organizations. The participant's revealed many factors that influenced their experiences in the workplace. Unexpected definitions of implicit bias, microaggression, and systemic racism were revealed in the study and represented outside factors that influenced the participant's' experiences. The themes that emerged supported the progression of incivility, bullying, and aggression as related to the participant's' minority representation in most cases.

This research with its minority nurse focus, application of Colaizzi's (1978) seven-step method to the data analysis, calls for a new understanding about incivility, bullying, and empowerment. The findings support the need for future research and interventions to prevent and intervene in cases of incivility and bullying of minority nurses. The study also supported organizations' actions in listening to minority nurses, acknowledging incivility and bullying, and providing consequences to stop the behavior within the organization. A frustration of one of the participant's was the lack of action on the part of the organization. "People need to be held accountable, managers accountable

when they have incivility and bullying in the workplace, excuse me, so you have these issues, but there's no action" (Layla, lines 00:31:00-00:31:24).

Taking action also applies to support empowerment in the workplace. If minority nurses are to individually recognize incivility and bullying, and report it, organizations must listen to them regarding what would empower them individually and support minority nurses as a whole within the organizations. Eva summarized her work experience as "I think there is an inequivalence in the treatment of minority people in almost every aspect of life and I would not expect the workplace to be different" (Eva, line 43). I am challenged by that statement, as the workplace should be different, and incivility and bullying should not be expected, permitted, or without consequence.

A final point is an application of study findings to patient care. If minority nurses are treated poorly, on almost a daily basis, how are minority patients treated? "What your coworkers do, not only do they do it to you, but they do it to patients too…you know, they're not giving them the same care…versus the Black mother who's on her 20th kid, it looks differently" (Jackie, lines 22:05-22:14). Jackie's perception coincides with Ciocco's (2018) statement, reflecting on the consequences that bullying has on the nursing workforce, because "what affects the individual nurse affects the entire health care system and the quality of care patients receive (Ciocco, 2018, p. 57). In conclusion, to give quality care to minority patients, nurses and organizations must take action and improve treatment of minority nurses.

APPENDIX

Appendix A: Tables

Table 2.1

Components of the empowerment model.

Empowerment component	Description
Communication	Clear and accurate sharing of key information toward meeting a shared goal.
Collegiality	Mutually respectful and meaningful relationship with another individual with a shared goal.
Autonomy	Possessing or granting others the authority and capability to function independently to achieve a goal.
Accountability	Assuming responsibility for individual decisions and resulting outcomes and holding others responsible for behavior/decisions.

Worrell et al. (1996).

Table 2.2

Nursing: A Profession of Caring

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Anderson et al., 2015	Caring, Conceptions, person-centeredness	To describe nurses' concepts of caring	Qualitative with a phenomenology approach	n = 21	Interviewing process consisting of four steps using an iterative process to check interpretations of interviews	Four descriptive categories developed for caring as: person-centeredness, safeguarding, nursing interventions, and contextually intertwined	Caring is strongly linked to context.
Bagdonaite-Stelmokiene et al., 2016	Caring, Nursing	To discover how the meaning of caring is perceived by nursing and social work students in Lithuania	Qualitative descriptive, Snowball sampling, reflective narratives	n = 60 Nursing students n = 63 social work students	Latent conventional content analysis	The meaning of caring to nursing and social work students is manifested through work mission, worker proficiency, values at work, and collaboration with patient's well-being	Nursing and social work students view the meaning of caring as a way of thinking and acting collaboratively for the well-being of patients.
Glerean et al., 2019	Nurse image, nursing profession, perception	To explore nursing applicants' perceptions of the nursing profession and to identify factors influencing their perceptions.	Qualitative exploratory	n = 18	Inductive content analysis	Historical virtuous caregiver images of nurses were still a common perception in the participant's descriptions.	Nurses are observed working in multi-professional teams and the tasks of nurses are described in caring roles.
Gözütok Konuk, & Tanyer, 2019	Caring, behavior, nursing care	Nursing student's perceptions of nursing care and identifying caring behaviors and associated factors of caring in nursing practice.	Descriptive correlational study	n = 530	Confirmatory factor analysis using caring assessment questionnaire	Perceptions of nursing students about nurse caring behaviors is at a good level and behaviors are affected by attitudes, plans, and experiences of the students about the profession of nursing.	Caregiving has always been at the core of nursing.

Table 2.3

Organizations and Associations of Nursing

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Brewer et al., 2020	Bullying, burnout, work environment, administration	Exploring associations and organizations betrayal and support of well-being for nurses exposed to bullying.	Cross-sectional with convenience sampling	n = 242	Chi-square d test and Hierarchic logistic regression analysis	Organizational betrayal increases burnout, job dissatisfaction and support decrease these things.	Awareness that organizations and associations of nursing are important in supporting and improving nurse's well-being.
Glerean et al., 2019	Nurse image, nursing profession, perception	To explore nursing applicants' perceptions of the nursing profession and to identify factors influencing their perceptions.	Qualitative exploratory	n = 18	Inductive content analysis	Historical virtuous caregiver images of nurses were still a common perception in the participant's descriptions.	Collaboration between nursing organizations needs to increase to make a clear strategy for updating the image of nursing. What organizations and nurse's perceive and what patients perceive are different.
Spence Laschinger et al., 2012	Workplace empowerment, positive organizational culture, workplace incivility	To test a model linking a positive leadership approach and workplace empowerment to workplace incivility, burnout, and job satisfaction.	Study sample, survey by mail	n = 1161	Descriptive, inferential, and reliability analyses using SPSS	Resonant leadership had a direct influence on job satisfaction and indirect effect for creating empowerment and lowering incivility and burnout.	Supports role of positive leadership approaches and empower nurses and discourage incivility and burnout.
Torkelson et al., 2016	Workplace incivility, organizational change, perpetrator	To identify antecedents of workplace incivility by looking at organizational aspects and being the target of incivility from co-workers and supervisors could induce incivility.	Online Survey	n = 512	Structural equation modelling analyses	The importance of focusing on perspective of instigator to gain knowledge about the process of workplace incivility.	Organizational variables of low social support from co-workers, job demands, and organizational change were related to instigated incivility.

Table 2.4

Minorities and Incivility in Nursing

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Alshehry et al., 2019	Professional quality of life (ProQOL), Saudi Arabia nurses, workplace incivility	To examine workplace incivility of nurses working in two Saudi Arabia hospitals and its influence on the professional quality of life for nurses.	Descriptive cross-sectional	n = 378	Descriptive statistics: SPSS. Independent sample t test, one-way analysis of variance with post hoc Tukey HSD test and Pearson's product moment correlations.	There was an association between the perceived sources of incivility and nurses' demographics and work-related variables and results showed that nurses have good ProQOL.	Reduce Saudi nurse's workplace incivility experiences and improve nursing competencies.
Beard & Julion, 2016	African American nursing faculty, Race	To see if barriers contribute to the lack of African American faculty representation.	Narrative grounded in social construction and critical race theory.	n = 23	Thematic analysis responses to eight question interviews using the lens of social constructionist approach to analyze the data.	Race still matters in nursing and identifying and eliminating remnants of race in academia.	The research studied "microaggressions" and "slights" or other discriminatory acts directed at the minority individual.
Kieft et al., 2014	Nursing work environment, patient experiences, quality improvement	To understand views of Dutch nurses on how their work environment and work as a nurse contributes to positive patient experiences.	Descriptive qualitative	n = 26	Interview fragments compared using MaxQDA software for coding analysis.	If the eight-essentials of magnetism are incorporated into nursing practice it will have positive patient experiences of nursing care in the Dutch healthcare setting.	Dutch nurses regard their role related to achieving positive patient experiences.

Table 2.5

Hierarchical and Leadership Relationships in Nursing

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Arslan Yürümezoğlu et al., 2019	Coworker incivility, supervisor incivility, structural empowerment, intention to leave	To test the theoretical model involving the relationships between nurses' perceptions of structural empowerment, supervisors and coworker incivility and their intention to leave nursing and their organization.	Cross-sectional correlational	n = 547	Hypothetical path model LISREL 9.2	Factors impacting nurse's intent to leave their organization and profession of nursing is perception of structural empowerment and supervisor incivility.	Key characteristics of a supervisor is empowerment of the work environment and relationship-oriented understanding. Supporting nurses with resources and opportunities to achieve professional development and career advancement.
Clark & Springer, 2007	None listed	Examine incivility in nursing education in the university environment from the nurse faculty and student perceptions.	Incivility Nursing Education (INE) survey	n = 32 nursing faculty n = 324 nursing students	Row-mean-score text a variation of a Cochran-Maentel-Haenszel test to compare results of the INE survey between faculty and students' responses.	Nursing faculty challenging other faculty's knowledge was the most frequent problem considered beyond civil. Student perceptions were that incivility was a moderate problem in the nursing academic school.	A greater tolerance of incivility is occurring and is worrisome that students might consider uncivil behavior as normal in the workplace.
Kennedy & Anderson, 2017	Power, status, hierarchy, ethics	To examine why people at the top of organizational hierarchies fail to stop unethical practices as often as they do.	Descriptive correlation with archived data set, experimental	n = 11162 employees n = 271adults	Logistic regression analysis	High ranking individuals engaged in less principled dissent because they identified with the group more than those with lower rank.	The top of the hierarchy should stop unethical behavior, but this study shows the position makes people less likely to do this because they identify strongly with their group of higher rank.
Park et al., 2017	Empowering leadership, positive organizational behavior, job engagement	Examine the effect of empowering leadership on the psychological well-being of employees.	Survey data accrued from eight large firms in South Korea	n = 285	Confirmatory factor analyses and structural equation modeling	Leader's empowering behaviors impact employee's positively, giving them a positive state of mind in their person work and life.	Effective leadership shows that empowerment is motivational rather than delegation of power.
Schilpzand, Leavitt & Lim, 2016	Incivility, rudeness, attribution, self-blame	To see if the differences in how incivility is experienced can have a significant effect on the cognitions and behaviors that follow uncivil treatment in the workplace.	Experimental within a team task environment	n = 289	Confirmatory factor analyses	Displayed that witnessing incivility moderated the effects of experiencing the incivility, and this created a relationship that is conditional mediated by a self-blaming personal attribution, for outcomes of rumination, task related stress, and psychological withdrawal behavior.	By focusing on the harm caused by Incivility in the organization it is easier to identify those causing the most harm and management can look the individuals behaving badly.

Table 2.6

Modeling in Nursing

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Rad et al., 2014	Incivility, disrespectful behavior, education	To explore the experiences of uncivil or disrespectful behavior from the stand point of students and instructors.	Non-empirical quantitative	n = 100 educators n = 540 students	Quantitative content analysis MAXQDA	Students perception of instructor highest: waste of class time, distraction, and incompetence in class management. Instructors highest: disrespect toward instructors and class order and humiliating fellow classmates.	Disruptions due to incivility in the learning environment and disrespectful behavior could influence future behavior.
Labrague et al., 2015	Caring, caring behavior, nursing education, nursing students	To Identify the relationship between instructor's and student's caring behaviors to see if the impact of instructors' caring on students' perceptions.	Descriptive, nonexperimental	n = 586	SPSS using descriptive and inferential statistics.	The instructors' caring behaviors does influence nursing students' behavior positively.	The quality of the learning environment matters as nursing students are influenced an and model the behavior of nursing instructors.
Nouri et al., 2013	Role modeling, nursing students, nursing instructors, humanization, Iran	To examine the perceptions and experiences of nursing students and their instructors and role modeling.	Qualitative	n = 22 nursing students n = 7 nursing instructors	Content analyses	Three themes presented from the data of the role model of the nursing instructor was the person to : attempt to promote emotional development, attempt to promote spiritual development, and attempt to promote intellectual development.	Role modeling in teaching is important in the perception of the nursing student and understanding how it influences students will help to develop ways to integrate role modeling in nursing education.

Table 2.7

Power and Empowerment

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Baillien et al., 2009	Bullying, mobbing, frustration, conflict and integrated model	To develop a model of the development of workplace bullying.	Qualitative case study comparison	n = 87 Belgian employees	Analytic induction-analysis of semi-structured interviews and integration of the case analyses into a global scheme or model	Resulted in a three-way model of workplace bullying. Intrapersonal frustrations, interpersonal conflict and explicit or implicit stimulation through team and organizational characteristics.	New nurses assimilate to the nursing culture to avoid becoming victims and the cycle repeats. Empowering nurses is key.
Read & Laschinger, 2015	Authentic leadership, empowerment, job satisfaction, mental health, new graduate nurses	To examine a theoretical model testing the effects of authentic leadership, structural empowerment and relational social capital on mental health and job satisfaction on new nurses.	Longitudinal survey	n = 191	Path analysis Structural equation modelling	Structural empowerment mediated the relationship between authentic leadership and nurses' relational social capital which has a negative effect on mental health symptoms.	Opportunities are empowering and enable employees to accomplish their work in meaningful ways.
Ugwu, Onyishi, & Rodrigez-Sanchez, 2014	Trust, organization, engagement, psychological empowerment	To examine the relationship between organizational trust, psychological empowerment, and employee engagement.	Hierarchical regression analyses	n = 715	Descriptive analyses and intercorrelations using SPSS and AMOS.	Organizational trust and psychological empowerment were predictors of work engagement.	Organizational trust and psychological empowerment matters to the employee work engagement.
Zhang & Bartol, 2010	None listed	To build and test a theory that addresses the connection between empowering leadership and creativity.	Web based survey, descriptive correlational	n = 367	Hierarchical Multiple regression analysis Structural equation modeling with EQS 6.1	Empowering leadership positively affects psychological empowerment which influenced intrinsic motivation and creative process.	Leadership does matter by empowering employees affecting creativity and influencing psychological empowerment.

Table 2.8

Costs of Incivility

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Hutton & Gates, 2008		To examine incivility experienced by direct health care staff in the workplace.	Correlational	n = 184	Descriptive statistics SPSS Logistic regression analysis	The greatest frequency of workplace incivility was from the general environmental incivility. The lowest was directly from supervisors.	Variables included in the cost of incivility in the workplace are loss of productivity and staff and adversely effects the health of employees.
Kutney-Lee et al., 2013	Burnout, Intent to leave, job satisfaction, nurse management, nurse retention, nurse work environments	To alleviate nursing shortages by promoting organizational efforts that will improve nurse recruitment and retention.	Retrospective two-stage panel	Data from 1999-2006 n = 137 hospitals	Statistical analyses SAS V 9.2	Nurses with high burnout across hospitals decreased by 5% between the 1999-2006 years. Nurses with intention of leaving decreased from 22.4% to 14.2 %.	There is a strong link between the dissatisfaction in work environment and nursing job outcomes.
Torkelson et al., 2016	Workplace incivility, organizational change, perpetrator	To identify antecedents of workplace incivility by looking at organizational aspects and being the target of incivility from co-workers and supervisors could induce incivility.	Online Survey	n = 512	Structural equation modelling analyses	The importance of focusing on perspective of instigator to gain knowledge about the process of workplace incivility.	There is a significant cost to the organization and nurse when incivility is perpetuated in the workplace.

Table 2.9

Measures

Article citation, author year	Keywords	Aim	Study design	Sample size	Analysis	Results	Application to research question
Anthony et al., 2014	None listed	To develop and validate the Uncivil Behavior in the Clinical Nursing Environment (UBCNE) tool to measure perceived incivility in incivility in clinical nursing education by nursing students.	UBCNE testing	n = 106	Descriptive statistics	The UBCNE was easy to administer with good internal consistency with an interitem reliability of the total test at a = .93. Age and gender were not found to be a significant factor, but stress was.	The UBCNE determines the magnitude of the problem of uncivil behavior as perceived by nursing students and identifies the unique relationships between nursing students and staff nurses, but the UBCNE was not used as part of the main study.
Clark, Sattler, & Barbosa-Leiker, 2018	None listed	To conduct psychometric testing of the Workplace Civility Index (WCI) tool.	WCI testing using a convenience sample	n = 393	Factor analysis	Cronbach's alpha for WCI was .82 and WCI is psychometrically sound used to measure perceptions of workplace incivility acumen, raise awareness, and generate group discussion about perceived incivility.	Measures nurses' perceptions of workplace incivility. WCI was considered as part of the research but not used in the study.
Cortina et al., 2001	None listed	To examine the incidence, targets, instigators, and impact of incivility using the Workplace Incivility Survey (WIS).	Survey WIS testing	n = 1180	Confirmatory factory analysis	Uncivil workplace experiences are associated with psychological distress.	The WIS measures the participant's experiences of uncivil behavior from supervisors or co-workers in the span of the last five years. The WIS was used in the main research as a tool to screen the respondents to show they have experienced/perceived incivility in the workplace.
Liao et al., 2015	Instrument development, nurse collaboration scale, psychometric testing	To develop and test the reliability and validity of the Nurse-Nurse collaboration Behavior Scale (NNBS).	46 item NNBS testing	n = 202	Exploratory factor analysis	Cronbach's alpha for NNBS was .929 and demonstrates validity and reliability and the information helps to identify collaboration and strength of interpersonal relationships between nurses.	Helps to identify what helps positive relationships between nurses and to improve cooperation.
Schumaher, Milani & Alexandre, 2019	Empowerment, power (psychology) psychometrics, validation studies	To evaluate the psychometric properties of the Psychological Empowerment Instrument (PEI) among Brazilian nurses.	PEI testing	n = 219	Confirmatory factor analysis	The PEI responses may have been influenced by where the nurses worked, the positive direction to deny undesirable attributes to nurses and a ceiling effected occurred due to the self-reporting of the PEI.	The PEI leaned on the evaluation on the psychometric properties of the instrument and was not used in the main study.

Table 4.4

Interview Question Fourteen

Name	What do you think would increase empowerment in the workplace for you?
Angela	Acknowledgment, recognition of positive feedback of performance. Not having to prove I am enough. Team-building exercises (line 36).
Beatrice	Increase communication and listening (line 40).
Carly	Positive and inclusive. Owning errors and open communication (line 32).
Darlene	Empowerment "need to continue to be redefined and improved" (line 27).
Eva	Good leadership and more "diversity in my peer/co-worker groups" (line 33).
Francis	"More diversity in leadership including representation of Black & Hispanic nurses" (line 37).
Georgia	"Access to resources, executive leadership team encouragement, support from mid-level management, creating a work environment where it is the expected norm, and recognition for accomplishment(s) by the executive leadership" (line 32).
Hailey	"I can't allow anyone else to give me that empowerment. I have to be empowered myself. So that is the first thing I do not think anyone can give you an empowerment. I believe that you can have an environment that you can strive to be the best you can be and demonstrate how you are empowered, I just have to do it for myself" (lines 19:30-19:55).
Inga	"True education around diversity, more diverse representation, consequences for bullying behavior" (line 18).
Jackie	"Crucial conversations need to be had…if there was more diversity in hiring and there was more diversity in management I think that organizations can bet more well-rounded picture of what employees are experiencing when there's a problem as opposed to just going with the culture because you can't change the culture if you don't recognize the issues and you have minimal to no representation of people that are experiencing some of the cancers of the issue" (lines 01:31-02:00).
Keisha	"Being heard, being valued, I get the feeling that some individuals that work directly with me are afraid to allow me to sine or be productive or successful as if it would interfere with their success" (lines 19:35-20:00).
Layla	"Your immediate supervisor or the…leadership team that you always are meeting with you know regularly to give you and make you feel valued…give you that green light to be great" (lines 00:31:48-00:32:25).
Molly	"if she would have sat all four down and we communicated to find out what was going on, you know, I guess I would put her at ease, what was going on and what she would have liked to have done, you know within me, what was it you know that was the problem" (line 12:29-12:46).
Nora	"a comment box, like where it's anonymous, but people bring it up, because for some reason people have a problem expressing themselves if they're put on the spot…some kind of way to communicate, but more anonymous" (line 120).
Olivia	"When bullying is reported it needs to be handled, swift and effectively. It is hard to convince yourself to file a complaint but it's worse when nobody cares, and they act like you are the problem" (line 15).

Table 4.5

Interview Question One

Name	What is your understanding of incivility and bullying in the workplace?
Angela	"Negative interactions" that "counteract harmony" and "denigrate" staff (Angela, line 4).
Beatrice	"Intimidation, by making you feel you have to do something you don't want to do" (Beatrice, line 0:02:15).
Carly	"Emotional and psychological abuse with words, and treatment of a person" (Carly, line 4).
Darlene	"instances where a person intentionally refuses to be courteous to another" engaging in "hurtful actions" (Darlene, line 4).
Eva	"behavior that negatively impacts another person or persons" but doesn't "warrant high level responses/actions" from the organization (Eva, line 5).
Francis	"being rude and disrespectful toward others," "Defaming the character of others" (Francis, line 5).
Georgia	"behavior and or language is foul, discriminatory, profane, physically or mentally aggressive, or harassing toward a person or persons" (Georgia, line 5).
Hailey	"It doesn't matter what ethnicity or culture you are, saying things that are degrading that are intrusive and belittling" (Hailey, line 01:01-01:11).
Inga	"It seems as if this accepted behavior that has become the norm" (Inga, line 4).
Jackie	Incivility: "You're just not a nice, kind person." Bullying: "you have a sense of power over someone else and you use that power to make that person less than" (Jackie, lines 01:51-02:13).
Keisha	Incivility: "when people aren't treating you fairly or…treating you the way you deserve to be treated." Bullying: "creating a hostile environment…making people feel uncomfortable…unwanted." "rude, disrespectful, and of the hospital environment "adversarial" (Keisha, lines 00:18-01:05).
Layla	"an environment as professionals where you feel integrity antagonized…you feel less than". Behaviors as "rude and crude, no matter if you're a new nurse or a seasoned nurse" (Layla, lines 00:00:58-00:01:31).
Molly	"when someone actually antagonizes you, they can't never do anything right, everything you do they just come and criticize; they complain about it (Molly, lines 00:31-00:41).
Nora	"it's everywhere, very common in nurses (Nora, line 8).
Olivia	"rude, unprofessional behaviors" and bullying is the "harassment and intimidation" (Olivia, line 2).

Table 4.6

Interview Question Twenty

Name	If you understand systemic racism as related to your experiences, what do you think your organization and we as nurses can do to stop it?
Hailey	"We've been saying for years that nurses need to stop eating their young. I don't know why we do that; I don't know why that initiation is allowed" (lines 38:00-38:14). "I belong to all of these diversity groups and mentor trying to come up with strategic ways in helping it to get better, but we're not getting any better, so I honestly don' t know…it's no action and that goes for everyone there is no action". "It needs to come from the top and not the bottom" (lines 38:42-39:08).
Inga	"People need to admit & see their own biases. If not, it will spill over into patient care" (line 26).
Jackie	"I think my organization they need to have more oversight and accountability…ensure a consistent level of diversity in their management". "we need a diversity council in hospital organizations to make sure not only from the patient level that we're addressing these things, but from the employee level as well and no tolerance whatsoever…and HR has to be confidential" (lines 33:54-34:31, 34:47-34:48).
Keisha	"Listen to their complaints and I feel like they do they tried to do that when …that person I shared the examples with is no longer with us and I felt that was very responsive, I appreciated that". "treat each other with respect and we need not to judge people based on the color of their skin…recognize our differences, our biases and that goes both ways". "Black people can have biases about other races as well, so we need to recognize those implicit biases and discuss them" (32:19-32:49).
Layla	"So I'm going to put your arms and try to help them in in in help guide them if they need some guidance or hell or what should I, you know, I've been that ear like a lot of people. Trust me." "Females as CEOs and then there's your position, but you also need to have people of Color to diversify organizations (lines 01:08:15, 01:10:16-01:14:47).
Molly	"treat everybody the same for job positions and opportunities and raises and different stuff like that…things need to change". "Nurses need to start working together…some of the things we need to do for us is lobbying…that all the way up we gonna start having a change" (line 25:50-26:14, 26:27-26:40).
Nora	"I think if we were more united as a team and our responsibilities that it wouldn't be an issue but I've seen it be an issue everywhere I've gone I've run into some more bullies, but I you know, I avoid them like the plague" (line 199).
Olivia	"I think nurses need to work together and work toward a better workplace for everybody. I think there needs to be a way for management to be held accountable when they are not doing their duties" (line 21).

Appendix B: Participant Recruitment Letter

Dear Participant's,

Hello, my name is Corrine Floyd, and I am a graduate student at the University of Missouri-St. Louis College of Nursing under the direction of faculty advisor Dr. Julie Bertram. To complete my doctoral studies at the University of Missouri-St. Louis, I am conducting a research study to explore the lived experiences of nurses who represent the minority population and their lived experiences of incivility, bullying, and empowerment in the workplace.

You are eligible to participate in this study if you are:

- Have a registered nurse license
- Work in the United States
- Are over 18 years of age
- Represent the minority population of nurses, identified by the United States Census as non-White.
- Speak English

You are not eligible to participate in this study if you:

- No longer have a registered nurse license
- Work in a different country
- Are under 18 years of age
- Are White or Caucasian
- Do not speak English

Your participation in this research is voluntary, and you may opt-out at any time. The duration of this research is for two weeks. If you agree to participate, you will be contacted up to four times by email. The first email is the invitation to participate or the recruitment email with an attached 10-minute survey (consent to take the survey is given by clicking on the survey). The second email will be sent to confirm participation and to arrange an interview, including written consent. The interview will take up to one hour, and you may be contacted to verify the information following the interview. Final email contact will be made to confirm the transcription and conclusion of the study.

There is *minimal risk* associated with this research. The degree of discomfort is subjective and is likely to be low. There may be subjective discomfort in sharing personal and sensitive information and the potential for a breach of confidentiality.

 Steps for the study:

During a two-week time period, the following steps will be followed if you choose to participate in the study.

1. You will receive an initial letter of invitation to the study.

2. At the end of the letter, a link to a 10-minute demographic and Workplace Incivility Survey (WIS) will be attached. By clicking on the survey, you are consenting to take the survey, and this is explained in the invitation letter and listed at the top of the survey. The survey is used as a screener to test participant's for workplace incivility.

3. If you test positive for incivility in the workplace, you will be sent a calendar link to arrange a one-hour interview at your convenience, and a signed consent form to participate in the study and proceed with the interview.

4. Once the date, time, and kind of interview per your preference (you will pick choices in the first survey of face-to-face, Skype, Zoom, cell phone, cell phone texting, email, or by the United States Postal Service mail for the interview). Face-to-face, Skype, Zoom, or cell phone interviews will be recorded or videotaped for transcription purposes for the study.

5. The last contact will be through email with the conclusion of the study. As part of the data analysis method, the participant will voluntarily be able to confirm the transcription and conclusion of the study.

6. All emails and interviews recorded audio or videos will be deleted at the conclusion of the study. Any information in the recordings or video will be kept on a password-protected computer by the Principal Researcher until the end of the study. After five years, the participant's information, recordings, or videos will be deleted. During transcription, the Principal Researcher will give each participant a pseudonym such as "Respondent one" and "Respondent two," and so forth before the analytic committee views the transcription.

7. If you become significantly uncomfortable with being interviewed, you may elect to stop participating in the study at any time. Additionally, I

will take every precaution to safeguard your privacy, and your data is considered confidential. There are no direct benefits for participation. If you decide to participate, you are free to withdraw at any time. There are no alternative procedures for the study.

Lastly, your participation is voluntary, and you may opt-out at any time. If you have questions, please contact Corrine Floyd MSN, RN, at (573) 721-3967 or cmfd23umsl.edu. Dr. Julie Bertram is my faculty chair at the University of Missouri-St. Louis and she may be reached at bertramje@umsl.edu. If you would like any follow-up information or results from this survey, please contact me via my email address, as noted above.

 Sincerely,

Corrine M. Floyd MSN, RN
Doctoral Student
University of Missouri-St. Louis
College of Nursing
St. Louis, MO

Please complete the attached Link: Consent to take the survey is given by clicking on the link to take the survey.

https://www.surveymonkey.com/r/DCDCJRT

Appendix C: Approval letter from author to use the Workplace Incivility Survey

(WIS)

Re: WIS

Lilia Cortina <lilia@umich.edu>
Mon 3/30, 10:24 AM
Floyd, Corrine ⌄

You forwarded this message on 3/30/2020 1:15 PM

Thank you for your interest in the Workplace Incivility Scale (WIS). You have my permission to use this scale for research purposes. The full text of the scale (both stem and items) is available in articles published in *Journal of Occupational Health Psychology* and *Journal of Management*. To download copies of those articles, please visit my lab website and scroll to the bottom: http://lsa.umich.edu/psych/lilia-cortina-lab/

Best of luck with your project,
Lilia Cortina

--
Lilia M Cortina, PhD
Professor of Psychology, Women's Studies, & Management
Associate Director of ADVANCE for the College of LS&A
Co-Director, ICOS Program

Web: http://www.lsa.umich.edu/psych/lilia-cortina-lab/

Mailing Address: Department of Psychology, 530 Church St, Ann Arbor, MI 48109-1043
Office: 3270 East Hall
Tel: 734.647.3956

On Mon, Mar 30, 2020 at 2:30 AM Floyd, Corrine <cmfd23@umsl.edu> wrote:

Appendix D: Workplace Incivility Survey (WIS): Sent via SurveyMonkey Inc.

Workplace Incivility Survey

2. Workplace Incivility Survey

Please complete the following Likert survey to the best of your knowledge and click on the "Done" button when completed.

The word incivility as defined as uncivil behavior in which "uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (Cortina et al., 2001, cited in Andersson & Pearson, 1999, p. 457).

18. During the past five years while employed as a registered nurse, have you been in any situation where any of your superiors or coworkers..

	Never	Once or Twice	Sometimes	Often or many times	Most of the time
Put you down or was condescending to you?	○	○	○	○	○
Paid little attention to your statement or showed little interest in your opinion?	○	○	○	○	○
Made demeaning or derogatory remarks about you?	○	○	○	○	○
Addressed you in unprofessional terms, either publicly or privately?	○	○	○	○	○
Ignored or excluded you from professional camaraderie?	○	○	○	○	○
Doubted your judgment on a matter over which you have responsibility?	○	○	○	○	○
Made unwanted attempts to draw you into a discussion of personal matters?	○	○	○	○	○

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Appendix E: Demographic Questions- In digital form sent via SurveyMonkey Inc.

Workplace Incivility Survey

1. Demographics

By clicking on this survey you have agreed to consent to take the survey.

* 1. What is your age?

- ○ Under 18
- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65+

* 2. What is your sex?

- ○ Male
- ○ Female
- ○ Other (please specify)

[ ]

3. What state do you reside in?

[▲▼]

* 4. Which race/ethnicity best describes you? (Please choose only one.)

- ○ American Indian or Alaskan Native
- ○ Asian / Pacific Islander
- ○ Black or African American
- ○ Hispanic
- ○ White / Caucasian
- ○ Multiple ethnicity / Other (please specify)

[ ]

1

5. What is your country of birth?

- ⊙ Australia
- ⊙ Brazil
- ⊙ Canada
- ⊙ China
- ⊙ France
- ⊙ Germany
- ⊙ India
- ⊙ Italy
- ⊙ Japan
- ⊙ Mexico
- ⊙ New Zealand
- ⊙ Russia
- ⊙ Spain
- ⊙ United Kingdom
- ⊙ United States
- ⊙ None of the above
- ⊙ Other (please specify)

6. Is english your first language?

- ⊙ Yes
- ⊙ No

7. About how many years have you been in your current position?

- ⊙ Less than 1 year
- ⊙ At least 1 year but less than 3 years
- ⊙ At least 3 years but less than 5 years
- ⊙ At least 5 years but less than 10 years
- ⊙ 10 years or more

* 8. Are you a registered nurse?

2

9. Employment Status?

○ Part-time

○ Full-time

○ Per Diem

○ Retired

10. What is your primary job description?

○ Staff Nurse

○ Leadership: (i.e. Nurse Manager, Lead, Supervisor, Charge, Administrator)

○ Clinical Instructor

○ Nurse Faculty

○ Other: (i.e. Case manager, long term care)

[   ]

* 11. How many years as a registered nurse?

○ Less than 6 months   ○ 21-25 years

○ 7 months- 1 year   ○ 26-30 years

○ 2-5 years   ○ 31-40 years

○ 6-10 years   ○ 41-50 years

○ 11-15 years   ○ 51 years plus

○ 16-20 years

* 12. Highest level of academic preparation in nursing?

○ Associates   ○ Doctoral

○ Baccalaureate   ○ Post Doctorate

○ Master's

○ Other (please specify)

[   ]

3

13. Do you intend to leave your employer in

○ 0-3 months   ○ 7-10 years

○ 4-6 months   ○ 10-15 years

○ 7-12 months   ○ 16-20 years

○ 1-3 years   ○ 21 years plus

○ 4-6 years

14. Why do you intend to leave?

○ Not leaving   ○ Promotion

○ Moving   ○ Retiring

○ Bad work environment   ○ Better job/pay

○ Other (please specify)

[ ]

* 15. Preference of interview (will take approximately one hour or more based on your responses. In person, Zoom or Skype or phone will be recorded for transcription purposes. For interview email through private or personal email only, no organization or facility emails.

○ Email   ○ Skype

○ Cell phone text   ○ Zoom

○ Cell phone   ○ USPS mail

○ Other (please specify)

[ ]

16. What is your marital status?

○ Single

○ Married

○ Partnered

○ Divorced

○ Other (please specify)

[ ]

4

17. What is your private email other than your organization or facility email?

After the survey is completed and you meet the criteria for the study, you will receive a follow-up email for a consent to an interview by the researcher. Thank you

5

Contacts

If you have questions, please contact Principle Researcher Corrine Floyd MSN, RN at (573) 721-3967 or cmfd23@umsl.edu or Dr. Julie Bertram as faculty chair at the University of Missouri-St. Louis and she may be reached at jbertram@umsl.edu

If you would like any follow-up information or results from this survey, you may contact me at my email address, as noted above.

Thank you for your time,

Corrine Floyd MSN, RN
Doctoral Candidate
University of Missouri-St. Louis
College of Nursing

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Appendix F: University of Missouri-St. Louis IRB Application

Office of Research Administration

One University Boulevard
St. Louis, Missouri 63121-4499
Telephone: 314-516-5899
Fax: 314-516-6759
E-mail: ora@umsl.edu

DATE: May 26, 2020

TO: Corrine Floyd, MSN
FROM: University of Missouri-St. Louis IRB

PROJECT TITLE: [1603770-1] Empowering Nurses of Minority in the Face of Incivility and
                         Bullying: Through the Lens of Phenomenology
REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: May 26, 2020
EXPIRATION DATE: May 26, 2021
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review categoryies # 6,7

The chairperson of the University of Missouri-St. Louis IRB has reviewed the above mentioned protocol
for research involving human subjects and determined that the project qualifies for expedited review
under Title 45 Code of Federal Regulations Part 46.110b. The time period for this approval expires one
year from the date listed below. You must notify the University of Missouri-St. Louis IRB in advance of
any proposed major changes in your approved protocol, e.g., addition of research sites or research
instruments.

You must file an annual report with the committee. This report must indicate the starting date of the
project and the number of subjects to date from start of project, or since last annual report, whichever is
more recent.

Any consent or assent forms must be signed in duplicate and a copy provided to the subject. The
principal investigator must retain the other copy of the signed consent form for at least three years
following the completion of the research activity and they must be available for inspection if there is an
official review of the UM-St. Louis human subjects research proceedings by the U.S. Department of
Health and Human Services Office for Protection from Research Risks.

This action is officially recorded in the minutes of the committee.

If you have any questions, please contact Carl Bassi at 314-516-6029 or bassi@umsl.edu. Please include
your project title and reference number in all correspondence with this committee.

- 1 -   Generated on IRBNet

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Appendix G: Participant Consent Form A: Informed Consent for Participation in a Survey

<u>**Introduction**</u>
College of Nursing
One University Boulevard
St. Louis, Missouri 63121-4499
Telephone: (314) 516-6066
Email: cmfd23@umsl.edu

Informed Consent for Participation in Research Activities

Participant _____
HSC Approval Number _____
Principal Investigator: <u>Corrine Floyd MSN, RN</u>
PI's Phone Number: <u>(573) 721-3967</u>
<u>**Summary of the Study**</u>
My name is Corrine Floyd MSN, RN, and I am completing this research study under the supervision of faculty advisor, Dr. Julie Bertram, at the College of Nursing at the University of Missouri-St. Louis.   I ask that you read this form and ask any questions you may have before agreeing to be in the research.   Your participation in this research is voluntary. You are free to withdraw at any time. If you agree to participate, you will complete one electronic survey (10-minutes) and consent to being contacted for further research, based on results of you survey.
There is minimal risk associated with this research. The degree of discomfort is subjective and is likely to be low. There may be subjective discomfort in sharing personal and sensitive information and the potential for a breach of confidentiality. There is a monetary $20 e-gift card given after completion of the interview. If you decide to participate, you are free to withdraw at any time. There are not alternative procedures for the study.

1. You are invited to participate in a research study because you are a nurse who is in a minority population scored high in experiencing incivility in the workplace and agreed to be contacted for further research in this area.. This study is about incivility, bullying, and empowerment in the workplace.

2. a) Your participation will involve completing a short on-line survey and consenting to be contacted by email for further research.

Approximately 210 people will need to complete the survey for the inclusion criteria in the demographics and for those who have experienced incivility in the workplace. A total of 15 people may be involved in this research at the University of Missouri-St. Louis. The participant selection is based on a first come first serve basis and after 15

participant's is reached for testing positive for experiencing workplace incivility the survey will close.

2 b) The amount of time involved in your participation will be 10 minutes for the consent, demographics, and survey. If you don't test positive for experiencing incivility in the survey you will receive an email form the researcher saying that part of the study is concluded.

3.   There is minimal risk associated with this research, which may include discomfort sharing experiences of incivility and bullying in the workplace. The degree of discomfort is subjective and is likely to be low. There may be potential for a breach of confidentiality using email. Confidentiality will be strictly maintained during and after the study, and participant's will remain confidential during and after the study concludes.

4.   There is a monetary incentive provided after completion of the interview in the form of a $20 e-gift card sent directly to the participant's email by the Principal Researcher. Other possible benefits in this study are: to help nurses improve the workplace for minority registered nurses and provide education, knowledge, and give a voice to minority nurses based on their experiences of incivility, bullying, and empowerment in the workplace.

 5.   Your participation is voluntary, and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you decided not to participate or withdraw.

6.   Your participation is voluntary, and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you decide not to participate or withdraw.

7.   We will do everything we can to protect your privacy. The information includes emails, correspondence, recordings, and files; all will be preserved in locked storage and under a password-protected computer. An email not linked to your organization or associations email is requested at the end of the survey after it is completed to give you confidentiality to use private email to remain confidential. All emails from participant's to the Principal Researchers' emails will be kept confidential and saved on a password-protected computer.   As part of this effort, your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to the disclosure of your data as well as any other information collected by the researcher.

8.   If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Corrine Floyd 573-721-3967, cmfd23@umsl.edu, or Faculty Advisor, Dr. Julie Bertram bertramje@umsl.edu. You may also ask questions or

state concerns regarding your rights as a research participant to the Office of Research at 314-516-5897.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I hereby consent to my participation in the research described above by clicking "Yes" button below.

○ Yes (1)

○ No (2)

Please click on the link below to the survey. Thank you for your participation.

Survey

End of Block: Default Question Block

Appendix H: Form B-Informed Consent for Participation in Research Activities

College of Nursing
One University Boulevard
St. Louis, Missouri 63121-4499
Telephone: 314-516-6066
Email: cmfd23@umsl.edu

Informed Consent for Participation in Research Activities
Empowering Nurses of Minority in the Face of Incivility and Bullying

Participant ------____Corrine Floyd MSN, RN_____ HSC Approval Number __

Principal Investigator __Corrine Floyd MSN, RN_____ PI's Phone Number _573-721-3967_

 Summary of the Study

My name is Corrine Floyd MSN, RN, and I am completing this research study under the supervision of faculty advisor, Dr. Julie Bertram, at the College of Nursing at the University of Missouri-St. Louis.

I ask that you read this form and ask any questions you may have before agreeing to be in the research.

You are invited to participate in a research study about nurses who represent minorities. The study explores the experiences of empowerment in comparison to incivility and bullying in the workplace.

Your participation in this research is voluntary. You are free to withdraw at any time. The duration of this research is for two weeks. If you agree to participate, you will be contacted up to four times by email. The first email will be sent to confirm participation and to arrange an interview. You will complete one electronic survey (10-minutes), one interview (up to one hour), and will be contacted to verify information following the interview. There is a monetary incentive provided after completion of the interview in the form of a $20 e-gift card sent directly to the participant's email by the Principal Researcher.

There is minimal risk associated with this research. The degree of discomfort is subjective and is likely to be low. There may be subjective discomfort in sharing personal and sensitive information and the potential for a breach of confidentiality. There are no direct

benefits for participation. If you decide to participate, you are free to withdraw at any time. There are not alternative procedures for the study.

2. a) The total length of time for the study will be a two-week time period the following steps will be followed if you choose to participate in the study.

• You will receive an initial letter of invitation to the study

   • At the end of the letter, a link to a 10-minute demographic and (WIS) is attached to the invitation. By clicking on the survey, you are consenting to take the survey. This is explained in the invitation letter and listed at the top of the survey. The survey is used as a screener to test participant's for workplace incivility.

   • If you test positive for incivility in the workplace, you will be sent a calendar link to arrange a one-hour interview at your convenience, and a signed consent form to participate in the study and proceed with the interview.

   • You will choose the date, time, and kind of interview per your preference. (You will pick choices in the first survey of face-to-face, Skype, Zoom, cellphone, cell phone texting, email, or by the United States Postal Service mail for the interview). Face-to-face, Skype, Zoom, or cell phone interviews will be recorded or videotaped for transcription purposes for the study. The interview will be a series of questions to ask the participant about their experiences of incivility, bullying, and empowerment in the workplace for approximately a one-hour duration based on the participant's' responses.

   • The last contact will be through email with the conclusion of the study. As part of the data analysis method, the participant will voluntarily be able to confirm the transcription and conclusion of the study.

Approximately 15 people may be involved in this research at the University of Missouri-St. Louis.

b) The amount of time involved in your participation will be 10 minutes for the survey, one hour for the interview, 10 minutes for scheduling an appointment, and 30 minutes after the interview to complete a review of the themes. There is a monetary $20 e-gift card after the interview is completed.

3.	There is minimal risk associated with this research, which may include discomfort sharing experiences of incivility and bullying in the workplace. The degree of discomfort is subjective and is likely to be low. There may be subjective discomfort in sharing personal and sensitive information. Discomforts may be related to sharing experiences of incivility and bullying. If you become significantly uncomfortable with being interviewed, you may elect to stop participating in the study at any time. There may be potential for a breach of confidentiality using email or other researchers reading or viewing the recordings. Confidentiality will be strictly maintained during and after the study, and participant's will remain anonymous during and after the study concludes.

4.	There is a monetary incentive provided after completion of the interview in the form of a $20 e-gift card sent directly to the participant's email by the Principal Researcher. Other possible benefits in this study are to help nurses improve the workplace for minority registered nurses and provide education, knowledge, and give a voice to minority nurses based on their experiences of incivility, bullying, and empowerment in the workplace.

5.	In this study, there is no clinically relevant research result. As part of the data analysis method, using Colaizzi's seven-step method, the participant's will be given the opportunity to review the transcription and research results of the study, maintaining all participant's' confidential information as anonymous. The findings of the study will be available for the participant's at the conclusion of the study.

6.	Your participation is voluntary, and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you decide not to participate or withdraw.

7.	We will do everything we can to protect your privacy. Any information in the recordings or videos will be kept on a password-protected computer. During transcription, names will be replaced with pseudonyms such as "Respondent one" and "Respondent two," and so forth before the analytic committee viewing the transcription. The participant's confidential information will not be published nor in the final dissertation. The information includes emails, correspondence, recordings, and files; all will be preserved in locked storage and under a password-protected computer.

An email not linked to the participant's organization or associations email is requested at the end of the WIS after it is completed to give the participant confidentiality to use private

email to remain anonymous. All emails from participant's to the Principal Researchers' emails will be kept confidential and saved on a password-protected computer.

All interviews recorded through participant's' choice of face-to-face, Zoom, Skype, or cell phone will be kept confidential on the Principal Researchers password-protected computer. The interviews will be transcribed, and participant's will be given numbered pseudonyms of respondent one, respondent two, etc. before the data analysis to protect personal identity.

 As part of this effort, your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to the disclosure of your data as well as any other information collected by the researcher.

8.   If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Corrine Floyd 573-721-3967, cmfd23@umsl.edu, or Faculty Advisor, Dr. Julie Bertram bertramje@umsl.edu. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research at 314-516-5897.

> **I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I hereby consent to my participation in the research described above.**

_____   _____

Participant's Signature   **Date**

_____   _____

Signature of Investigator or Designee   **Date**

Appendix I: Introduction after the survey was completed and prior to the interview

Thank you for completing this survey. My doctoral dissertation study focuses on your experiences as a minority registered nurse of incivility, bullying, and empowerment experiences in the workplace. I am requesting your participation in an interview in the study titled "Empowerment of Nurses of Minority in the Face of Incivility and Bullying." The feedback you provide in this study will allow me to give a voice to minority nurses experiencing incivility or bullying in the workplace and give insight to empowerment experiences that need to be shared, so we can support our minority nurses in the workplace.

It is estimated it will take an hour to complete the interview. I have provided a link to Doodle poll to coordinate calendars or you may contact me via email directly to arrange a time for the interview. The interview will be per your choice of phone, web conferencing, email, cell phone texting or mail. While every effort will be made to keep confidential all of the information you complete and share, it cannot be absolutely guaranteed. Individuals from the University of Missouri-St. Louis Institutional Review Board (a committee that reviews and approves research studies), the Principal Researcher and supervisor chair Dr. Julie Bertram PhD, RN, will protect your identity with the utmost caution. Recorded phone or video/web conferencing conversations are transcribed by the Principal Researcher and then a pseudonym replaces the name of each participant. Interviews may be pulled to ensure accuracy of the transcription, however; the identity of each participant is protected, and information will be deleted after five years of the study from the principal researchers password protected computer and files.

After the conclusion of the study you will be contacted one final time through email to read the concluded study to confirm it is accurate as part of the data analysis of the study. The final evaluation will also be voluntary, and the participant may opt out at any time.

If you have questions, please contact Corrine Floyd at (573) 721-3967 or cmfloyd@ccis.edu. Dr. Julie Bertram is my faculty chair at the University of Missouri-St. Louis, and she may be reached at bertramje@umsl.edu. If you would like any follow-up information or results from this survey, you may contact me via my email address, as noted above.

Please sign the attached consent to participate in the interview for the study.

Thank you, Corrine Floyd MSN, RN

Appendix J: Instrument Scoring for Workplace Incivility Survey screener

Name (Pseudonym) Respondent 1-15	Workplace Incivility Survey Score	Scored Positive for Incivility
Angela	21	X
Beatrice	4	X
Carly	4	X
Darlene	15	X
Eva	11	X
Francis	11	X
Georgia	14	X
Hailey	17	X
Inga	21	X
Jackie	16	X
Keisha	20	X
Layla	18	X
Molly	18	X
Nora	28	X
Olivia	12	X

Appendix K: Semi-Structured Interview Questions-Interview Guide

Interview Guide: Completed per respondents' preference of style of interview via face-to-face: in-person, Zoom or Skype or by telephone or cellular phone with all dialogue recorded or email, cellular texting or mail.

Note taking and reflexivity in each phase.

<div align="center">Semi-Structured Interview Questions</div>

Section One:

1.What is your understanding of incivility and bullying in the workplace?

2.Please describe your work environment.

3.Please describe the events of incivility and/or bullying that occurred?

4.What are your thoughts and feelings when this happened?

5.What is your understanding of empowerment in the workplace?

6.Please tell me your experiences with empowerment.

Section Two:

7.What does a typical day look like when you are at work?

8.What sort of things would you describe as happening when you were bullied?

9.Please elaborate on how you feel when you were bullied.

10.Who were all the players in the incidence of being bullied?

11.Who were the individuals who were involved in your experiences of empowerment?

12.Comparing your experience(s) of incivility and/or bullying to your experience(s) of empowerment what sticks out to you?

13.How do you feel about the comparison?

14.What do you think would increase empowerment in the workplace for you?

15.If you were talking with someone who expressed they were bullied in the workplace, what advice would you give them?

Third Section:

In reflection of the interview questions for the study Empowering Minority Nurses in the Face of Incivility and Bullying I have a couple of more questions.

16. Because you are a minority nurse do you feel your experiences of incivility and/or bullying, or empowerment are related to how you were treated? Please elaborate.

17. If it is related to your ethnicity or minority representation, if given the chance, what would you say to other minority nurses in the same situation?

18. From your experience as a nurse, do you feel minority nurses are treated equivalent in the workplace?

19. Do you have any additional questions or comments you may have in terms of what we discussed in the interview?

Appendix L: Data Analysis Method

Colazzi's Seven-Step Descriptive Phenomenological Method

Step	Descriptions
1. Familiarization	The researcher familiarizes him or herself with the data, by reading through all the participant accounts several times.
2. Identifying significant statements	The researcher identifies all statements in the accounts that are of direct relevance to the phenomenon under investigation.
3. Formulation of meanings	The researcher identifies meanings relevant to the phenomenon that arise from a careful consideration of the significant statements. The researcher must reflexively "bracket" his or her presuppositions to stick closely to the phenomenon as experienced.
4. Clustering themes	The researcher clusters that identified meanings into themes that are common across all accounts. Again, bracketing of presuppositions is crucial, especially to avoid any potential influence of existing theory.
5. Developing an exhaustive description	The researcher writes a full and inclusive description of the phenomenon, incorporating all the themes produced at step 4.
6. Producing the fundamental structure	The researcher condenses the exhaustive description down to a short, dense statement that captures just those aspects deemed to be essential to the structure of the phenomenon.
7. Seeking verification of the fundamental structure	The researcher returns the fundamental structure statement to all participant's (or sometimes a subsample in larger studies) to ask whether it captures their experience. He or she may go back and modify earlier steps in the analysis in the light of this feedback.

Morrow, Rodriguez, & King (2015)

Appendix M: Member Checking Email for Colaizzi's Step Seven

Dear Participant,

Thank you for your participation in my dissertation research. Currently, I am conducting member checks to increase trustworthiness for the data analysis. I have listed the random pseudonym for you in the study as "pseudonym". Please check your transcribed comments under your given pseudonym name and email me any changes. Review the attached document that categorizes themes that emerged during analysis and send comments in a response email. Comments should reflect your opinion regarding the accuracy of the themes from your point of view. The due date for comments is 9/06/2020. Participation is voluntary.

Thank you very much for this last effort at assisting me in this project. A full report of the study will be accessible one year from the time the study was conducted. I appreciate your contributions.

Sincerely,

Corrine Floyd MSN, RN
PhD Nursing Candidate
University of Missouri-St. Louis

Appendix N: List of Organizations and Associations of Nursing

Below is a list of organizations and associations contacted:

Advancing Men in Nursing

American Association of Nurse Anesthetists

American Assembly for Men in Nursing

American Holistic Nurses Association

American Nurses Association

Arizona Nursing Association

Asian American Pacific Islander Nurses Association (and its chapters)

Association of Black Nurse Faculty

Association of Medical Professionals with Hearing Losses

Chi Eta Phi Sorority, Inc. (and its chapters/regions)

Eastern Nursing Research Society

Hospice and Palliative Nurses Association

HSHS St. Mary's Hospital, Decatur, IL

International Society of Psychiatric and Mental Health Nurses

Midwest Nursing Research Society

Minority Nurse Magazine

Mount Sinai Health System

Muslim Nurses Association

National Alaska Native American Indian Nurses Association

The National American Arab Nurses Association

National Association of Hispanic Nurses (chapters)

National Association of Indian Nurses of America

National Black Nurses Association (chapters)

National League for Nursing

Native Alaska Native American Indian Nurses Association

Native American Nurses Association of Arizona

New York State Nurses Association

The Nurses Organization of Veterans Affairs

Oregon Health & Science University

Organization for Associate Degree Nursing

Philippine Nurses Association of America, Inc.

Sigma Theta Tau (chapters)

Society of Trauma Nurses

The Southern Nursing Research Society

Transcultural Nursing Society

University of Nevada, Las Vegas

U.S. Public Health Service Nurses

University of Florida

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