Ninety-eight percent of employees have experienced incivility in their workplace, and nursing faculty in academic nursing education are not immune. Workplace incivility is a low-intensity, deviant interaction between two parties that has negative implications for individuals and their organization. Nursing faculty have reported the physical and psychological impact of incivility on their lives, and it is necessary to gain a deeper understanding of this problem as it may negatively impact the recruitment and retention of nursing faculty. The aims of this study were to (1) explore the relationship between the attributes of nursing faculty and their experiences with workplace incivility and (2) explore the effect of experiences with workplace incivility on the physical and psychological health of nursing faculty. An electronic, 53-item survey was distributed via E-mail to nursing faculty in the state of North Carolina. Respondents provided quantitative data about their demographics, experiences with workplace incivility, perceived levels of stress, physical health, and psychological health. Using two open-ended questions, respondents also provided qualitative data about their experiences with workplace incivility.

Through a multiple linear regression analysis, five variables were found to be significant predictors of nursing faculty experiences with workplace incivility: age, full-time equivalent status, highest degree earned, orientation program participation, and program type. Specifically, experiences with workplace incivility were higher for faculty who were older, full-time, and prepared with a doctoral degree. Furthermore, incivility

experiences were higher in faculty who did not participate in an orientation program and who taught in graduate degree programs. Additionally, through a three-step hierarchical multivariate multiple regression analysis, increased experiences with workplace incivility were found to be significantly related to an increase in headaches among nursing faculty, while controlling for participant demographics and perceived levels of stress. Finally, using qualitative content analysis, four themes emerged from the data in the two-open ended questions: (1) *the experience*, (2) *personal and professional impact*, (3) *a reciprocal, cultural problem*, and (4) *survival.* The findings from this study provided quantitative and qualitative evidence that workplace incivility is negatively impacting the health of nursing faculty. Future work about workplace incivility in academic nursing education should be aimed at evaluating strategies to reduce the prevalence of incivility, as well as exploring of the broader impact that workplace incivility in academic nursing education has on the nursing profession.

WORKPLACE INCIVILITY AND ITS EFFECTS ON

NURSING FACULTY

by

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Approved by

_____
Committee Chair

I dedicate this work to anyone, nurse or otherwise, who has

experienced workplace incivility.

This dissertation written by Jayme Trocino Sherrod has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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CHAPTER I

INTRODUCTION

Civility, derived from 'civis' in Latin, is generally defined as polite and courteous behavior (Abolfazl Vagharseyyedin, 2015), in which individuals treat others with dignity (Andersson & Pearson, 1999). More specifically, civility is necessary to maintain the functions of a society (Abolfazl Vagharseyyedin, 2015). Incivility is just the opposite. Andersson and Pearson (1999) state "that incivility involves acting rudely or discourteously, without regard for others, in violation of norms for respect in social interactions" (p. 455). The presence of incivility within organizations, also described as workplace incivility, has negative implications for individuals (Hershcovis, Ogunfowora, Reich, & Christie, 2017; Kabat-Farr, Cortina, & Marchiondo, 2018; Lim, Cortina, & Magley, 2008; Yıldırım, 2009) and the organization as a whole (Bartlett & Bartlett, 2011; Porath & Pearson, 2012, 2013).

Workplace incivility is a low-intensity, deviant interaction between at least two parties without clear intention of harm (Andersson & Pearson, 1999; Pearson & Porath, 2004). Workplace incivility can be experienced, witnessed, or instigated by the members of an organization (Schilpzand, De Pater, & Erez, 2016). When researchers study experienced incivility, they are studying the feelings and thoughts of the victim, or target, of incivility. When witnessed incivility is studied, the researchers are exploring the thoughts and feelings of those observing incivility in the workplace. Finally, instigated

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incivility describes research about the individual who is acting uncivilly (Schilpzand et al., 2016). There is minimal research on witnessed incivility and even less on instigated; yet, research has shown that experienced incivility has many negative implications for the target, including both physical and psychological effects (Hershcovis et al., 2017; Kabat-Farr et al., 2018; Lim et al., 2008). Porath and Pearson (2013) describe incivility as a "soul-destroying experience" (p. 116). Incivility exists in many organizational settings, including academic nursing education.

Incivility in academic nursing education is a phenomenon that has been widely studied over the past decade. In 2007, just over 70% of nursing faculty and students perceived incivility to be a moderate problem in their department (Clark & Springer, 2007a). An entire decade later, little has changed, with 71% of nursing faculty and 73% of nursing students continuing to identify incivility as a moderate to serious problem (Aul, 2017). The purpose of this study was to advance the inquiry by exploring workplace incivility and its effects on faculty physical and psychological health. Results of this study helped identify specific factors related to negative impacts of incivility, expanded the evidence base of incivility in nursing education, and provided a foundation for future research to develop and test interventions that can improve the negative impacts incivility has on nursing faculty.

Background

The definitions of incivility in nursing education vary. Peters (2014) describes incivility as an intentional disrespect from one individual to another that leaves the afflicted party doubting his or her own abilities. Clark and Springer (2007b) define

incivility as rude or disrespectful actions that can progress to abusive or even violent behavior. The authors indicate that academic incivility results when these behaviors impact the learning environment. Depending on the severity of the behaviors, it is possible that incivility can terminate learning altogether (Clark & Springer, 2007b). DeMarco, Fawcett, and Mazzawi (2018) describe the presence of covert incivility in academic nursing education, in which individuals act in what appears to be a civil way, but they are intending to be uncivil. For example, covert incivility is a superficial display of kindness (e.g. an encouraging smile and nod) toward a new faculty member with intention to not actually be helpful to that individual (DeMarco et al., 2018). This definition contradicts the notion that incivility has ambiguous intent to harm. Therefore, the presence of covert incivility has damaging consequences. Despite the varying definitions of incivility in the nursing academic setting, research has demonstrated that incivility is a prevalent, concerning problem.

The route of incivility in any environment can vary based on hierarchical status. Incivility can be passed in three different directions: top-down, bottom-up, or laterally (Marchiondo, Marchiondo, & Lasiter, 2010). Top-down incivility is when incivility travels from a person of higher authority to a person of lower authority (Marchiondo et al.). In nursing education, this is most commonly seen as incivility from faculty toward students or administration toward faculty. Bottom-up incivility occurs when a person of lower status acts uncivilly toward a person of higher status (Marchiondo et al.). This is demonstrated when students are uncivil toward faculty or faculty toward administrators. Finally, lateral incivility is incivility between two individuals who are of equal status in

an organization (Marchiondo et al.). In nursing education, lateral incivility most often occurs between faculty members or between students.

The reach that incivility has in nursing education is great, as essentially all members in the academic environment are affected. Students, faculty, and administrators are all instigators and targets of incivility (Clark & Springer, 2007a; LaSala, Wilson, & Sprunk, 2016; Sauer, Hannon, & Beyer, 2017). The research on incivility among these groups is abundant; yet, in order to effectively and reasonably understand the phenomenon of interest, it is necessary to focus the research on a sub population (e.g., students, faculty, or administration) of the nursing academic environment. Nursing faculty, specifically, are at a high risk of experienced incivility, as they can experience it from students, administration, and other faculty. DalPezzo and Jett (2010) deem nursing faculty "a vulnerable population" (p. 132) due to their susceptibility of physical and emotional harm related to experiencing incivility from students, administrators, and other faculty.

There is ample evidence surrounding student-to-faculty incivility and workplace incivility, which includes faculty-to-faculty and administration-to-faculty incivility, in nursing education. Qualitative evidence has demonstrated that both types of incivility, student and workplace, impact the physical and psychological health of nursing faculty (Luparell, 2007; Peters, 2014). For this study, the researcher chose to focus on workplace incivility, due to the continuous presence of faculty and administrators. Students come and go each semester or year, while nursing faculty are often expected to continue working with the same peers and administrators over many years. Due to the ever-

present, ongoing nature of workplace incivility, it is possible that nursing faculty may have more difficulty separating from and handling experiences with workplace incivility than they do with student incivility. Therefore, this study focused on the impact of workplace incivility specifically to provide evidence for future inquiry and intervention.

Significance

Identifying and understanding the experiences that nursing faculty have with incivility is critical to advancing the evidence base of incivility in nursing education, as well as understanding potential barriers to recruitment and retention of new nursing faculty. In October 2016, the American Association of Colleges of Nursing (AACN) reported that there were 1,567 faculty vacancies for baccalaureate and graduate nursing programs across the country (AACN, 2017). Additionally, 64,067 qualified candidates were refused admission to nursing school due to faculty shortages, space, and budget constraints (AACN, 2017; National League for Nursing [NLN], n.d.). The average age of Associate Professors holding doctoral degrees is 57.6 years. The average age of retirement for nursing faculty is 62.5 years, and a wave of retirements is expected over the next decade (AACN, 2017). A 2015 assessment determined that one third of faculty were over the age of sixty and predicted that by year 2025 many of those faculty would be retired, marking a severe shortage (Fang & Kesten, 2017). The need to recruit new nursing faculty and retain existing ones is imperative to the future of the profession. Workplace incivility in the academic setting may be a barrier.

Organizational behavior research has found that experiences with workplace incivility have a direct impact on turnover intention among employees (Lim et al., 2008;

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Porath & Pearson, 2013). Specifically, nursing faculty have reported leaving their roles due to experiences with incivility, albeit student or workplace (Kolanko et al., 2006; Luparell, 2007; Lynette, Echevarria, Sun, & Ryan, 2016). Faculty have also reported feeling empowered to leave when they see other faculty leave their roles due to incivility (Wieland & Beitz, 2015). They see this action as overcoming the incivility and as a resilience-building experience (Wieland & Beitz). While this may be perceived as a positive for the individual, it has negative implications for the school and academic process. The impact of workplace incivility on nursing faculty is profound and has implications for the entire nursing profession.

In 2017, the National League for Nursing (NLN) made a call for a dialogue among nurse educators and leaders to help foster a culture of civility (National League for Nursing [NLN] Vision Series, 2018). This call was in alignment with other organizations, including The Robert Wood Johnson Foundation, Quality and Safety Education for Nurses, and The American Nurses Association, which had already advocated for a more civil work culture (NLN Vision Series). As a result, the NLN published a Vision Series entitled *Creating Community to Build a Civil and Healthy Academic Work Environment*. Through this document, the NLN calls for a "cultural transformation in schools of nursing to co-create and implement civility and inclusiveness strategies and interventions among nurse educators" (NLN Vision Series, 2018, para. 1).

Through this Vision Series, the NLN proposed recommendations for faculty, leaders, and the NLN. The majority of recommendations for faculty are aimed at creating

and sustaining civility between faculty and students. For example, the NLN recommends that faculty raise student awareness of incivility, model civil behavior for students, and create ways to include civility within student evaluations (NLN Vision Series, 2018). While these recommendations are valuable to promoting civility between students and faculty, there is only one recommendation made to faculty that will promote general workplace civility. The NLN calls for faculty to become more self-aware of personal behaviors that may harm a civil environment (NLN Vision Series). Authentic self-awareness among nursing faculty can be invaluable in creating and sustaining civility in academic nursing education. The document also calls nurse leaders to play a larger role in eliminating workplace incivility.

Nursing education leaders are encouraged to create a dialogue about civility among nursing faculty, demonstrate self-care behaviors that promote civil behavior, mandate civility training, and consider ways to include civility in faculty evaluations (NLN Vision Series, 2018). The NLN has positioned the administration of the academic nursing environment to be the catalyst for creating and sustaining workplace civility. However, administration, faculty, and staff are all responsible for establishing and maintaining a civil environment. Finally, the presence of incivility in nursing education has the potential to set the expectation of incivility in nursing practice (Lashley & de Meneses, 2001). Morrissette (as cited in Clark, 2008b) suggests that "incivility often begets incivility" (p. E38). As faculty experience workplace incivility, there may be an increase in incivility directed at other faculty, as well as students. Clark and Springer (2007a) suggest that there is a culture shift toward the tolerance of incivility, and this is a

concerning phenomenon as uncivil faculty continue to prepare students for the workforce. Therefore, it is necessary to gain a deeper understanding about workplace incivility and its impact in the academic nursing environment.

Theoretical Framework

The Theory of the Nurse as Wounded Healer (NWH) served as the theoretical framework for this study. Rooted in the work of Carl Jung, Dr. Marion Conti-O'Hare published this middle range theory in 2002 to describe the process in which nurses transcend personal traumatic experiences to more effectively heal others (Conti-O'Hare, 2002). The concept of healing has been discussed for centuries, yet the motive of those providing the healing, the healers, is not as well understood (Conti-O'Hare, 2002). Jung's (1951) work on the wounded healer began to describe the potential motive of healing practices (as cited in Conti-O'Hare, 2002). Jung (1953) asserts that everyone has experienced some sort of trauma in life, and these experiences drive, consciously and unconsciously, human behavior (as cited in Christie & Jones, 2014). Conti-O'Hare (2002) discovered the relevance this concept has to nursing and uses the NWH to more adequately describe nurses' experiences with wounding – defined in this theory as the experience of receiving a wound – and their transcendence from those wounds.

Historically, healing has been thought of in a holistic approach: healing of the mind, body, and spirit of individuals. Yet, nursing has experienced a shift to a more reductionist method in which healing is focused on decreasing and eliminating disease (Conti-O'Hare, 2002). Despite this shift, "nursing's most singular constant endures: *it is the ability of the nurse to care and heal*" (Conti-O'Hare, 2002, p. 15). Jung's (1951)

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work on the wounded healer noted that a holistic approach to healing, rather than "clean hands perfection" (p. 17), is imperative to a successful healing process for professionals (as cited in Conti-O'Hare, 2002). The nursing profession values perfection, but this expectation can inhibit the healing ability of nurses (Conti-O'Hare). Under the assumption that all individuals experience trauma in their lives, the ability of nurses to effectively heal is greatly impacted by their own wounding and the desire for perfection. The NWH explains how nurses cope with these challenges and ultimately provide effective healing to their patients (Conti-O'Hare). The NWH asserts nine assumptions which can be found below in Table 1.

Table 1

Fundamental Assumptions of the Theory of the Nurse as Wounded Healer

All human beings experience trauma in their lives
For nurses, trauma may be of a personal nature, a professional nature, or a combination of both
The way nurses cope with trauma has a profound effect on patient care
Trauma does not automatically resolve itself without intervention
Trauma can be transformed and transcended, then used to help others
Healing involves transforming the self from walking wounded to wounded healer
Therapeutic use of self is dependent on the degree to which trauma has been transformed and transcended in a person's life
The wounded healer represents the highest level of using the self therapeutically
Nursing is a wounded profession that needs to heal itself in order to survive

(Conti-O'Hare, n.d., para. 2)

The NWH consists of three distinct levels: the walking wounded, transformation, and transcendence to a wounded healer (Conti-O'Hare, 2002). The walking wounded

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level is preceded by a traumatic event and distress. The traumatic event may occur in an individual's personal life or through a work experience. If the traumatic event is significant enough, the individual will experience physical or psychological distress. This process results in individuals being considered "the walking wounded." Conti-O'Hare (n.d.) defines the walking wounded as "an individual who remains physically, emotionally and spiritually bound to past trauma" (para. 3). Conti-O'Hare (2002) also speculates that nurses are attracted to the nursing profession based on previous, personal traumatic experiences. As a result, the nursing profession is made up of the walking wounded.

The coping strategies of the walking wounded will determine their path to transcendence or not (Conti-O'Hare, 2002). Those with ineffective coping strategies will not be able to resolve their wounds leading to painful results, such as emotional problems, addiction, or burnout. Others, who have an awareness of their wounding and are able to employ effective coping strategies, are able to move from the path of the walking wounded to a pathway of healing (Conti-O'Hare). The first step on the pathway to healing is recognition of pain. Conti-O'Hare asserts that it is unknown to what extent a person can even recognize his or her own wounding. In some cases, it may require that an individual is encouraged to explore his or her emotions related to situations and identify these as potential traumas. Conti-O'Hare discusses that nurses with more professional experience are more capable of recognizing and identifying their own wounds.

After the trauma and pain is recognized by the nurse, he or she moves toward a process of transforming that pain into a useful experience. At the transformation level,

nurses gain more healing capabilities for their patients as well as for themselves (Conti-O'Hare, 2002). Transformation is a dynamic process in which the nurse must commit to the integration of a new form of self. When individuals commit and believe in this process, they gain the capacity to accept themselves and encourage the change to occur (Conti-O'Hare). Through transformation, individuals gain a high level of self-awareness, ultimately preparing them for transcendence.

Transcendence is the final and highest level in the process to becoming a wounded healer. Conti-O'Hare (2002) indicates that transcendence and transformation "may be viewed as two sides of the same coin" (p. 88), but transcendence extends beyond the simplicity of becoming self-aware. Transcendence is achieved when individuals are engaged in ongoing conscious thought about their feelings and actions. Conti-O'Hare asserts that practices such as meditation and centering are key in moving toward transcendence. Upon reaching the level of transcendence, individuals are granted new possibilities for their lives. Ultimately, transcendence is met by three factors: one's awareness of the impact of the trauma in his or her life, one's continuous awareness of feelings and behaviors related to that trauma, and one's ability to integrate his or her wounding into healing processes for others (Conti-O'Hare). The nursing profession desires transcendence and healing for both nurses and patients, and the healing process of patients cannot begin without nurses transcending into wounded healers (Conti-O'Hare).

Unfortunately, the process of transcendence from wounding is not always achievable for nurses. In some cases, nurses do not possess the coping strategies to transform and transcend pain. In other cases, nurses are not even able to recognize their

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own wounding. Conti-O'Hare (2002) poignantly states, "yet even with the proclivity of recognizing trauma in others, nurses often have difficulty in seeing themselves as victims" (p. 57). In some cases, nurses may be difficult to convince of their own wounding, and as they remain in stressful conditions, the trauma is repeatedly reinforced (Conti-O'Hare). In the case of incivility in nursing education, nursing faculty may have trouble even recognizing that workplace incivility is negatively impacting their lives. They are victims of this trauma, and they may be unwilling to recognize or even accept it.

The severity of wounding has implications for the ability of an individual to transcend that trauma (Conti-O'Hare, 2002). Emotional and psychological wounding can leave individuals with such feelings of inadequacy that they lack any capability of transforming into a wounded healer. Conti-O'Hare discusses that cumulative stress can result in sleep disturbances, difficulty concentrating, and an overall decrease in social functioning. Even under good circumstances, the stress of persistent wounding can lead to burnout and even post-traumatic stress disorder (Conti-O'Hare).

Theory Application

The NWH has excellent applicability to the experiences that nursing faculty have with incivility in their roles. Workplace incivility serves as a work-related trauma that negatively impacts nursing faculty. Although the NWH is originally described with the outcome of effectively healing patients, effective teaching and scholarship are the desired outcomes for nursing faculty. Nursing faculty who experience incivility will not be able to effectively teach without first transcending their pain. Therefore, it is important to first

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empirically understand the theoretical proposition that a trauma leads to physical and psychological distress.

Figure 1 displays a visually adapted conceptual model of the NWH. Although the high- level concepts in the theory can be complex, or even difficult to understand, the early proposition of the theory posits that a trauma leads to physical and psychological distress. Qualitative evidence already suggests that workplace incivility has negative psychological and physical outcomes on the victim (Peters, 2015). Under this proposition made in the NWH, this study explored the relationship between the trauma of workplace incivility and the physical and psychological health of nursing faculty. The trauma of workplace incivility has the potential to turn nursing faculty into the walking wounded leading to negative physical and negative psychological effects. Following Figure 1, Figure 2 displays a schematic of the variables of this research study under the proposition that trauma leads to physical and psychological distress.

Figure 1

Conceptual Model of the Theory of the Nurse as Wounded Healer - Adapted from Christie & Jones (2014)
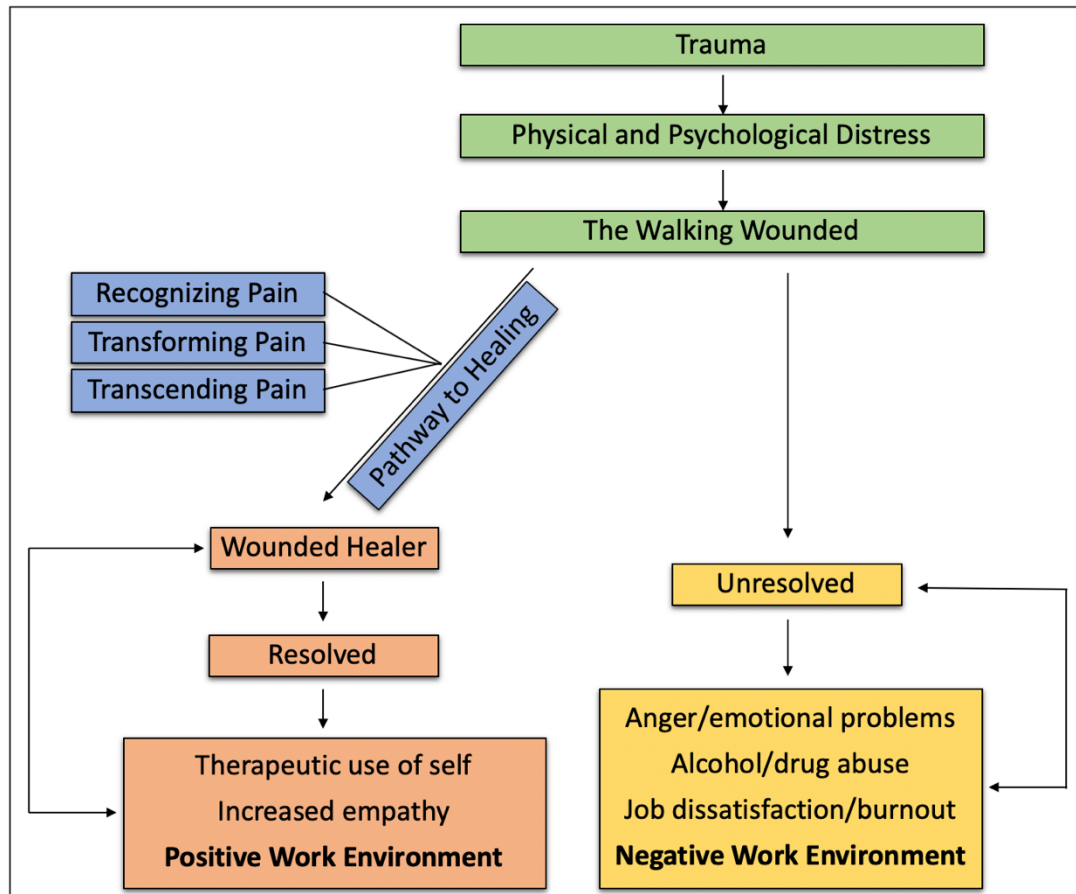
Figure 2

Visual Representation of the Research Study

Workplace Incivility

Physical Health

Sleep Disturbances, Headaches, Digestive Problems, and Respiratory Problems

&

Psychological Health

Decreased General Well-Being
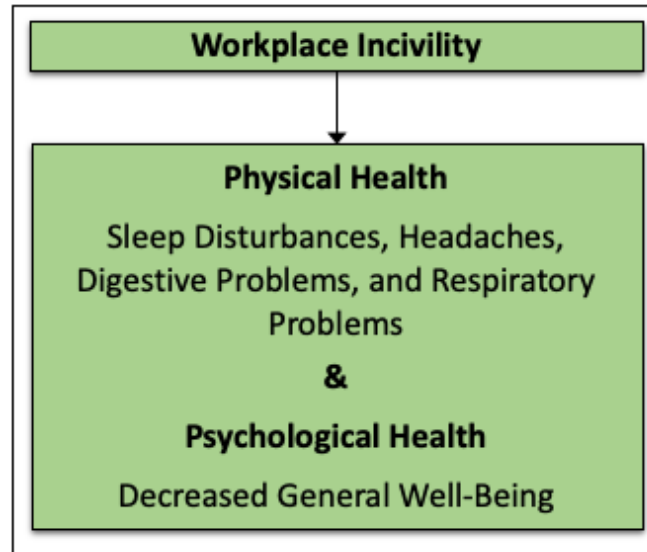
Assumptions

There were several assumptions considered for this study. First, it was assumed that the respondents were honest and open when answering the questions about their health and incivility on the survey. Second, it was assumed that the respondents only reported on the uncivil experiences that they had in their current roles. It was also assumed that the instruments used to measure the variables were accurate in measuring the desired constructs. Finally, it was assumed that workplace incivility is a suitable concept to represent a trauma, as discussed in the chosen theory.

CHAPTER II

LITERATURE REVIEW

Workplace incivility exists in many organizational settings, including academic nursing education. Nursing faculty, in particular, have experiences with workplace incivility that negatively impact their lives. This chapter will provide a literature review on the phenomenon of workplace incivility to help further understand the basis for the proposed research study. This review has four sections. The first section will explore workplace incivility as a concept in the organizational behavior literature and the impact it has on employees. The second section will discuss the role of organizational culture on the prevalence of workplace incivility. The third section will describe the prevalence of incivility in nursing education. The final section will summarize the current state of the evidence and discuss the specific needs for future research on workplace incivility in nursing education.

Historically, research related to workplace incivility focused on deviant behaviors or workplace aggression (Andersson & Pearson, 1999). Workplace aggression included more overt behaviors that were physical and direct (Andersson & Pearson); yet, a small study of 178 participants in the mid 1990s revealed that the majority of aggression in the workplace is verbal and passive, as opposed to physical and direct (Baron & Newman, 1996, as cited in Andersson & Pearson, 1999). This work set off an exploration to further understand this type of workplace aggression. The concept of workplace incivility

appeared in the literature in the late 1990s in an effort to describe how minor uncivil behaviors can spiral out of control into aggressive behaviors between employees (Andersson & Pearson).

Through their work, Andersson and Pearson (1999) identified examples of minor incivility in the workplace, such as not saying please and thank you, leaving an empty pot of coffee for another employee to fill, or leaving trash on the floor for janitorial services to clean. The new concept of incivility was contrasted with workplace civility, which was described as polite behavior while regarding others with respect (Andersson & Pearson). Through this work, Andersson and Pearson suggested that the absence of civility in an organization erodes the relationships of employees and hinders the ability of an organization to function effectively. This work championed a movement to study workplace incivility and the impact it has on employees.

Since its advent in 1999, the definition of workplace incivility has remained a standard with minor variations. Andersson and Pearson (1999) constructed the first working definition for workplace incivility: "Workplace incivility is low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (p. 457). Cortina, Magley, Williams, and Langhout (2001) extended this definition by specifying that incivility may be due to ignorance of the instigator and cause accidental harm. Estes and Jia Wang (2008) assert that uncivil behaviors are not only ambiguous in intent to harm, but they have no intention of harming. This has been refuted by DeMarco et al. (2018), as they posit that covert

incivility is intentional incivility disguised by civil behavior. These definitions are similar

to that of workplace bullying with a difference in intention. Bartlett and Bartlett (2011)

define workplace bullying as a negative, repetitive act from an instigator toward a target

in which there is a power imbalance and an intent to harm. Comparable to workplace

bullying, workplace incivility is negative, can be ongoing, and can certainly occur with

an imbalance in power. As a result, the terms bullying and incivility have often been used

interchangeably in the literature.

Early work described examples of uncivil behaviors, such as screening phone

calls with voicemail or answering the phone with a curt "yeah" (Andersson & Pearson,

1999); yet, more recent work has shown behaviors such as eye-rolling, interrupting, and

gossiping to also represent the construct (Schilpzand et al., 2016). For the purpose of this

review and this study, workplace incivility was defined as a low-intensity, deviant

interaction between at least two parties without clear intention of harm (Andersson &

Pearson, 1999; Pearson & Porath, 2004). Additionally, for the purpose of this review and

this study, the individual demonstrating the uncivil behavior was termed the instigator,

and the individual experiencing the incivility was termed the target.

In 2013, Porath and Pearson polled thousands of employees and found that 98%

of them had experienced uncivil behaviors in their workplace (Porath & Pearson, 2013).

More importantly, these experiences with workplace incivility have negative impacts on

employees. In a survey of 800 respondents from 17 different types of organizations, 80%

of employees and managers indicated that they spent time at work worrying about the

uncivil encounters. Additionally, 78% reported a decrease in their commitment level to

their organization, and 12% even left their jobs (Porath & Pearson, 2013). In a review of the literature on workplace bullying and incivility, Bartlett and Bartlett (2011) identified three negative effects of bullying in the workplace: effects on the target's work, health, and attitude. Work outcomes included absenteeism, lower job satisfaction, and decreased work performance. The authors also identified both physical and mental health outcomes, such as headaches, sleep disturbances, and posttraumatic stress disorder (PTSD). Finally, attitude changes, such as anger, impatience, and motivation were impacted by bullying experiences in the workplace (Bartlett & Bartlett, 2011).

In 2001, Dr. Lilia Cortina and colleagues laid the foundation for the science surrounding workplace incivility in their development of the Workplace Incivility Scale (WIS; Cortina et al., 2001). The scale has served as a standard for measuring the phenomenon in much of the organizational behavior literature over the last decade (Demsky, Fritz, Hammer, & Black, 2018; Hershcovis et al., 2017; Kabat-Farr et al., 2018; Lim et al., 2008; Nicholson & Griffin, 2015; Torkelson, Holm, Bäckström, & Schad, 2016; Zhou, Yan, Che, & Meier, 2015).

Schilpzand, De Pater, and Erez (2016) consider workplace incivility to be divided in three categories: experienced, witnessed, and instigated. Much of the workplace incivility evidence has been focused in the domain of experienced incivility, and research has demonstrated the impact of experienced workplace incivility on organizations and the physical and psychological health of employees (Schilpzand et al.). Therefore, the following will provide a review on the impacts of experienced workplace incivility.

The Impact of Workplace Incivility

Although incivility is said to differ from bullying in that there is ambiguous intent to harm, Estes and Jia Wang (2008) state, "the fact that harm is not intended does not mean that harm will not occur. In fact, it does" (p. 227). The following paragraphs will discuss the impact that workplace incivility has on the organization and the health of its targets.

Organizational Outcomes

In three studies of public sector employees, respondents indicated that workplace incivility had caused an overall dissatisfaction with their jobs, including dissatisfaction with supervisors, coworkers, pay, and advancement opportunities (Cortina et al., 2001). This dissatisfaction influences overall workplace commitment, which has been negatively associated with experiences of workplace incivility (Bartlett & Bartlett, 2011; Schilpzand et al., 2016). Employees report increased absenteeism due to workplace incivility (Porath & Pearson, 2012; Schilpzand et al., 2016) and ultimately intention to leave (Bartlett & Bartlett, 2011; Cortina et al., 2001).

In addition to lack of commitment, absenteeism, and intent to leave, workplace incivility has effects on productivity of employees. Andersson and Pearson (1999) indicate that incivility is a naturally reciprocal process, in that incivility incites more incivility. In a study of 325 employees and supervisors, there was a significant, positive relationship between experienced incivility and behavioral incivility (Harold & Holtz, 2015). More specifically, those who had higher levels of experienced incivility were also demonstrating higher levels of uncivil behavior. Furthermore, research suggests that these

employees are more likely to reciprocate, retaliate, and become more deviant (Harold & Holtz, 2015). Experiences with incivility can be perceived by the target as injustices, and evidence indicates that not only does the target of the injustice retaliate, but the target's team members rally around the target and retaliate as well (Siegel Christian, Christian, Garza, & Ellis, 2012). Team members are impacted by witnessing incivility, and they naturally respond. For example, research suggests that those who witness incivility demonstrate fewer organizational helping behaviors (Schilpzand et al., 2016), also known as "organizational citizenship behaviors" (Heilman & Chen, 2005, p. 431). Overall, the presence of retaliation, deviance, and a decrease in citizenship behaviors can create a challenging work environment and cause the organization to suffer.

Porath and Pearson (2013) assert that these outcomes "chip away at the bottom line" (p. 116). They further discuss that workplace incivility negatively impacts relationships with customers which in turn decreases profits. Even more alarmingly, research has suggested that workplace incivility costs organizations approximately $14,000 annually, per employee, due to its ability to cognitively distract employees from the work to be done (Pearson & Porath, 2009, as cited in Schilpzand et al., 2016). Organizations must pay special attention to these outcomes and recognize that the impact of workplace incivility on employees extends beyond the individuals, themselves. Yet, it is necessary to also gain a deeper understanding into the direct psychological and physical impact of workplace incivility on individual targets.

Psychological Outcomes

In 1984, Richard Lazarus and Susan Folkman developed the Transactional Model of Stress and Coping, also known as Cognitive Appraisal Theory (Lazarus & Folkman, 1984). This theory suggests that individuals are faced with stressors that need to be evaluated. The first step in this evaluation is the primary appraisal process in which a person identifies a stressor either as a harm/loss, threat, or challenge. Cortina and Magley (2009) used the Transactional Model of Stress and Coping to describe how individuals evaluate their experiences with workplace incivility and cope with these uncivil experiences. Respondents included university employees, attorneys, and court employees. As predicted, the researchers found that individuals consider uncivil experiences to be more uncivil when the behaviors are varied (i.e. unpredictable), repeated, and from a higher ranking member of the organization (Cortina & Magley). This research has been extended by showing an association between workplace incivility and negative affect (i.e. negative feelings, such as anger and guilt) (Kabat-Farr et al., 2018). Ultimately, the negative emotional responses to incivility, including anger and guilt, are significantly associated with a decrease in employee self-esteem and empowerment (Kabat-Farr et al.).

Poor mental health has been found to be significantly associated with experiences of workplace incivility among various employee types (Bartlett & Bartlett, 2011; Cortina et al., 2001; Schilpzand et al., 2016; Yıldırım, 2009). In a seminal piece on workplace incivility, Cortina et al. (2001) found, in their study of employees in the federal court system, that psychological distress was greater in individuals with more encounters of workplace incivility. Additionally, in a study of 286 nurses in Turkey, workplace

bullying was significantly associated with clinical depression, with 45% of participants displaying moderate to severe depression symptoms (Yıldırım, 2009). More severely, employees have reported experiences with PTSD in response to uncivil, bullying behaviors in the workplace (Bartlett & Bartlett, 2011).

In a study of 356 individuals from 15 different organizations, researchers purposefully sampled employees based on their reports of daily or weekly bullying in their workplace (Rodríguez-Muñoz, Moreno-Jiménez, Sanz Vergel, & Garrosa Hernández, 2010). The study randomized participants into two groups: targets of bullying and a control group, those who had not been bullied. Of those who had experienced workplace bullying, 42.6% met the clinical criteria for PTSD, such as re-experiencing symptoms. It was also found that women experienced more PTSD from workplace bullying than did men (Rodríguez-Muñoz et al.). Research has indicated that such experiences also have physiological impacts on the targets.

Physical Outcomes

The direct or indirect impact that workplace incivility has on the physical health of targets varies in the evidence. Lim et al. (2008) conducted a study with 1,158 employees of the federal court system seeking to understand the relationship between workplace incivility and mental and physical health outcomes. Workplace incivility was measured with the Workplace Incivility Scale (WIS) from Cortina et al. (2001), while mental health and physical health were measured with the Mental Health Index and Health Satisfaction Subscale of the Retirement Descriptive Index, respectively. For the measure of physical health, participants were asked to respond to questions describing

how much health care they require and how often they experience illnesses (Lim et al., 2008).

The results from the first Lim et al. (2008) study indicated that workplace incivility had a significant, direct impact on the mental health of participants and a significant, indirect effect on the physical health, by way of mental health. More specifically, the relationship between workplace incivility and poor physical health was mediated by poor mental health (Lim et al.). In a follow up study by the same researchers, 271 employees of a city government system were surveyed using the WIS measuring workplace incivility and the Brief Symptom Inventory measuring mental and physical health (Lim et al.) In this study there were direct effects of workplace incivility on the physical and mental health of the targets, in addition to indirect effects of incivility on physical health by way of mental health (Lim et al.). In a review of the literature on workplace bullying, Bartlett and Bartlett (2011) describe a variety of physical outcomes due to workplace incivility. These include increases in chronic illnesses, weight gain, and headaches. Studies also report an increase in sleep disturbances, the need to take sleep medications, and an overall increase in substance abuse (Bartlett & Bartlett).

In a more recent study evaluating impacts of single perpetrator incivility, researchers sought to explain the relationship between an uncivil experience with one individual and the target's perception of job security and somatic symptoms, mediated by embarrassment (Hershcovis et al., 2017). Using purposeful sampling, 45 full-time employees were recruited for the study (Hershcovis et al.). The researchers used the WIS to measure workplace incivility ($\alpha = 0.75$). Somatic symptoms were measured by

participants' responses to how frequently they experienced three common symptoms: "stomach problems," "sleeplessness," and "headaches" (Hershcovis et al., 2017, p. 11). Researchers found that single perpetrator incivility was significantly and positively related to somatic symptoms, both directly and indirectly. In addition to the main effect, the relationship between incivility and somatic symptoms was mediated by an increase in embarrassment (Hershcovis et al.). These findings further support the work by Lim et al. (2008), in that physical outcomes are both directly and indirectly related to workplace incivility.

Impact of Organizational Culture

The culture that is created and maintained in organizations impacts the presence, or absence, of workplace incivility. Before beginning a discussion of organizational culture, it is necessary to first differentiate culture from climate. Although Schneider (1987) indicates that culture and climate are complementary of one another, he makes clear distinctions between the two concepts. Organizational climate describes how employees perceive what is important and rewarded in their organization. More specifically, an organizational climate is present when members of the organization understand what actions are valued to make the organization effective. Edgar and Peter Schein (2016), culture and leadership researchers, suggest that climate is more of a manifestation of culture, such that it is an objective product of an organization's underlying assumptions. They posit that one could gain a sense of an organization's climate by its physical layout and observance of how individuals interact with one another or with customers.

The concept of culture expands on climate, in that an organization is deemed to have a culture when members of the organization share the same set of beliefs and values (Schneider, 1987), albeit positive or negative. Therefore, organizational climate describes *what* is valued, while organizational culture describes *why* it is valued (Schneider). Schein (2016) offers a dynamic definition of culture:

> The culture of a group can be defined as the accumulated shared learning of that group as it solves its problems of external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel, and behave in relation to those problems (p. 6).

In using this definition of culture, it is reasonable to understand how positive or negative behavior can be learned among a group of individuals and eventually reinforced as new individuals join an organization. Many organizational behavior researchers suggest that the culture of an organization plays a major role in the presence or absence of incivility (Andersson & Pearson, 1999; Bartlett & Bartlett, 2011; Estes & Jia Wang, 2008; Torkelson et al., 2016). Most notably, Estes and Jia Wang (2008) assert, "organizational culture may provide a viable, if not complete, explanation relating to the cause of workplace incivility because culture can either reject or embrace incivility" (p. 222). Therefore, the role of workplace incivility is largely influenced by the organization's culture rather than its climate.

Every work environment has a set of norms, or "a shared moral understanding and sentiment among the members," which members of the organization follow (Andersson & Pearson, 1999, p. 455). Schein (2016) discusses that these beliefs and norms become

so integrated in a culture that they "eventually drop out of awareness" for individuals (p. 6). It is also important to note that norms are often implicit standards that are understood by an organization's members (Schein, 2016), but this implicit nature may explain why expectations for civil behavior in an organization are not clearly understood by the members. Understanding why workplace incivility is present only occurs by examining how an organization encourages certain actions and norms (Estes & Jia Wang, 2008). If uncivil behavior toward coworkers, customers, or supervisors is an unconscious norm for the organization, then incivility will continue to grow. In a study of workplace aggression, Torkelson et al. (2016) discuss the importance of preventing a culture of workplace incivility from an organization's inception. It is necessary to establish positive norms for an organization early on, given that a lack of established social norms is also a contributor to workplace incivility (Miner et al., 2012).

Members of organizations rely on leadership to demonstrate what is considered acceptable behavior for employees (Estes & Jia Wang, 2008). Furthermore, incivility moves from the top of organizations downward toward employees. More importantly, research suggests that individuals with greater levels of power have more opportunities to act uncivilly and are more likely to get away with it. The hierarchy of organizations can make the targets of incivility feel as if their experience is unimportant (Estes & Jia Wang). Moreover, Pearson and Porath (2004) report that less than half of targets who have experienced workplace incivility believe that a report would lead to any reprimand of the instigator. Leaders have a strong influence on the prevalence of workplace incivility within their organizations by way of how they respond to reports of it. It is also

necessary for leaders to end the reciprocal process of incivility. Although evidence suggests that experiences with incivility incite more incivility from the target (Harold & Holtz, 2015), it is the responsibility of leaders who experience bottom-up or lateral incivility to demonstrate that reciprocity will not be a part of their organization's culture.

The presence of workplace incivility in organizations has been studied among a variety of employees in the organizational behavior literature; yet, incivility is also prevalent in nursing. While incivility has been widely studied among nurses in the practice setting, the presence of incivility in academic nursing education remains a concerning phenomenon. Over 70% of nursing faculty and nursing students consider incivility a moderate to serious problem in nursing education (Aul, 2017), and it is necessary to continue a scholarly discussion about its impact on the nursing academic environment.

Incivility in Nursing Education

Research on incivility in nursing education began in 2001 when 409 nursing program administrators completed a survey about nursing student incivility (Lashley & de Meneses, 2001). Higher education research had established the presence of incivility in the academic setting, but this had not yet been explored in the nursing realm (Lashley & de Meneses). In this study, participants were asked to compare how students behaved currently compared to five years before. Researchers found that 43.4% of administrators felt that student disruptive behaviors had increased in the past five years. The study also reported the top uncivil student behaviors, including student lateness to class, inattention

in class, and holding disruptive conversations (Lashley & de Meneses). This seminal

piece marked the beginning of an abundance of incivility research to come.

A few years later, Dr. Susan Luparell (2004; 2007) conducted a qualitative study,

using critical incident technique, with 21 nursing faculty to describe their experiences

with uncivil students. She described incivility as "battle" (Luparell, 2004, p. 61) for the

nursing faculty and indicated that their experiences with uncivil students were a "threat to

their own well-being" (Luparell, 2007, p. 16). In 2007, Dr. Cynthia Clark began making

contributions to the incivility evidence base and started to shape the way that incivility in

nursing education would be discussed over the next decade.

Clark and Springer (2007a) created and used the Incivility in Nursing Education

(INE) survey to help describe the phenomenon of interest. The INE, composed of

common uncivil student behaviors and common uncivil faculty behaviors, was

administered to students and faculty in an effort to understand their perceptions of these

behaviors and how frequently they had experienced them. Clark and colleagues

eventually revised the INE to reflect more recent evidence on incivility (Clark, Barbosa-

Leiker, Gill, & Nguyen, 2015).

Clark (2008b) went on to describe incivility in nursing education as a "dance" (p.

E37) between students and faculty. She discussed that student incivility incites faculty

incivility and vice versa (Clark, 2009). Clark expanded her research to the People's

Republic of China and sought to understand how incivility is experienced in schools of

nursing internationally (Clark et al., 2012; Clark, Otterness, Allerton, & Otterness, 2010).

In 2013, Clark took attention to lateral incivility and the experiences that faculty had with

incivility from other faculty. Through this research she created the Faculty-to-Faculty

Incivility Survey (Clark, Olender, Kenski, & Cardoni, 2013), which was later renamed

the Workplace Incivility/Civility Scale (WICS). This research incited the discussion on

faculty-to-faculty incivility, which had not yet received much attention.

Subsequent qualitative studies described the impact that faculty-to-faculty

incivility had on new nursing faculty (Gazza, 2009; Peters, 2014) and the experiences

that nursing administrators had with faculty-to-faculty incivility (Peters & King, 2017).

Recently, incivility in nursing education research has been conducted in Iran

(Masoumpoor, Borhani, Abbaszadeh, & Rassouli, 2017), Oman (Natarajan, Muliira, &

van der Colff, 2017), and Canada (Tourangeau, Wong, Saari, & Patterson, 2015),

broadening the knowledge base.

Most recently, researchers have focused on generational differences in

perceptions of incivility (Tourangeau et al., 2015; Ziefle, 2018), as well as explored

moderators to incivility, such as resilience (Wieland & Beitz, 2015) and resonant

leadership (Casale, 2017). Finally, the literature is abounding with non-research articles

that discuss solutions to incivility in nursing education. Some strategies include the use of

an empowerment model (Shanta & Eliason, 2014), ethical systems (Burger, Kramlich,

Malitas, Page-Cutrara, & Whitfield-Harris, 2014), codes of conduct (Authement, 2016b),

and mindfulness (Green, 2018). The reach that incivility has in nursing education is great,

as essentially all members in the academic environment are affected. Students, faculty,

and administration are all instigators and targets of incivility (Clark et al., 2013; Clark &

Springer, 2007a; LaSala et al., 2016; Sauer et al., 2017), yet it is necessary to narrow the

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focus to a subpopulation in order to advance the science in a focused way. Therefore, the remainder of this review will focus specifically on nursing faculty experiences with incivility.

Nursing Faculty Experiences with Incivility

Similar to the work in organizational behavior research, the presence of incivility in the academic environment has often been described as a problem rooted in the school's culture. Goldberg, Beitz, Wieland, and Levine (2013) conducted a phenomenological study to explore social bullying among 16 nursing faculty. One of the themes discovered was the concept of a "bully culture" (p. 193). A bully culture is one in which bosses act aggressively toward subordinates, cliques permeate the environment, and there is a profound lack of teamwork among faculty (Goldberg et al.). Participants indicated that the bully culture prohibited the recruitment of new faculty, and "that the faculty shortage was entirely understandable given the bullying experience pervading academia" (Goldberg et al., 2013, p. 194).

In a hermeneutical phenomenological qualitative study on new nursing faculty experiences with faculty-to-faculty incivility, one participant described that the culture is one in which new nursing faculty are treated with disrespect until they prove themselves to more experienced, senior-level faculty (Peters, 2014). Nursing faculty have reported that they expected a "utopia" when they left practice and entered academia, and they were surprised to find that even doctoral-prepared faculty are still behaving in an uncivil way (Gazza, 2009, p. 224). This culture is also recognized by the administration. Peters and King (2017) conducted a phenomenological study with 11 nursing academic

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administrators who described incivility as an "ingrained culture" (p. 40). Participants

reported that incivility was an expected part of their institution (Peters & King, 2017). In

a qualitative study on incivility and resilience, some participants justified incivility by

simply stating, "this is academia" (Wieland & Beitz, 2015, p. 290). It is evident that an

uncivil culture potentiates the problem.

The early research from Lashley and de Meneses (2001) suggests that students are

changing and contributing to a more uncivil environment. Respondents in this landmark

study reported that the quality of students, student preparation, and clinical performance

was worse than it was five years before (Lashley & de Meneses). Morrissette (as cited in

Clark, 2008b) suggests that "incivility often begets incivility" (p. E38). As faculty

experience these negative changes in student behaviors, faculty incivility will continue to

rise. The "dance of incivility" between faculty and students, as described by (Clark,

2008b, p. E37), will continue, along with the culture of incivility that pervades the

academic environment. Clark and Springer (2007a) suggest that there is a culture shift

toward the tolerance of incivility, and this is a concerning phenomenon.

Experiences with student incivility.

Student incivility, specifically uncivil student-to-faculty behaviors, can be most

effectively described as bottom-up incivility. Researchers have sought to describe this

phenomenon, and through these efforts, the most common uncivil student behaviors have

been noted. In the seminal study, 95% of respondents indicated that student

lateness/absences from class, inattention in class, cheating, and talking during class were

problematic behaviors (Lashley & de Meneses, 2001). Subsequent research using the

INE, originally created in 2007 (Clark & Springer, 2007a) and revised in 2015 (Clark et al., 2015), reinforced all of the above behaviors as some of the most highly experienced uncivil actions (Clark, 2008a; Clark & Springer, 2007a). Additional qualitative research from Luparell (2004) documents other uncivil student behaviors ranging from sarcastic, disrespectful comments to foul language and non-verbal aggressive gestures. Faculty report being "subjected" to these unacceptable student behaviors (Sprunk, LaSala, & Wilson, 2014, p. 3). Most recently, in a systematic literature review, researchers reported the most frequent uncivil behaviors from students, including a lack of preparedness for class, sleeping in class, and acting apathetic in class (Ayu Eka & Chambers, in press).

International research has suggested different types of student incivility compared to that in the United States. As part of a larger mixed methods study in the People's Republic of China, Clark et al. (2010) reported quantitative findings that the most frequently experienced student behaviors were being unprepared for class, sleeping in class, and acting apathetic in class, all of which were further reinforced in a recent systematic literature review that explored uncivil student behaviors from studies around the world (Ayu Eka & Chambers, in press). Additionally, a qualitative study enrolling nursing faculty in Iran reported poor time management of students as a major barrier to the learning environment (Masoumpoor et al., 2017). Finally, quantitative work in Oman found general taunts and challenging faculty as the most common uncivil student behaviors (Natarajan et al., 2017). The perception of student behaviors likely varies due to the differences in values and demographics of the Chinese, Iranian, and Omani nursing cultures.

Experiences with faculty-to-faculty incivility.

Lateral incivility in the nursing academic environment can be represented by uncivil faculty-to-faculty behaviors. Early discussions on faculty-to-faculty incivility were described as "joy-stealing games" (Heinrich, 2007, p. 35) or "mean girl games" (Kolanko et al., 2006, p. 41), but it was eventually studied in a more rigorous way in a national mixed methods study. Quantitatively, the most frequently cited faculty behaviors included resistance to change, not performing workload, distracting others in meetings, and refusing to communicate (Clark et al., 2013). Yet, qualitative findings suggested berating and insulting to be the most frequent faculty-to-faculty behaviors, followed by undermining and sabotaging (Clark, 2013).

Goldberg et al. (2013) described faculty-to-faculty incivility as social bullying and described the bullying behaviors as bullying tactics, which included gossiping, isolation, manipulating, and slandering. Similar findings of isolation and belittling were found in a phenomenological study with new nursing faculty (Peters, 2014). Additionally, faculty have reported making efforts to avoid perpetrators of incivility by physically preventing contact with them, such as avoiding certain hallways (Wieland & Beitz, 2015). Student and faculty-to-faculty incivility research is broad, complex, and needs further understanding.

The Cause of Incivility in Nursing Education

In order to effectively understand any phenomenon, it is valuable to discuss its potential causes. As a part of larger mixed methods studies, some qualitative research has sought to explore the potential causes of incivility. Student incivility and faculty incivility

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have been largely attributed to stress of the instigators (Clark, 2008b; Clark & Springer, 2007b) Specifically, the high-stress academic environment is what potentiates the problem (Clark & Springer, 2007b). Clark (2008b) found that student stress was related to a challenging workload, a competitive environment, and feeling the need to cheat for success. Student stress has also been attributed to the challenges of balancing school, with family and other work obligations (Clark & Springer, 2010).

The stress contributing to faculty incivility is related to challenging workloads, faculty turnover, and challenges with work-life balance (Clark, 2008b). Faculty reported that the high faculty turnover can cause tension in the work environment (Clark, 2008b). Additionally, the hierarchical structure of academia creates a high-risk environment for incivility (Goldberg et al., 2013). Research in the People's Republic of China suggests different contributors to faculty stress and incivility. Clark et al. (2012) found that "moodiness" and "dissatisfaction with the faculty role" were contributors to acts of incivility in that country (p. 88). Respondents indicated that students and faculty within the Chinese culture lack a willingness to compromise and handle conflict (Clark et al., 2012).

Student incivility has also been attributed to students displaying a consumer mentality or an attitude of entitlement (Clark, 2008b; Clark & Springer, 2007b). Students report that they are making a financial investment in their education and feel that they are owed their education in return (Clark, 2008b). Faculty report that this sense of entitlement is a generational difference in which students have a "know-it-all attitude" and are not "respectful to authority" (Clark, 2008b, p. E42). The attitude of entitlement

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also extends beyond the United States. In a qualitative study on student incivility in Iran, faculty reported a concept of self-centeredness among the nursing students (Masoumpoor et al., 2017). Faculty describe students threatening teachers when they do not get their way (Masoumpoor et al.).

Finally, both faculty and students report that experiences with incivility cause uncivil responses (Clark, 2008b; Clark & Springer, 2010). Faculty have described faculty-to-faculty relationships as "toxic", and their stress is greater when experiencing this incivility (Clark, 2008b, p. E43). Students also feel that a lack of faculty support and faculty-to-student incivility incites uncivil behavior from students (Clark & Springer, 2010). Organizational behavior research confirms these statements and suggests that those who experience incivility are more likely to behave uncivilly (Harold & Holtz, 2015). This notion that "incivility often begets incivility" (Morrissette, as cited in Clark, 2008b, p. E38) is evident, and this cycle must be terminated.

Nursing Faculty Desire Support

Nursing faculty reportedly find themselves in uncivil situations within their roles, and they desire support from peers and administration; yet, many faculty report a lack of administrative support (Clark et al., 2013; Goldberg et al., 2013; Luparell, 2004). The organizational behavior research also suggests that individuals often seek informal support, such as family and friends, when dealing with workplace incivility, rather than placing formal complaints with administration (Cortina & Magley, 2009). This lack of support may be explained by the perception of employees that a formal report to administration would be futile (Pearson & Porath, 2004).

In dealing with student challenges, faculty have indicated that they are fearful of disciplining students due to a risk of reprise, such as poor course evaluations (Lashley & de Meneses, 2001). In some cases, more severe uncivil events have occurred because faculty were not addressing student incivility earlier (Luparell, 2004). One faculty member reported feeling like "a sitting target" when incivility from students was not addressed by administration (Sprunk et al., 2014, p. 7). Faculty require support in handling student incivility early; yet, evidence suggests they also need support in handling faculty-to-faculty incivility.

In a national study on faculty-to-faculty incivility, Clark et al. (2013) found that 48% of nursing faculty are fearful of approaching other faculty about incivility for fear of retaliation. Furthermore, the second most cited reason for avoiding a discussion about faculty-to-faculty incivility was a lack of administrative support, with 43% of faculty reporting this (Clark et al., 2013). Senior faculty are described as the individuals who are leading the incivility in these environments (Beckmann, Cannella, & Wantland, 2013), and faculty are ultimately becoming intimidated by one another (Peters, 2014).

Nursing administrators have reported that they felt regret for not handling faculty-to-faculty incivility encounters more quickly (Peters & King, 2017). Given that these nurse leaders perceived 80% of all faculty incivility to be directed at other faculty (Clark & Springer, 2010), it is crucial that they begin to discuss their role in improving incivility. In a recent study including 260 nursing faculty from 17 different universities, Casale (2017) found that experiences of faculty-to-faculty incivility were significantly lower in environments where resonant leadership, a style in which leaders are focused on

their relationships with followers, was high. This empirical evidence suggests that effective leadership and support from immediate supervisors and administration can have a positive impact on incivility in the environment, and faculty are looking for it.

Workplace Incivility among Nursing Faculty

The research on workplace incivility within the organizational behavior discipline has included incivility from co-workers, supervisors, and customers. In nursing education, incivility in the workplace includes incivility from faculty, administrators, and students. It can be argued that co-workers are analogous to faculty, and supervisors are analogous to administrators. Yet, the connection between customers and students is not as clearly defined. Some nursing literature has suggested that student incivility is a result of students maintaining a consumer mentality (Kolanko et al., 2006). Students perceive that they have power over faculty because "the tuition pays the salaries" (Kolanko et al., 2006, p. 38). Despite the differences in terminology, the behaviors of the instigators and the outcomes for the targets are consistent across the organizational behavior and nursing literature. The following will discuss the gaps in the nursing education literature surrounding nursing faculty experiences with incivility in their workplace.

Gaps in the Literature

Evidence suggests that experiences of workplace incivility have a direct impact on the faculty targets. In nursing education research, all of the work on outcomes of incivility has been qualitative, which has provided rich descriptions of the impact. Nursing faculty report being anxious, humiliated, devalued, isolated, and rejected. The targets describe a loss of self-esteem and confidence and have indicated the need to seek

therapy for treatment (Goldberg et al., 2013; Peters, 2014; Sprunk et al., 2014). In some

cases, faculty have had to work to overcome post-traumatic stress disorder after leaving

their roles due to experienced traumas (Wieland & Beitz, 2015). For example, nursing

faculty reported the need to remove memorabilia or visual reminders about their former

job in order to effectively function in their new environment (Wieland & Beitz). Incivility

in nursing education also creates a physical response in its targets. Examples include

sleep disturbances, weight gain, hypertension, headaches, and skin rashes (Luparell,

2007; Goldberg et al., 2013; Sprunk et al., 2014). The direct impact that incivility has on

nursing faculty is disturbing and requires further exploration.

The descriptive, qualitative literature is necessary and valuable, but it is time to

advance the inquiry. In 2015, the American Nurses Association (2015) developed a

position statement titled *Incivility, Bullying, and Workplace Violence* and stated the

following:

> …all registered nurses and employers in all settings, including practice, academia,
> and research must collaborate to create a culture of respect, free of incivility,
> bullying, and workplace violence. Best practice strategies based on evidence must
> be implemented to prevent and mitigate incivility, bullying, and workplace
> violence; to promote the health, safety, and wellness of registered nurses (para. 2).

 Nursing education research has explicitly indicated that incivility is impacting the health

and wellness of nursing faculty (Goldberg et al., 2013; Luparell, 2004, 2007; Peters,

2014; Sprunk et al., 2014; Wieland & Beitz, 2015); yet, there are no quantitative studies

to support these findings. It is time to address this gap.

Theory Application

In 2013, Mealer and Jones used the Theory of the Nurse as Wounded Healer

(NWH) to guide a concept analysis about post-traumatic stress disorder (PTSD) within

the nursing population. The authors posit that the concept of PTSD in nursing has been

focused on outcomes such as compassion fatigue and secondary stress; yet, research has

not focused on the lasting, long-term outcomes of particular traumas in the workplace.

Mealer and Jones (2013) used the NWH to understand the relationship between

experiencing a trauma and becoming the walking wounded (i.e. developing PTSD).

Mealer and Jones (2013) state that the "concept of walking wounded can help us better

understand the effects of the environment on the nurse and the manifested symptoms that

are associated with PTSD" (p. 284). Through their work, the authors used Walker and

Avant's method for concept analyses and determined that antecedents to PTSD include

exposure to a traumatic event, such as witnessing the death of a patient or witnessing

futile care. The consequences of PTSD impact both individuals and organizations, as

Mealer and Jones assert that nurses who experience these traumatic events experience

hopelessness, self-blame, and sleep disturbances. Additionally, PTSD has led to retention

issues with those nurses. This was attributed to avoidance behaviors, such as absenteeism

or avoiding certain types of patients that reminded those nurses of the trauma (Mealer &

Jones). These findings are in direct alignment with the NWH in that trauma leads to

physical and psychological distress. The concept analysis did not extend into the

transformation or transcendence levels; yet, the authors suggest that nursing is a wounded

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profession, and direct patient care will be impacted without transformation and transcendence from these wounds.

The NWH was used again in 2014 to guide a dissertation about experiences with patient perpetrated workplace violence among emergency department nurses (Christie, 2014). This study approached the theory in a more holistic way and used it to guide a phenomenological inquiry using 13 emergency department nurses. The study found four themes: feelings, working in the emergency department, changes, and coping. Feelings were described by subthemes of fear, helplessness, and the desire to seek revenge (Christie), which are in alignment with the proposition made by the NWH that traumas lead to psychological distress. The theme of working in the emergency department was explained by the nurses reporting support from their peers but not from administration. Additionally, the theme of changes was described by the nurses' reports of the physical and psychological changes they faced after experiencing patient perpetrated workplace violence. Finally, coping was manifested by both effective and ineffective coping strategies (Christie), which is in direct alignment with the potential processes outlined in the NWH.

Finally, and most recently, the NWH has been used as a framework for a review about lateral incivility within nursing practice (Christie & Jones, 2014). Christie and Jones assert that experiences with incivility in the workplace are work-related traumas that must be recognized, transformed, and transcended in the same way as personal traumas. Christie and Jones note the high stress environment of clinical practice, similar to that found in the academic environment, and suggest that incivility is an outcome of

nurses needing an outlet for their stressors. The authors posit that as lateral violence pervades the environment, the nurses become consumed by it, ultimately creating a group of the walking wounded. As described in the NWH, it is suggested that nurses must first recognize their wounding from the incivility and seek to transform that pain (Christie & Jones).

The application of the NWH in the review from Christie and Jones (2014) has excellent transferability to workplace incivility in academic nursing education. Nursing faculty are experiencing the trauma of incivility from peers and supervisors that creates wounds. Without proper recognition of their trauma, transformation, and transcendence, the nursing academic environment will be made up of the walking wounded. The NWH asserts that trauma leads to wounding, and when these wounds persist individuals can experience burnout and traumatic stress (Conti-O'Hare, 2002). The nursing education literature has qualitatively shown that a work-related trauma, such as workplace incivility, has physical and psychological impacts on nursing faculty. Although this proposition has been made in the NWH, this relationship has not been explored in a quantitative way. Under the proposition from Conti-O'Hare that trauma leads to physical and psychological distress, this research study quantitatively explored the relationship between workplace incivility and physical and psychological distress among nursing faculty. A visual representation of this study can be found in Figure 1 of Chapter One.

Conclusion

The organizational behavior literature has demonstrated that workplace incivility is a pervasive problem that has negative implications for both individuals and

organizations. Individual outcomes include physical distress, such as sleep disturbances, weight gain, and headaches, along with psychological distress, such as guilt, depression, and PTSD. These findings have been supported in the nursing education literature about nursing faculty experiences with workplace incivility; yet, these findings are qualitative, and it was time to advance the science. The Theory of the Nurse as Wounded Healer has served as a framework to guide research about nurses' experiences with PTSD, patient violence, and workplace incivility. It asserts that nurses have physical and psychological distress from traumatic experiences. Therefore, this study used that proposition and sought to fill a gap by quantitatively exploring the relationship between the work-related trauma of workplace incivility and physical and psychological distress among nursing faculty.

CHAPTER III

METHODS

This chapter describes the study's aims, research questions, conceptual and operational definitions, research design, sampling strategy, data collection strategies, data analysis, and plan to protect human subjects.

Specific Aims and Research Questions

The purpose of this study was to explore nursing faculty experiences with workplace incivility and its impact on their health. More specifically this study examined the effects of workplace incivility on the physical and psychological health of nursing faculty. Below are the specific aims and research questions for the research study.

Specific Aim #1

Explore the relationship between the attributes of nursing faculty and their experiences with workplace incivility.

Research question #1.

What variables (gender, age, race, years of faculty experience, full-time equivalent status, highest degree earned, orientation program, mentoring program, civility training, civility policy, college/university type, program type, and work from home) predict nursing faculty experiences with workplace incivility?

Specific Aim #2

Explore the effect of experiences with workplace incivility and the physical and psychological health of nursing faculty.

Research question #2.

What is the relationship between experiences with workplace incivility and the physical and psychological health of nursing faculty (sleep disturbances, digestive problems, headaches, respiratory problems, and general well-being)?

Conceptual Definitions

1. Nursing faculty – A Registered Nurse who is employed to teach students in an academic nursing program (i.e. a school of nursing).

2. Workplace incivility – A low-intensity deviant interaction between at least two parties without clear intention of harm (Andersson & Pearson, 1999; Pearson & Porath, 2004). This interaction occurs within the context of an organizational setting.

3. Psychological health – A state of general well-being in which an individual can function independently, sustain relationships with others, and effectively cope with life's stressors.

4. Physical health – A state of somatic wellness in which individuals deny generic somatic complaints (e.g. sleep disturbances, digestive problems, headaches, and respiratory problems).

5. Perceived stress – "The degree to which situations in one's life are appraised as stressful" (Cohen, Kamarck, & Mermelstein, 1983, p. 387). The concept was used as a control variable in Research Question 2.

6. Program type – Nursing faculty teach Registered Nursing students at various academic levels, and this describes the academic level (e.g. Baccalaureate or Graduate) in which they spend the most time teaching.

7. College/university type – The designation of a higher education institution based on how it is funded and the degrees it offers.

8. Years as a Registered Nurse – The cumulative number of years a respondent has maintained a Registered Nursing license.

9. Years as a nursing faculty member – The cumulative number of years a respondent has been in the role of a part-time and/or full-time nursing faculty member.

10. Full-time equivalent status – A nursing faculty's status of how many hours he or she is expected to work each week in their nursing faculty role.

11. Highest degree earned – The highest level of education obtained by a respondent. This includes degrees earned in fields other than nursing.

12. Orientation program – A formal program offered through the nursing program that helps new nursing faculty become familiarized and acclimated to their roles and responsibilities as a faculty member in their new school of nursing.

13. Mentoring program – A formal program offered through the nursing program in which new nursing faculty are assigned a seasoned mentor to help new faculty transition into their new roles.

14. Civility policy – A written plan of action that guides expectations of civil behaviors and management of uncivil behaviors for the members in a school of nursing.

15. Civility training – A training program in which individuals learn how to promote a civil academic environment.

16. Work from home – The location in which the respondent works.

Operational Definitions

1. Nursing faculty – Determined by the respondents' indication of status as nursing faculty with a Registered Nursing license.

2. Workplace incivility – The 7-item Workplace Incivility Scale (WIS; Cortina, Magley, Williams, & Langhout, 2001) was used with an amendment to the directions asking respondents to reflect on the past six months, instead of five years, when answering the items.

3. Psychological health – An assessment of general well-being using the World Health Organization (WHO) 5-item Well-being Index (Psychiatric Research Unit, 1998).

4. Physical health – The 14-Item Physical Health Questionnaire (PHQ; Schat, Kelloway, & Desmarais, 2005).

5. Perceived stress – The 10-Item Perceived Stress Scale (PSS-10; Cohen & Williamson, 1988).

6. Program type – Determined by the respondents' selection of in which program they spend the most time teaching. Respondents chose between an Associate/Diploma degree program, a Baccalaureate degree program, or a Graduate degree program.

7. College/university type – Determined by the respondents' selection of in which type of college/university they teach. Respondents chose between public university, private university, community college, or other.

8. Years as a Registered Nurse – Determined by the cumulative number of years (in a whole number) that respondents reported they have maintained a Registered Nursing license.

9. Years as a nursing faculty member – Determined by the cumulative number of years (in a whole number) that respondents reported working in a part-time or full-time nursing faculty role.

10. Full-time equivalent status – Determined by the respondent's selection of either full-time or part-time employment status.

11. Highest degree earned – Determined by the selection made by the respondents as to what is their highest level of education. They chose from the following options: Associate, Bachelor's, Master's, Doctoral-DNP, or Doctoral-EdD/DNS/PhD.

12. Orientation program – Determined by the respondents' selection of "yes" or "no" as to whether or not they have participated in a formal orientation program within

their school of nursing. Respondents were given the following brief description of a program: *A formal orientation program includes receipt and discussion of a resource manual, an ongoing discussion of roles and responsibilities for the role of the nursing faculty member, and ongoing meetings with relevant individuals to check on progress and transition to the new role.*

13. Mentoring program – Determined by the respondent's selection of "yes" or "no" as to whether or not they have participated in a formal mentoring program within their school of nursing. Respondents were given the following brief description of a program: *A formal mentoring program involves the designation of at least one seasoned faculty member, who will invest time and energy, to help a new faculty member transition into his or her new role and environment.*

14. Civility policy – Respondents were asked if their school of nursing has a civility policy. Determined by the respondent's selection of "yes", "no", or "I don't know."

15. Civility training – Determined by the respondent's selection of "yes" or "no" as to whether or not they have participated in formal civility training as a part of their current role.

16. Work from home – Determined by the respondent's selection of "yes" or "no" as to whether or not they exclusively work from home.

Research Design

This study employed a cross-sectional, correlational survey design to evaluate relationships between variables. Cross-sectional designs allow for data to be collected in

a short amount of time, and they provide statistical data for several predictors and their outcomes (Hulley, Cummings, Browner, Grady, & Newman, 2013). The principal investigator (PI) E-mailed an electronic survey to participants using Qualtrics, a survey software that allowed for protection of data and anonymity of participants (Qualtrics, 2018). Nursing faculty were asked questions using tools that measure their demographics, perceived stress, experiences with workplace incivility, psychological health, and physical health. For data collection, all potential participants received two E-mails, three weeks apart, requesting participation in the study. The 53-item electronic survey consisted of several sections to collect data on major constructs. The survey also included two open-ended questions which were asked to allow respondents to provide additional, qualitative information about incivility experiences.

For RQ1, an analysis in G*Power suggested that a sample of 131 participants would provide 80% power to detect an R^2 of 0.15 with thirteen predictive variables, using a two-sided alpha of 0.05 (Faul, Erdfelder, Lang, & Buchner, 2007). For RQ2, multivariate multiple regression analyses require a minimum of 10 complete responses per model parameter (Jackson, 2003). Research question 2 used 15 parameters, requiring a minimum of 150 participants. Therefore, a minimum sample of 150 participants was required to power this study.

Sample and Sampling Plan

The PI used a convenience sampling strategy by first compiling a list of nursing schools offering prelicensure, Master, and Doctoral degrees throughout the state of North Carolina. The PI obtained this list from the North Carolina Board of Nursing website.

The PI then accessed the school of nursing websites and gathered E-mail addresses of all potential faculty participants. The PI compiled a master list of nursing faculty names and their E-mail addresses to be included in the study. Faculty from the University of North Carolina Greensboro (UNCG) were not sampled. It is possible that faculty familiar to the PI and faculty advisor could provide inaccurate data out of a concern for their anonymity. To minimize inaccurate reports of incivility, the school was not included in sampling.

There were 12 cases in which E-mails were unavailable on the school of nursing websites, and the PI kept detailed notes of which schools were excluded and the rationale. At the end of sampling, the PI analyzed the notes to see if the schools that were excluded differed in any meaningful way from those that were included, as faculty from these types of programs may be underrepresented. The PI determined through this analysis that no faculty types or groups were excluded based on the sampling strategy, as the school types, degrees offered, and geographic locations were all varied and represented in other accessible schools. Inclusion criteria of the participants were as follows: able to read English, part-time or full-time nursing faculty teaching in either a Diploma, Associate, Baccalaureate, or Graduate degree nursing program. Exclusion criterion: nursing faculty who did not report regular interaction with other nursing faculty or staff.

Work by Dillman (2015) has found that internet-only surveys have markedly low response rates, some even in the single digits. However, a recent study on faculty-to-faculty incivility boasted a 53.46% response rate over three weeks (Casale, 2017). The PI estimated that a 10% response rate was expected for this study. If response rates were lower than 10% after three weeks, then the PI would extend the sampling strategy by

randomly choosing one of the 15 Southern Regional Educational board (SREB) states and compile faculty E-mail addresses in a similar fashion. The PI would continue to randomly choose states within the SREB and compile faculty E-mail addresses until the study was adequately powered with ample responses.

<div align="center">**Measurement**</div>

Demographic Tool

A 14-item demographic tool was created by the PI and requested information about the participants' personal characteristics and characteristics of their workplace. The tool asked respondents about the following: gender, age, race, years as a Registered Nurse, years as a faculty member, part-time or full-time faculty member status, highest degree earned, type of nursing program in which they spend the most time teaching, college/university type, participation in an orientation program, participation in a mentoring program, the presence of a civility policy within their school of nursing, participation in faculty civility training, and whether or not they worked exclusively from home.

Workplace Incivility Scale

Workplace incivility was measured using an amended version of the original 7-item Workplace Incivility Scale, or WIS (Cortina et al., 2001). In the directions, the measure asks the respondents to reflect on the past five years in their current job and consider if they had been in a situation in which any of their coworkers or superiors had demonstrated the seven uncivil behaviors listed (Cortina et al., 2001). In 2011, five items were added by Cortina and colleagues, and the directions were changed to have

respondents reflect on the past year (Cortina, Kabat-Farr, Leskinen, Huerta, & Magley, 2011). Since the development of the 12-item WIS, the 7-item version has continued to serve as a standard in measuring workplace incivility (Demsky et al., 2018; Hershcovis et al., 2017; Kabat-Farr et al., 2018). Additionally, although the 12-item measure was considered to still be a uni-dimensional scale, a confirmatory factor analysis revealed that it may have two dimensions, overt incivility and covert incivility (Tarraf, 2012). This is not an unsurprising result, as two of the items added appear to be high-intensity behaviors. For example, the 12-item measure includes, "Yelled, shouted, or swore at you" (Cortina et al., 2011, p. 22). This item, and others, are not in alignment with the way Cortina and colleagues (2011) define incivility, which is "low intensity," "ambiguous" behavior (p. 2).

Therefore, due to the discrepancies in the dimensionality of the 12-item measure and the addition of high-intensity behaviors to the tool, this study utilized the original 7-item measure. Yet, the original measure asks respondents to reflect on the past five years in their current role. For this study, the directions asked respondents to reflect on the past six months instead. This is based on two reasons. First, this study sought to explore the impact that incivility was having on the current physical and psychological health of nursing faculty. The tools to measure physical and psychological health, to be described below, asked respondents about their health within the last month and two weeks, respectively. Theoretically, an experience with incivility five years ago may not have the current impact on faculty that more recent experiences would. Secondly, this measure asked respondents to report on experiences with incivility in their current jobs. This study

was inclusive of all nursing faculty, regardless of time in the role. Therefore, some of the respondents may have only been in their faculty role for less than a year. As a result, it was important to ensure that they were reflecting on their current role and not considering experiences related to other jobs.

In recent years, the 7-item measure has been used with amendments to the directions. In a sample of 699 government forest workers, the researchers asked respondents to reflect on the past six months, and the measure demonstrated excellent internal consistency with a coefficient alpha of 0.93 (Demsky et al., 2018). Additionally, the same directions were given to a sample of 300 and demonstrated strong reliability with a coefficient alpha of 0.89 (Hershcovis et al., 2017). The original measure has also asked respondents to reflect on the past year, and two studies have demonstrated good reliability ($\alpha = 0.89$-0.92; Miner, Settles, Pratt-Hyatt, & Brady, 2012; Torkelson, Holm, Bäckström, & Schad, 2016). Given this evidence, it would have been reasonable to choose either the "past six months" or "past year" time frame in the directions. For this study, the original 7-item WIS was used with an amendment in the directions to ask respondents to reflect on the past six months in their role.

The WIS measures low-intensity behavior, and example items include, "Made demeaning or derogatory remarks about you?" and "Doubted your judgement on a matter over which you have responsibility?" (Cortina et al., 2001, p. 70). The item responses are on a five-point Likert Scale ranging from 0 to 4. The following responses are awarded the following scores: 0 = never, 1 = once or twice, 2 = sometimes, 3 = often, 4 = many times. A sum score is calculated for the single dimension scale and can range from 0 - 28. A

higher score indicates more experiences with workplace incivility (Cortina et al.).

Construct validity has been evaluated and supported with a demonstration of strong

negative correlations between the WIS and the Perception of Fair Interpersonal

Treatment Scale (Cortina et al.). The tool has also been used in a study predicting the

physical health, mental health, and turnover intention of federal employees (Lim et al.,

2008). This study demonstrated a coefficient alpha of 0.89 for the instrument. Permission

to use this measure was granted by Dr. Cortina in an E-mail communication and can be

found in Appendix B (L. Cortina, personal communication, November 22, 2018).

WHO-5 Well-Being Index

Psychological health, or general well-being, was measured using the World

Health Organization 5-item Well-being Index, or the WHO-5. This measure was

originally presented at a WHO conference in 1998 and is intended to measure subjective

well-being (Psychiatric Research Unit, 1998). Using positively worded items, the tool has

been widely used as a screening measure for depression. It has also been used to measure

psychological distress and overall poor well-being (Topp, Østergaard, Søndergaard, &

Bech, 2015). Respondents are asked to reflect on how they have been feeling over the last

two weeks and indicate how often they have felt a certain way. An example item is,

"Over the last two weeks, I have felt cheerful and in good spirits."

Item responses are on a six-point Likert scale and range from 0 – 5. Responses are

coded as follows: 0 = at no time, 1 = some of the time, 2 = less than half of the time, 3 =

more than half of the time, 4 = most of the time, 5 = all of the time (Psychiatric Research

Unit, 1998). The score is calculated by summing all of the respondents' answers and

multiplying by 4. The total score ranges from 0 – 100. Higher scores indicate higher

levels of well-being (Psychiatric Research Unit). No studies were found that used the

WHO-5 Well-being Index in nursing faculty. Recently though, in a study exploring

college students who may be at risk of mental health issues, the WHO-5 Well-being

Index demonstrated a single dimension measure with good internal consistency, reporting

a coefficient alpha of 0.86 (Downs, Boucher, Campbell, & Polyakov, 2017).

Additionally, the instrument was used to measure subjective well-being among a sample

of 359 adults and demonstrated a coefficient alpha of 0.91 (Cartwright, White, &

Clitherow, 2018). The WHO-5 Well-being Index is free to use.

Physical Health Questionnaire

Physical health was evaluated using the 14-item Physical Health Questionnaire

(PHQ; Schat et al., 2005). Based on factor analysis, the scale has four dimensions: sleep

disturbances, digestive problems, headaches, and respiratory infections. Respondents are

asked four questions about sleep disturbances (items 1-4), three questions about

headaches (items 5-7), four questions about digestive problems (items 8-11), and three

questions about respiratory infections (items 12-14). Respondents are asked to rate how

frequently they have experienced a symptom over the past 30 days. Item responses are on

a seven-point Likert scale, and the responses range from 1-7 (1 = not at all; 2 = rarely; 3

= once in a while; 4 = some of the time; 5 = fairly often; 6 = often; 7 = all of the time).

Item 4 is reverse scored. The mean score is calculated across each set of items that

constitutes each of the four symptom dimensions (A. Schat, personal communication,

August 30, 2018). Scores for each dimension range from 1-7. In a study among nurses,

internal consistency reliabilities were assessed with a coefficient alpha for each of the

four dimensions: sleep disturbances = 0.80; headaches = 0.88; digestive problems = 0.83;

and respiratory infections = 0.66 (Schat et al., 2005). Permission to use the scale was

granted through an E-mail communication with the author and can be found in Appendix

C (A. Schat, personal communication, August 30, 2018).

Perceived Stress Scale

The 10-item Perceived Stress Scale (PSS-10) was used to measure the construct

of perceived stress (Cohen & Williamson, 1988), which served as a control variable for

Research Question 2. The PSS-10 is an updated and abbreviated version of the original

14-item Perceived Stress Scale (Lee, 2012). Early work on the 10-item measure (Cohen

& Williamson, 1988) and more recent work (Lee, 2012) have demonstrated that it is as

valid and reliable in measuring the construct of perceived stress as the original PSS-14.

The PSS-10 has four positively worded items and six negatively worded items.

Respondents are asked to reflect on their thoughts and feelings over the past month and

indicate how often they have experienced the behavior that is described. An example of a

negatively worded item is, "In the last month, have you felt that you were unable to

control the important things in your life?" An example of a positively worded item is, "In

the last month, how often have you felt that things were going your way?"

Item responses are on a five-point Likert Scale ranging from 0 to 4. The responses

are coded as follows: 0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often, 4 =

very often. Items 4, 5, 7, and 8 are reverse scored. A sum score is calculated for the single

dimension measure, and the score can range from 0 – 40 (Department of Psychology,

Carnegie Mellon University, 2010). In a systematic review of 12 studies using the PSS-10, coefficient alphas for the English version of the PSS-10 range from 0.78 to 0.91 (Lee, 2012). Most recently, the PSS-10 has been used in a sample of bedside nurses and demonstrated a coefficient alpha of 0.89 (Barbe, Kimble, & Rubenstein, 2018). Permission to use the scale was granted on Dr. Cohen's website under the premise that the scale is used for non-profit academic research (Department of Psychology, Carnegie Mellon University, 2015).

Survey and Data Collection

The following measures were aggregated into a single 53-item survey: 1 exclusion question, 14-item demographic questionnaire, 10-item Perceived Stress Scale (PSS-10), 7-item Workplace Incivility Scale (WIS), 5-item World Health Organization Well-being Index (WHO-5), the 14-item Physical Health Questionnaire (PHQ), and 2 open ended questions. The survey was input into the Qualtrics survey software for electronic distribution to participants. The complete survey is located in Appendix A.

The entire survey was estimated to take less than 10 minutes using the Qualtrics survey program. The E-mail requesting participation included an information sheet that described the study, offered an incentive for participation, and indicated the efforts to maintain confidentiality of the responses. The information sheet included an anonymous link to the survey. Upon clicking this link to enter the survey, participants indicated that they are nursing faculty, they understood the risks and benefits of the study, and they knew that their participation in the study conveyed their consent.

The demographic portion of the survey was presented using a multiple choice format with three manually-typed responses (age, years as a Registered Nurse, and years as a nursing faculty member). For age, respondents were required to type a whole number between 21-99. For years as a Registered Nurse and years as a faculty member, respondents were required to type a whole number between 0-99. The remainder of the survey was presented using a matrix table. In order to limit missing data, respondents were forced to respond to all items (excluding the two open-ended questions) using the "force response" option in Qualtrics. Given that all responses were to remain anonymous, three weeks after the initial contact, all participants received a second E-mail thanking those who had participated and requesting participation again from those who had not. Participants only received one follow-up E-mail. If the response rate had been less than 10% two weeks after initial contact, the PI would have sent the follow up E-mail to North Carolina nursing faculty and simultaneously began sampling in an additional state.

Incentive

In the E-mailed information sheet, participants were notified of an opportunity to enter a drawing to win one of ten $50 Amazon.com Gift Cards. Upon completion of the survey participants had the opportunity to enter their E-mail address for entry into the drawing. It was necessary to ensure anonymity for the participants during the incentive process. Therefore, in order to disconnect E-mail addresses with survey responses, the survey software rerouted to a separate link upon completion of the survey for the participants to provide their preferred E-mail address. This disallowed the investigator to connect survey responses with the individual. Once the survey had closed, the PI

gathered all 249 E-mail addresses into one document with corresponding numbers from 1-249. Using an electronic random number generator, the first ten random numbers were associated with their corresponding E-mail addresses. The incentive was electronically distributed to the ten participants using a designated Amazon account associated with the PI's UNCG E-mail address.

Protection of Human Subjects

An application was sent to the Institutional Review Board (IRB) of UNCG seeking permission to conduct this study, and the study was deemed to be exempt. As described above, participants received an electronic information sheet that gave the purpose of the study, the risks and benefits of participating, and provided a link to enter the survey. Participants were not asked to provide any identifying personal data beyond the demographic questionnaire, and data were collected anonymously by using an anonymous link from the Qualtrics survey software. Participation in the study ended upon completion of the survey. The drawing incentive of a $50 gift card for ten different recipients was not considered to be coercive for this population.

It was possible that nursing faculty would have experienced some emotional distress while taking the survey, as it may have required them to reflect on past negative experiences with incivility. The information sheet at the beginning of the survey informed participants that they were able to stop the survey at any time should such feelings of emotional distress arise. The information sheet suggested that participants contact a health care provider should the feelings of distress persist.

Files containing the data were stored on the PI's UNCG Box account, which is password protected. The Box account was only shared with the dissertation committee and statistician. Any dissemination was without identifiers or small groups that would provide deductive disclosure. Data files were used on a personal laptop computer with firewall and password protection. There were no personal identifiers in the data set for analysis.

Coding

Categorical survey responses were numerically coded in Qualtrics before data collection. Coding occurred in the survey software before the survey was sent to participants. In addition to the coding of variable responses, variable names were given to each item to allow for easy interpretation during analysis. The coding plan used for categorical responses is below.

Demographics.

- Program type
    - o 0 - Associate/Diploma
    - o 1 - Baccalaureate
    - o 2 - Graduate
- Gender
    - o 0 - Female
    - o 1 - Male
    - o 2 - Other/Prefer not to answer
- Race

- - 0 - White/Non-Hispanic

  - - 1 - Black/Non-Hispanic

  - - 2 - Hispanic/Latino

  - - 3 - American Indian/Alaska Native

  - - 4 - Asian/Pacific Islander

  - - 5 - Other

- Part-time/Full-time status

  - - 0 - Full-time

  - - 1 - Part-time

- What is your highest degree earned?

  - - 1 - Associate

  - - 2 - Bachelor's

  - - 3 - Master's

  - - 4 - Doctorate-DNP

  - - 0 - Doctorate-EdD/DNS/PhD

- College/University type

  - - 0 - Community College

  - - 1- Public University

  - - 2 - Private University

  - - 3 - Other

- Orientation program

  - - 0 - Yes

- $\circ$ 1 - No

- Mentoring program

  - $\circ$ 0 - Yes

  - $\circ$ 1 - No

- Civility policy

  - $\circ$ 0 - Yes

  - $\circ$ 1 - No

  - $\circ$ 2 - I don't know

- Civility training

  - $\circ$ 0 - Yes

  - $\circ$ 1 – No

- Work from Home

  - $\circ$ 1 – Yes

  - $\circ$ 0 – No

Perceived stress scale.

- Items 1-3, 6, 9, 10

  - $\circ$ 0 - Never

  - $\circ$ 1 - Almost Never

  - $\circ$ 2 - Sometimes

  - $\circ$ 3 - Fairly Often

  - $\circ$ 4 - Very Often

- Items 4, 5, 7, 8

- o 4 - Never

- o 3 - Almost Never

- o 2 - Sometimes

- o 1 - Fairly Often

- o 0 - Very Often

Workplace incivility scale.

- All item responses

  - o 0 - Never

  - o 1 - Once or twice

  - o 2 - Sometimes

  - o 3 - Often

  - o 4 - Many times

WHO-5 well-being index.

- All item responses

  - o 5 - All of the time

  - o 4 - Most of the time

  - o 3 - More than half of the time

  - o 2 - Less than half of the time

  - o 1 - Some of the time

  - o 0 - At no time

Physical health questionnaire.

- Items 1-3, 5-14

- o   1 - Not at all

- o   2 - Rarely

- o   3 - Once in a while

- o   4 - Some of the time

- o   5 - Fairly often

- o   6 - Often

- o   7 - All of the time

- Item 4

  - o   7 - Not at all

  - o   6 - Rarely

  - o   5 - Once in a while

  - o   4 - Some of the time

  - o   3 - Fairly often

  - o   2 - Often

  - o   1 - All of the time

Data Analysis

After the data were exported from Qualtrics into SPSS (Statistical Package for the

Social Sciences) Version 25 for data analysis, the PI manually verified that the correct

codes and variable names were exported using the responses of 10 random participants.

Before analysis, the PI created seven new variables to represent the scores for the WIS,

PSS-10, WHO-5 Well-being Index, and the four PHQ scales. Descriptive statistics were

calculated to describe the sample. Frequencies and percentages were calculated on the

categorical variables. Mean and standard deviation were calculated for the continuous variables.

Quantitative

Research Question 1. What variables (gender, age, race, years of faculty experience, full-time equivalent status, highest degree earned, orientation program, mentoring program, civility training, civility policy, college/university type, program type, and work from home) predict nursing faculty experiences with workplace incivility?

Multiple linear regression was used to assess the relationship between 13 demographic indicator variables and nursing faculty experiences with workplace incivility. The PI first checked the assumptions of the multiple linear regression analysis using the residuals of the data. Outliers were assessed on the residuals using box plots. Normality was assessed on the residuals using Q-Q plots and the One-sample Kolmogorov-Smirnov test. Independence of observations were assessed using the Durbin-Watson statistic. Homoscedasticity and linearity were evaluated using scatterplots of the residuals. Finally, multicollinearity was assessed using the variance inflation factors (VIFs). If assumptions were not met, the data were transformed using techniques such as taking logs or using the square roots of the values. After necessary adjustments, the PI simultaneously entered the 13 demographic variables as independent variables and the workplace incivility sum score as the dependent variable into a regression model.

Research Question 2. What is the relationship between experiences with workplace incivility and the physical and psychological health of nursing faculty (sleep

disturbances, digestive problems, headaches, respiratory problems, and general well-being)?

A three-step hierarchical multivariate multiple regression (MMR) analysis was used to assess the relationship between experiences with workplace incivility and the five outcomes: sleep disturbances, digestive problems, headaches, respiratory problems, and general well-being. Assumptions of MMR include independence of observations, normality of residuals, equal variances, and a lack of multicollinearity. Independence was assessed using the Durbin-Watson statistic. Normality was assessed on the residuals of the continuous variables using Q-Q plots and the One-sample Kolmogorov-Smirnov test. The assumption of equal variances was assessed using Box's M Test and multicollinearity was assessed using VIFs. If assumptions were not met, transformations were conducted and those transformed variables were used for analysis.

In the first step of the regression, workplace incivility was entered alone as the predictive independent variable. The five psychological and physical outcomes were entered as the dependent variables. In the second step, 13 demographic indicator variables were added as independent variables for control. Finally, in the third step, the perceived stress score was added as the final control variable. Parameter estimates, confidence intervals, p–values, and F statistics were gathered to thoroughly assess the relationships in each step.

Perceived stress as control.

In RQ 2, the construct of perceived stress was used as a control variable when evaluating the relationship between workplace incivility and the five health outcomes.

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Cohen and Williamson (1988) state that "stressful events are not, in and of themselves, sufficient causes of pathology and illness behavior" (p. 31). The authors further describe that individuals must first evaluate whether or not a stressful event is threatening to them. Evidence suggests that if an event is deemed to be a threat, the risk of illness or disease is then increased (Cohen & Williamson, 1983). Therefore, individuals who perceive higher levels of stress within their lives may be more susceptible to illness than those who do not perceive certain experiences to be stressful, and it is necessary to consider that when evaluating predictors of health. Within RQ 2, the PI explored the relationship between experiences with workplace incivility and an individual's health, while also controlling for the degree to which the individual is perceiving other stressors as a threat in his or her life. An individual's level of perceived stress may be a confounder in the relationship between workplace incivility and physical and psychological health. Therefore, the concept of perceived stress was added to the model in the third step of RQ 2 to control for this potential confounding variable.

Qualitative

The data from the two open-ended questions were analyzed using content analysis, as it permits a straightforward description of the data (Bradshaw, Atkinson, & Doody, 2017). Content analysis uses open coding to identify main concepts and categories (Elo & Kyngäs, 2008). Through an iterative process, codes were placed in categories which allowed themes of the data to emerge (Bradshaw et al., 2017; Vaismoradi, Turunen, & Bondas, 2013). A member of the dissertation committee experienced in qualitative analysis reviewed the codes, categories, and themes. Any

differences were resolved with consensus. These themes were described to complement and enhance the quantitative findings.

Conclusion

This study sought to fill a gap in the literature. Qualitative nursing research has indicated that nursing faculty are experiencing physical and psychological distress due to experiences with incivility. The organizational behavior literature supports this relationship in a quantitative way; yet, this had not been explored among nursing faculty. This study narrowed the focus to experiences of workplace incivility among nursing faculty and provided a foundation for further exploration of these relationships.

CHAPTER IV

RESULTS

The purpose of this study was to, first, explore which variables are predictive of

nursing faculty experiences with workplace incivility (Research Question 1) and, second,

examine the relationship between workplace incivility and the physical and psychological

health of nursing faculty (Research Question 2). A Qualtrics survey was created by the

researcher and titled Workplace Incivility and its Effects on Nursing Faculty. This survey

included a researcher-created demographic tool, the Workplace Incivility Scale (WIS;

Cortina et al., 2001), the 10-item Perceived Stress Scale (PSS-10; Cohen & Williamson,

1988), the Physical Health Questionnaire (PHQ; Schat et al., 2005), and the World Health

Organization (WHO) 5-item Well-being Index (Psychiatric Research Unit, 1998). Data

were collected from nursing faculty working in the state of North Carolina, and the

results of the study are reported in this chapter.

Quantitative Data Management

The data were exported from Qualtrics into Statistical Package for the Social

Sciences (SPSS) Version 25 for analysis. The survey was delivered electronically to

1,452 nursing faculty in North Carolina. The survey was opened by 316 individuals;

however, 24 surveys were unanswered. Seven respondents had partial missing data. Of

those seven, three respondents completed the WIS only, one respondent completed the

WIS and PSS-10 only, and two respondents completed the WIS, PSS-10, and WHO-5

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Well-being Index. One respondent only completed the demographic survey and was thus removed from data analysis because the response did not provide any data to answer either research question. Finally, one respondent indicated an age of 21; however, the same respondent indicated 20 years of RN experience, 4 years of faculty experience, and the attainment of a doctoral degree. Based on this information the PI determined that the age was an inaccurate entry, and the entire case was removed from analysis.

Seven new variables were created in SPSS to reflect the scale scores of the WIS, PSS-10, WHO-5 Well-being Index, and the four subscales of the PHQ. The data set was finalized for analysis and included 290 responses to be analyzed for Research Question (RQ) 1 and 284 responses to be analyzed for RQ 2. All data were shared with the PI's advisor and statistician through the university's secured cloud space, Box.

Sample

The sample was comprised of 290 nursing faculty (20.0% response rate) working in the state of North Carolina. See Chapter 3 for full inclusion/exclusion criteria. The majority of the sample was White/non-Hispanic (86.9%) and female (95.2%). The average age of nursing faculty was 51.66 years (SD = 10.44 years), and the ages ranged from 27 to 76 years. Time in the role of a nursing faculty ranged from 0 to 45 years, with an average of about 12 years (SD = 9.25 years). Table 2 further describes the sample demographics.

Table 2

Sample Characteristics (N = 290)

Demographic Characteristics	N (%) or Mean ± SD (Min, Max)
Gender	
Female	276 (95.2)
Male	13　(4.5)
Other/Prefer not to Answer	1　(0.3)
Age	51.66 ± 10.44 (27, 76)
Race/Ethnicity	
White/non-Hispanic	252 (86.9)
Black/non-Hispanic	23　(7.9)
Hispanic/Latinx	5　(1.7)
American Indian/Alaska Native	1　(0.3)
Asian/Pacific Islander	5　(1.7)
Other	4　(1.4)
Years Registered Nurse*	27.07 ± 10.99 (3, 55)
Years Nursing Faculty	12.02 ± 9.25 (0, 45)
Program Type	
Associate/Diploma	121 (41.7)
Baccalaureate	102 (35.2)
Graduate	67 (23.1)
Full-time Equivalent Status	
Full-time	275 (94.8)
Part-time	15　(5.2)
Highest Degree Earned	
Bachelor's	5　(1.7)
Master's	147 (50.7)
Doctorate – DNP	58 (20.0)
Doctorate – EdD/DNS/PhD	80 (27.6)
College/University Type	
Community College	107 (36.9)
Public University	110 (37.9)
Private University	63 (21.7)

Other	10 (3.4)
Orientation Program Participation	
Yes	149 (51.4)
No	141 (48.6)
Mentoring Program Participation	
Yes	142 (49.0)
No	148 (51.0)
Civility Policy	
Yes	104 (35.9)
No	96 (33.1)
I don't know	90 (31.0)
Civility Training Participation	
Yes	53 (18.3)
No	237 (81.7)
Work Location-Exclusively Work from Home	
Yes	7 (2.4)
No	283 (97.6)

Note. SD = Standard deviation; DNP = Doctor of Nursing Practice; EdD = Doctor of Education; PhD = Doctor of Philosophy; * = The North Carolina Board of Nursing requires 2 years of clinical experience for faculty. One response of "0" years was removed due to its inaccuracy. Data from "Years Registered Nurse" includes 289 cases.

Almost half of the sample taught in an Associate degree or Diploma program (41.7%), just over a third taught in a Baccalaureate degree program (35.2%), and about 23% taught in a Graduate degree program. The majority of the sample worked full-time (94.8%) and had a Master's Degree (50.7%) or Doctoral Degree (47.6%). Just over a third of the respondents reported teaching at a community college (36.9%), while about 38% and 22% taught at a public or private university, respectively. Ten respondents indicated "Other" for the type of college at which they taught, and four of them further

indicated in a free text box that they taught at a hospital-based college. Approximately half of the sample reported participation in a formal orientation and a formal mentoring program at their school of nursing. While the presence of a civility policy in the school of nursing was evenly distributed between the responses of Yes (35.9%), No (33.1%) and I Don't Know (31.0%), the majority of the sample indicated that they had not participated in any civility training (81.7%). Finally, only seven respondents indicated that they exclusively worked from home.

Measurements

Workplace incivility, perceived stress, physical health, and psychological health were measured with the WIS, PSS-10, PHQ, and WHO-5 Well-being Index, respectively. All scales or subscales demonstrated good internal consistency with coefficient alphas between 0.79 and 0.90, and these measures of reliability are specifically displayed in Table 3. The mean WIS score was 6.74 (SD = 5.85) and ranged from 0-27. Higher scores on the WIS scale indicated increased experiences with workplace incivility. The PSS-10 scores ranged from 1-34 and averaged 14.72 (SD = 6.70) with higher scores indicating higher levels of perceived stress. Scores from the PHQ subscales ranged from 1-7. The sleep disturbances subscale was the highest at an average of 3.51 (SD = 1.24), and the respiratory problems subscale was the lowest at an average of 2.00 (SD = 0.99). Higher scores for each subscale of the PHQ indicated higher levels of each physical symptom. The average WHO-5 Well-being Index score was 60.32 (SD = 19.34) and ranged from 8-100. Low scores on the WHO-5 Well-being Index indicated decreased general well-

being, while higher scores indicated higher levels of general well-being. The results are

specifically displayed in Table 4.

Table 3

Reliability Measurements for Instruments

Instrument	Number of Items	Coefficient alpha
Workplace Incivility Scale	7	0.898
Perceived Stress Scale	10	0.900
World Health Organization – 5 Well-being Index	5	0.897
Physical Health Questionnaire – Sleep Disturbances Subscale	4	0.794
Physical Health Questionnaire – Headaches Subscale	3	0.889
Physical Health Questionnaire – Digestive Problems Subscale	4	0.861
Physical Health Questionnaire – Respiratory Problems Subscale	3	0.785

Table 4

Instrument Scale Scores

Scale Score	Mean ± SD (Min, Max)
Workplace Incivility Score ($N = 290$)	6.74 ± 5.85 (0, 27)
Perceived Stress Scale Score ($N = 287$)	14.72 ± 6.70 (1, 34)
WHO-5 Well-being Index Score ($N = 286$)	60.32 ± 19.34 (8, 100)
PHQ, Sleep Disturbances Score ($N = 284$)	3.51 ± 1.24 (1, 6.75)
PHQ, Headaches Score ($N = 284$)	2.84 ± 1.45 (1, 7)
PHQ, Digestive Problems Score ($N = 284$)	2.50 ± 1.32 (1, 7)
PHQ, Respiratory Problems Score ($N = 284$)	2.00 ± 0.99 (1, 6.67)

*Note. SD = Standard Deviation. WHO = World Health Organization. PHQ = Physical Health Questionnaire.

Results

Research Question 1

What variables (gender, age, race, years of faculty experience, full-time equivalent status, highest degree earned, orientation program, mentoring program, civility training, civility policy, college/university type, program type, and work from home) predict nursing faculty experiences with workplace incivility?

The following assumptions of multiple linear regression were checked on the variables included in RQ 1: independence, normality, homoscedasticity, linearity, and multicollinearity. Normality of the residuals was not met. After a square root transformation of the WIS score, the assumption of normality was met. Additionally, to eliminate multicollinearity, the following categorical variables were collapsed into

indicator variables: gender, race, program type, highest degree earned, college/university

type, and civility policy. Table 5 displays the coding used to collapse categorical

variables into respective indicator variables.

Table 5

Variable Coding for Regression Analyses

Variable	Data Entered	Indicator Coding	
Gender			
Female	0	0	
Male	1	1	
Other/Prefer not to Answer	2	1	
Race/Ethnicity			
White/non-Hispanic	0	0	
Black/non-Hispanic	1	1	
Hispanic/Latinx	2	1	
American Indian/Alaska Native	3	1	
Asian/Pacific Islander	4	1	
Other	5	1	
Program Type			
Associate	0	1	
Baccalaureate	1	1	
Graduate	2	0	
Full-time Equivalent Status			
Full-time	0	0	
Part-time	1	1	
Highest Degree Earned		Bachelor's/Master's	DNP
Bachelor's	1	1	0
Master's	2	1	0
Doctorate – DNP	3	0	1
Doctorate – EdD/DNS/PhD	0	0	0

		No Civility Policy	Don't Know Civility Policy
College/University Type			
Community College	0	0	
Public University	1	1	
Private University	2	1	
Other	3	0	
Orientation Program Participation			
Yes	0	0	
No	1	1	
Mentoring Program Participation			
Yes	0	0	
No	1	1	
Civility Policy			
Yes	0	0	0
No	1	1	0
I don't know	2	0	1
Civility Training Participation			
Yes	0	0	
No	1	1	
Exclusively Work from Home			
Yes	0	0	
No	1	1	

*Note. DNP = Doctor of Nursing Practice; EdD = Doctor of Education; PhD = Doctor of Philosophy.

Multiple linear regression.

The thirteen indicator variables were simultaneously entered into the regression model as independent variables with the transformed WIS score entered as the dependent variable. Full-time equivalent (FTE) status, highest degree earned, participation in an

orientation program, age, and program type were all significant predictors of experiences with workplace incivility. Workplace incivility is significantly higher for those in full-time faculty roles compared to those in part-time positions. Specifically, the predicted mean of the square root of the workplace incivility score is 0.723 points lower for part-time faculty compared to full-time faculty (95% CI = [-1.420, -0.026]; p = 0.042), adjusting for the other variables in the model. Additionally, adjusting for the other variables in the model, the predicted mean of the square root of the workplace incivility score is 0.556 points lower for nursing faculty with a Bachelor's or Master's degree compared to faculty with a doctoral degree (95% CI = [-1.016, -0.096]; p = 0.018), indicating that incivility levels are higher among those with higher degrees. Finally, incivility levels are significantly higher for those who did not participate in an orientation program. Specifically, the predicted mean of the square root of the workplace incivility score is 0.359 points higher for faculty who did not participate in a formal orientation program compared to those who did (95% CI = [0.048, 0.670]; p = 0.024), adjusting for the other variables in the model.

Workplace incivility was also predicted by age and program type. Specifically, for every additional year increase in age, the predicted mean of the square root of the workplace incivility score increases by 0.017 points (95% CI = [0.00, 0.033]; p = 0.046), adjusting for the other demographic variables in the model. Furthermore, nursing faculty who work in graduate degree programs experience higher levels of workplace incivility compared to prelicensure programs. Specifically, adjusting for the other variables in the model, the predicted mean of the square root of the workplace incivility score is 0.417

points lower for faculty who teach in Diploma, Associate, or Baccalaureate programs compared to faculty who teach in a graduate program (95% CI = [-0.828, 0.006]; p = 0.047). Although not significant, workplace incivility scores are higher for nursing faculty who identify as male or other, for those who did not participate in a mentoring program, and for those who have not participated in civility training. Details of the regression are specified in Table 6.

Table 6

Multiple Linear Regression Analysis for Predicting Workplace Incivility (N = 290)

Variable	b	95% CI for b	*p*-value
Gender			
Male/Other (I)	0.530	(-0.147, 1.207)	0.125
Female (RC)			
Age	0.017	(0.000, 0.033)	0.046*
Race			
Not White (I)	0.295	(-0.146, 0.735)	0.189
White/non-Hispanic (RC)			
Years as Nursing Faculty	-0.004	(-0.023, 0.016)	0.718
Full-time Equivalent Status			
Part-time (I)	-0.723	(-1.420, -0.026)	0.042*
Full-time (RC)			
Highest Degree Earned			
Bachelor's/Master's Degree (I)	-0.556	(-1.016, -0.096)	0.018*
Doctoral Degree (RC)			
DNP Degree (I)	0.132	(-0.309, 0.573)	0.556
All Other Degrees (RC)			
Orientation Participation			
Yes (RC)	0.359	(0.048, 0.670)	0.024*

No (I)

Mentoring Program Participation			
Yes (RC)	0.273	(-0.040, 0.585)	0.087
No (I)			
Civility Training Participation			
Yes (RC)	0.070	(-0.327, 0.466)	0.730
No (I)			
Civility Policy			
Yes/I Don't Know (RC)	0.305	(-0.061, 0.670)	0.102
No (I)			
Yes/No (RC)	-0.005	(-0.370, 0.359)	0.977
I Don't Know (I)			
College/University Type			
Community College/Other (RC)	-0.313	(-0.700, 0.075)	0.114
Public/Private University (I)			
Program Type			
Graduate (RC)	-0.417	(-0.828, -0.006)	0.047*
Prelicensure (I)			
Exclusively Work from Home			
Yes (RC)	0.337	(-0.639, 1.313)	0.497
No (I)			

*Note. DNP = Doctor of Nursing Practice; CI = Confidence interval; b = slope; I = Indicator variable; RC = Reference category; * = p-value is < 0.05.

Research Question 2

What is the relationship between experiences with workplace incivility and the physical and psychological health of nursing faculty (sleep disturbances, digestive problems, headaches, respiratory problems, and general well-being)?

A three-step hierarchical multivariate multiple regression (MMR) analysis was used to assess the relationship between workplace incivility and nursing faculty health. Multivariate multiple regression was chosen to account for the expected moderate correlation of the five outcome variables. Table 7 provides a correlation matrix including the five outcome variables and the WIS and PSS-10. As predicted, sleep disturbances, headaches, digestive problems, and respiratory problems were significantly, positively, and moderately correlated. Additionally, as expected, general well-being was significantly and negatively correlated with the four physical outcomes.

Table 7

Correlation Matrix with Main Research Question 2 Variables

Variable	1	2	3	4	5	6	7
1. Workplace Incivility Scale	(0.90)						
2. Perceived Stress Scale	0.390**	(0.90)					
3. PHQ-Headaches	0.254**	0.458**	(0.89)				
4. PHQ-Sleep	0.231**	0.486**	0.333**	(0.79)			
5. PHQ-Digestive	0.225**	0.486**	0.377**	0.398**	(0.86)		
6. PHQ-Respiratory	0.136*	0.344**	0.176**	0.342**	0.382**	(0.79)	
7. WHO-5 Well-being	-0.306**	-0.765**	-0.447**	-0.542**	-0.488**	-0.370**	(0.90)

*Note. * = p < 0.05. ** = p < 0.001; The numeric in the parentheses represents each scale's internal consistency reliability score; PHQ = Physical Health Questionnaire; WHO = World Health Organization.

The following assumptions of multivariate multiple regression were checked: normality of residuals, independence, equal variance, and multicollinearity. The assumptions of independence, equal variance, and multicollinearity were met; however, the assumption of normality was not met for the respiratory and digestive PHQ subscales. After two transformations, the natural log of the two dependent variables (PHQ-Respiratory and PHQ-Digestive) was taken, and the assumption of normality was met through visualization of the Q-Q plots. The collapsed, indicator variables that were used in RQ 1 (Table 5) were also used in steps 2 and 3 in RQ 2.

Hierarchical multivariate multiple regression.

In the first step, workplace incivility was modeled alone with the five outcome variables: sleep disturbances, digestive problems, headaches, respiratory problems, and general well-being. Workplace incivility significantly predicted all outcomes, with the exception of respiratory problems (Figure 3). As workplace incivility experiences increased, sleep disturbances also significantly increased. Specifically, for every additional point increase in the workplace incivility scale score, the predicted mean PHQ sleep disturbances subscale score significantly increases by 0.049 points (F = 15.966; b = 0.049; 95% CI = [0.025, 0.073]; $p < 0.001$). Subsequently, workplace incivility scores also significantly predicted an increase in headaches. For every additional point increase in the workplace incivility scale score, the predicted mean PHQ headache subscale score significantly increases by 0.063 points (F = 19.510; b = 0.063; 95% CI = [0.035, 0.091]; $p < 0.001$). Additionally, digestive problems increased with increased experiences with workplace incivility. Specifically, for every additional point increase in the workplace

incivility scale score, the predicted mean of the natural log of the PHQ digestive

problems subscale score significantly increases by 0.022 points (F = 18.618; b = 0.022;

95% CI = [0.012, 0.031]; p < 0.001). Finally, a negative relationship was found between

workplace incivility scores and nursing faculty well-being. Specifically, for every

additional point increase in the workplace incivility scale score, the predicted mean

WHO-5 Well-being Index score significantly decreases by 1.007 points (F = 29.023; b =

-1.007; 95% CI = [-1.376, -0.639]; p < 0.001).

Figure 3

Step 1: Workplace Incivility Predicting Nursing Faculty Health (N = 284)
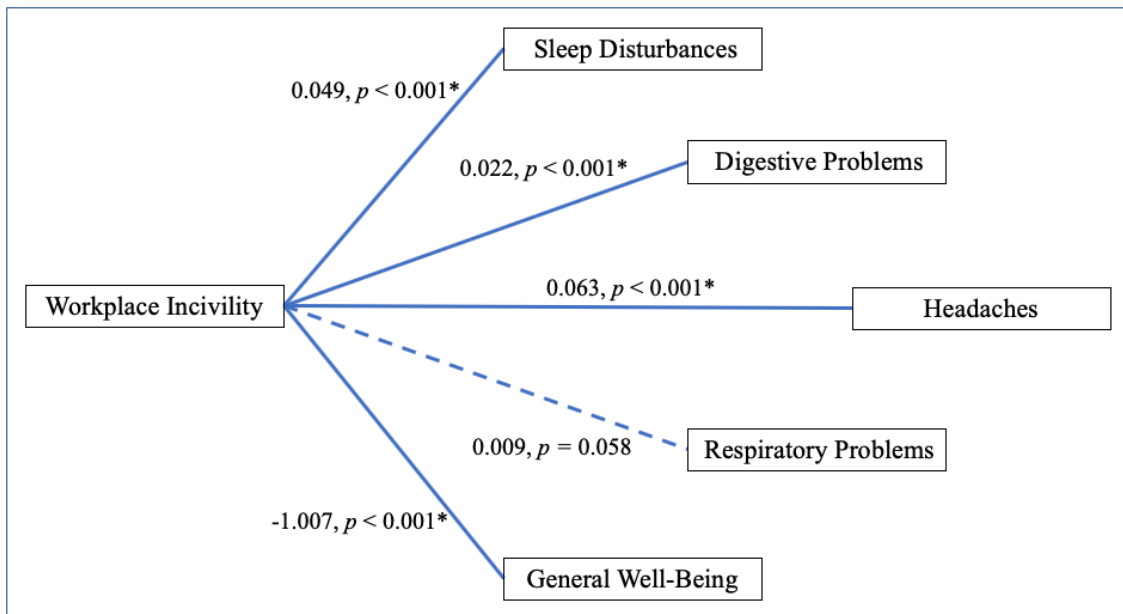
Note. Numeric = slope, *p*-value; * = *p*-value <0.05; Solid line = significant relationship; Dashed line = non-significant relationship.

In the second step, the demographics used to predict workplace incivility in RQ 1

were added to the model. These included gender, age, race, years of faculty experience,

FTE status, highest degree earned, orientation program, mentoring program, civility training, civility policy, college/university type, program type, and work from home. The significance remained for the relationship between workplace incivility and sleep disturbances, digestive problems, headaches, and general well-being (Figure 4). There was a positive relationship between workplace incivility and the physical health of nursing faculty: an increase in sleep disturbances, headaches, and digestive problems. Specifically, for every additional point increase in the workplace incivility scale score, the predicted mean PHQ sleep disturbances subscale score significantly increases by 0.042 points, adjusting for demographic variables ($F = 9.680$; $b = 0.042$; 95% CI = [0.015, 0.068]; $p = 0.002$). Furthermore, for every additional point increase in the workplace incivility scale score, the predicted mean of the natural log of the PHQ digestive problems subscale score significantly increases by 0.021 points, adjusting for demographic variables ($F = 14.618$; $b = 0.021$; 95% CI = [0.010, 0.032]; $p < 0.001$). For every additional point increase in the workplace incivility scale score, the predicted mean PHQ headache subscale score significantly increases by 0.071 points, adjusting for demographic variables ($F = 22.467$; $b = 0.071$; 95% CI = [0.042, 0.101]; $p < 0.001$). Finally, the significant, negative relationship between workplace incivility and general well-being was retained in the second step. Specifically, for every additional point increase in the workplace incivility scale score, the predicted mean WHO-5 Well-being Index score significantly decreases by 0.958 points, adjusting for demographic variables ($F = 21.779$; $b = -0.958$; 95% CI = [-1.362, -0.554]; $p < 0.001$).

Figure 4

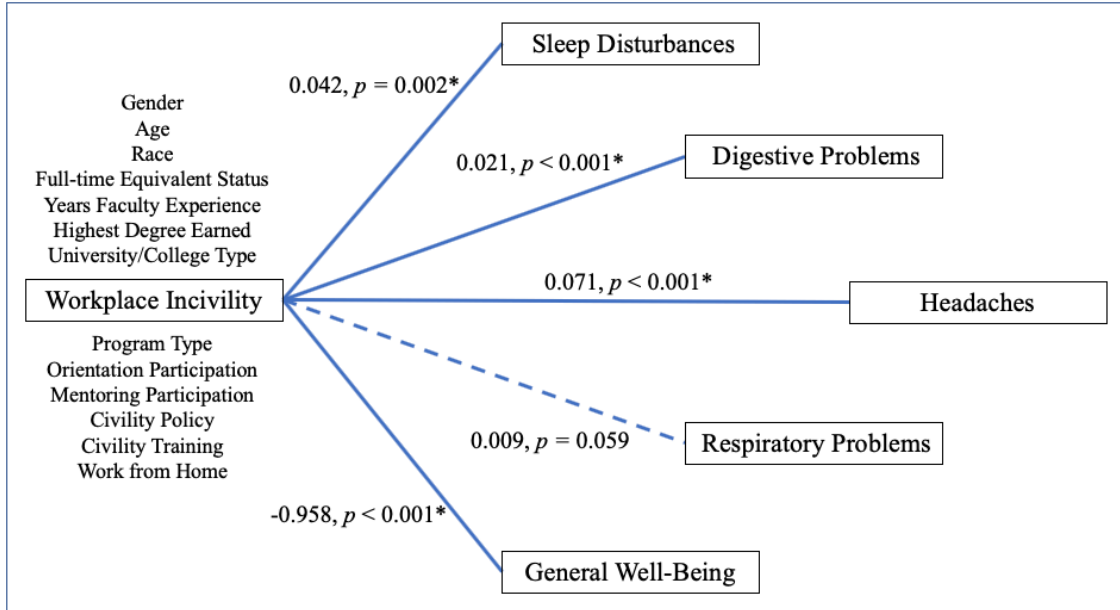*Step 2: Workplace Incivility Predicting Nursing Faculty Health, Controlling for Demographics (N = 284)*

Note. Numeric = slope, *p*-value; * = *p*-value <0.05; Solid line = significant relationship; Dashed line = non-significant relationship.

In the third and final step, perceived stress was added to the model for control (Figure 5). The significant, positive relationship between workplace incivility and headaches was retained. Specifically, for every additional point increase in the workplace incivility scale score, the predicted mean PHQ headache subscale score significantly increases by 0.034 points, adjusting for demographic variables and perceived stress (F = 5.379; *b* = 0.034; 95% CI = [0.005, 0.063]; *p* = 0.021). However, the relationships between workplace incivility and sleep disturbances, digestive problems, and general well-being were no longer significant. Tables 8 through 12 provide additional data for the regression of each outcome variable.

Figure 5

Step 3: Workplace Incivility Predicting Nursing Faculty Health, Controlling for Demographics and Perceived Stress (N = 284)
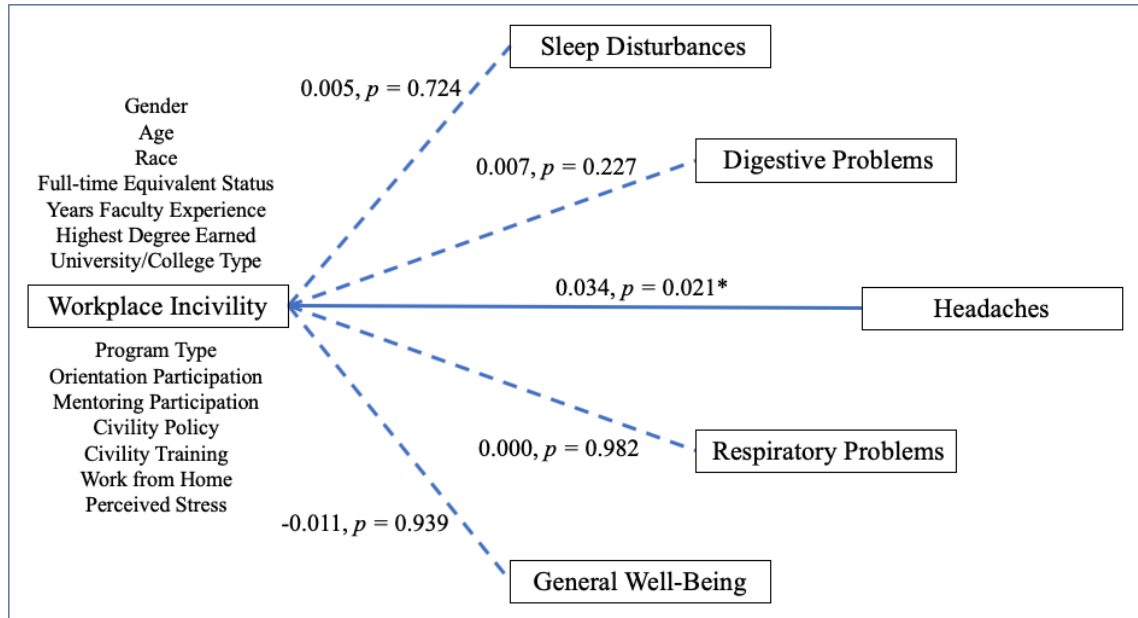
Note. Numeric = slope, *p*-value; * = *p*-value <0.05; Solid line = significant relationship; Dashed line = non-significant relationship.

Table 8

Hierarchical Multivariate Multiple Regression Analysis for Workplace Incivility
Predicting Sleep Disturbance (N = 284)

		Numbers presented are: F Statistic b 95% CI for b *p*-value	
Covariate	Step 1	Step 2	Step 3
Workplace Incivility	15.966 0.049 (0.025, 0.073) <0.001*	9.680 0.042 (0.015, 0.068) 0.002*	0.125 0.005 (-0.021, 0.030) 0.724
Demographics for Control		Not applicable	Not applicable
Perceived Stress			65.570 0.088 (0.067, 0.109) <0.001*

Note. CI = confidence interval; *b* = slope.

Table 9

Hierarchical Multivariate Multiple Regression Analysis for Workplace Incivility
Predicting Digestive Problems (N = 284)

		Numbers presented are: F Statistic b 95% CI for b *p*-value	
Covariate	Step 1	Step 2	Step 3
Workplace Incivility	18.618 0.022 (0.012, 0.031) <0.001*	14.618 0.021 (0.010, 0.032) <0.001*	1.466 0.007 (-0.004, 0.017) 0.227
Demographics for Control		Not applicable	Not applicable
Perceived Stress			58.576 0.035 (0.026, 0.043) <0.001*

Note. CI = confidence interval; *b* = slope.

Table 10

Hierarchical Multivariate Multiple Regression Analysis for Workplace Incivility Predicting Headaches (N = 284)

		Numbers presented are: F Statistic b 95% CI for b *p*-value	
Covariate	Step 1	Step 2	Step 3
Workplace Incivility	19.510 0.063 (0.035, 0.091) <0.001*	22.467 0.071 (0.042, 0.101) <0.001*	5.397 0.034 (0.005, 0.063) 0.021*
Demographics for Control		Not applicable	Not applicable
Perceived Stress			48.569 0.087 (0.062, 0.111) <0.001*

*Note. CI = confidence interval; *b* = slope.

Table 11

Hierarchical Multivariate Multiple Regression Analysis for Workplace Incivility Predicting Respiratory Problems (N = 284)

		Numbers presented are: F Statistic b 95% CI for b *p*-value	
Covariate	Step 1	Step 2	Step 3
Workplace Incivility	3.630 0.009 (0.000, 0.018) 0.058	3.596 0.009 (0.000, 0.019) 0.059	0.001 0.000 (-0.010, 0.010) 0.982
Demographics for Control		Not applicable	Not applicable
Perceived Stress			27.863 0.023 (0.014, 0.031) <0.001*

Note. CI = confidence interval; *b* = slope.

Table 12

Hierarchical Multivariate Multiple Regression Analysis for Workplace Incivility Predicting General Well-Being (N = 284)

	Numbers presented are: F Statistic b 95% CI for b *p*-value		
Covariate	Step 1	Step 2	Step 3
Workplace Incivility	29.023	21.779	0.006
	-1.007	-0.958	-0.011
	(-1.376, -0.639)	(-1.362, -0.554)	(-0.303, 0.280)
	<0.001*	<0.001*	0.939
Demographics for Control		Not applicable	Not applicable
Perceived Stress			321.645
			-2.231
			(-2.476, -1.986)
			<0.001*

Note. CI = confidence interval; *b* = slope.

Qualitative Data Management

Respondents were given the opportunity to respond to two open ended questions about workplace incivility at the end of the Qualtrics survey. Although a "force response" technique was used for the former, quantitative part of the survey, respondents were not electronically forced to respond to either open ended question. Of the 291 respondents, 247 nursing faculty provided a response for the first open ended question and 249 nursing faculty provided a response for the second open ended question, ultimately indicating the salience of the topic of workplace incivility among nursing faculty. The data were exported from Qualtrics into Excel and then transferred to a numbered Word document and formatted in a way that qualitative data is often transcribed. All data were shared with the PI's advisor via the university's secure cloud space, Box.

Analysis

Analysis of the qualitative data was conducted using qualitative content analysis in a series of steps outlined by Elo and Kyngäs (2008). The data were first organized by the response to each question, not paired by each respondent's answers. First, the PI read all of the data to get a sense of the whole data. Second, the PI began an open coding process that was inductive in its approach. The PI made detailed notes of codes and which data corresponded with each of those codes. The PI then read the data and the codes to assess if the coding had been accurately transcribed. During this assessment, the PI identified that many codes had been duplicated, and the PI took this time to combine those duplicated codes into one complete code.

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The PI then reformatted the data to reread it in a way that each respondent's responses to both questions were read together. This allowed the PI to assess the context for some of the responses, as some respondents had expanded on their response to the first open-ended question when they were responding to the second open-ended question. During this portion of the analysis, the PI was able to determine that 19 of the responses had been coded as two different responses when they were really one. These duplicates were corrected and noted in the coding document. Six codes were removed from further analysis. Five of those codes referred to incivility that was not representative of workplace incivility as it was meant to be applied in this study (e.g. incivility from students and incivility from staff nurses in the clinical setting). Finally, eight respondents indicated that they did not have challenges with incivility, and it did not affect them. An additional 31 respondents indicated that they had either not experienced workplace incivility or it had not affected them. These responses were coded as "none" and were removed from further analysis.

After open coding, the PI completed second-level coding and was able to collapse 346 codes from the first coding process into 21 second-level codes. The codes were then categorized into seven different categories. Finally, four themes emerged from the data. Each level of coding was discussed with the faculty advisor experienced in qualitative methods and consensus was reached. Table 13 provides the list of second-level codes, their definitions, and an example respondent quotation. Table 14 provides the collapse of those codes into categories and then the further collapse into themes. The definitions and example quotes are also provided for the seven categories.

Table 13

Second-Level Codes with Definitions and Example Quotes

Second-Level Code	Definition	Example Quote
Manifestations of Incivility	If an outsider were to observe faculty in a school of nursing, these would be abstract, subjective actions or behaviors that would indicate a culture of incivility.	"The department leadership had difficulty with some faculty early in their tenure which has resulted in a strong fisted, controlling approach to all issues while singing the shared governance mantra."
Behaviors of the Instigator	If an outsider were to observe uncivil faculty in a school of nursing, these concrete behaviors would demonstrate workplace incivility.	"My co-worker was constantly reporting any every mistake I made, she would leave her clinical unit to come to mine and yell at my students for doing what I told them to do, my director couldn't say a nice thing to me ever."
Qualities of the Instigator	These are the personal qualities of the individual displaying uncivil behaviors.	"It is often subtle and the faculty has a VERY strong personality. The word bully comes to mind often."
How Incivility Makes the Target Feel Physically	These are the physical responses that targets describe when they experience workplace incivility.	"After a day (may be as short as 4-6 hours) being at the school, I feel fatigued/exhausted

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		and I end up going to bed as soon as I get home."
How Incivility Makes the Target Feel Emotionally/Mentally/Spiritually	This is the direct emotional effect of experienced or witnessed workplace incivility on the target/witness.	"I have had undue stress, feelings of frustration, and I have seriously considered the value my position really brings to my life."
How Incivility Makes Nursing Faculty Feel about Work	These are the ways that nursing faculty feel incivility has made them feel about work.	"Work feels heavy, tedious, and puts a damper on creativity and energy."
How Incivility Affects Nursing Faculty Outside of Work	These are the ways that incivility is impacting the personal and family lives of nursing faculty.	"There has been a decrease of interest in maintaining my home. That has led to an increase in stress at home."
How Incivility is Changing the Target's Behavior	These are the behaviors that a target of incivility displays as he or she changes the way he or she functions in the work environment.	"Not wanting to participate in faculty committees or voice areas of possible improvements; keeping my mouth shut to maintain peace and status quo"
How Incivility is Changing the Target's Values	These are the ways in which incivility has changed the way the target lives out his or her values.	"I still go about my job and do what I am supposed to do, but it I guess it can dampen my enthusiasm somewhat. Maybe I don't bend over

		backwards as much as I otherwise would to help out someone."
Causes of Incivility	These are the reasons that workplace incivility exists in academic nursing education.	"All employees are not always treated equally, this is a source of frustration."
Segregation/Division of Faculty	These are the ways that faculty are different by degree/experience/rank/status and how that division influences uncivil behavior.	"Ageism. There is a sentiment by a few individuals in leadership positions that "younger" faculty are inexperienced and treated in a way that is condescending and does not respect their expertise."
Incivility Originates from Administration/Leadership	Targets of incivility report that many uncivil faculty are those in superior positions.	"My greatest challenge is that workplace incivility occurs often from administrators (chairs/deans) and this behavior trickles down to junior faculty. The tension/stress from incivility is palpable in our organization and everyone seems to know it is there, but administrators do not take action to address it."

Why Incivility is not Getting any Better/Why it is Persistent/Why the Targets or Witnesses do not Try to Fix	These are the reasons that faculty feel incivility cannot improve or why they do not take action to help the situation.	"I do not know if I will be supported when I speak up about things. I make my opinions known and wait to see what kind of response I get. Most of the time I do not feel that my concerns are validated."
Explanations for Why Target Perceives Incivility	These are the reasons that a target might think that another faculty member is being uncivil toward them.	"When I experience an uncivil type event, it seems to me that it is either my own insensitivity or the other person involved didn't' mean to offend but is also under pressure."
How it Impacts the Work Environment	These are the ways that incivility negatively influences the productivity and experience of nursing faculty in their work environment.	"Getting through faculty meetings can be very difficult because of the constant bickering of 3 specific faculty members- nothing ever gets accomplished and everyone leaves meetings frustrated because nothing can get accomplished."
Intent to Leave/Turnover	Nursing faculty report a desire to leave their role or the nursing profession as a result of workplace incivility.	"I am leaving my university and going to another university. If this is a universally

		experienced incivility I will leave academics all together."
Effects Beyond the School of Nursing	These are the way that incivility impacts the university and nursing profession.	"missed opportunities to advance the mission of the university"
Why Incivility, While Present, is not a Problem for Some Faculty	These are the reasons that some faculty feel incivility is not a problem for them personally, even though they know it exists.	"I've done this long enough to know to drop the B.S. [sic] at the door of the school. I never carry any of it home."
Target's Actions to Cope	These are the ways that a target manages experiences with workplace incivility.	"Initially it bothered me and made me have a physical response. Most of the time I am now able to rise above because I have supportive administration and the majority of our team is supportive."
Why Nursing Faculty Persist	These are the reasons that nursing faculty continue to stay in their academic roles.	"I have stayed because I believe in the critical need to educate and train nurses for the future. I cope because I also have a lifetime of successful experience and expertise in my chosen area of specialization as well as a highly regarded faculty

		position and many national awards."
Time/Rank Helps	Nursing faculty report that time/experience/increased rank minimize the experience of workplace incivility.	"I look forward to being tenured. I feel I can be more open about these behaviors and better address that they are not beneficial to our work when I tenured."

Table 14

Progression of Second-Level Codes to Categories and Themes

Second-Level Code	Category *Definition* **"Example Quote"**	Theme
Manifestations of Incivility	The Experience *The way in which nursing faculty are demonstrating and encountering workplace incivility in the work environments.* "Upper level administration outside the nursing department likes to micro-manage everything." "Gossip about my personal life has been deflating and caused me to dislike many of the people I work with."	The Experience
Behaviors of the Instigator		
Qualities of the Instigator		
How Incivility Makes the Target Feel Physically	Personal Effect: Physical and Emotional *The negative impacts that nursing faculty experience as a result of workplace incivility.* "The effect has been so distressing. I also know that it is unnecessary and purely selfish on the part of the perpetrator(s). I have had sleepless nights and have felt hopeless. One night I did not sleep at all recently because of a situation that was so unfair and filled with vengeance. However, I am very fortunate that I can always fall back on working as a nurse and leave the incivility in the faculty structures/schools/colleges behind…"	Personal and Professional Impact
How it Makes the Target Feel Emotionally/Mentally/ Spiritually		
How it Makes Nursing Faculty Feel about Work		
How it Affects Nursing Faculty Outside of Work		

How Incivility is Changing the Target's Behavior	Personal Effect: Changes made by the Target *The way in which nursing faculty are changing their behaviors and values as a result of workplace incivility.* "I spend time hunkered down in my office to avoid running into the uncivil individuals; keep my mouth shut at meetings so no one has an opportunity to belittle me."	
How Incivility is Changing the Target's Values	"I avoid uncivil people and "brace myself" with a pep talk when I know I must meet or for any unavoidable interaction. This experience has strengthened my faith and my prayer life."	
How it Impacts the Work Environment	A Far-Reaching Effect *The broader effects of workplace incivility that extends beyond the direct, personal impact of the target.* "Incivility distracts you from your job functions which impacts our ability to teach our students."	
Intent to Leave/Turnover		
Effects Beyond the School of Nursing		
Causes of Incivility	A Reciprocal, Cultural Problem *The reasons that workplace incivility continues to be a prevalent issue among nursing faculty in academic nursing education.* "The culture of the University promotes academic snobbery if you do not have a PhD."	A Reciprocal, Cultural Problem
Segregation/Division of Faculty		
Incivility Originates from Administration/ Leadership		
Why it is not Getting any Better		
Explanations for Why Target Perceives Incivility		

	Intentional Coping	
Why Incivility is not a Problem for Some Faculty	*The way in which faculty manage their experiences with workplace incivility.*	
Target's Actions to Cope	"Initially it brought me down and I withdrew. Currently, I have a sense of empowerment as I recognize the behavior as uncivil where I once saw it as negative feedback."	Survival
Why Nursing Faculty Persist	Intent to Persist *The reasons that nursing faculty continue to serve in their faculty roles despite their experiences with workplace incivility.*	
Time/Rank Helps	"I am dissatisfied and unhappy but stay because the benefits are so good and the flexibility of my schedule is a huge benefit."	

Findings

Four themes emerged from the data: (1) *the experience*, (2) *personal and professional impact*, (3) *a reciprocal, cultural problem*, and (4) *survival*.

The Experience

The first theme, *the experience*, represents the ways in which nursing faculty demonstrate and encounter workplace incivility in their work environment. Nursing faculty provided many examples of how incivility manifests in their environment and what behaviors instigators display that create an uncivil experience for those who are targeted by the incivility. The experiences that nursing faculty described range from subtle acts of incivility to more overt, aggressive behaviors. *The experience* was represented by instigators who were "condescending," "rude," and "demeaning." Faculty

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discussed behaviors of instigators such as "micromanaging," "gossiping," and

"belittling." Faculty described the experience:

> It's like living in an abusive relationship. One day my superior (who is not a nurse) will berate me and the department in public and tell us we're incompetent. Then she'll do something for us and tell us we should be grateful. Then she'll be nice for a while, but the whole time you know she's likely to come after you again.

> We have a bully who uses very subtle but effective methods to consistently undermine others. She is a truly toxic person. For over a decade she was able to sabotage the careers of others…

> In our workplace exclusion of people from activities and condescending remarks are common. Faculty do not work well together and are superficially supportive of each other but do things "behind the scenes" to step on people to make themselves look better or get ahead. Some people only participate in work that is high profile/minimal work and dump the more mundane, time consuming activities to others. Quite a few do not pull their weight and dump committee work on the few willing to do it. People that are young and pretty are valued over substance and surprisingly that has been openly voiced on multiple occasions. The departmental goal is to make a good impression even it [sic] that means misrepresenting the facts. I have worked in many nursing roles and have always thrived as a team player and valued team member. People here do not work as a team and there is a significant amount of back stabbing.

Personal and Professional Impact

The second theme, *personal and professional impact*, was derived from the

examples that nursing faculty gave in how workplace incivility directly impacts their

personal lives and indirectly impacts the workplace, university, and nursing profession.

Nursing faculty described physical effects of workplace incivility, such as "fatigue,"

"chest pain," and "headaches," along with emotional effects including "anxiety,"

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"frustration," and feelings of "worthlessness." A nursing faculty member further

elaborated on the personal impact:

> The environment here has made me seriously question my value as a nurse and educator. I have so much experience in so many areas and have never experienced this type of workplace before. I physically feel run down and feel that I am teetering on the brink of depression. I am depressed but don't think I am in the clinical depression category yet. I feel certain I will retire sooner than I planned but honestly, if I stay here I think my life will be shorter.

> The effect has been so distressing. I also know that it is unnecessary and purely selfish on the part of the perpetrator(s). I have had sleepless nights and have felt hopeless. One night I did not sleep at all recently because of a situation that was so unfair and filled with vengeance…

Nursing faculty also reported the impact of workplace incivility on the work environment

and organization as a whole by describing their intent to leave:

> I get very stressed when going into meetings, as I feel I have things I could contribute but am frequently ignored. I have withdrawn from my peers, and frequently look for available positions outside of my current organization.

> I am retiring in May. If I could leave sooner I would. I regret choosing to major in nursing education at the end of a long career.

One nursing faculty member described both the personal and professional impact that

workplace incivility has had on his or her life:

> I have been directly impacted by incivility and have suffered physically and emotionally over the past 2.5 years since transitioning from a fixed-term position to tenure-track faculty. In order to escape this unhealthy situation, I have attempted to seek employment elsewhere… While I feel I am coping better with my situation, I feel a disconnect with my organization, my role as faculty, and my

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identity as a nurse. How can we be known as one of the most caring disciplines when we don't care for each other??? They say we "eat our young" (new graduate nurses); however, I would argue that we continue to eat our seasoned as well. Will we ever become full?

A Reciprocal, Cultural Problem

The third theme, *a reciprocal, cultural problem*, represents the reasons that nursing faculty report for the prevalence and persistence of workplace incivility in academic nursing education. Nursing faculty describe causes of the incivility, such as a lack of faculty awareness of uncivil behaviors, along with issues of faculty segregation by degree, experience, and rank. Faculty further describe the impact of hierarchy, uncivil leadership, and a lack of action to eradicate the incivility as cultural problems that further potentiate the presence of workplace incivility. Faculty describe the reciprocal, cultural problem:

> My greatest challenge is that workplace incivility occurs often from administrators (chairs/deans) and this behavior trickles down to junior faculty. The tension/stress from incivility is palpable in our organization and everyone seems to know it is there, but administrators do not take action to address it. Because of this disregard, the perpetrators continue to bully and faculty who do not generally 'act out' are becoming uncivil.

> It seems that there is a real issue between DNP prepared nurse faculty and PhD prepared nurse faculty at my institution. It appears that the PhD prepared faculty feel as if the DNP prepared faculty are somehow less qualified to teach. However, the reality is that neither degree truly prepares you to teach…

> Age-ism- a long practice in the field should be respected, rather than looked down upon as less important than an academic career. Both are important, and can inform each other.

…There needs to be a way to break out of the circle and have someone with any power to do something about the incivility that is occurring…

Survival

The fourth and final theme, *survival*, describes the ways in which nursing faculty have managed to cope with their experiences and why they choose to stay in their positions. Nursing faculty reported a sense of obligation to remain in their academic roles:

…I have stayed because I believe in the critical need to educate and train nurses for the future…

Other nursing faculty describe their motivation for enduring the uncivil experiences:

It has made me want to work harder to out others of a job eventually.

…I hated going to work. I wanted to quit but knew she was retiring at the end of May so I stuck it out.

One nursing faculty member described his or her effort to "care less" in order to survive in the role:

Three years ago I felt suicidal because of the toxic behaviors of a few. I tried to go to counseling (they have this service at my university) but they couldn't see me in the moment so, decided against it… Since then, I try not to be too passionate about my work (try to care less).

Conclusion

The results that have been reported in this chapter provide evidence about the impact that workplace incivility has on the physical and psychological health of nursing faculty. A total of 291 nursing faculty in the state of North Carolina provided data for this study. Research Question 1 explored the predictors of nursing faculty experiences with workplace incivility and found age, FTE status, highest degree earned, orientation participation, and program type to all significantly predict experiences workplace incivility. Furthermore, RQ 2 sought to explore the impact of workplace incivility on the health of nursing faculty and found that workplace incivility is significantly related to an increase in headaches, while controlling for nursing faculty demographics and perceived stress levels.

Qualitative data was also gathered to more deeply explore the experiences that nursing faculty have with workplace incivility. Nearly 85% of respondents answered the open-ended questions asked at the end of the survey. Four themes surrounding nursing faculty experiences with workplace incivility emerged from the data: *the experience*; *personal and professional impact*; *a reciprocal, cultural problem*; and *survival*. The qualitative data produced results that explained and enhanced the quantitative findings. These findings will be further discussed in Chapter 5.

CHAPTER V

DISCUSSION

In order to advance the evidence base about incivility in nursing education, it is necessary to identify and understand the experiences that nursing faculty have with workplace incivility. The presence of workplace incivility has negative implications for individuals. This study sought to understand these implications as they relate to nursing faculty in academic nursing education. While much of the incivility literature has qualitatively focused on nursing faculty experiences with workplace incivility, this study provided data that quantitatively explored the relationship between workplace incivility and the physical and psychological health of nursing faculty. Additional qualitative evidence was gathered to highlight and expand these findings. This study has provided evidence that will help guide interventions to reduce the problems associated with workplace incivility in academic nursing education. This chapter will first provide a discussion on the quantitative answers to the research questions, followed by a discussion of the qualitative findings. Furthermore, the chapter will include the study's findings as they relate to the theoretical framework and extant literature, the study's limitations, and the implications the results have for nursing education and nursing education research.

Discussion of the Quantitative Findings

Workplace Incivility

In this study of nursing faculty, workplace incivility was measured using the 7-item Workplace Incivility Scale (WIS; Cortina et al., 2001) under the direction of asking respondents to reflect on the past six months. Scores in this study could range from 0-28 with higher scores indicating higher levels of incivility, and this range was based on the WIS scoring proposed in Cortina et al. (2011). Score results from this study ranged from 0-27, and the mean WIS score was 6.74 (SD = 5.85) among this study's sample. The 7-item WIS has been used in two other studies with the same directive of reflecting on the past six months; however, both studies used a 7-35 scale range compared to the 0-28 range used in this study. Cut points for the WIS have not been discussed in the literature. Therefore, score comparisons between studies were based on average score distance from the midpoints of each scale.

The nursing faculty sampled in this study experienced higher levels of workplace incivility than were found by Demsky et al. (2018) and lower levels than were found by Hershcovis et al. (2017). The midpoint of the 7-35 scale used in the previous two studies indicated above is 21, while the midpoint of the scale in the present study is 14. In the present study, nursing faculty reported an average WIS score of 6.74 which was 7.26 points from the midpoint of the 0-28 scale. Hershcovis et al. (2017) found, in a study of full-time North American employees, an average WIS score of 18.62 which was only 2.38 points from the midpoint of the respective scale. However, Demsky et al. (2018) used the WIS in government employees in the Southwestern United States, asked

respondents to rate workplace incivility from coworkers and supervisors, and found lower scores than the present study. Average WIS scores for coworkers was 12.95, which was 8.05 points from the midpoint for that study. Additionally, WIS scores were higher for respondents in the same study when they considered incivility from supervisors. Supervisor incivility was found to be at 13.65, which was 7.35 points from the midpoint of the 7-35 scale (Demsky et al., 2018).

The WIS scores among nursing faculty in the present study were higher than coworker and supervisor incivility scores found in Demsky et al. (2018). The findings from Demsky et al. (2018) support the notion that there is more incivility from individuals in leadership or supervisor positions, which was also supported by the qualitative data in the present study. Furthermore, using the WIS, Demsky et al. (2018) reported a significant relationship between workplace incivility and somatic health complaints, mediated by embarrassment. Previous literature about workplace incivility among employees has demonstrated that increased experiences with workplace incivility negatively impacts the physical and psychological health of the targets (Hershcovis et al., 2017; Kabat-Farr et al., 2018; Lim et al., 2008; Schilpzand et al., 2016). This physical and psychological impact has also been qualitatively described in the incivility literature on nursing faculty (Goldberg et al., 2013; Peters, 2014; Wieland & Beitz, 2015); yet, findings from the present study have quantified the severity of workplace incivility among faculty in nursing education.

Research Question 1

Research question 1 sought to explore which variables may predict nursing faculty experiences with workplace incivility. The study results suggested that full-time equivalent (FTE) status, age, highest degree earned, program type, and orientation program participation were all significant predictors of workplace incivility. More specifically, nursing faculty who worked full-time compared to those who worked part-time had increased experiences with workplace incivility ($p = 0.042$). This was an expected finding given that increased experiences with workplace incivility would often coincide with more time at the workplace. However, research addressing incivility or bullying experiences in nursing faculty has only sampled full-time nursing faculty (Beckmann et al., 2013; Clark et al., 2013; Goldberg et al., 2013; Peters, 2014); therefore, this finding fills a gap and further enforces the need to keep a focus on incivility among full-time faculty.

The present study also found that age was a significant predictor ($p = 0.046$); specifically, experiences with workplace incivility increased as nursing faculty age increased. Additionally, within the present study's qualitative evidence, seven respondents suggested that some of their experiences with workplace incivility were directly related to their older age. This was an unexpected finding, as research has not suggested that older faculty are experiencing more incivility. First, Beckmann et al. (2013) found no significant differences in bullying experiences based on age. Additionally, in a study of generational differences in perception of incivility found that those in Generation X (born between 1965-1980) experienced more incivility than the

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Baby Boomers (born between 1946-1964) (Ziefle, 2018). These findings are not in alignment with the present study. Furthermore, in a study exploring generation-specific disincentives for nursing faculty to remain in their academic roles, the Silent Generation (those born in 1945 or earlier) had the lowest proportion of respondents who would leave their roles due to incivility, while almost 77% of Generation Y (those born in 1980 or later) indicated they would leave due to incivility. It seems that experiences with incivility and intent to leave are related but not perfectly correlated concepts, and although experiences with incivility may be higher for older faculty, intent to leave due to those uncivil experiences may be higher for younger faculty. Ziefle (2018) attributes these differences to generation-specific values, such that the Baby Boomers value hard work and job loyalty, while members of Generation X value independence and work-life balance. Therefore, it is necessary to further understand the differences in how older and younger nursing faculty experience incivility but also recognize how their values impact their response to it.

This study also found that nursing faculty who had doctoral degrees experienced more incivility compared to those with Bachelor's or Master's degrees ($p = 0.018$). Much of the qualitative evidence (Goldberg et al., 2013; Peters, 2014; Peters & King, 2017), including that from this study, has suggested that incivility often moves from faculty in higher positions toward faculty of lower rank. Therefore, the top-down movement of incivility from leaders or supervisors does not seem to target those with Bachelor's or Master's degrees but may exist more between the doctoral prepared faculty who hold different ranks in the academic hierarchy. Furthermore, respondents in the qualitative

portion of this study reported the division between those who are tenured or tenure-seeking and those who are on clinical or fixed-term tracks. However, Goldberg et al. (2013) found that nursing faculty issues with tenure were more closely related to division between tenured faculty and those who were tenure-seeking. More specifically, they noted that tenured faculty were protected, while tenure-seeking faculty were defenseless and fearful of their tenure outcomes. Therefore, since tenured and tenure-seeking faculty often hold terminal degrees, it is not surprising to find that incivility levels are higher among doctoral prepared faculty.

The finding that incivility is higher among nursing faculty with doctoral degrees is further supported by the significant relationship between program type and experiences with workplace incivility. This study found that incivility is higher ($p = 0.047$) for nursing faculty who teach in a graduate program compared to those who teach in a prelicensure program. Although some of the incivility literature has only focused on faculty in prelicensure programs (Aul, 2017; Goldberg et al., 2013), the literature that has had some graduate faculty in the samples has not compared incivility levels between graduate and prelicensure faculty. The finding that incivility is higher in graduate degree programs and among doctoral prepared faculty has filled a gap in the literature and highlighted the need to further explore this environment and this particular population.

The lack of participation in a new faculty orientation program was also found to be a significant predictor of experiences with workplace incivility ($p = 0.024$), and 48.6% of respondents in this study indicated that they did not participate in a formal orientation program for their faculty role. Nursing faculty who did not participate in a formal

orientation program experienced significantly higher levels of workplace incivility compared to those who did, and this was an expected finding. Previous evidence has suggested that orientation programs provide new nursing faculty with the opportunity to become more familiar with the school's culture and expectations (Grassley & Lambe, 2015); yet, no studies were identified that have looked at the role of orientation programs as they related to incivility. While the present study did not explicitly explore the content of the participants' orientation programs, it is possible that orientation programs would present the opportunity to discuss civility and the school's position on uncivil behavior. The use of a new faculty orientation program, although only experienced by half of this study's respondents, gives new faculty an opportunity to gain a sense of the school's culture and enhance feelings of belongingness. Therefore, schools of nursing that offer orientation programs may place a higher value on promoting positive experiences for new faculty, which may in turn be a reflection on the type of culture established in that school.

Although lack of participation in a mentoring program was only a marginally significant predictor of workplace incivility, one participant in the present study indicated that she had frequently experienced incivility from her mentor. Therefore, the provision of a mentor through a mentoring program will likely not reduce all experiences with workplace incivility. Interestingly, neither participation in civility training nor the presence of a civility policy within the school of nursing was predictive of experiences with workplace incivility, despite the continued discussions to use those strategies to alleviate this problem (Authement, 2016; NLN Vision Series, 2018). Less than 20% of this study's respondents had participated in civility training; therefore, it is possible that

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an increase in training programs and an increase in civility policy discussion may eventually enhance the effectiveness of those programs in reducing workplace incivility.

Research Question 2

Research question 2 sought to explore the relationship between workplace incivility and nursing faculty physical and psychological health. A hierarchical multivariate multiple regression analysis was conducted. In the first step, workplace incivility was modeled alone and significantly predicted an increase in nursing faculty headaches, digestive problems, sleep disturbances, and a decrease in general well-being. There was not a significant relationship between workplace incivility and respiratory problems. These same significant findings were retained in the second step with the addition of nursing faculty demographics as control variables; however, in the final step with the addition of perceived stress as a control variable, an increase in headaches was the only significant outcome related to experiences with workplace incivility. This was the first study of its kind to explore and find a significant relationship between increased experiences with workplace incivility and a decrease in the health of nursing faculty.

The addition of perceived stress to the final step of the model proved to considerably influence the findings in the first and second steps, as evidenced by a large F statistic. The findings suggested that perceived stress was a significant predictor of the five outcomes variables; therefore, it is possible that the model was misspecified. More specifically, perceived stress was used as a control variable in this study, and it may be more accurate as a mediator in the relationship between workplace incivility and the five outcomes used. Although previous studies have not used perceived stress as a mediator

between workplace incivility and physical and psychological health, two studies have used mediators in understanding the relationship between incivility and physical health of employees (Hershcovis et al., 2017; Lim et al., 2008).

Lim et al. (2008) assessed the relationship between workplace incivility and physical health for federal court employees, mediated by mental health, and found a significant relationship for both pathways. Additionally, Hershcovis et al. (2017), explored how embarrassment mediated the relationship between workplace incivility and the physical symptoms of employees and found both direct and indirect relationships. This evidence suggests that the relationship between workplace incivility and the physical and psychological health of employees may be mediated or moderated by a variety of different variables. The qualitative data from this study, to be further discussed below, suggests that incivility leads to an increase in stress. Therefore, the variable of perceived stress may be more accurately positioned as a mediator in the relationship between workplace incivility and the physical and psychological health of nursing faculty. This is a fertile area for future research.

Discussion of Qualitative Findings

The quantitative results discussed above were further augmented by the extensive response to the two open-ended questions at the end of the Qualtrics survey. Despite the respondents' option to forgo responding to the two open-ended questions, nearly 85% of the survey respondents provided qualitative data about their experiences with workplace incivility. This sizeable response rate suggests the extensiveness of workplace incivility among nursing faculty and their desire to share their experiences. The four themes (*the*

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experience; *personal and professional impact*; *a reciprocal, cultural problem*; and *survival)* provided evidence about the trajectory of workplace incivility among nursing faculty. The themes first begin with the experience of either being a target of incivility or witnessing it among peers. The themes progress with a deeper understanding of the impact that workplace incivility has on nursing faculty, followed by a theme describing the reasoning for its prevalence and persistence in nursing education. Finally, the nursing faculty describe their strategies to survive within their uncivil environments.

Much of the data from the second theme, *personal and professional impact*, is in direct alignment with this study's quantitative findings. Quantitative data showed a significant relationship between an increase in experiences of workplace incivility and an increase in headaches, sleep disturbances, and digestive problems. Three nursing faculty specifically describe an increase in headaches, six report sleep disturbances, and six discuss GI upset symptoms, including stomach pain and nausea. There was also a substantial level of qualitative evidence surrounding a decrease in psychological health among nursing faculty as a result of workplace incivility. Decreases in psychological health were depicted by faculty reports of increases in anxiety, depression, post-traumatic stress, and even suicidal ideation.

Variations of each of the four themes that emerged from the data in this study have also been found in previous literature. The first theme, *the experience*, included manifestations of incivility and the behaviors of the instigator, which has been widely described among both qualitative and quantitative research. Goldberg et al. (2013) qualitatively described uncivil, bullying behaviors of nursing faculty as bullying tactics,

which included gossiping, sabotaging, and unequal workloads. Peters (2014) described belittling behaviors of instigators in her phenomenological study of new nursing faculty and their experiences with incivility. Quantitatively, Clark et al. (2013), described the top highly uncivil behaviors among nursing faculty, which included setting up a coworker to fail, making rude remarks toward a coworker, and making personal attacks. All of these behaviors and many others described in Clark et al.'s (2013) study were supported in this study.

However, within the theme of *the experience*, this study uncovered qualities of the instigators, which has not been as widely discussed as the actual behaviors of the instigator. Some faculty in the present study described instigators as being insecure or having a personality issue and suggested this was the cause of their uncivil behavior. This perspective has not been described in the incivility in nursing education literature. Much of the focus has been on the experiences of the target and has not looked at the personal qualities of the instigator. In the present study, several respondents also suggested that the greatest challenge with workplace incivility is that nursing faculty are unaware they are being uncivil. It is common for nursing faculty to behave in an uncivil way without realizing how their behavior is negatively impacting others. It is necessary to enhance nursing faculty awareness of their own behaviors. In 2018, Clark, Sattler, and Barbosa-Leiker (2018) developed the Workplace Civility Index, a self-assessment of civil behavior in the workplace. It is thought to help nursing faculty measure their own workplace civility acumen and promote the self-awareness of nursing faculty. The Workplace Civility Index may be a reasonable place to advance the inquiry surrounding

nursing faculty awareness of their behavior and further explore how qualities of instigators may be contributing to the uncivil experience.

The theme of *personal and professional impact* has been widely described in the qualitative research surrounding incivility in nursing education. In previous studies, nursing faculty have reported the physical impact of incivility including weight gain, hypertension, and headaches (Goldberg et al., 2013). The qualitative findings of this study did not include hypertension or weight gain; however, the physiological impact is still present. The psychological impact reported in the previous literature was equally reported in this study. Nursing faculty have previously reported anxiety, isolation, and a decreased sense of value (Goldberg et al., 2013; Peters, 2014), all of which were consistently found in the present study.

Contrary to the consistencies about personal impact between this study and previous literature that were reported above, the findings about professional impact from this study were not in exact alignment with previous research. Although some of the former research on incivility among nursing faculty has indicated that some faculty are leaving their roles due to incivility, much of the research has discussed the ways in which faculty are coping and building resilience within their uncivil situations (Goldberg et al., 2013; Peters, 2014; Wieland & Beitz, 2015). The present study found an alarming number of faculty reporting intent to leave their positions as a result of workplace incivility, even though this question was not specifically asked. Within the present study, seven faculty reported the intent to retire earlier than planned, eleven faculty indicated they were actively looking for another job, and fourteen faculty reported that they had left

their previous role, including academic or clinical practice roles, due to workplace incivility. The lack of attention on faculty intent to leave as a result of incivility may be related to the small sample sizes of qualitative inquiry. More specifically, if only one participant in a qualitative study describes his or her intent to leave, this may not be reported or discussed in study findings. The present study has uncovered the professional impact of intent to leave among nursing faculty, and it will be necessary to further explore this finding and its impact.

The third theme of *a reciprocal, cultural problem* has been consistently reported in the previous literature. Clark (2008b) first described the reciprocal nature of incivility, albeit between faculty and students, as a "dance." However, the reciprocity of incivility is also present between nursing education administrators and nursing faculty. The present study found that, although much of the incivility originated from superior faculty or administrators, nursing faculty who are recipients of incivility are responding with uncivil behavior. This finding is in direct alignment with the previous literature, from both nursing and organizational behavior, that incivility promotes more incivility (Andersson & Pearson, 1999; Clark, 2008b; Harold & Holtz, 2015). However, Casale's (2017) study on the positive impact of resonant leadership supports the notion that civil behavior from leadership will reciprocate civil behavior from faculty. Although incivility will promote more incivility, civil behavior can promote more civil behavior. It is necessary for nursing education leaders to recognize their important role to shift from an uncivil culture toward a civil one.

The idea that incivility is pervasive due to a cultural problem was also found in this study and has been supported in previous literature. Nursing faculty respondents from the Goldberg et al. (2013) study described a "bully culture," while nursing administrators from the Peters and King (2017) study reported that the uncivil culture was "ingrained." Peters and King (2017) further suggest an imbalance of power as a major barrier to a civil academic work environment. Estes and Jia Wang (2008) suggest that members of an organization rely on leaders to demonstrate what is acceptable or unacceptable behavior within the organization. Furthermore, research indicates that incivility moves from the top of an organization and trickles down to employees (Estes & Jia Wang, 2008). Therefore, workplace incivility is not unique to academia or a direct result of a competitive, tenure-seeking environment. Any organization with designated leaders is at risk of workplace incivility just by way of the hierarchical structure or the lack of leaders establishing a culture free of incivility. Miner et al. (2012) report the need for an organization to establish a set of cultural norms early in its inception to prevent workplace incivility; however, the challenge comes when leaders are called to change an already established culture that is battling workplace incivility between its members.

Schein (2016) suggests that the norms and beliefs of an organization become so ingrained in the culture that the members become unaware of them. As a result, as incivility permeates the academic environment, the established culture makes it hard for faculty and administrators to stop it. Under the assumption previously discussed in the literature and found in this study that incivility incites more incivility (Andersson & Pearson, 1999; Clark, 2008b; Harold & Holtz, 2015), leaders must recognize their crucial

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role in demonstrating civil behavior that incites civil behavior from employees. The pervasive culture of workplace incivility in academia, and organizations as a whole, cannot be stopped without positive changes from those in leadership positions.

Finally, the theme of *survival* describes the reasons that nursing faculty remain in their roles and how they cope with their experiences with incivility. Previous research findings related to this theme have been consistently represented as coping strategies. Goldberg et al. (2013) described these actions as "fighting-back strategies" (p. 194); however, Wieland and Beitz (2015) put a positive perspective on the experiences and suggested that they were "resilience building" (p. 291). Despite the positive, resilience building aspect of these negative experiences, the authors reported that nursing faculty still planned to leave their roles as a result of the bullying (Wieland & Bietz, 2015). Although there are both positive and negative perspectives in the literature on how nursing faculty are coping with these uncivil experiences, nursing faculty are unable to thrive in these conditions. They are merely surviving. The quantitative and qualitative findings from this study illuminate the experiences that nursing faculty are having with workplace incivility, and these findings are closely related to the propositions made in the Theory of the Nurse as Wounded Healer (Conti-O'Hare, 2002).

Theoretical Framework

The Theory of the Nurse as Wounded Healer (NWH) was used to guide this study. The theory first proposes that individuals have traumatic experiences that lead to physical and psychological distress and subsequently turn these individuals into the walking wounded (Conti-O'Hare, 2002). Individuals must recognize, transform, and

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transcend these wounds to become a wounded healer. This process is facilitated by effective coping strategies (Conti-O'Hare, 2002). The present study was guided by the first proposition of the theory and sought to explore the relationship between a workplace trauma, workplace incivility, and the impact it had on the physical and psychological health of the target. The quantitative findings provide strong evidence that workplace incivility is a workplace trauma that affects the physical and psychological health of nursing faculty. There were significant relationships between an increase in workplace incivility and an increase in nursing faculty headaches, digestive problems, and sleep disturbances. Furthermore, there was a significant decrease in general well-being as experiences with workplace incivility rose, all while statistically controlling for the participants' demographics. Although the significant relationships with digestive problems, sleep disturbances, and general well-being were not retained after adding perceived stress to the model, there is statistical evidence that perceived stress plays a different role in those relationships. The quantitative findings from this study provide evidence that the propositions made by Conti-O'Hare (2002) are accurate.

Even more importantly though, the qualitative findings provide strong evidence for additional propositions in the theory. First, nursing faculty in the present study described the specific ways that the trauma of workplace incivility has impacted their physical well-being, including experiences of GI upset, chest pain, headaches, and poor sleep. They also described the severe psychological impact, including suicidal ideation, anxiety, and depression, ultimately supporting the proposition explored in this study. Some nursing faculty respondents also reported effective and ineffective coping

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strategies. They described effective strategies, such as increasing prayer time, confronting the instigator, and choosing to ignore the uncivil behavior. However, many nursing faculty reported ineffective strategies, including avoidance behaviors, intentions to leave, and intentional efforts to "care less" about work. Conti-O'Hare (2002) suggests that ineffective coping will lead to job dissatisfaction and burnout. Findings from this study, and in conjunction with the proposition from NWH, indicate that workplace incivility is a work-related trauma that has severe negative implications for the individual and eventually the nursing profession.

Despite the abundance of research on incivility in nursing education, there is a paucity of research that has utilized theories or conceptual models to guide the scientific inquiries. Clark and Davis Kenaley (2011) merged two conceptual models to create a model in which faculty empowerment could lead to student empowerment and ultimately create a reciprocal culture of incivility. This framework has been limited in its utilization and would not be applicable in this study given its distinct focus on incivility between faculty and students rather than that between faculty alone. Furthermore, in a study on generational differences among nursing faculty and their perceptions of incivility, Ziefle (2018) briefly discussed Bandura's Social Cognitive Theory as it relates to the way individuals learn and interact within their environments, but the author does not explicitly indicate the use of the theory to guide the study. However, the same theory was explicitly used to guide the research about resonant leadership and its impact on incivility among nursing faculty (Casale, 2017). The researcher described how Bandura's Social Cognitive Theory helps explain why nursing faculty behave the way they do in their environment,

specifically as it relates to workplace incivility and the role of leaders in their organization. Casale's (2017) is the only study identified that used a framework to guide the inquiry.

As identified in the present study, a school of nursing's culture influences the presence, or absence, or workplace incivility. Social Cognitive Theory provides a framework to explore the role of environment on explaining the behaviors of an organization's members, and Casale (2017) provides an excellent example of its use. Future inquiry into the role of organizational culture should consider this framework. However, the present study sought to explore the direct, personal effects that workplace incivility had on individuals, and the NWH provided a strong framework to guide that inquiry and future work in this area. As nursing researchers consider advancing the evidence base on workplace incivility in nursing education, inquiry focused on the direct impact of incivility on nursing faculty should consider using the NWH. Future work using the NWH can help researchers fully understand the process in which nursing faculty recognize, transform, and transcend their wounds inflicted by workplace incivility.

Limitations

The cross-sectional design of this research study allowed for rapid data collection, but the relationship findings cannot be used to infer causality due to the capture of information at one point in time. Furthermore, the sample in this study is limited to one state, North Carolina, which limits the generalizability of the findings to other regions of the United States. Another limitation of this study was the method by which qualitative

data was gathered, as respondents typed their responses into open text boxes. This did not allow the PI to probe for further details into the responses nor understand the context of the respondents' answers. Additionally, 1,452 faculty were invited to participate in the study, however only 20% of the potential sample responded. Therefore, 80% of faculty in the state of North Carolina were not represented in this study. It is possible this limited sample does not adequately represent all nursing faculty types and groups. Additionally, faculty who chose to participate in this study may have had a personal interest in workplace incivility and therefore may have been more inclined to participate. The findings may be skewed due to the different levels of interest in the study topic. Finally, it would have been valuable for the PI to ask respondents about their intent to leave their faculty roles. This PI did not recognize the prevalence of intent to leave as it related to experiences with workplace incivility, and this piece of information would have strengthened the findings of the quantitative and qualitative data.

Implications

The findings of the research study shed light on the severe impact that workplace incivility has on nursing faculty, nursing education, and the entire nursing profession. While previous research has adequately described the experiences that nursing faculty have with workplace incivility, this study advanced the evidence base by providing statistical evidence that workplace incivility is significantly impacting the health of nursing faculty. Below are recommendations for nursing education and for nursing education research.

Implications for Nursing Education

The need to recruit and retain nursing faculty is imperative for the future of the nursing profession and may be impacted by workplace incivility. The research suggests that much of the incivility in academic nursing education originates from those in administrative and higher- ranking positions, and this is creating a culture of incivility. Therefore, it is necessary to consider the impact that civility training, or retraining, of uncivil administrators can have on decreasing workplace incivility. Furthermore, the recruitment and retention of civil administrators and leaders who will address and eliminate workplace incivility within their departments must occur in order to combat this cultural problem.

Evidence from this study also suggests that faculty participation in an orientation program reduces faculty experiences with workplace incivility. Nearly half of the respondents in this study did not participate in a new faculty orientation program, marking a severe need to bring orientation experiences to all schools of nursing. Formal new faculty orientation programs that commit to continued discussions of civility within the workplace may see a positive long-term impact on reducing incivility in the organization. Additionally, expanding on the study's qualitative findings surrounding the role of tenure and experiences with incivility, it may also be valuable to use this orientation time to intentionally discuss the promotion and tenure process for all new faculty, those who are tenure-seeking and those who are clinical track or fixed-term.

This study also illuminated the severity of workplace incivility in graduate nursing education and among doctoral prepared faculty. While it is unclear why incivility

is greater at this level, it is assumed that there are greater levels of competition for promotion and tenure. Therefore, although incivility is present at all levels of nursing education, early interventions to decrease the effects of workplace incivility should begin at the graduate level programs and then move toward the baccalaureate and associate degree programs. While this study did not find a significant relationship between civility training or civility policies and experiences with workplace incivility, there were negative relationships between both. More specifically, faculty who had participated in training or reported that their school of nursing had a civility policy reported fewer experiences with workplace incivility. Respondents from this study also suggested that there is a lack of awareness of what incivility is. Therefore, schools of nursing are encouraged to continue discussing workplace incivility, putting policies in place, and providing training for faculty as they are able. Finally, this study highlighted the severe physical and psychological impact of workplace incivility on nursing faculty, and it is important for schools of nursing and colleges to put provisions in place for nursing faculty to seek help in a safe, private manner. Many schools have employee assistance programs, but these must be promoted and encouraged for nursing faculty.

Implications for Research

This study produced findings that can guide numerous future research studies. First, future research should focus on workplace incivility as it occurs specifically in graduate nursing education. Previous research has been conducted using faculty from all academic levels; however, this study has demonstrated that experiences with workplace incivility are higher among those teaching primarily at the graduate level. More

specifically, it would be valuable to further explore the experience of incivility between those prepared with a PhD versus those prepared with a DNP. The a priori design of this study did not permit an analysis between these two degree types, but the qualitative evidence suggests that experiences with incivility may vary between them.

Second, the results from the multivariate regression analysis in this study suggested that perceived stress may function as a mediator between workplace incivility and the physical and psychological health of nursing faculty. Future research could use the same data set and explore the role of perceived stress in its relationship to workplace incivility and the health of nursing faculty. Third, future inquiry should quantitatively explore nursing faculty intent to leave as a result of workplace incivility. Qualitative findings in this study strongly suggest that workplace incivility is a reason for faculty turnover; therefore, it would be valuable to quantitatively explore this relationship. In the same vein, the Workplace Incivility Scale can be used to measure experiences from different instigators, and it would be useful to use the same scale to explore nursing faculty experiences with workplace incivility from peers and from supervisors. This would help quantify the qualitative data suggesting that incivility is higher from those in higher ranking positions.

Finally, future research surrounding nursing faculty experiences with workplace incivility should be focused on interventions, such as civility training, to address the problem. All of the descriptive and correlational evidence surrounding nursing faculty and their experiences with workplace incivility suggests its prevalence and negative impact. Researchers must take these findings and create practical, thoughtful

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interventions to at least reduce, if not eliminate, workplace incivility in academic nursing education.

Conclusion

Marion Conti-O'Hare (2002), author of the Theory of the Nurse as Wounded Healer, stated:

> The social and cultural patterns that affect women and other susceptible groups tend to build trauma into everyday life, producing outcomes that inhibit the expansion of energy for self-development. Nurses may be particularly vulnerable to this outcome by virtue of their sex since the majority are female. Furthermore, as an oppressed group within the health care hierarchy, they may experience abuse not only from the medical establishment and hospital administration but also, in some situations, from one another… (p. 67)

The uncivil way in which nursing faculty treat each other within the academic setting has negative implications, not only for the target, but for the entire nursing profession. The results of this study have highlighted the need to combat workplace incivility in academic nursing education, as it is drastically impacting the profession's ability to recruit and retain qualified nursing educators. The prevalence of this problem, as demonstrated in the existing literature and now in this study, provides evidence of the need to invest time, energy, and resources into solutions. Nursing faculty and administrators are well-positioned to create an environment that is civil and representative of the values that are held so closely by the nursing profession.

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Workplace Incivility and its Effects on Nursing Faculty Survey

1. Within your work environment, do you regularly interact with other nursing faculty or administrators?

    a. Yes (software will allow participant to continue survey)

    b. No (software will exclude participant from study)

2. In what type of program do you currently spend the most time teaching?

    a. Associate/Diploma

    b. Baccalaureate

    c. Graduate

3. What is your gender?

    a. Female

    b. Male

    c. Other/Prefer not to answer

4. What is your age in years?

    a. _____

5. Which of these groups best represents the race with which you identify?

    a. White/Non-Hispanic

    b. Black/Non-Hispanic

    c. Hispanic/Latinx

d. American Indian/Alaska Native

e. Asian/Pacific Islander

f. Other

6. How many years have you been a Registered Nurse?

   a. _____

7. How many years have you worked in the role of a nursing faculty member?

   a. _____

8. Are you currently a full-time or part-time nursing faculty member?

   a. Full-time

   b. Part-time

9. What is your highest degree earned?

   a. Associate's

   b. Bachelor's

   c. Master's

   d. Doctorate-DNP

   e. Doctorate-EdD/DNS/PhD

10. At what type of university or college do you currently teach?

    a. Community College

    b. Public University

    c. Private University

    d. Other

11. Did/do you participate in a formal new nursing faculty orientation program within your school of nursing?

   a. *A formal orientation program includes receipt and discussion of a resource manual, an ongoing discussion of roles and responsibilities for the role of the nursing faculty member, and ongoing meetings with relevant individuals to check on progress and transition to the new role.*

   b. Yes

   c. No

12. Did/do you participate in a formal new faculty mentoring program within your school of nursing?

   a. *A formal mentoring program involves the designation of at least one seasoned faculty member, who will invest time and energy, to help a new faculty member transition into his or her new role and environment.*

   b. Yes

   c. No

13. Does your nursing program have a civility policy?

   a. Yes

   b. No

   c. I don't know

14. Does your nursing program require civility training?

   a. Yes

   b. No

15. Do you exclusively work from home?

    a. Yes

    b. No

During the PAST 6 MONTHS while employed in your current faculty role, have you been in a situation where any of your superiors or coworkers:

16. Put you down or was condescending to you?

    a. Never

    b. Once or twice

    c. Sometimes

    d. Often

    e. Many times

17. Paid little attention to your statement or showed little interest in your opinion?

    a. Never

    b. Once or twice

    c. Sometimes

    d. Often

    e. Many times

18. Made demeaning or derogatory remarks about you?

    a. Never

    b. Once or twice

    c. Sometimes

d. Often

e. Many times

19. Addressed you in unprofessional terms, either publicly or privately?

    a. Never

    b. Once or twice

    c. Sometimes

    d. Often

    e. Many times

20. Ignored or excluded you from professional camaraderie?

    a. Never

    b. Once or twice

    c. Sometimes

    d. Often

    e. Many times

21. Doubted your judgement on a matter over which you have responsibility?

    a. Never

    b. Once or twice

    c. Sometimes

    d. Often

    e. Many times

22. Made unwanted attempts to draw you into a discussion of personal matters?

    a. Never

b. Once or twice

c. Sometimes

d. Often

e. Many times

For the remainder of this survey, please respond based on your experiences both at work and outside of work.

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, please indicate your response by selecting HOW OFTEN you felt or thought a certain way.

23. In the last month, how often have you been upset because of something that happened unexpectedly?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

24. In the last month, how often have you felt that you were unable to control the important things in your life?

    a. Never

    b. Almost Never

c. Sometimes

d. Fairly Often

e. Very Often

25. In the last month, how often have you felt nervous and "stressed"?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

26. In the last month, how often have you felt confident about your ability to handle

    your personal problems?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

27. In the last month, how often have you felt that things were going your way?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

28. In the last month, how often have you found that you could not cope with all the

things that you had to do?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

29. In the last month, how often have you been able to control irritations in your life?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

30. In the last month, how often have you felt that you were on top of things?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

31. In the last month, how often have you been angered because of things that were

outside your control?

    a. Never

b. Almost Never

c. Sometimes

d. Fairly Often

e. Very Often

32. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

    a. Never

    b. Almost Never

    c. Sometimes

    d. Fairly Often

    e. Very Often

Please indicate for each of the 5 statements which is closest to how you have been feeling over the last two weeks.

33. I have felt cheerful and in good spirits.

    a. All of the time

    b. Most of the time

    c. More than half of the time

    d. Less than half of the time

    e. Some of the time

    f. At no time

34. I have felt calm and relaxed.

a. All of the time

b. Most of the time

c. More than half of the time

d. Less than half of the time

e. Some of the time

f. At no time

35. I have felt active and vigorous.

a. All of the time

b. Most of the time

c. More than half of the time

d. Less than half of the time

e. Some of the time

f. At no time

36. I woke up feeling fresh and rested.

a. All of the time

b. Most of the time

c. More than half of the time

d. Less than half of the time

e. Some of the time

f. At no time

37. My daily life has been filled with things that interest me.

a. All of the time

b. Most of the time

c. More than half of the time

d. Less than half of the time

e. Some of the time

f. At no time

The following items focus on how you have been feeling *physically* during the past month. Please respond by selecting the appropriate number.

Over the past month…

38. How often have you had difficulty getting to sleep at night?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

39. How often have you woken up during the night?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

e. Fairly often

f. Often

g. All of the time

40. How often have you had nightmares or disturbing dreams?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

41. How often has your sleep been peaceful and undisturbed?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

42. How often have you experienced headaches?

    a. Not at all

    b. Rarely

c. Once in a while

d. Some of the time

e. Fairly often

f. Often

g. All of the time

43. How often did you get a headache when there was a lot of pressure on you to get

things done?

a. Not at all

b. Rarely

c. Once in a while

d. Some of the time

e. Fairly often

f. Often

g. All of the time

44. How often did you get a headache when you were frustrated because things were

not going the way they should have or when you were annoyed at someone?

a. Not at all

b. Rarely

c. Once in a while

d. Some of the time

e. Fairly often

f. Often

g. All of the time

45. How often have you suffered from an upset stomach (indigestion)?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

46. How often did you have to watch what you ate carefully to avoid stomach upsets?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

47. How often did you feel nauseated ("sick to your stomach")?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

e. Fairly often

f. Often

g. All of the time

48. How often were you constipated, or did you suffer from diarrhea?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

49. How often have you had minor colds (that made you feel uncomfortable but

    didn't keep you sick in bed or make you miss work)?

    a. Not at all

    b. Rarely

    c. Once in a while

    d. Some of the time

    e. Fairly often

    f. Often

    g. All of the time

50. How often have you had respiratory infections more severe than minor colds

    (such as bronchitis, sinusitis, etc.) that "laid you low"?

a. Not at all

b. Rarely

c. Once in a while

d. Some of the time

e. Fairly often

f. Often

g. All of the time

51. When you have a bad cold or flu, how often does it last longer than it should?

a. Not at all

b. Rarely

c. Once in a while

d. Some of the time

e. Fairly often

f. Often

g. All of the time

Open-ended Questions:

52. Please describe your greatest challenges with workplace incivility.

53. Please describe the effect that workplace incivility has had on you.

APPENDIX B

WORKPLACE INCIVILITY SCALE PERMISSION

Lilia Cortina Thu, Nov 22, 8:30 AM ☆ ↩

to me ▾

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

--

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•••

APPENDIX C

PHYSICAL HEALTH QUESTIONNAIRE PERMISSION

Schat, Aaron <schata@mcmaster.ca>
to me ▾

Thu, Aug 30, 4:58 PM ☆ ↰ ⋮

Hello Jayme,

Thank you for your interest in the measure. You are welcome to use the scale provided in the Appendix of the paper. You may want to review p. 375 in the paper, where I present revised wording for the respiratory questions, as well as revised response options (basically, that wording allows for the use of the same response options as the other items on the measure, rather than the response options shown in the appendix (where the options are different for the respiratory items). Either set of response options is fine, in that both demonstrated acceptable validity.

To score the measure, first reverse score item 4. Then I normally calculate an average score across all of the items (including the reversed item 4, not the original item).

If you want to score the specific symptom categories, then you would reverse item 4, and then calculate average scores across each of the sets of items corresponding to the 4 symptom categories.

Feel free to follow up if you have further questions.

All the best with your research,

Aaron

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