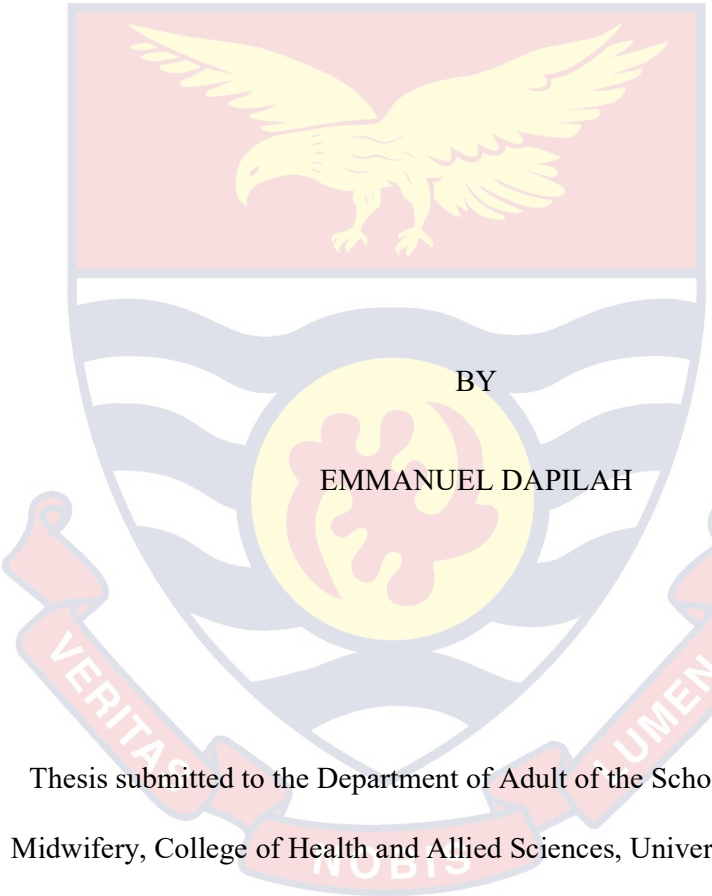
UNIVERSITY OF CAPE COAST

WORKPLACE BULLYING AMONG NURSES IN THE UPPER WEST REGION OF GHANA.



BY

EMMANUEL DAPILAH

Thesis submitted to the Department of Adult of the School of Nursing and Midwifery, College of Health and Allied Sciences, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Nursing

JULY 2020

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: …… Date: …….

Name: Emmanuel Dapilah

Supervisor's Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Supervisor's Signature: …..... Date: …….

Name: Dr Andrews Adjei Druye

ABSTRACT

Workplace bullying (WPB) is a multi-dimensional concept characterized by a constellation of actions taken and those not taken in workplaces and include but not limited to hostile remarks, spreading of rumours and intimidation. Nursing is a caring profession where effective communication, interpersonal relationships and teamwork are essential. However, over the years, bullying among nurses has become endemic and presents serious safety and health hazards which can result in physical and psychological difficulties for victims. This compromises the quality of care, patient safety and the wellbeing of the nurses, yet there is paucity of research on the subject in Ghana. The purpose of this study was to determine the prevalence of WPB among nurses in the UWR of Ghana using a cross-sectional design. Three hundred and twenty-three (323) nurses were recruited using a multistage sampling technique and data collected through a self-administered questionnaire with a 98.5% (N=318) response rate. Data analysis was done using SPSS version 22. The results indicate a high prevalence of WPB among this study group. Eighty percent (80%; n=252) and 54.6% (n=172) were classified as being bullied over a six-month period by the operational and self-labelling methods respectively. WPB was also found to have strong positive linear relationships with both intentions to quit (r=0.487; N=315, p<0.001), and depression among the nurses (r=0.559; N=315; p<0.001). The results further indicate that WPB occurs irrespective of the nurses' gender or professional nursing background. WPB is a common phenomenon in this study area. Hence, all stakeholders should institute measures aimed at reducing its incidence and mitigating against its consequences on nurses and other employees.

KEYWORDS

Bullying/incivility/violence

Depression

Intention to quit

Nurses

Prevalence

Staff turnover

Workplace

ACKNOWLEDGEMENTS

A lot of efforts have gone into the preparation of this thesis, hence the need to show gratitude to individuals and institutions that have contributed in diverse ways to its successful completion.

I would like to acknowledge the contribution of Dr Andrews Adjei Druye, my supervisor who doubles as the Head of Department, Adult Health Nursing, School of Nursing and Midwifery-UCC. Your guidance and inputs were significant to the study and are highly appreciated.

I would also like to remember and thank the management and nurses of the Ahmadiyya Muslim Hospital, Kaleo-UWR where this study was piloted. Allah richly reward you.

My heartfelt gratitude goes to the managements of the various hospitals where this research was conducted. Your decision to contribute to knowledge in the profession is very much appreciated.

I am highly indebted to the authors of the countless publications that I consulted, without which this study would have been impossible.

I owe a debt of gratitude to my research assistants: Mr. Leming Cletus and Mr. Yendoo-naa John for their sacrifice and assistance. I appreciate your efforts greatly.

To the Samuel and Emelia Brew-Butler-SGS/GRASAG UCC Research fund, am most grateful for the research grant to support this study.

This show of gratitude will be incomplete if I do not mention my family, friends and course mates who have over the period offered support, guidance and encouragements. To all of you, may Almighty God grant your hearts desires.

DEDICATION

Dedicated to my wife Rita Kuuleneh, and children; Alan Benedict Dapilah, Mwin-maalu Kingsley Dapilah and Yentomo Almarick Dapilah.

TABLE OF CONTENTS

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

DASS	Depression Anxiety Stress Scale
EN	Enrolled Nurse
NAQ-R	Negative Acts Questionnaire-Revised
NO	Nursing officer
PEN	Principal enrolled nurse
PNO	Principal nursing officer
RGN	Registered General Nurse
SEN	Senior enrolled nurse
SN	Staff nurse
SNO	Senior nursing officer
SSN	Senior staff nurse
UWR	Upper West Region
WPB	Workplace bullying

CHAPTER ONE

INTRODUCTION

Bullying among nurses has been an issue of concern for some time now. This has affected the interpersonal and professional relationship between employees and has the tendency to compromise the quality of care and the wellbeing of staff. The purpose of this study was to determine the prevalence of workplace bullying among nurses working in the various public hospitals in the Upper West Region of Ghana. This first chapter offers an introductory background on workplace bullying, research questions and hypotheses, problem statement, and significance of the study.

Background to the Study

Bullying in general has a long history as a common negative behavior among children. As a result, the word 'bully' immediately paints a picture of the inconsiderate child molesting and maltreating other kids during play however, bullying is not exclusive to childhood (Olweus, 1996). Bullying was initially identified as an issue in the workplace in the 1980s by Leymann, a Swedish researcher who first used the term mobbing to describe workplace bullying (Leymann, 1986). In 1992, British Freelance journalist Andrea Adams wrote a book titled *Bullying at Work* and aired a documentary on British Broadcasting Corporation (BBC) about WPB, which led to the creation of awareness and subsequent interest in WPB across industry sectors including nursing in the United Kingdom (UK) and other anglophone countries (Adams, 1992).

Andrea Adams coined the phrase *workplace bullying* and it has since remained in use with English speaking researchers. However, studies have shown that researchers continue to use different terms for the same phenomenon including 'incivility (Twale & DeLuka, 2008), "bullying" (Einarsen, Hoel, Zapf & Cooper, 2003) and "psychological terror" (Leymann, 1990). For the purpose of this study, the term workplace bullying is used to describe these negative behaviours at work.

WPB is mostly perceived as a work environment wellbeing and security danger (Catley et al., 2013; Caponecchia & Wyatt, 2009). It is part of a bigger complex marvel which incorporates a series of unsafe activities taken and those not taken in the facilities (Saltzberg, 2011) and may incorporate, yet not restricted to, unfriendly comments, insults, physical abuse, and retaining support (McNamara, 2012). While a few activities might be obvious, others will in general be clandestine, for example, refusing to intercede or retaining imperative information when activities are plainly demonstrated and required for work to be done in a protected way (American Nurses Association [ANA], 2015). WPB is considered as repeated behaviours perpetrated by members of an organization which are considered offensive, often escalating in intensity with a perceived intent to harm (Einarsen, Hoel & Notelaer, 2009) usually in situations where there are power differences. The power imbalances between the bully and the bullied may be a result of different positions/ranks within the organization (formal) or attributes specific to the individual (informal) including but not limited to ethnic grouping and gender (Einarsen et al., 2009).

WPB can emanate from different sources such as management against workers (top-down), workers against management (bottom-up) or workers

against workers (horizontal) (ANA, 2015). Based on its characteristics, Einarsen and colleagues has classified WPB as "work-related, person-related and physical intimidation" and incorporated them into the Revised Negative Acts Questionnaire (Einarsen et al., 2009). Work-related bullying consists of counter-productive attitudes and practices targeted at an employee's professional roles which have the tendency to affect the worker's performance negatively. With person-related bullying, the negative attitudes are directed at the worker with the aim of belittling or embarrassing him or her. Physical intimidation is an extreme form of abuse which includes physical violence to the victim (Notelaers & Einarsen, 2013).

WPB is a global phenomenon with 15% of employees worldwide perceiving themselves as targets at some time (Nielsen, Matthiesen, & Einarsen, 2010). However, there are considerable variations in the prevalence across different sectors and geographical areas. The variations in prevalence rates can be accounted for by such factors as characteristics of the culture and changes in social values, and issues related to research methodology (Nielsen et al., 2010). Prevalence rates also vary greatly across sectors with the health sector considered as an area with a high prevalence rate (Bentley et al., 2009).

It is suggested that, prior to the occurrence of bullying, a number of precedent circumstances are deemed necessary including conflicting schedules, ill-defined roles, magnitude of work and level of independence in the job (Baillien, De Cuyper & De Witte, 2011; Baillien & De Witte, 2009). Other antecedents that trigger WPB are stress (Hauge, Skogstad & Einarsen, 2009; 2007), and organisational change (Skogstad, Matthiesen & Einarsen, 2007).

Researchers have found that WPB is a complex, multi-faceted, subjective and sometimes pervasive negative workplace behavior with potential consequences to workers as well as the workplaces (Bartlett & Bartlett, 2011; Nielsen & Einarsen, 2012). A number of studies have identified victims of WPB to have experienced a cascade of negative consequences such as low self-esteem, heightened anxiety, poor concentration, stress, increased errors at work and low output (Cooper-Thomas et al., 2013; Barlett & Barlett, 2011).The negative consequences of WPB are not limited to only individuals but also affect organizations' fortunes including injury to the culture and reputation with subsequent high staff turnover, decreased performance, and low morale (Barlett & Barlett, 2011; Gardner & Johnson, 2001).

Globally, WPB among nurses across a wide spectrum of specialties and backgrounds has been documented and represents a persistent problem both locally and globally with strong associations to staff turnover (Johnson, 2009). Because the nursing profession has not been insulated from the devastating consequences of WPB, a reasonable number of studies have suggested its widespread within the profession where it creates a harmful and fearful environment (e.g., Nielsen, Indregard & Øverland, 2016; American Nurses Association, 2015; Verkuil, Atasayi & Molendijk, 2015; Nielsen & Einarsen, 2012). For example, Yildirim (2009) identified reduced work motivation, lowered productivity and lack of commitment as repercussions of WPB on nurses working in such environments.

The health facilities have also not been spared the effects of this canker. Staff turnover resulting from bullying can culminate in significantly high operational expenses (Hutchinson, Vickers, Wilkes & Jackson, 2010), reduced

staff productivity, potential litigation and tainting of organizational reputation (Lamberth, 2015). The costs of bullying on health facilities is enormous taking into cognizance demands related to supervising the bully; salvaging the situation; consultation with lawyers; interviewing witnesses; and employing new workers (Lipscomb & London, 2015; Griffin & Clark, 2014; Pearson & Porath, 2013). Earlier studies have suggested that sustained WPB could result to lowered job satisfaction, psychological distress among workers (including depression), and subsequently increase their propensity to quit the profession (Van Dyk, 2016).

The intention to quit is mostly associated with actual staff turnover with its attendant problems. Staff turnover leads to loss of experienced nurses and result to a decline in patient safety (Crutcher, Szafran, Woloschuk, Chatur & Hansen, 2011). Schalk, Bijl, Halfens, Hollands and Cummings (2010) contend that voluntary turnover is fueling the global shortage of nurses and is now considered a crisis. There are suggestions that the estimated costs associated with turnover may be greater than 5% of the annual operating budget (Waldman, Kelly, Arora & Smith, 2004) of most facilities. Additionally, WPB has been identified as a major cause of distress that is associated with subsequent ill-health and decreased well-being (Hoobler, Rospenda, Lemmon, & Rosa, 2010). Evidence show that employees exposed to WPB are susceptible to a number of negative psychological health outcomes including depression (Hammond, Gillen, & Yen, 2010; Kivimaki et al., 2003). For example, a researcher found that 33% of the patients with mood disorders attributed their mental problems to their work situation (Hansson, Chotai, & Bodlund, 2010). This, according to

Verkuil et al. (2015) places issues at work as the number one cause of self-reported depression.

Over the years, there have been efforts aimed at preventing the consequences of bullying at work, albeit little progress. Laws and policies mandating organizations to ensure that employees are protected abound in many nations (Crimp, 2017) including Ghana. In Ghana, the Labour Act, 2003 Act 651 Section 9c states that the duty of the employer among other duties is to:

> *take all practicable steps to ensure that the worker is free from risk of personal injury or damage to his or her health during and in the course of the worker's employment or while lawfully on the employer's premises (Labour Act, 2003).*

Though a number of research findings have revealed the devastating consequences of WPB against nurses (e.g., Nielsen et al., 2016; Verkuil et al., 2015; Nielsen & Einarsen, 2012), little progress has been made on promoting the explication of bullying within nursing in the recent past especially in developing countries. The fact that WPB can result in errors at work (Cooper-Thomas et al., 2013), wellbeing of nurses and safety of patients cannot be guaranteed in facilities where it exists. There is therefore the need to create awareness about the existence of this phenomenon at the workplace. This will lead to the formulation of policies that will help address existing cases as well as prevent the occurrence of new cases thereby creating peaceful and cordial work environments where the safety of patients and wellbeing of nurses will be promoted. As a result, more research is currently required on the subject matter, such as the current study to provide the evidence to inform decisions and

strategies to deal with bullying among nurses in the Upper West Region of Ghana.

Statement of the Problem

Studies have revealed that WPB poses a considerable challenge among nurses in a number of hospitals and is more endemic among nurses compared with other professionals within the health sector (Jahner, 2011; Stelmaschuk, 2010). The reported frequency of bullying among nurses range from 43% reported in the UK (Carter et al. 2013) to 85% in the USA (Phelps & Wilson, 2013). However, there are no national statistics on the subject in Ghana. The effects of WPB are detrimental to the nurse, the quality of care provided, the effectiveness of the healthcare organization and the nursing profession (Ahliquist & Riehl, 2013). It has been reported that female nurse managers are the principal perpetrators of these negative acts, with female junior nurses being the primary targets and victims (McKenna, Smith, Poole & Coverdale, 2003). Due to the alarming rates and impact of WPB, it is now considered as a workplace health and safety hazard (Catley et al., 2013; Caponecchia & Wyatt, 2009). Evidence suggest that nurses around the globe are susceptible to escalating levels of violent actions on daily basis at the workplace (Jackson, Clare & Mannix, 2002).

Bullying at work is a major safety and health concern which can cause permanent physical and psychological harm to the victims (Washington State Department of Labour Industries, Safety and Healthcare Assessment and Research for Prevention Program, 2011). It leads to feelings of defenselessness and injustice in the target, undermines an individual's inherent right to dignity (ANA, 2015); and puts the nursing profession and nursing's contract with

society in jeopardy (Saltzberg, 2011). Relationships marred by WPB can contribute to unhealthy work environments that ultimately have a negative impact on the quality and safety of care delivered (American Association of Critical-Care Nurses, 2005). Unfortunately, effects consequent to bullying have negatively affected nurses across the globe for a long time and has "touched far too many members of the nursing profession" (ANA, 2015). What is most disturbing is the notion that bullying can be "surrounded by a 'culture of silence', fears of retaliation, and the perception that 'nothing' will change" (Vessey, DeMarco & DiFazio, 2010, p. 142). These have led to the institutionalization, perpetuation and underreporting of the phenomenon in most facilities. Because bullying can affect the psychological and physical wellbeing of nurses, it could result in increasing medical errors thereby compromising quality of care and patient safety.

The importance of the concept of WPB in understanding negative workplace behaviour has long been recognized by scholars and practitioners, yet it remains an under-researched phenomenon in Ghana. In fact, there is paucity of research on the subject with no national data on WPB coupled with non-reporting of incidents in most workplaces. Even with the limited studies on the subject and related phenomena in Ghana (e.g. Darko, Bjorkqvist & Osterman, 2019; Boafo & Hancook, 2017; Boafo, Hancook & Gringart, 2016; Doe, 2016), there are still gaps in the literature that require further studies. For example, Darko et al. (2019) studied WPB and psychological distress in public institutions in Ghana and concluded that "workplace bullying appears to be common in Ghana, and has significant negative outcomes for individuals, especially, junior staff members". Doe (2016) conducted a study on the impact

of WPB on workers' psychological and emotional wellbeing and lamented the paucity of data on WPB and its effects. He stated that "the prevalence of workplace bullying in the nation's universities should be further investigated…" (p. 18). Also, Asamani (2010) argues that "although sexual harassment in the workplace has been extensively studied in Ghana, unfortunately there is no official record indicating the extent of other forms of bullying in Ghanaian workplaces". Therefore, a study on the prevalence of WPB and its associations among nurses in the Upper West Region will contribute to bridging these gaps in literature.

The study in the Ghanaian context is important because it will help create awareness, enhance the meaning, determine prevalence rates and ascertain the association between WPB and; demographic variables, depression, as well as intention to quit the job. Also, the fact that violence against nurses is underreported (Hutchinson, Wilkes, Vickers & Jackson, 2008), it is important that WPB and its associations are properly studied to help inform practitioners, researchers and management so that the necessary steps will be implemented to curb its occurrence. This will lead to the creation of cordial relationships and improved quality of care with high levels of safety in our hospitals.

Personal Motivation about the Research Topic

As a mortal being, my personal values, past experiences and personal philosophy affects my thinking and my perception of the world around me. This reasoning is supported by Moustakas (1994) who contends that a researcher's "personal history brings the core of the problem into focus" (p. 104). This is true because the current study was inspired by my personal experience. My past experience as a witness of WPB ignited my passion in this study and awakened

me of the attention that this problem deserves as a professional and a student. As a result, I committed to contributing to the literature aimed at understanding and addressing the problem of WPB. However, in conducting this study, I was mindful of my personal biases, excesses and weaknesses in order to present the findings as objectively as possible.

Purpose of the Study

The purpose of this study was to determine the prevalence of WPB and its associations among nurses in the Upper West Region of Ghana. Specifically, the study sought to:

1) Measure the prevalence of WPB among nurses in the Upper West Region.
2) Determine the association between demographic variables (age, gender, professional background, rank/position) and WPB.
3) Ascertain the relationship between WPB and nurses' intention to quit.
4) Investigate the association between WPB and depression.

Research Questions and Hypotheses

This study is crafted with the aim of answering the following research question:

RQ1: What is the prevalence of WPB among nurses working in the various public hospitals in the Upper West Region of Ghana?

The study further tested the following hypotheses about the relationships or differences between some variables. The following hypotheses were postulated to guide the study;

1) H_{01}: There is no statistically significant relationship between WPB and demographic factors.

H_{11}: There is statistically significant relationship between WPB and demographic factors.

2) H_{02}: There is no statistically significant difference between WPB prevalence and gender of nurses.

   H_{12}: There is statistically significant difference between WPB prevalence and gender of nurses.

3) H_{03}: There is no statistically significant relationship between WPB and nurses' intention to leave the profession.

   H_{13}: There is a statistically significant relationship between WPB and nurses' intention to leave the profession.

4) H_{04}: There is no statistically significant association between WPB and depression among nurses who are victims.

   H_{14}: There is statistically significant association between WPB and depression among nurses who are victims.

Significance of the Study

This research will attempt to explicate the nature of WPB, create awareness about its existence, prevalence and effects on nurses in the Upper West Region of Ghana. Because of the paucity of research on this subject, this study will help inform nurses in the study area about the existence of this negative workplace behavior and ways to handle it in order to reduce its impact on nurses, patients and the health facilities.

The findings will serve as a starting point for the design and implementation of strategies by stakeholders and hospital managements aimed at preventing or reducing it in the workplace. This will ensure that the safety of the patients can be guaranteed leading to improved quality of care. Also, the

findings from this study will contribute to bridging the gaps identified from previous studies and add up to the existing literature on the subject since research on the phenomenon in the Ghanaian context remains scanty. Additionally, suggestions for further research on the phenomenon will be given based on the findings from this study to enable other researchers contribute meaningfully to the knowledge on the phenomenon.

Delimitation

This study was conducted among Enrolled Nurses (ENs) and Registered General Nurses (RGNs) who are employed in public hospitals in the Upper West Region of Ghana. Public hospitals were selected because in the view of Zapf and colleagues, public sector employees seem to be more at risk than their colleagues in the private sector (Zapf, Escartin, Einarsen, Hoel & Vartia, 2011). It is therefore envisaged that any form of negative workplace behavior in the form of bullying will be commonplace among these cadre of employees.

WPB is a complex phenomenon. Some of the dimensions of WPB include characteristics of targets and victims, antecedents, prevention, consequences, organizational and individual factors, and genetics. Therefore, any attempt at studying all its components in a single study like this would have been impossible. Given the above reasons coupled with time and financial constraints, I focused specifically on determining its prevalence among nurses working in public hospitals in the Upper West Region. The prevalence rate was determined using both the operational method and the self-reporting method. Additionally, associations between WPB on the one hand; and demographic factors, intentions to quit, and depression on the other hand were ascertained.

Limitation

1) This study like any other survey is limited in its inability to make inferences about cause and effect.

2) Another limitation likely to affect the study is the response rate as most surveys are associated with low response rates. In order to overcome this issue, I employed an in-person method of distribution and collection of the questionnaires.

3) Also, this research is specific to registered general nurses and enrolled nurses working in public district hospitals. Therefore, the results cannot be generalized to the entire nursing population in the region. However, based on sound methodology and the use of instruments with high validity and reliability, the results can be generalized to the population from which the sample was selected; all registered general nurses and enrolled nurses working in public hospitals in the Upper West Region of Ghana.

Operational Definition of Terms

Workplace bullying:

Although the debate on the definition of WPB continues (Carbo & Hughes, 2010), for the purpose of this study, the operational definition of "*workplace bullying*" was the same as the definition by Einarsen, Hoel, Zapf and Cooper (2011), which is:

> *Bullying at work means harassing, offending, socially excluding someone or negatively affecting someone's work tasks. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process, the bullying behavior has to occur repeatedly and regularly (e.g., weekly) and over a period of time (e.g. about six months).*

> *Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying, if the incident is an isolated event or if two parties of approximately equal strength are in conflict (p. 22).*

WPB in this study was measured by the operational method and self-labelling method using the Revised Negative Acts Questionnaire (NAQ-R) by Einarsen et al. (2009). The operational method was measured by the first 22 items on the NAQ-R. Respondents with a cutoff score less than 33 were classified as not bullied. If respondents obtained a score between 33 and 44, they were considered occasionally bullied or targets of WPB. From a score of 45 upwards, respondents were considered victims of WPB (Notelares & Einarsen, 2012). The self-labelling method was measured using the 23rd item on the NAQ-R. The 23rd self-labeling item on the NAQ-R provides the respondents with a formal definition of WPB (Einarsen et al., 2011) and respondents asked if they have been bullied based on the given definition on a five-point response category such as *no; yes, but rarely; yes, now and then; yes, once a week; and yes, several times a week.* This presents a measure of perceived victimization regarding WPB (Notelaers & Einarsen, 2013).

Depression: Denotes a mood disorder that results in persistent feeling of sadness and loss of interest in a person's environment (work, family and social interaction). Depression in this study was measured with DASS-21 by Lovibond and Lovibond (1995) and was classified as follows:0-9 points indicated normal or no depression, 10-13 points indicated mild depression, 14-20 points indicated

moderate depression, 21-27 points indicated severe depression, and 28 and more points indicated extremely severe depression.

Intention to quit: The increased likelihood or propensity that a nurse will leave the nursing profession as a result of WPB. Intention to quit was measured by a single-item, five-point scale ranging from 0 *(Never)* to 4 *(Very often)* constructed by Einarsen et al. (2009).

Nurse: A person who has undergone a prescribed programme of training in an accredited training college or university, and has being licensed by the Ghana Nursing and Midwifery Council. In this study, nurses included Registered General Nurses (RGN) and Enrolled Nurses (EN).

Perpetrator/bully: Any individual or group of people (either employer or employee) who's actions or inactions negatively affect a worker's performance and/or health.

Target/victim/bullied: Refers to an employee who has been subjected to bullying behaviors within his or her organization.

Organization of the Study

This study was organized in line with the University of Cape Coast (UCC) guidelines for preparing and presenting theses. As such, it was divided into five (5) chapters. Chapter One presents an introductory background to what the study is all about. It covers the background to the study, the statement of the problem to be studied and the objectives of the study. It also covers the research question and the hypotheses to be tested, the scope of the study, the significance of the study, the limitations and the operational definition of concepts. Chapter Two entails review of related literature focusing on grey literature, theoretical review and empirical studies that are relevant to WPB. Also inherent in this

chapter is the conceptual framework guiding the study. Basically, the first two chapters are meant to make explicit what is already known about the phenomenon.

Chapter Three outlines the methodology of the study. This section provides details of the activities that were undertaken in conducting the study including: the research design, the study area; the study population; the sampling procedures; the sources of data; data collection instruments; pre-testing of the survey instrument; data collection procedure; ethical clearance and; data processing and analysis. Data were analyzed using descriptive and inferential statistics. The findings of the study are presented and discussed in Chapter Four taking into cognizance the empirical evidence gathered from various studies from the literature review as points of convergence or divergence. The discussions either corroborated or disagreed with earlier findings and strengthen certain claims or opened up more avenues for further research in the future.

Chapter Five is made up of the summary, conclusions, implications, recommendations and suggestions for further research. A snapshot of the findings is presented and conclusions drawn. Implications for nursing practice, management and research are suggested. I have also made recommendations and proposed areas for further research. The main purpose of this chapter is to disseminate the findings of the study so that lessons can be learnt and measures instituted to curb or reduce the occurrence of WPB and help build a cordial and peaceful work environment. In order to reach a wider audience, I intend to publish the results from this study in one of the journals after my presentation at the defense.

Chapter Summary

This chapter is the first of a series of five chapters that makes up the complete thesis to be submitted to the University of Cape Coast in partial fulfilment for the award of the Master of Nursing degree. It has set the pace by providing an introductory background to WPB. Objectives have been set and research questions as well as hypotheses postulated to guide the study. Potential limitations have been identified and measures instituted to mitigate them in order to ensure a smooth conduct of the study and also to help improve the quality of the results. The preceding chapter details a comprehensive review of literature on WPB taking into consideration the objectives and delimitation of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this study was to determine the prevalence of WPB among nurses working in the various public hospitals in the Upper West Region of Ghana. This chapter entails a review of the relevant literature on WPB and describes the conceptual framework supporting the study. The literature review has been organized around the phenomenon under investigation, that is WPB as well as the specific objectives of the study. As a result, the literature review was categorized into four sections. The first section presents an in-depth investigation into what is already known about the concept; from conceptualization to prevention strategies. The second section consists of a theoretical review while the third section is made up of empirical studies carried out over the years on WPB among nurses. This section is divided into: prevalence studies, WPB and demographic variables, WPB and the intention to quit, and WPB and depression. The fourth section describes the conceptual framework guiding the study. The chapter ends with a summary and conclusions from the literature review.

Information for the review was obtained from books, journals and article publications with emphasis on recently published materials between 2009 and 2020 except landmark studies relevant to the study. I reviewed empirical studies in order to identify points of divergence or convergence on the phenomenon. My search was conducted in electronic data bases including PubMed, EBSCO Host and CINAHL and google scholar search engine using the following keywords*: bullying, workplace bullying, workplace incivility, prevalence, workplace violence, depression, staff turnover, intention to quit, and nurses.*

Also, I have consulted grey literature from textbooks on the phenomenon to a greater extent. Two of such textbooks I consulted are; *Bullying and harassment in the workplace: Developments in theory, research and practice* by Einarsen, Hoel, Zapf and Cooper (2011), and *Preventing workplace bullying: An evidence-based guide for managers and employees* written by Caponecchia and Wyatt (2011).

Conceptualization, Measurement, Consequences and Prevention of WPB

Though bullying generally has existed since time immemorial, bullying at work is considered a relatively new phenomenon. As a result, it is conceptualized differently by different authors and researchers and the debate continuous till date. According to Einarsen et al. (2011):

> *Bullying at work means harassing, offending, socially excluding someone or negatively affecting someone's work tasks. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process, the bullying behavior has to occur repeatedly and regularly (e.g., weekly) and over a period of time (e.g. about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying, if the incident is an isolated event or if two parties of approximately equal strength are in conflict (p. 22).*

Also, the Royal College of Nursing (2002) has described WPB as humiliating an individual in the presence of others, provoking someone; belittling someone, thwarting someone's ability to function effectively; and violent acts or threats of violence. Furthermore, Einarsen (1999) contends that

WPB entails instances at the workplace where workers are persistently and over a protracted time period subjected to harassing behavior from one or more colleagues (including juniors and bosses) resulting in the victim being incapable of defending him/herself against the abuse. While some actions may be overt, others tend to be covert, such as failing to intervene or withholding vital information when actions are clearly indicated and needed for work to be done in a safe manner (American Nurses Association [ANA], 2015).

Despite the differences in opinions regarding what constitute WPB, scholars have generally agreed on three factors significant for defining WPB. To begin with, the practice or behaviour should be repeated; then again, the bullying behaviour should have negative consequences on the victim; and lastly, those exposed to bullying should have difficulty in defending themselves against the abuse (Einarsen et al., 2011).

Although WPB generally is considered to occur frequently and persistently over time, some authors hold a different perspective. A case in point is where Baldry, Farrington and Sorrentino (2017) argue that single cases of extremely damaging behaviours may be regarded as WPB if they cause some degree of severe harm. Rouse and colleagues further made a strong contention that "bullying involves acts of commission or omission that are seen as negative and unwelcome, tend to be repeated, involve power imbalances, and are abusive in effect regardless of conscious intent" (Rouse, Gallagher-Garza, Gebhard, Harrison, & Wallace, 2016). These views tend to refute the subject of intentionality in the WPB debate. It must be noted that because WPB is sometimes a clandestine act perpetuated against an individual or group of workers, most offenders will not readily agree to consciously committing the

act for fear of reprimands, demotion or outright dismissals. In the face of the differences in definition of WPB, I have adopted the definition by Einarsen et al. (2011) to guide the study.

Nature of Bullies

Several authors view bullies with different lenses and some of the authors have been so critical and harsh in describing them. The literature is replete with descriptions of bullies such as people who envy others, having low self-esteem, and struggling for power (Namie & Namie, 2011, 2009; Matthiesen, Aasen, Holst, Wie & Einarsen, 2003). A number of studies seem to support the notion that people bully others partly due to been exposed to aggressive socialization through faulty family upbringing and/or societal influences (Namie & Namie, 2011; Crawshaw, 2007). Bullies have been labelled as psychopaths (Boddy, 2011). In the words of Namie and Namie (2011), bullies are "jerks, weasels, and snakes" (p. 3) and "inadequate, defective, and poorly developed people" (p. 15). Namie and Namie (2009) classified bullies into four categories as follows; the Constant Critics, the Two Headed Snake, the Gatekeeper and the Screaming Mimi.

Constant Critics

Perpetually criticizing the victim's capabilities with uncomplimentary comments, glaring or avoiding eye contact with them and reacting repulsively with a straight face are characteristics of the constant critics. In addition to the above, they are fond of blaming the victim for cooked-up errors with unrealistic timelines. They don't appreciate anything that is done well by the target.

Two-Headed Snakes

They fake being nice but in fact are saboteurs and can be cruel and distasteful in one breadth and pleasant and caring in another. They are highly unpredictable and tend to have mood swings.

Gatekeepers

They employ machinations to exclude the target from all forms of communication at the workplace by ignoring the targeted individual. They intentionally isolate the targeted person from others, control all resources and deny the rights and protection of the target.

Screaming Mimi's

They control the target through fear and intimidation, and intermittently cut in anytime the target is making a point during deliberations whiles denying the victims from expressing their thoughts.

Characteristics of the Targets

While a lot of efforts have been made in trying to understand what makes people targets of WPB, the findings so far are inconsistent and sometimes ambiguous. There are suggestions that targets of WPB in most cases may be exceptional employees (American Nurses Association [ANA], 2015). Westhues (2004) further opined that bullying among members of an academic setting could possibly be due to feeling of discontent and jealousy because of the outstanding achievements of others. Bullying in such workplaces might aim at establishing and perpetuating the group's underperformance and keeping the target in check so that the prevailing workplace culture is not disrupted (ANA, 2015) as excellence in the midst of mediocrity will be detrimental to existing group behavior.

Einarsen, Hoel, Zapf and Cooper (2005) argue that it is the target's deficient social skills and self-esteem, and heightened susceptibility to feelings of anxiety and depression that predispose them to being targets of bullying or that influences their perception of being targets. Again, Namie and Namie (2011) conclude that the target's non-confrontational approach makes him or her an easy prey to the bully; whereas if the target responded to the bully's initial aggression with aggression, the targeted behaviours would less likely lead to bullying. Contrary to this view is a study conducted by Matthiessen and Einarsen (2007) which found that some targets are in fact aggressive and that their aggression provokes the bullying behaviours from the perpetrator.

Measuring WPB

Over the years, researchers have used different methods in an effort to measure the prevalence of WPB including the Negative Acts Questionnaire (NAQ), the Negative Acts Questionnaire-Revised (NAQ-R), and the Leymann Inventory of Psychological Terror (LIPT) (Chipps, Stelmaschuk, Albert, Bernard & Holloman, 2013; Carbo & Hughes, 2010). The differences in methodology has resulted in different rates even at the same work environments and poses a setback in the determination of its actual prevalence. Despite the challenges encountered in measuring WPB, frequently used methods in research studies to estimate it are the self-report and operational methods (Carbo & Hughes, 2010). In the self-report method, WPB is defined and the participants allowed to state whether or not they have been bullied. In other instances, participants are asked the direct question whether they have been bullied over a stated period without providing a definition of WPB. The self-report method is however, associated with some level of underreporting (Lutgen-Sandvik, Tracy

& Alberts, 2007) due partly because many employees refuse to accept the fact that they are victims, since this role signifies weakness and passivity, personal attributes which undermine people's self-esteem (Einarsen, 1999) and also the associated stigmatization. When the definition of bullying is offered to the participants, the level of WPB among employees usually range from 2% to 17% (Zapf, Escartín, Einarsen, Hoel & Vartia, 2011), but in cases where the definition is not provided, the prevalence of bullying can be between 15 % and 20 % (Nielsen et al., 2010).

Conversely, the operational method determines whether respondents have been bullied based on their responses to a number of questions in a survey, and gives individuals the opportunity to state whether or not they have been exposed to specific negative behaviours at work and in some instances, the duration of such exposures (Carbo & Hughes, 2010). This method measures the exposure to negative acts without mentioning the term bullying or demanding respondents to identify themselves as victims of bullying. In the view of Mikkelsen and Einarsen (2001), using this method reduces the likelihood that the participants' responses will be influenced by their emotional and cognitive processes of the term bullying and therefore will yield a more objective response.

In a study by Chipps et al. (2013), they found the prevalence rates for the operational method and self-report methods to be 28% and 9.2% respectively. It is suggested that some individuals are not comfortable with the bullied tag and this might help explain the lower prevalence rates common with the self-report approach because in the view of Namie and Namie (2011), targets do not want to be associated with being a "victim". However, for studies

measuring prevalence, researchers advocate that both methods be used (Nielsen, Notelaers & Einarsen, 2011). It can therefore be concluded that the prevalence for the two methods will be different in this study.

Consequences of WPB among Nurses

There is evidence that nurses around the globe are susceptible to escalating levels of violent actions on daily basis at the workplace (Jackson et al., 2002). The American Nurses Association (2015) in its position statement on WPB bemoans its devastating consequences on nurses and has therefore called for all hands to be on deck to finding a lasting solution to this menace in order to safeguard the profession and ensure provision of quality care to all patients. Also, Rowell (2005) suggests that there is currently a surge in WPB particularly in our health facilities and that such behaviors far exceed sexual harassment.

The repercussions of WPB are diverse and have been looked into by players in healthcare and other work environments. The negative impact of WPB is not limited to only the targets, but also extend to witnesses, those seeking care and the very fabric of the facilities where it occurs. It is suggested that workers who are victims of bullying have a higher propensity to complain about ill-health and related issues compared to those not bullied (Nielsen et al., 2016) and this can be accounted for by a myriad of factors including the stressful nature of the act. Initially, victims of bullying may complain of such reactions as being worried, distressed, and confused (Einarsen, Raknes, Matthiesen & Hellesoy, 1996). With the passage of time, if the bullying behavior is not curtailed, physical and mental signs and symptoms become more evident and intense (Nielsen et al., 2016).

Evidence from research suggests that sustained acts of bullying may lead ultimately to anxiety (Verkuil et al., 2015; Nielsen & Einarsen, 2012) and depression (Finne, Christensen & Knardahl, 2014). Reports of a rise in the cases of WPB coupled with the increased relative risk of developing depression has ignited the claim that WPB remains the most devastating psychosocial workplace exposure (Bonde et al., 2016). A report from a meta-analysis by Nielsen, Magerøy, Gjerstad and Einarsen (2014) also indicates that exposure to negative behaviours at work predisposed employees to psychiatric and physical complaints. As can be seen, the repercussions of WPB are multi-faceted and traverse the physical and mental disturbances to include use of illegal substances, perpetual anger and psychological instability (Belayachi, Berrechid, Amlaiky, Zekraoui & Abouqal, 2010; Joa & Morken, 2010). These result in mistrust, loss of productive hours and staff underperformance (National Health Service [NHS], 2014) and warrant a need for post exposure care and rehabilitation.

Other researchers conclude that WPB increases the risk for cardiac and vascular conditions (Kivimaki et al., 2003) and thoughts of suicide (Carter et al., 2013; Brousse et al., 2008). In the view of Emdad, Alipour, Hagberg and Jensen (2013), WPB can also have an indirect effect on by-standers by increasing their risks for developing depression. Bullying can negatively affect the quality of concentration of employees (Yildirim, 2009) and long-term exposure may lead to decline in the ability to stay focused at work and loss of job satisfaction. This could weaken confidence and compromise the professional's ability to deliver effective healthcare (Trad & Johnson, 2014; MacIntosh, Wuest, Gray & Cronkhite, 2010) and ultimately affecting health

outcomes. Decreased ability to concentrate might result in medical errors and harm to patients. This is in tandem with the findings by Paice (2009), who indicated that when physician trainees are bullied at work, the propensity of committing very grievous or potentially grievous medical errors remain high.

Bullying is one of the negative behaviours that has been shown to disrupt peaceful co-existence between coworkers and mar the relationships between managers and workers (Schat & Frone, 2011). The interpersonal relationship between nurses and patients and the relationship required for therapeutic communication is also strained resulting in poor health outcomes and quality of care. Organisations have a huge price to pay when the work environment is bedeviled with bullying. For example, in the United States alone, organisations are said to spend over $200 billion on a yearly basis due to bullying at work (Lamberth, 2015). Opperman (2008) contends that the totality of the facility's functions and structures are affected by bullying which leads to increased excused duties, turnover, stress, risk of accidents, and poor client services whilst culminating in reduced output, motivation, morale, organisation's reputation and client satisfaction. Such organisations are often characterized by lack of innovative ideas, initiatives and risk-taking behavior because people have the feeling that they have to stick to the established norms in order to maintain the status quo. Also, when trust is eroded in a bullying workplace, the facility bears the brunt as employees will be reluctant to give their best at work, offer constructive advice for progress, and bring to light pitfalls which occur during work (Washington State Department of Labor & Industries, 2008).

Prevention of WPB

The effects of WPB can be prevented by a number of interventions and these can be categorized as primary, secondary and tertiary interventions following the Public Health Model (Crimp, 2017). The Public Health Model emanates from preventive medicine which outlines primary, secondary, and tertiary intervention opportunities at the facility, work and personal levels (Bartlett & Bartlett, 2011). Primary interventions prevent harmful events from occurring; secondary measures slow down or hamper the progression of events, hinder recurrence, and offer affected people with appropriate coping mechanisms (Vartia & Leka, 2011); whilst tertiary interventions decrease the negative consequences, offer victims with effective coping strategies, and enhance the restoration of health and wellbeing (Cooper, Dewe & O'Driscoll, 2001). Although appropriate primary measures are often advocated as being of paramount importance, it must be noted that bullying is not likely to be entirely wiped out, necessitating the need for effective secondary and tertiary interventions (Blackwood, 2015).

Primary Prevention

Primary interventions are measures which attempt to prevent the occurrence of negative consequences; and can be instituted at the organisational and individual levels (Vartia & Leka, 2011; Lamontagne, Keegel, Louie, Ostry & Landsbergis, 2007). Frantic efforts are being made to reduce or eliminate workers' exposure to stressors, by altering psychosocial and physical work environments (Lamontagne et al., 2007). Facilities with existing and functional anti-bullying culture frown on bullying as unacceptable, and therefore put in measures at the organisational level to eliminate this harmful workplace

behaviour (Duffy, 2009). A number of studies (Fox & Cowan, 2015; Cowan, 2011; Duffy, 2009) have considered developing and implementing policies against bullying at work (anti-bullying policies) as significant primary prevention measures.

The initial thing is to make an unequivocal statement of intent about the facility's position on WPB (Rayner & Lewis, 2011), and in most cases, this is a no-tolerance for bullying (Richards & Daley, 2003) statement. For ease of comprehension and compliance, policy documents must be brief and precise (Salin, 2008b; Richards & Daley, 2003). Policies once developed must be implemented correctly and consistently as Salin (2008a) have suggested that merely having a policy document will not likely reduce the occurrence of WPB. Consequently, some studies (Rayner & Lewis, 2011; Richards & Daley, 2003) have suggested that ignoring anti-bullying policy monitoring and review could lead to failure of the policy. Monitoring activities should consider the perceptions and complaints of workers through surveys to help evaluate a policy's effectiveness (Crimp, 2017). Therefore, anti-bullying policies and programs should be reviewed yearly (Rayner & Lewis, 2011).

Another primary intervention strategy likely to reduce the risk of WPB is identifying and subsequently eliminating antecedents (Crimp, 2017). Antecedents to WPB could be spotted via surveys, discussions, job interviews, or document analysis (Vartia & Leka, 2011). As a result, pre-employment interviews and mental examinations are likely to decrease the chances of employing someone with undesirable work behaviours (Gardner & Johnson, 2001). Training programs can also be instituted for staff and management to

assist them recognize and report promptly cases of WPB and other unproductive attitudes at work (Richards & Daley, 2003).

Secondary Prevention

Secondary measures seek to address existing cases of WPB and prevent further deterioration (Crimp, 2017). One significant secondary intervention identified for managing WPB is putting in place elaborate complaint investigating systems for all cases of bullying at the workplace (Hoel & Einarsen, 2011). Various other secondary measures have been recommended including: mediation (Fox & Stallworth, 2009); social support and counselling services (Vartia & Leka, 2011; Djurkovic, McCormack & Casimir, 2008); enhancing strategies for coping (Zapf & Gross, 2001); and promoting skills of leaders in dispute resolution and investigating complaints (Hoel & Einarsen, 2011).

It is incumbent for investigation processes to be explicitly stated in a workplace anti-bullying document and this should be based on the principle of natural justice or due process where every worker (bully or bullied) is fairly and equally treated throughout the investigation process (Hoel & Einarsen, 2011). One of the frequently recommended resolutions of WPB is mediation which involves a neutral third party, who works with affected workers to resolve the case (Saam, 2010). However, a number of studies (Jenkins, 2011; Keashly & Nowell, 2003) have suggested that mediation should only be used in the initial stages of bullying when the bully and bullied are eager to solve the conflict, not in escalated cases of bullying.

Tertiary Prevention

Tertiary interventions endeavor to decrease the negative consequences of bullying and also ensure the restoration of the health of victims (Crimp, 2017). Counselling is one of the many tertiary interventions for victims and perpetrators of WPB. Suffice it to say that the commonly used one-to-one counselling may be inappropriate for cases of WPB, hence the need for an integrated approach (Crimp, 2017). An integrated counselling program is one that focuses on the victim as well as other key players and workplace behaviours which could contribute to bullying at work (Tehrani, 2011).

One other tertiary measure is treating victims as in-patients (Crimp, 2017) where they are rehabilitated and during which time, they can avoid the perpetrators, understand the antecedents of WPB, and develop pragmatic coping strategies to handle the consequences (Schwickerath & Zapf, 2011). Additional measures during the in-patient treatment include physiotherapy, group therapy and physical exercises (Mikkelsen & Einarsen, 2006); and financial and nonfinancial compensations (Meglich-Sespico, Faley & Knapp, 2007).

With efforts aimed at preventing the consequences of bullying, health and safety policy documents are drafted to regulate and reduce psychosocial hazards in the work environment. Policy documents that guide workers to act against workplace hazards can be found in a number of countries (Crimp, 2017) including Ghana. In Ghana, the Labour Act, 2003 Act 651 Section 9c states that the duty of the employer among other duties is to:

> *take all practicable steps to ensure that the worker is free from risk of personal injury or damage to his or her health during*

and in the course of the worker's employment or while lawfully on the employer's premises (Labour Act, 2003).

However, this Act does not explicitly deal with bullying at work which is subtler in nature and mostly committed under secretive circumstances. As a result, incidents of WPB continue to rise with no clear guidelines or policies for handling them at the various workplaces in Ghana which affects both employees and the organisations.

Theoretical Review

In trying to understand WPB and taking into cognizance the objectives of this study, a comprehensive theoretical framework is desired to guide the study. Regrettably, research regarding WPB according to Einarsen (2000) lacks a strong theory base. This assertion is corroborated by Wheeler, Halbesleben and Shanine (2010) when they intimated that "we have yet to explain the phenomenon with a comprehensive theory" (p. 554). Despite the fact that WPB has been considered atheoretical in its conceptualization, there have been remarkable efforts by researchers to remedy the situation (Branch, Ramsay & Barker, 2013). Subsequently, some theories that pertain to WPB have been reviewed as presented below. It is significant to note that due to its complexity, no single theory is able to explain WPB in its entirety.

Bandura's (1977) Social Learning Theory (SLT)

The Social Learning Theory was developed by Albert Bandura in 1977 in the field of Psychology. SLT have combined the behavioral and cognitive theories of learning to offer an all-inclusive theory capable of explaining the wide range of learning experiences worldwide. The main propositions of the SLT according to Bandura (1977) are:

1. Learning is not purely behavioral; rather, it is a *cognitive* process that takes place in a social context.
2. Learning can occur by observing a behavior and by observing the consequences of the behavior (vicarious reinforcement).
3. Learning involves observation, extraction of information from those observations, and making decisions about the performance of the behavior (observational learning or modeling). Thus, learning can occur without an observable change in behavior.
4. Reinforcement plays a role in learning but is not entirely responsible for learning.
5. The learner is not a passive recipient of information. Cognition, environment, and behavior all mutually influence each other (reciprocal determinism).

SLT relies primarily on modeling as a major determinant in most learning endeavours and as such, Bandura (1977) identified different models:

1. **Live models**, someone exhibiting the expected behavior.
2. **Verbal instruction**, a person explains the expected behaviour comprehensively and instructs learners in ways to engage in the behavior.
3. **Symbolic models**: is achieved through the influence of mass media. Here, stimuli include either real or fictional characters.

Consequently, the type of information gathered from the observation is determinant on the nature of model and a number of cognitive and behavioural processes (Bandura, 1972). The cognitive and behavioural forces underpinning observational learning include attention, retention, motor reproduction and

motivation. Bandura's SLT speaks volumes to the significance of observing and modeling the behaviours, attitudes and emotions of others. He writes that:

> *Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action (p22).*

SLT attempts to explain learning as an uninterrupted reciprocal interplay between the mind, body and environmental influences. Since Bandura's SLT encompasses attention, memory and motivation, it is seen as traversing both cognitive and behavioural domains.

WPB as a learned behavior

Bandura's (1977) SLT is employed to partly elucidate WPB as a learned behaviour. Bandura and Walters (1963) argue that the principal issue that facilitates learning is modeling. According to Hill (2001), when people observe others, two main things would likely happen: increased tendency that they would perform the behavior, and fast tracking of the learning process.

Although Bandura did not make a case specifically for bullying, it can be argued that nurses might observe abusive colleagues and superiors at the workplace and subsequently imitate these acts. However, according to Bandura (1977), one's ability to acquire and perform certain behaviours is dependent on four processes. A nurse initially acquires some new responses from the model to perform the behaviour. Because nursing is a practice profession, newly qualified nurses are required to study the tenets of the profession through

socialization. As a result, whatever behaviours they encounter during the socialization process will determine the caliber of professionals they would likely become.

The nurse then moves to the next phase known as inhibition or disinhibition of an existing behaviour. Here, the nurse learns either to perform the given action in a particular circumstance or not. The third concept is elicitation. This is a situation where when a person performs a behavior witnesses may gain interest and join in the act despite not having the initial intentions to do so. What this implies is that merely being a witness to a bullying episode might predispose a nurse into becoming a bully. The final concept is known as vicarious reinforcement. Here, when acts of bullying are punished severely, the aggressive behavior is diminished. Conversely, if these acts are not punished, people imitate them by elicitation.

To help decrease the number of cases of bullying among nurses, it can be suggested that nurses should be encouraged to be role models who use non-aggressive conflict resolution strategies to ensure success and discourage those who achieve goals in aggressive ways. Hence, tackling bullying at the workplace should enhance behaviours that are acceptable socially at the hospitals through role modeling and mentorship programs.

Although the SLT is not adequate in explicating the WPB phenomenon, it is still important to this study because it offers an explanation to the phenomenon as a learned behavior acquired through modeling. Considering the fact that nursing is a practice occupation where nurses interact regularly, this may partly explain the high prevalence of WPB among nurses and this is

relevant to research question 1; RQ1: What is the prevalence of WPB among nurses in the Upper West Region of Ghana?

Oppressive Group Behavior and Relational Aggression Theories

The oppressive group behaviour theory was developed by Paolo Freire, a Brazilian educator and philosopher in 1972. Freire (1972) proposes that the educational system reinforces the belief that the dominant group is superior and with the passage of time makes the oppressed to cultivate feelings of inferiority, less worth and in due course become afraid of their own freedom. A state of psychic alienation occurs in which the marginalized assimilate and support their oppression rather than fight it (Watts, Griffith, & Abdul-Adil, 1999). This leads to the institutionalization and perpetuation of bullying among the oppressed group. Assertions from the Oppressive Group Behavior Theory sees nurses to be oppressed based on gender and medical dominance (Hockley, 2002). Proponents of the Oppressed Group Theory consider nurses as an oppressed group who have been dominated by medicine from time immemorial. Therefore, it is expected that WPB will be common among nurses in any setting.

Also, the Relational Aggression Theory was propounded by Nicki Crick and Jennifer Grotpeter in 1995 in the field of education. The term relational aggression was coined by Crick and Grotpeter (1995) and defined it as "harming others through purposeful manipulation and damage of their peer relationships," (p. 711). As such, relational aggression represents a nonphysical form of violence that targets a person's relationship with others and /or their reputation. They proposed that females tend to portray behaviours such as backbiting, formation of informal groups, intimidation and social exclusion which breeds WPB and other negative workplace behaviours. A number of constructs are

linked with the high prevalence of WPB among nurses and notable among these are the relational aggression (female gender) and oppression (Nwaneri, Onoka & Onoka, 2016).

Crick and Grotpeter (1995) in a study found that relational aggression is significantly higher in girls than in boys, indicating a strong association between gender and relational aggression. Since WPB is mostly subtle and nonviolent in nature, it stands to reason that gender will be strongly associated with it. Therefore, any organization that is dominated by females is a potential bullying environment because females have a natural inclination to bully other females due partly to relational aggression and also to male oppression (Namie, 2007).

The oppressed group behaviour model designed in nursing has offered a framework for understanding major issues on oppression and has been used as a tool for the development of models for practice in the profession (Roberts 2000; Taylor 2001). For example, the oppressed behavior and relational aggression theories have been used to study WPB and violence in the workplace in a number of studies including a study in Nigeria by Nwaneri et al. (2016) on WPB among nurses in tertiary hospitals in Enugu State.

However, Farrell (2001) argued that the explanations offered by the oppressed group behavior and relational aggression theories only provide a one-sided perspective in understanding bullying among nurses. Another setback of this model includes focusing primarily on horizontal violence to the exclusion of other forms of bullying among nurses (Hutchinson, Vickers, Jackson & Wilkes, 2006). This reasoning is limited because WPB can emanate from different sources such as management against employees, employees against management and employees against employees (American Nurses Association,

2015). Hutchinson et al. (2006) also argue that, the oppressed group and relational aggression theories do not consider the dynamics and organizational factors that may lead to bullying. Our inability to scrutinize these issues has resulted to a focus on bullying as something unique to how nurses are socialized, without examining the greater organizational contexts in which bullying occurs (Speedy, 2004). This has led to the assumption that bullying is a nurses-to-nurse affair that does not warrant the attention it deserves.

In summary, it is evident that though the oppressed group model has served as a useful guide to the study of the prevalence of WPB over the years, it is limited in its explication of the phenomenon. However, because gender (female gender) as a construct from these theories is important in the discussion on WPB, it is included as one of the variables under demographic characteristics in the theoretical framework for this study. This has facilitated the postulation of hypothesis 2:

H_{02}: There is no statistically significant difference between WPB prevalence and gender of nurses.

Affective Events Theory (AET)

The Affective Events Theory (AET) was developed by Howard M. Weiss and Russell Cropanzano in 1996 in the field of Psychology which proposes that people often react emotionally to incidents, which influences their subsequent behaviours, attitudes and ultimately their well-being. In the view of Branch et al. (2013), incidents of WPB can be considered as affective events and while the use of AET has been recent among researchers of WPB, the theory has been used widely in the general antisocial behavior literature.

One classical study where AET was linked to WPB, Brotheridge and Lee (2010) explored the emotional responses peculiar to bullying behaviours. They proposed that each bullying incident would lead to an affective event. Findings from their study show that belittlement, undermining a person's work, and verbal assault were associated with negative emotions such as sadness, restlessness and mostly confusion. The study also found that persistent bullying acts were likely to sensitize victims to increased negative events, which ultimately increased the level of emotions experienced. What this seeks to suggest is that the duration and intensity of any negative event are partly responsible for how the target will respond and the extent to which the target will be affected. Managers and other leaders are therefore expected to intervene timely in all cases of bullying at the workplace so as to reduce the incidence and deterioration of target's health and/or organizational fortunes.

D'Cruz and Noronha (2010) studied 10 targets of WPB. The study depicts the emotional strains which persistent negative events pose, including depression, anxiety, helplessness and hopelessness. These subsequently led to an increase in negative feelings about work and people, and ultimately leading employees to withdraw or quit. Hence, WPB could be perceived as an affective episode that consist of a number of affective events (Branch et al., 2013), where the emphasis is not on isolated or individual events but rather a compilation of negative behaviours over a period with consequences for both individual targets and organizations. In this study, WPB would be considered as an affective episode which has the tendency to result in depression and intention to quit the profession (these two variables are considered as emotional events).

The AET is important to this current study because it has helped to conceptualized bullying as a process and not a one-off event. This supports the operational definition provided by Einarsen et al. (2011) adopted for this study. Also, the AET is important to this study because it has guided the postulation of hypotheses 3 and 4 thus;

H_{03}: There is no statistically significant relationship between WPB and nurses' intention to leave the profession.

H_{04}: There is no statistically significant association between WPB and depression among nurses who are victims.

Summary of the theories

The SLT presents WPB as a behaviour which can be learnt at the workplace through modeling (more specifically, through professional socialization). It is therefore expected that bullying will be more prevalent among nurses due to imitation of this negative work behaviour. Also, oppression as a main concept of the oppressive group behaviour theory is fueled by medical dominance and male oppression in the health sector. This predisposes nurses to high levels of bullying at the workplace.

Gender is the principal concept of the relational aggression theory taken to support this study. Gender (female gender) according to this theory is strongly linked to WPB. Therefore, gender is measured as one of the demographic variables. However, since gender might not be the only demographic variable associated with WPB, the study measured other demographic variables in relation to WPB. The main proposition of the AET is that people mostly react to incidents, which influence their subsequent behaviours and ultimately their health. Hence, WPB incidents can be considered as affective events with

negative health implications including the intention to quit and depression. Therefore, the association between WPB and these two variables (intention to quit and depression) is determined.

Empirical Literature Review of WPB among nurses

Demographic Variables of Participants and WPB

In a quantitative study conducted by Ovayolu, Ovayolu, and Karadag (2014) among 260 nurses employed in government hospitals to establish if they were harassed by other employees and the impact of such practices on the nurses who were victims, the researchers as part of their findings discovered that being youthful and those with less expert experience were more likely to be victims of WPB. This could be accoutered for by the assertion that expert experience develops with increasing age and that experienced nurses might be less inclined to be harassed (Ayranci, Yenilmez, Günay, & Kaptanoglu, 2002).

In another case, Chen and colleagues in 2009 conducted a study to find the predisposing factors of violence at the workplace among nurses in a psychiatry hospital. They found that some of the factors responsible for workplace violence included being female and youthful age. As a result of the high prevalence of violence among this category of nurses, the researchers suggested pre-employment orientation aimed at reducing it (Chen, Sun, Lan & Chiu, 2009). Similarly, Efe and Ayaz (2010) studied 206 nurses in Turkey applying a mixed method approach. The findings of the study suggest that those 25 years and younger and nurses in intensive care departments were more likely to be victims to mobbing than others ($P < 0.05$).

When Yildirim (2009) carried out a study among 286 Turkish nurses with the aim of assessing WPB and its effects, the results show that more than 20% of the nurses were experiencing negative behaviours at work. Regarding the perpetrators of bullying, 40% were hospital administrators, 34% colleagues at work and 5% were subordinates. Further analysis was done using regression to establish the association between these negative behaviours at work and the age of the nurses, workload and total years of service (b = 0.48; $F = 39.70$; $P < 0.00$). The results indicate that 15% ($P < 0.01$) were affected by their age (being younger). However, duration of professional practice had no effect on the negative behaviours at work ($P > 0.05$). A further 45% of the nurses participating in that research were moderately or severely depressed. Also, as the nurses' depression levels increased, the likelihood of being bullied also increased (positive correlation between depression and WPB).

From the studies reviewed so far on demographic variables and WPB, there seems to be a common pattern regarding the age of targets and WPB. Being younger is associated with WPB while nurses who have served longer are less likely to be bullied due partly to their experience in the workplace.

WPB Prevalence Studies among Nurses

Hoel, Cooper and Faragher (2001) conducted a quantitative study among British workers to explore some epidemiological features of WPB. Questionnaires were mailed to employees from seventy workplaces. In all, 5288 survey instruments were answered indicating a 42.8% response rate. 553 workers showed they were bullied in the preceding six months. This represents a prevalence rate of 10.6% with 8.1% indicating they were occasionally bullied while 2. 4% were regularly bullied.

With regard to the status and gender of the perpetrators, more than 70% of the workers were harassed by someone in management position. Also, 36.7% of the workers were bullied by their colleagues, 6.7% by subordinates and 7.8% by a customer. They concluded that the fact that the sum of the figures for the perpetrators was well over 100% was an admission that some of the workers were bullied by multiple perpetrators (two or more people in different categories). They also found minor differences in prevalence in terms of gender.

In another instance, Ariza-Montes, Muniz, Montero-Simó, and Araque-Padilla (2013) conducted a study among 284 health professionals. It showed that 41.2% (n=117) of the workers were exposed to WPB. Among those who claimed to have been bullied, 72.6% were females while the remaining 27.4% were males. It was also established that WPB was common among shift workers, those who performed repetitive assignments, and workers who experienced high levels of stress.

This study's main weakness is that, using the self-labelling approach in the absence of a definition of what constitute bullying from the perspective of the researcher could have resulted in overestimation of the prevalence because the participants could have labelled cases that did not fit bullying according to what the researcher understood as WPB (Nielsen et al., 2010).

Al-Ghabeesh and Qattom (2019) sampled 134 Emergency Department nurses in Jordan. 90% (n=108) of those who took part in the study said they were bullied by the self-labelling approach. Also, one (0.93%) was harassed daily, 8 (6.6%) weekly, 33 (30.6%) now and then, and 66 (61.1%) rarely. The average mark on the NAQ-R was 44.47 (SD = 15.78). This shows that on average, the nurses were "sometimes bullied".

With reference to the different types of bullying measured on the NAQ-R scale, work-related bullying was the subcategory with the highest mean score (M= 2.08, SD = 0.78), preceded by person-related bullying (M= 1.99, SD = 0.73), and the lowest by physically-intimidating bullying (M= 1.95, SD = .83). Regarding the work-related bullying sub-scale, the highest item mean score was Item 21: "Being exposed to an unmanageable workload", (M= 2.29, SD = 1.25), while the lowest item mean score was Item 1: "Someone withholding information which affects your performance", (M= 1.77, SD = 1.90). Regarding the person-related bullying sub-scale, the highest item mean score was Item 11: "Repeated reminders of your errors or mistakes," (M= 2.20, SD = 1.19), while the lowest item mean score was Item 10: "Hints or signals from others that you should quit your job," (M= 1.83, SD= 1.96).

The study further found that the nurses who had little experience in the emergency unit were more likely to be harassed than the other nurses. Among the nurses exposed to WPB, over 60% said bullying was associated with reduced productivity, appropriate communication and competent care.

In West Africa, Nwaneri et al. (2016) conducted a cross-sectional study among 289 nurses employed at teaching hospitals in Nigeria using a modified NAQ for measuring negative behaviours at the workplace. In this study, 82.6% of the nurses said they were victims of WPB.

The researchers observed that in the case of WPB, 76% of the nurses have reported senior nurses as the principal perpetrators of these negative behaviours while 84.1% of nurses said junior or newly posted nurses were the primary targets. It was also observed that female nurses were the main perpetrators (92.1%) as well as targets (93.9%). The study further established

that the consequences of WPB among the participants included anger, anxiety, frustration, and impaired interpersonal relationship between the nurses.

In a quantitative, cross-sectional study, Karatza, Zyga, Tziaferi, and Prezerakos (2016) studied the consequences of WPB on nurses at selected hospitals in Greece using the NAQ-R with 841 participants. One third of the nurses (31.2%) who participated in this study said they were exposed to WPB during the preceding 6 months. Among those bullied, 17.2% were bullied rarely, 9.9% occasionally, 2% few times per week, and 1.1% almost daily.

The researchers also found nurses with children and those without support from friends and family members to be frequently harassed than others. This highlights the significance of support systems in the fight against WPB. As such, it is incumbent on managements of the various health facilities to provide adequate support systems to help targets and victims of this canker. A major pitfall of this study was the use of non-probability sampling technique. Participants recruited through a convenience sample might not depict the characteristics of nurses in the location, thus making generalization of the findings problematic.

In another quantitative study, Carter et al. (2013) studied 2950 workers of UK's National Health Service in order to study the prevalence and consequences of WPB and examine the factors which hinder the reporting of incidents of bullying. WPB was measured with the NAQ-R. In all, 20% of the workers said they were bullied to some extent by other employees while 43% indicated witnessing bullying within the past 6 months. Male workers and those who are physically challenged were seen to be exposed more frequently to WPB. Overall, WPB was not associated to the workers' ethnicity. However,

being a victim and witnesses of WPB had significant association with reduced mental health and job satisfaction, and higher incidence of workers willing to leave their current professions. It was observed that managers constituted a major source of WPB. The researchers also identified certain factors which hindered effective reporting of incidents of bullying including; the notion that things will not change, fear of being tagged as a trouble-maker, and lack of clear policies on WPB.

Sharma, Scafide, Dalal and Maughan (2019) conducted a cross-sectional study with the aim of examining persons and organizational characteristics of bullying in a sample of 178 school nurses in Virginia. They employed the Short-Negative Acts Questionnaire in the determination of the prevalence of WPB. About 60% of the nurses were exposed to WPB according to the Short Negative Acts Questionnaire. Among the percentage bullied, 34.8% were bullied occasionally, (now and then or monthly), and 25.3% were bullied often (weekly or daily). Also, 80% of nurses identified themselves as victims of WPB according to the self-reporting approach.

It must be noted that the high prevalence using the self-labelling approach might be an overestimation since a definition of WPB was not provided. As such, it is possible that some of the nurses might classify incidents as bullying which do not actually constitute the phenomenon. As a consequence, caution should be taken when interpreting findings from this study.

Harb, Rayan and Al.khashashneh (2019) undertook a cross-sectional study with 231 nurses in Jordan. It aimed at studying the relationship between WPB and positive mental health among the respondents. More than 70% (n=170) of the nurses were victims of violence at the work environment. The

nurses also reported that 60% of the perpetrators of violence were clients or visitors, 69% by superiors, and 16% by fellow workers. With reference to the gender of the bullies, the study found that 62% were men while 38% were women. The average score measured on the NAQ-R was 43.80 (SD=15.78). This suggests that the nurses were "sometimes bullied" at work. Additionally, about 24%, 37% and 38% were "not bullied or rarely bullied", "sometimes being bullied," and "victims of workplace bullying," respectively. Furthermore, work-related bullying was more frequent (M = 2.19, SD = 0.81), preceded by person-related bullying (M = 1.91, SD = 0.73), and then physical intimidation (M = 1.85, SD = 0.84).

In another descriptive cross-sectional study, Bardakçı and Günüşen (2016) sampled 284 nurses at a university hospital in Turkey with the aim of studying the influence of WPB on nurses' psychological distress. It was found that 21.8% of the nurses were victims of WPB. The bullies in this study were identified as charge nurses (33.5%), doctors (26.8%), fellow nurses (17.7%) and senior nurses (17.1%). The study also showed that psychological distress was significantly higher in nurses bullied compared to those not bullied. The nurses differed significantly regarding the relationship between their levels of education and exposure to WPB, with those holding a second degree prone to acts of bullying than others. However, the nurses did not differ significantly in their risk of exposure to bullying based on age, total years of professional practice, and current position at the workplace.

In a quantitative study of 345 licensed registered nurses in one state in America by Sauer and McCoy (2017) using the NAQ-R, 40% of the nurses were considered to be bullied in the preceding 6 months based on the self-labelling

method, 42.1 % were bullied according to the operational method while about two thirds (68%) witnessed coworkers being bullied. The researchers observed that the more a nurse was exposed to bullying, the lower his/her physical health and mental health scores. As a result, nurses who are victims of WPB are more vulnerable to deterioration of both physical and psychological conditions which may lead to reduced quality of care and compromised patient care.

Chipps et al. (2013) in a survey identified a huge difference in the prevalence of bullying between the self-report and operational approaches. The self-report approach found that less than six percent (6%) of the participants were bullied as against 34% by the operational approach within the same period using the NAQ-R. Similar study results were reported by Lutgen-Sandvik et al. (2007) where 9.2% and 28% of respondents were reported to be bullied by the self-report and operational methods respectively.

It can be seen form the studies above that there is a substantial difference in the prevalence rates as determined by the self-labelling and operational methods. In most of the studies, prevalence from the operational methods are higher than prevalence from the self-labelling method. This could possibly be due to stigmatization and feelings of weakness attached to the phenomenon as most people do not want to be associated with these attributes. Also, females tend to be affected most both as targets and perpetrators in the studies reviewed. This could be due to fact that in most of the studies reviewed, the participants were largely women.

WPB and the Intention to Quit

An increasing array of studies have been conducted to determine the consequences of WPB on people as well as the places where they work, and

some of these consequences include absenteeism due to illness, and higher turnover (Nielsen & Einarsen, 2012). For some time now, bullying among nurses across different specialties has been shown to be a persistent problem which has strong association to staff turnover (Johnson, 2009). Staff turnover affects organisations negatively and as Schalk and colleagues put it, voluntary turnover is fueling the shortage of nurses across the globe and is now seen as a crisis, because of its scope and resultant decline in the quality of care (Schalk et al., 2010).

In a study by Fochsen, Sjogren, Josephson and Lagerstrom (2005), they found that limited opportunities, lack of professional independence, and unsatisfactory renumerations were responsible for nurses willing to quit the profession. It was also identified that men, young nurses and nurses with muscle and joint problems were some of the predictors to nurses intending to leave the profession (Fochsen, Josephson, Hagberg, Toomingas & Lagerström, 2006). Additionally, Griffeth, Hom and Gaertner (2000) asserts that people who were less satisfied with their current job were more likely to leave the profession.

It must be noted that people intending to quit represent a significant precursor to them actually leaving the profession, hence intentions to quit is used as a yardstick to quantify nurse turnover rates (Hayes et al., 2006). Staff turnover leads to loss of experienced nurses, which can compromise the safety and wellbeing of patients (Crutcher et al., 2011) and ultimately quality care outcomes. There are suggestions that the estimated costs related to turnover could be more than 5% of the yearly budget of most facilities (Waldman et al., 2004). This places a huge financial burden on the affected institutions, thereby

negatively influencing incentives to staffs and also compromising the quality of care in the midst of limited resources.

Workers' intention to quit their employment is not limited to bullying victims only but also affects workers who are witnesses to bullying acts. For example, Houshmand, O'Reilly, Robinson and Wolff (2012) concluded that bullying at the workplace increases turnover of the victims as well as witnesses of these negative acts. It is worthwhile to add that the effect of WPB on staffs' turnover intentions linger for long periods even after the bullying incident. In consonance with this assertion, results from a research on health professionals in Denmark indicated that WPB resulted in staff turnover two years later (Hogh, Hoel, & Carneiro, 2011).

A number of researchers have studied the association between WPB and turnover intentions, and found a positive linear association between these variables (e.g. Boafo et al., 2016; Houshmand et al., 2012; Bowling & Beehr, 2006; Hoel & Cooper 2001; Quine, 2001).

Blackstock, Halos, Macleod and Hardy (2015) conducted a cross-sectional study on the impact of factors at the organizational level on bullying and intentions to quit among 103 nurses in Canada. They found that informal alliances and misapplication of procedures at workplaces predisposed workers to rising levels of bullying, and ultimately predicted elevated turnover intentions. However, one limitation of this study pertains the few number of nurses sampled, which was not representative of Canadian nurses and therefore, generalization of the results to that population of nurses could not be made.

In another instance, Coetzee and Oosthuizen (2017) carried out a cross-sectional study to investigate the mediation role of psychosocial flourishing on

WPB and employee turnover intention among 373 workers at various workplaces in South Africa. They used online web-based and paper-based surveys to collect the data from the participants on their perceptions of negative behaviours at work, intentions to quit, and psychosocial flourishing and analyzed using correlations and simple mediational modelling. WPB was positively associated with turnover intentions and negatively associated with psychosocial flourishing. This shows that strong perceptions of WPB could predict high turnover intentions and lower psychosocial flourishing.

Djurkovic et al. (2008) conducted a study aimed at determining if perceived organisational support (POS) moderates the relationship between WPB and victims' turn over intentions. Data was gathered from 335 school teachers and analyzed using hierarchical regression. It was established that WPB was significantly positively correlated with intentions to quit. What is most striking about this particular research lies in the fact that it excluded items that constitutes physical intimidation and abuse. Despite the absence of these extreme forms of bullying behaviours, even the less severe forms of bullying correlated positively with intentions to quit. This is an indication that workers will leave or plan to leave their current job in the face of the slightest form of abuse.

Between 2005 and 2007, Berthelsen, Skogstad, Lau and Einarsen (2011) conducted a longitudinal study using 1,775 employees in Norway. The researchers wanted to know whether WPB was related to intentions of workers to leave their profession and whether the intentions to leave actually resulted to staff turnover. They realized that employees exposed to WPB frequently thought of quitting the job than their counterparts who were not victims. It was

also revealed that employees exposed to negative behaviours at work had changed their professions more frequently compared to those not exposed.

In a similar study, Glambek, Matthiesen, Hetland and Einarsen (2014) examined WPB as a precedent factor to insecurity at work and workers intentions to quit among 734 North Sea employees. The researchers established that being a victim of WPB enhanced an employee's intention to quit and job insecurity. This meant that victims of WPB were less secured about the continuance of their job and may be predisposed to higher instances of staff turnover.

Another research by Hogh and colleagues, investigated turnover risk among bullied employees in Denmark. The results showed that 9.2% of the respondents were bullied at the first year after graduation. Further statistical analysis demonstrates a strong association between WPB in the first year after graduation and turnover two years after graduation. The researchers reported that three reasons were mainly responsible for turnover intentions: exposure to negative behaviours at work, ill-health, and leadership failure (Hogh, Hoel & Caneiro, 2011).

Josephson, Lindberg, Voss, Alfredsson and Vingard (2008) carried out a 3-year longitudinal prospective study of 2,293 Swedish nurses. The researchers found that over the 3-year study period, as much as 18% of the respondents had left their work and 16% took sick leave which lasted more than four weeks.

Furthermore, Simons (2008) studied 511 nurses in order to determine the association between WPB and intentions to quit. Results from the study indicated that 31% of the nurses said they have been bullied. It was further

determined that WPB significantly predicted the nurses' intentions to quit. As such, increased exposure to bullying led to increased intentions to quit one's profession. The findings from the study are limited because the researcher did not control for other variables which could predict turnover intentions.

From the literature reviewed so far, it is evident from a good number of studies that there is a significant positive relationship between WPB and the workers (in this case, the victims and sometimes witnesses) intention to quit/leave the profession. *It can therefore be hypothesized that H_{03}: There is no statistically significant relationship between WPB and nurses' intention to leave the profession.*

WPB and Depression

Over the years, depression and anxiety disorders have been identified as common mental ailments which pose danger to individuals and society (Whiteford et al., 2013). 7.8% of Europeans are affected by a mood disorder and 14% by anxiety disorder annually (Wittchen et al., 2011). Many reasons have been ascribed to the high prevalence of mental health conditions among the general population. In a survey conducted by Hansson et al. (2010), 33% of the patients with mood disorders attributed their mental problems to circumstances at the workplace, placing issues in the work environment as the number one cause of depression among employees. The fact that work plays an important part in employees' psychological health is not far-fetched, as they spend a lot of hours every day at work.

Work or employment is a two-edged sword. While it offers renumeration, meaning and avenues for social interactions, it can also be a source of great stress (Bhui, Dinos, Stansfeld & White, 2012). Apart from work

itself posing as a source of stress to the worker, other work-related factors and negative workplace social acts can poison the work environment thereby worsening the situation. Among the many work-related factors implicated in workers' mental health problems is the WPB phenomenon. In consonance with the stress theories, WPB is considered a major stressor among employees which can cause ill-health and compromised wellbeing (Hoobler et al., 2010) including depression and anxiety. On an individual level, WPB affects all aspects of a worker's being and might result to health-related issues such as severe headaches, depression, and anorexia (Cavanaugh, Campbell & Messing, 2014). It is recognized that victims of WPB are prone to mental illnesses such as anxiety (Brousse et al., 2008) and depression (Niedhammer, David & Degioanni, 2006).

According to Quine (2001), nurses who became victims of WPB experienced high anxiety levels, distress, and depression. Also, a study investigating WPB and depression in physicians established that instances of bullying at work correlated positively with risk of developing depression (Loerbroks, Weigl, Li, Glaser, Degen & Angerer, 2015). Furthermore, two studies conducted in Denmark concluded that there was an increased risk of depression among employees who were frequently bullied (Gullander et al., 2014; Rugulies et al, 2012).

Some studies have also attempted determining the relationship between WPB and depression. Verkuil et al. (2015) in a meta-analysis of cross-sectional and longitudinal studies found that the cross-sectional data showed positive associations between WPB and symptoms of depression. Also, Bowling and Beehr (2006) showed from a meta-analysis that harassment in the work

environment was clearly positively associated with depression, frustration, anxiety and physical symptoms. Then again, in a study by Nielsen and Einarsen (2012), the results indicated that WPB was positively associated with mental illness in general and also specifically anxiety and depression. In another study, Karatza et al. (2016) found that people with negative perceptions about their work due to bullying had deteriorated health symptoms, while Verkuil et al. (2015) established a positive relationship between WPB, depression, and symptoms of distress.

Furthermore, a longitudinal study in Finland among hospital employees by Kivimäki et al. (2003) showed bullying to be correlated positively with the incidence of depression several years later.

Also, Doe (2016) undertook a cross-sectional study on the impact of WPB on mental wellbeing of 139 university workers in Ghana found that 62.6% (n=87) of the employees had reported that negative behaviours at work led to depressive symptoms. Despite this finding, further statistical analysis using Chi-squared test showed no significant association between WPB and depression among the workers. This is clearly inconsistent with earlier studies which found significant positive relationship between WPB and depression.

It is significant to note that the effects of WPB are so diverse that even witnesses of the phenomenon are prone to suffer from ill-health (Hansen et al., 2006; Vartia, 2001). Hence, some research works have established that being a witness to WPB leads to feelings of stress, depression, and anxiety (e.g. Hansen et al., 2006; Niedhammer et al., 2006). From the literature reviewed on the association between WPB and depression, most of the results showed a positive relationship between these two variables except one study (i.e. Doe, 2016). *It*

can therefore be hypothesized that H_{04}: There is no statistically significant association between WPB and depression among nurses who are victims.

Conceptual Framework

From my search of literature, it became increasingly problematic identifying a framework or single theory that could adequately fit this current study considering the specific objectives. As a result, I have drafted a conceptual model taking cues from the existing literature and the theories reviewed in the literature search as guiding principles as presented in figure 1.

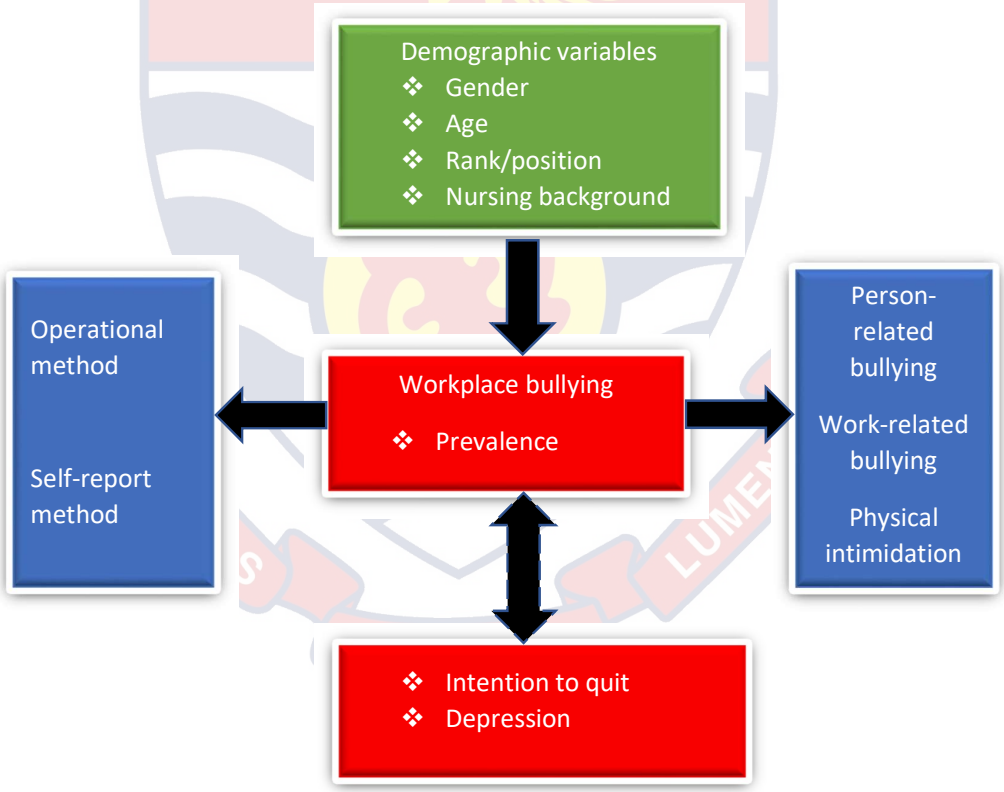


Figure 1: Conceptual Model for WPB

Conceptual framework for WPB: Designed by the researcher based on literature and theoretical review.

Explanation of the conceptual framework

The first component of this conceptual model is made up of demographic factors. For this study, the demographics to be considered are age, gender, professional background, and rank/position. Gender is expected to play out as a major antecedent of WPB because females naturally love to torment other females as explained by the relational aggression theory (Nwaneri et al., 2016). The nurses' rank/position is also considered as an antecedent factor in WPB because greater power differences (formal or informal) will lead to bullying of those down the leadership ladder. This is supported by the statement that bullying is common in the midst of disproportional power structures (Jackson et al., 2002; Yamada, 2000). Findings from previous studies regarding age as a precedent factor in WPB are divergent and inconclusive.

The second component of the conceptual model depicts the phenomenon under investigation. WPB from the perspective of social learning theory by Bandura (1977) can be regarded as a learned behavior and a process. The prevalence of WPB among the study population can be determined using either the operational method (objective approach) or self-report method (subjective approach). However, some researchers have strongly suggested the need to use both techniques (Nielsen, Notelaers & Einarsen, 2011) so as to compare the prevalence between the two methods since prevalence rates differ greatly between methods. As a result, prevalence of WPB was determined using both the operational and self-report methods. Also, the items in the operational method were categorized into person-related, work-related and physical intimidation bullying and comparisons made in order to identify which category of WPB was common among the study participants.

The third component of the conceptual framework details the outcomes of WPB over time. From the literature review, these outcomes could be physical or psychological and could impact individuals, groups or the health facility. However, in this study, the outcomes that were measured were psychological at the individual level and included depression and the intention to quit. It is recognized that targets of WPB suffer psychological problems such depression (Niedhammer et al., 2006). It can also be inferred from Weiss and Cropanzano's (1996) AET that WPB is an affective episode that can result in emotional events such as the intention to quit the profession and depression among nurses.

Some studies have also established a positive association between WPB and depression (e.g. Verkuil et al., 2015; Nielsen & Einarsen, 2012; Bowling & Beehr, 2006) while others have found the association between WPB and nurses' intention to leave the profession (e.g. Coetzee & Oosthuizen, 2017; Blackstock et al., 2015; Djurkovic et al., 2008; Simons, 2008). As such, in this study, attempts were made to establish the relationships between WPB and these two psychological outcomes (depression and intention to quit).

From this concept map, demographic factors were suggested as antecedents which could lead to bullying at work. The occurrence of WPB in any organization over time would result in lasting psychological consequences on individuals including depression and nurses' intention to quit the profession and in due course actual staff turnover. These could subsequently affect the wellbeing of the nurses and compromise the quality of their work and ultimately patient safety.

Summary and Conclusions Drawn from the Literature Review

Nursing is a profession which relies on effective communication to provide the services that it is mandated to offer. Nurses communicate with their colleagues, patients and their families, and other professionals to ensure the delivery of quality care. However, over the years, WPB has affected the interpersonal and interprofessional relationship between nurses and other professionals with dire consequences. WPB presents a negative force at work and compromises patient care, wellbeing of nurses and the overall functioning of health facilities.

The primary objective of this literature review was to examine WPB as a phenomenon with particular emphasis on its prevalence among nurses. In doing so, the review was organized into three sections: conceptualization of WPB, theoretical review and empirical review. The review concluded with a conceptual framework informed by concepts from the theories reviewed and also variables selected from the empirical literature to guide the study. Because WPB is an emerging phenomenon and still at its infancy, its theory based in nursing is largely weak. Attempts are however made at explicating it with theories mostly from the field of Psychology.

It was observed from the review that a lot of studies have been conducted on WPB in the European countries and Scandinavia. These studies were mostly cross-sectional in nature with very few longitudinal studies. However, there is a certain disinterest or a seeming lack of awareness about the phenomenon in developing countries with paucity of research on the phenomenon in Africa. Studies on WPB specifically among nurses in Ghana are scanty and throughout my search, I could not locate any study on WPB that was conducted among

nurses in the Upper West Region of Ghana. This problem is compounded by a lack of national data on the subject. It is this void in the existing knowledge that this study sought to fill by studying the prevalence of WPB among nurses in the UWR of Ghana.

CHAPTER THREE

RESEARCH METHODOLOGY

The purpose of this study was to determine the prevalence of WPB among nurses working in the various public hospitals in the Upper West Region of Ghana. This chapter sets out and describes the entire approach and principles that guided the conduct of this study. The subsections discussed in this chapter include: research design, study area, study population, sample size determination, sampling procedure, data collection instruments, validity and reliability, ethical consideration, data collection procedure, data management, and data analysis.

Research Design

As indicated by Burns and Grove (2011), the basic measure of any successful research exists in the research design. The chosen design ought to be generally appropriate so as to accomplish the purpose of the study (Barbour, 2008). Leavy (2017) posits that research methods should be chosen based on their ability to best address the research purpose and to assist you answer your research questions taking into cognizance factors such as time, resources, and researcher skill set. In the view of Moule and Goodman (2009), the objective of quantitative research is to create information that can be examined utilizing numerical or factual procedures. It mostly focuses on the size, prevalence, and quantifiable parts of a subject under investigation (Polit & Beck, 2010). Conversely, Barbour (2008) asserts that the quantitative methodology is restricted in light of the fact that it doesn't address the significance of subjective life experiences when contrasted with qualitative research.

Qualitative approaches on the contrary deal with the subjective feelings of participants in a research (Burns & Grove, 2011). Barbour (2008) argues that the qualitative approach to research is the most appropriate since it places the people and their perceptions of things into focus. Based on the purpose of my study and the research questions generated for the study, I have used a quantitative method underpinned by the post positivist paradigm. Post positivism is a perspective that speaks to the deduction after positivism and challenges the customary idea of the existence of absolute truth or knowledge, consequently evidence established in any study is constantly flawed and uncertain (Phillips & Burbules, 2000). Also, post positivism holds that there is an objective reality that exists independent of the research process and that laws which govern the social world can be predicted and tested through hypothesis testing that investigates causal relationships or associations between/among variables (Leavy, 2017). In the view of Haig (2013), although researcher objectivity and neutrality are central to this philosophy, it acknowledges that researchers have values and subjective feelings that influence research. As such I have instituted measures to guide against personal biases that are likely to influence the conduct and results of this study.

Research designs speak to the essential procedures that scientists embrace to address their inquiries or test their speculation (Polit & Beck, 2010). They are also referred to as types of inquiry within the various research approaches that provide specific direction for procedures in the conduct of a study (Creswell, 2014), and as strategies of inquiry (Denzin & Lincoln, 2008). There are basically two designs in quantitative research approach: experimental and non-experimental or observational. Surveys form part of the non-

experimental approaches and consist of longitudinal and cross-sectional studies which mostly employ structured interviews or questionnaires to collect data aimed at using results from the sample to make inferences about the population being studied (Fowler, 2009). According to Leavy (2017), cross- sectional designs seek information from a sample at one point in time. I have chosen an analytical cross-sectional design which is a type of survey because I collected data from nurses in the Upper West Region at a particular point in time and established relationships between bullying and related variables.

Study Area

This study was conducted among nurses working in the various public hospitals in the Upper West Region (UWR) of Ghana. The study areas included Lawra, Nandom, Jirapa, Nadowli, Wa West, Tumu, Gwollu and Wa municipal. The remaining three (Daffiema-Busie-Issah, Lambussie and Wa east) were exempted because they do not have a hospital. The Upper West Region is located in the north-western part of Ghana and shares boundaries to the south with the Northern Region, to the north and west with Burkina Faso and to the east with the Upper East Region. Covering a land area of 18,476 km^2, it has a population density of 40 persons per square kilometre.

There are three hundred and thirty-three (333) health facilities in the region. These include eleven (11) hospitals (government, private and CHAG). The rest are four (4) Polyclinics, seventy (70) health centres, fifteen (15) clinics, two hundred and twenty-seven (227) CHPS Compounds and five (5) maternity homes (Upper West Regional Health Services [UWRHS], 2017). Figures from the 2010 population and housing census puts the region's total population at 702, 110 (2.8% of national percentage) comprising 341,182 males and 360,928

females with a growth rate of 1.9. The region's median and mean ages are 18 and 24 years respectively with 114,653 dwelling in the urban centres while 587,457 reside in the rural areas (Ghana Statistical Service [GSS], 2012).

Population

The population refers to all the elements or people in which a researcher has interest and is divided into two: the target population being the entire elements in which the researcher is interested (in this study my target population represents all nurses working in the various hospitals in the Upper West Region of Ghana), while the accessible population represents cases from the population that are readily available to the researcher as study participants (Polit & Beck, 2010). The accessible population to this study included all nurses working in the various hospitals that were randomly selected as clusters. The total number of nurses in these eight hospitals is 1,123 as shown in Table 1.

Table 1: Population of Nurses in each Hospital

	RGN			**EN**			**Total**
Hospital	M	F	**T**	M	F	**T**	
Wa West	23	17	**40**	24	35	**59**	**99**
Nandom	32	15	**47**	45	29	**74**	**121**
Lawra	37	24	**61**	39	48	**87**	**148**
Nadowli	31	29	**60**	30	29	**59**	**119**
Tumu	31	13	**44**	34	30	**64**	**108**
Jirapa	45	30	**75**	47	52	**99**	**174**
Wa	65	85	**150**	40	66	**106**	**256**
Gwollu	26	20	**46**	28	24	**52**	**98**
Total	**290**	**233**	**523**	**287**	**313**	**600**	**1123**

Source: Hospital Records, (2019)

However, the following nurses were excluded from the study:

1) Student nurses on clinical rotation.
2) All nurses on study-and/or annual-leave. This is because this category of nurses might not be available at the time of data collection.
3) Nurses with less than 12 months' post qualification experience at their current workplace. Once WPB is measured over the past 6 months, nurses who have worked less than 12 months might not have experienced bullying behaviours well enough to give accurate assessment of the situation.
4) All other workers in the hospitals who did not have the requisite training, certification and license to practice nursing. This study specifically targets nurses and not all healthcare professionals.

Sampling Procedure

Sampling refers to the process whereby a portion of the participants or elements in a population is selected to represent all the members in the population while the sample is a subset of population elements (Polit & Beck, 2010). The sampling technique can either be nonprobability or probability. Nonprobability sampling involves choosing participants by nonrandom methods where it is not possible to estimate the probability of including each participant in the sample, and every participant usually does not have a chance for inclusion (Polit & Beck, 2010). On the contrary, probability sampling is based on probability theory and involves the use of any strategy in which samples are selected in a way that every person (element) in the population has equal chance of being selected (Leavy, 2017). These include simple random, systematic, stratified and cluster (multi-stage) sampling techniques.

I employed a cluster (multistage) sampling technique which is a probability method to recruit the participants. Initially, preexisting clusters are randomly selected from the population and then elements in each cluster are sampled; in some cases, all elements in each sample are included in the sample (Leavy, 2017). My choice of this technique is informed by the fact that it would be extremely difficult to individually track nurses across the region. As a result, I treated nurses in each district hospital as a cluster. The multistage sampling was conducted through the following steps:

Stage 1: selection of districts

The region is made up of eleven (11) districts. Eight (8) districts were included in the study because three of the districts (Daffiema-Bussie-Issa, Lambussie and Wa east) did not have a hospital.

Stage 2: selection of hospitals

Hospitals in these eight (8) districts were used as study sites. Nurses at each of these district hospitals were considered as a cluster where the respondents were drawn. Also, the nurses were divided into two sub-clusters based on their professional background: enrolled nurses and registered general nurses. In situations where there was more than one hospital in a particular district, one was randomly selected by putting them in a hat and drawing out. In Nadowli district for instance, there were two hospitals namely: Nadowli district hospital and Ahmadiyya Muslim hospital. These were placed in a hat and Nadowli district hospital was drawn out. As a result, nurses at the Nadowli district hospital were considered for the current study. The same procedure was carried out for the hospitals in Wa municipality. The Upper West Regional

hospital was selected from the balloting as one of the study sites and nurses from this facility were added to the study population.

Stage 3: sample size calculation

A representative sample was then determined from the randomly selected hospitals using Yamane's (1967) sample size calculation formula, thus:

$$n = \frac{N}{1+N(e)2}$$

Where: n=sample size, N= population size, e=margin of error or level of precision (usually, 0.05) and 1=a constant. Population size (N)in this case is 1,123

The total number of nurses in these eight hospitals is 1,123. Therefore, the sample size using Yamane's (1967) sample size calculation formula will be:

$$n = \frac{N}{1+N(e)2}$$

$$n = \frac{1123}{1+112\ \ (0.05)2}$$

$$n = \frac{1123}{3.8075}$$

$$n = 294$$

Ten percent (10%) of the calculated sample size was added to cater for non-responses as suggested by Israel (2009). Therefore, 10% of 294 respondents was:

(10/100) x 294

=29.4

Hence the sample size (n)=294+29

n=323 respondents

Stage 4: selection of participants (nurses)

Finally, a simple random sampling technique was used to select nurses from each of the eight district hospitals using proportions as shown in the table below. The registers of the nurses were obtained from all the participating hospitals and each register formed a sampling frame from which the nurses were drawn. All the nurses were serially numbered for each hospital. The serial numbers were then placed in a hat, mixed thoroughly and randomly picked until the required number was reached based on the proportions. The respondents were categorized into registered general nurses (RGNs) and enrolled nurses (ENs).

The final sample was made up of 46.7% (n=151) registered general nurses (84 males and 67 females) and 53.3% (n=172) enrolled nurses (83 males and 89 females) which summed up to 323 nurses (167 males and 156 females) as presented in Table 2.

Table 2: Calculated Sample Size from each Hospital

	RGN			**EN**			
Hospital	M	F	**T**	M	F	**T**	**TOTAL**
Wa West	06	05	**11**	07	10	**17**	**28**
Nandom	10	04	**14**	13	08	**21**	**35**
Lawra MH	11	07	**18**	11	14	**25**	**43**
Nadowli	09	08	**17**	09	08	**17**	**34**
Tumu	09	04	**13**	10	08	**18**	**31**
Jirapa	13	09	**22**	13	15	**28**	**50**
Wa	19	24	**43**	12	19	**31**	**74**
Gwollu	07	06	**13**	08	07	**15**	**28**
Totals	**84**	**67**	**151**	**83**	**89**	**172**	**323**

Source: Field data, (2020)

Data Collection Instruments

Data was collected using an adapted self-administered questionnaire. I have decided to use a questionnaire to collect the data because according to Leavy (2017), questionnaires are less exorbitant and require less time and energy to administer, ensure anonymity or to some extent perceived privacy, and minimize response bias. This questionnaire is made up of four sections: demographic variables, prevalence of WPB, level of depression among nurses, and intention to quit as presented in Appendix A.

Demographic variables

The demographic variables of the respondents that were considered in this study included gender, age, professional background and rank/position in the profession.

Prevalence of WPB

I adopted the Negative Acts Questionnaire Revised (NAQ-R) developed by Einarsen et al. (2009) to measure bullying. The prevalence of WPB was determined by two approaches:

1) The operational method in which the 22-items on the NAQ-R measures negative behaviours at the workplace without making reference to the word bullying and;
2) Self-report method in which a universal definition of WPB was provided and respondents asked to indicate whether they have been bullied within the last six months.

In a study conducted by Einarsen et al. (2009), Cronbach's alpha for the 22 items in the NAQ-R was 0.90, indicating excellent internal consistency. The 22-items on the instrument has categorized bullying into three types: **person-related bullying, work-related bullying and physical intimidation.** Each of the 22-items on the instruments was rated on a 5-point Likert scale (1=never, 2=now and then, 3=monthly, 4=weekly, 5=daily). A 23rd question which is a single-item that measures self-labelled abuse at work in the past 6 months preceded by a generally accepted definition of bullying with a number of questions pertaining to the bullying experience, such as frequency, duration and the principal bullies (Einarsen et al., 2009) is then asked. Participants were given six alternatives: *''no,'' ''yes, very rarely,'' ''yes, now and then,'' ''yes, several times per month,'' ''yes, several times per week''* and *''yes, almost daily.''*

By being provided with a relatively unambiguous definition of bullying, respondents' tendency to use their own definitions when considering this question should be reduced (Einarsen et al., 2009). In the view of Einasen and colleagues, this question can serve as a general WPB indicator as well as a criterion validity indicator in association with the other questions of the test. Total scores on bullying ranged from 22 to 110 points. With respect to current developments on the use of cutoff criteria in determining targets of WPB; respondents with a cutoff score less than 33 were classified as not bullied. Respondents with scores between 33 and 44 were considered occasionally bullied or targets of WPB. From a score of 45 upwards, respondents were considered victims of WPB (Notelaers & Einarsen, 2013).

Level of depression among nurses

The level of depression was measured with the abridged version of the Depression Anxiety Stress Scale (DASS-21). The Depression Anxiety Stress Scale (DASS-42) was developed by Lovibond and Lovibond (1995a) to assess the core symptoms of depression, anxiety and stress. The DASS is made up of 42 questions which are divided into three categories (Depression, Anxiety and Stress) of 14 items each measured over the past week and scores range from 0, "Did not apply to me at all," to 3, "Applied to me very much, or most of the time." The Depression sub-scale looks at hopelessness, low self-esteem, and low positive affect. The Anxiety sub-scale measures autonomic arousal, physiological hyperarousal, and the subjective feeling of fear. The Stress sub-scale items consider tension, agitation, and negative affect.

A major advantage of the DASS is that it was designed as a single instrument to measure symptoms of depression, anxiety and stress (Lovibond & Lovibond, 1995a; Lovibond & Lovibond, 1995b). The DASS has been translated to different languages and used in many validation studies and it was found to be psychometrically sound (Habibi, Dehghani, Pooravari & Saleh, 2017). The DASS-21 is a short form of the original DASS-42. The scale to which each item belongs is indicated by a letter: D (Depression), A (Anxiety) and S (Stress). For each subscale, the scores for the identified items are summed. Because DASS-21 is a short version of the original 42-item scale, the final score of each subscale (Depression, Anxiety and Stress) was multiplied by two (x2) and then compared with the DASS Severity Ratings as presented in Table 3.

Table 3: DASS Severity Ratings

Severity	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

Source: Lovibond and Lovibond (1995).

To test the psychometric properties of DASS-21 in Sub-Saharan Africa, Coker and colleagues conducted a study among medical students in Nigeria and found that the Cronbach's alpha values for the depression, anxiety and stress sub-scales were 0.81, 0.89 and 0.78 respectively indicating excellent internal consistency for the three sub-scales. They added that DASS-21 was a reliable and suitable research tool useful for quick screening of depression, anxiety, and stress (Coker, Coker & Sanni, 2018).

Intention to quit

Finally, intention to leave (quit) was measured with a single-item, five-point scale constructed by Einarsen et al. (2009). The respondents were required to answer the question: *"Have you considered quitting your present job over the last 6 months?"* based on responses which ranged from 0 *(Never)* to 4 *(Very often).* Intention of workers to quit their professions has been found to strongly predict actual staff turnover and this indicator has been used widely in nurse turnover studies (Hayes et al., 2006).

Pilot Study

A pilot study is a test run to determine whether the instrument is useful in producing the desired information (Polit & Beck, 2010). As such, a pilot study was conducted among 32 nurses at Ahmadiyya Muslim Hospital at Kaleo

in the UWR. I personally distributed and retrieved the questionnaires from the participants. The 32 nurses represent 10% of the calculated sample size (N=323) for the study as suggested by Israel (2009). The questionnaire was initially made up of 62 items measuring the different study variables. However, adjustments were made in some sections of the instrument based on results from the pilot study. For example, the items on demographic variables were reduced to only four (gender, age, professional background and rank/position in the profession). As a result, academic qualification, years of professional practice, marital status and type of residence were deleted. Also, the section on demographic variables was moved from the end of the questionnaire to the beginning. Hence, the final questionnaire for the main study has been reduced to 58 items.

Distribution of scores and the reliability of the various scales were tested statistically. Results from the NAQ-R indicate significant deviation from normality (Kolmogorov Smirnov test = 0.205, $p < .001$) while the scores on the DASS-21 scale were normally distributed (Kolmogorov Smirnov test=0.080, $p>0.05$) as shown in Appendix E. This is an indication that data for the actual study were likely to be positively skewed for the NAQ-R and normally distributed for the DASS-21. The reliability of both scales was tested using Cronbach's alpha. The Cronbach alpha values for the NAQ-R and DASS-21 were 0.929 and 0.744 respectively as shown in Appendix D. This means that the two scales were likely to be consistent in measuring the variables that they were designed to measure. Also, it is expected that WPB would be prevalent among the nurses in the actual study. See Appendix F for results of the pilot study.

Validity and Reliability of the Instrument

Validity refers to the ability of an instrument to measure what it is purported to measure appropriately and accurately (Gerrish & Lathlean, 2015). After putting the questionnaire together, it was presented to my supervisor and other seasoned researchers for assessment and inputs. This ensured that the instrument was suitable for measuring the variables it was supposed to measure. Conversely, reliability is the extent to which a research instrument is able to produce the same results given the same conditions and participants sometime in the future (Gerrish & Lathlean, 2015). According to Macneen and McCabe (2006), an instrument is said to be reliable when its Cronbach's alpha statistic exceeds 0.70. In order to determine the reliability coefficient of the instrument, I tested the various scales using Cronbach's alpha test. The Cronbach's alpha values as determined in this study for the NAQ-R and DASS-21 are 0.929 and 0.895 respectively, indicating excellent internal consistency for both scales.

Ethical Consideration

Issues related to ethics play a pivotal role in every research process (Burns & Grove, 2011). The basic tenets guiding research are universally accepted and include but not limited to honesty and respect for the rights of the participants (Welman, Kruger & Mitchell, 2005). In carrying out this study, I ensured that all the principles underlying the ethical conduct of research were followed and these include:

Authorization from the Institutional Review Board (IRB) and hospitals

First and foremost, ethical clearance was obtained from the Institutional Review Board (IRB) of the University of Cape Coast (UCC) and is attached at Appendix B. Secondly, permission was sought from managements of the

various hospitals from which the participants were recruited. Please refer to Appendix C for the authorization letters from the hospitals.

Respect for persons, right to self-determination and voluntary participation

Respect for the participant's autonomy is the guiding principle behind the right to self-determination (Burns & Grove, 2011). In conducting this study, participants were given the chance to make voluntary choices devoid of any form of coercion (Holloway & Wheeler, 2010). Also, potential participants were given the liberty and right to make enquiries about the study, decline to offer information and withdraw from the study at any stage as suggested by Burns and Grove (2011). These two principles are actualized through the signing of an informed consent.

Informed consent consists of four guiding principles as stated by Burns and Grove (2011). These include: full disclosure of relevant information including risk and benefits if any; participants should be able to understand the information; the respondents should have the mental capacity and reach the legal age to give consent; and the participant's participation in the study should be voluntary. However, in this study, informed consent was implied and all potential participants were required to carefully read, understand all information and voluntarily decide to partake in the study before they were allowed to answer the questionnaire.

Protection from physical and/or psychological harm

The right to protection from discomfort and harm is mainly based on the ethical principle of beneficence which states, above all do no harm (Burns & Grove, 2011). WPB is an emotional experience. As such, respondents were

given the chance to answer the questionnaires at their own time and at a place of their own choice. This ensured that the study did not unduly interfere with participants' work or family life. Participants were also informed of the need to stop answering the questionnaires if they felt the questions were evoking emotions and likely to negatively affect their psychological wellbeing. Also, protection from physical and/or psychological harm include anonymity and confidentiality. According to Barbour (2008), the need to preserve the confidentiality and anonymity of all study participants is an enshrined principle when undertaking research.

While anonymity entails non-disclosure of participants' identities, confidentiality deals with protecting participants' information from unauthorized persons. As a result, participants were not required to write their names and other identifiers on the questionnaires. Details including workplace and residential addresses were made anonymous throughout the study and within the findings. In order not to breech confidentiality of participant information, I used passwords and encryptions after data have been entered into the computer software. This prevented unauthorized persons from gaining access to the data.

Data Collection Procedures

Survey delivery is another important decision (Leavy, 2017) to make in gathering research data. My desire was to maximize response rate in the midst of time and budgetary constraints. Available delivery methods include in-person, online, mail, and telephone. Taken many factors into consideration, the in-person method was adopted for this study. Leavy posits that in-person surveys generally occur in group settings and have the highest response rate. I

trained two assistants who helped with the in-person distribution and subsequent collection of the questionnaires which lasted three weeks. The questionnaires were usually distributed during shift changes when a greater number of the nurses were present.

The participants were given a period of two weeks and the freedom to choose where to complete the questionnaire, either at home or work. I also encouraged and reminded the participants to ensure that they completed the instrument within the stipulated time. For participants who were unable to complete the questionnaires within the stipulated time, another week was added after which we retrieved all completed questionnaires. During the collection process, the completed questionnaires were placed in two envelops labelled *enrolled nurses* and *registered general nurses.* These were kept in a drawer and locked at the close of each day until all questionnaires were retrieved. A total of 323 questionnaires were distributed across the eight study sites. However, we were able to retrieve 318 questionnaires representing a response rate of 98.5%.

Data Management

After the questionnaires were retrieved, they were inspected for completeness. Three (3) questionnaires with incomplete entries representing 0.9% were rejected and the rest given unique serial numbers. Coding was done and the completed questionnaires were entered manually into SPSS Version 22. To prevent loss of data during the entry process, the data were saved after entering every ten questionnaires. Also, the data was saved to an external hard drive and on Google Drive to provide backup in case of accidental data loss.

Data Analysis

Data analysis procedures allow you to determine the answers to the research questions or hypotheses (Leavy, 2017). Analysis involves first processing the data into forms that can be utilized statistically and secondly performing the statistical analyses themselves to answer the research questions and/or test the hypotheses. Initially, frequencies were run for the data and inspection done to identify any missing values and errors. Three (3) of the 318 questionnaires retrieved had missing values and as such were excluded from the analysis. Also, some of the data were transformed to ensure usability during the statistical analysis. Moreover, some of the ordinal variables were transformed into dichotomous variable to allow for better result presentation, discussion and communication of findings. For example, the variable 'age' which was recorded as a continuous variable was transformed into a categorical variable based on the following groups: 20-29, 30-39, 40-49 and 50-59 years. Current professional ranks were grouped into two: junior nurses and senior nurses. The junior nurses were made up of staff nurses, senior staff nurses, enrolled nurses, senior enrolled nurses and principal enrolled nurses. The senior nurses were those that fell within the nursing officer, senior nursing officer and principal nursing officer ranks.

All items in the questionnaire measuring each variable were transformed into a single variable to facilitate analysis of the data. For example, the 22 items in the NAQ-R were coded and transformed into one main dependent variable which measures exposure to bullying. The total score on each scale was dependent on the number of items it contained and also the number of points on the Likert scale. For instance, the first part of the NAQ-R has 22 items and each

item was measured on a 5-point Likert scale (1-never, 2-now and then, 3-monthly, 4-weekly and 5-daily). The total score on the NAQ-R was therefore 110 (5*22=110). The total score obtained by each respondent was further categorized into three groups according to cutoff points by Notelares and Einarsen (2013) as follows: less than 33, not bullied; 33-44, occasionally bullied or targets of bullying, and 45+, victims of bullying. The total score for the NAQ-R was further transformed into three categories namely; person related bullying, work related bullying and physical intimidation. The specific items that made up each type of bullying were as follows: person related bullying included items numbered 2,4,5,6,7,10,11,12,13,15,17, and 20; work related bullying was made up of items numbered 1,3,14,16,18, and 21; while physical intimidation comprised of items numbered 8,9 and 22.

Similarly, there were seven (7) items on the DASS-21 that measured depression. Each item was measured on a 4-point Likert scale from 0 to 3. So, the total score for depression as measured by the DASS-21 was 21 (3*7=21). However, since the DASS-21 is an abridged version of the original DASS-42, whatever score that was obtained from DASS-21 was multiplied by 2 to obtain the actual depression score. Based on the actual scores, the level of depression among the respondents was categorized according to the DASS Severity Rating by Lovibond and Lovibond (1995) as follows: 0-9=normal, 10-13=mild depression, 14-20=moderate depression, 21-27=severe depression and 28+=extremely severe depression.

Statistical analysis

The purpose of the statistical analysis is to answer the research questions and/or test the hypotheses to find areas of convergence or divergence with other studies and adduce reasons for the findings. The study sought to determine the prevalence of WPB among nurses in the Upper West Region and this was achieved through research question 1. Initially, the demographic variables of the respondents were summarized and presented in frequency distribution tables. The prevalence of WPB among the respondents was determined using descriptive statistics. The study also aimed at investigating the relationship between demographic variables and WPB as depicted by Hypothesis 1 and was tested using Chi-squared. Hypothesis 2 was formulated to explore if there was a significant difference in WPB prevalence based on the gender of the respondents and was tested using independent samples t-test. Additionally, Hypothesis 3 sought to establish the relationship between WPB and intention to quit, while Hypothesis 4 intended to establish the relationship between WPB and depression among nurses. These hypotheses were tested using Pearson Product Moment correlation.

Study variables

The variables in this study were largely drawn from the literature search, theoretical review and the conceptual model guiding the study. However, some of the variables have been modified to suit the study. There is one dependent variable which is, *workplace bullying*; and three independent variables which influence the dependent variable and include *demographic factors*, *intention to quit* and *depression.*

Workplace bullying

This dependent variable was measured using the NAQ-R. The NAQ-R is made up of 23 questions. The first 22 items on the scale presented an inventory of negative behaviours at the workplace and respondents were expected to state how often they have been exposed to these behaviours (1-never, 2-now and then, 3-monthly, 4-weekly and 5-daily). This approach is more objective and is referred to as the operational method. Respondents were categorized into three groups based on their scores from the 22 items. Respondents who obtained a score less than 33 were considered as not bullied, respondents with scores between 33 and 44 were considered occasionally bullied or targets of bullying and respondents with scores of 45 and above were classified as victims of bullying. The 23rd question provided the opportunity for respondents to label themselves either as being bullied or not over a 6-month period following a theoretical definition of WPB. This approach is more subjective and is known as the self-report method. Also, WPB was categorized into three types depending on whether the negative behaviours targeted the individual's personality, work effort or involved physical attacks (thus, person related bullying, work related bullying or physical intimidation).

Demographic variables

The demographic variables of the respondents that were important to the current study included age, gender, professional nursing background, and current rank within the profession.

Intention to quit

The increased likelihood or propensity that a nurse will leave the nursing profession as a result of WPB. This independent variable was measured by a single item, 5-point Likert scale ranging from 0 *(Never)* to 4 *(Very often).*

Depression

Denotes a mood disorder that results in persistent feeling of sadness and loss of interest in a person's environment (work, family and social interaction). Depression was measured with the DASS-21 which has 7 items out of the 21 items on the scale. Each of the items on the scale was scored on a 4-point Likert and the level of depression categorized as follows: 0-9=normal, 10-13=mild depression, 14-20=moderate depression, 21-27=severe depression and 28+=extremely severe depression.

Summary Chapter

This chapter presented the methodology and related issues that were considered in this study. This is a quantitative study, using an analytical cross-sectional survey. A multistage (cluster) sampling technique (a probability sampling approach) was employed to recruit 323 registered general nurses and enrolled nurses in eight district hospitals in the UWR. The data collection instrument was a survey questionnaire, which was adapted from the NAQ-R and DASS-21. The NAQ-R and DASS-21 used in this study were tested for validity and reliability and the Cronbach's alpha values were 0.90 and 0.86 respectively, indicating excellent internal consistencies. A total of 318 respondents had returned the survey instrument, indicating a response rate of 98.5%, while 3 (0.9%) were rejected. After the data were obtained from the

field, they were cleaned, coded and entered into SPSS version 22 and subsequently analyzed. Demographic characteristics were summarized using frequency distribution tables. Descriptive statistics were used to analyze research question 1 while inferential statistics were employed to test the four hypotheses postulated to guide the study.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

The purpose of this study was to determine the prevalence of WPB and its associations among nurses working in the various public hospitals in the Upper West Region of Ghana. The study specifically sought to:

1) Measure the prevalence of WPB among nurses in the Upper West Region.
2) Determine the association between demographic variables (age, gender, professional background, rank/position) and WPB.
3) Ascertain the relationship between WPB and nurses' intention to quit
4) Investigate the association between WPB and depression.

This chapter presents the study's results and the discussions pertaining to the results. The results of the study are presented in two major parts. The first section employed descriptive statistics to summarize the demographic variables of the respondents and also to determine the prevalence of WPB. The second section applied inferential statistics to determine the relationship between WPB and; intention to quit, depression as well as demographic factors. Also, the difference in bullying prevalence and the gender of the respondents was established. Data was collected with the aid of a well-structured questionnaire, and analysis was carried out using SPSS version 22. The sample size used was 323 nurses from 8 district hospitals across the UWR of Ghana. However, 318 of the questionnaires were filled and returned to the researcher representing a 98.5% response rate.

Demographic Characteristics of Respondents

Some demographic variables of the respondents were important in this study. Demographic variables such as gender, age distribution, professional background as well as current ranks of respondents were looked at. The responses are presented in Table 4.

Table 4: Demographic Characteristics of Respondents

Demographic variables	Frequencies	Percentages (%)
Gender		
Male	164	52.1
Female	151	47.9
Total	**315**	**100.0**
Age (years)		
20-29	151	47.9
30-39	124	39.4
40-49	34	10.8
50-59	6	1.9
Total	**315**	**100.0**
Professional background		
Registered general nurses	148	47.0
Enrolled nurses	167	53.0
Total	**315**	**100.0**
Current professional rank		
Staff nurse (SN)	50	15.9
Senior staff nurse (SSN)	29	9.2
Nursing officer (NO)	31	9.8
Senior nursing officer (SNO)	22	7.0
Principal nursing officer (PNO)	18	5.7
Enrolled nurse (EN)	78	24.8
Senior enrolled nurse (SEN)	55	17.5
Principal enrolled nurse (PEN)	32	10.2
Total	**315**	**100.0**

Source: Field Survey, (2020)

I observed that the respondents were almost evenly distributed based on gender. This is because 52.1% (n=164) were males while 47.9% (n=151) were females. With regard to the age distribution of the respondents, I observed that about 48% of the nurses were between the ages of 20 to 29 years. This was followed by about 39% for those between 30 to 39 years. 13% of the nurses were within the 40 to 59 age brackets. On the issue of professional background of the nurses, I observed that 53% of them were enrolled nurses while the remaining proportion (47%) were registered general nurses. Concerning the professional ranks of the nurses, 25% of them held the position of EN. This was followed by about 18% and 16% respectively for those who were SEN and SN. The least number of nurses were found within the rank of PNO and represented approximately 6%. The rest of the distribution regarding the professional ranks of the nurses are displayed in Table 4.

Research Objective 1: Prevalence of WPB among nurses in the UWR

The first objective was to measure the prevalence of WPB among nurses in the study area. This objective was achieved through research question 1: *what is the prevalence of WPB among nurses working in the various public hospitals in the UWR?* The prevalence of WPB among the study sample was determined by two methods: the operational method and the self-labelling method. According to results from the operational method, 80% (n=252) of the respondents in this study have been bullied to some extent and 20% (n=63) have not been bullied. Out of this number, 33% (n=104) have been bullied occasionally or are targets of bullying, while 47% (n=148) have been classified as victims of bullying based on cutoff points defined by Notelaers and Einarsen

(2013) as shown in Table 5. Among those bullied according to the operational method, 54% (n=136) were male nurses while 46% (n=116) were female nurses.

Table 5: Prevalence of WPB among Nurses Measured by Scores on NAQ-R (Operational Method)

Options	Frequency	Percentage (%)
Not bullied	63	20.0
Occasionally bullied or targets	104	33.0
victims of bullying	148	47.0
Total	**315**	**100.0**

Source: Field Survey (2020)

With the self-labelling method which is more subjective, the reported prevalence of WPB among the respondents was 54.6% (n=172) while 45.4% (n=143) labelled themselves as not bullied within the stated period. Table 6 presents details of the extent to which the respondents were bullied. It can be seen that the prevalence of WPB as determined by the operational method is higher than the self-labelling method.

Table 6: Bullying by Self-labelling Method

Options	Frequency	Percentage (%)
No	143	45.4
Yes, but rarely	78	24.8
Yes, now and then	55	17.5
Yes, several times per week	32	10.2
Yes, almost daily	7	2.2
Total	**315**	**100.0**

Source: Field Survey (2020).

In order to test for criterion validity, Pearson correlation was conducted between scores on the self-labelling and operational methods. The results are presented in Table 7 below.

Table 7: Correlation between the Operational method and Self-labelling Method

	Statistics	Total score
Whether the respondent has been bullied at work over the last six months	Pearson Correlation	0.672**
	Sig. (2-tailed)	0.000
	N	**315**

Source: Field Survey (2020) **Significant at p< 0.001

The Pearson correlation between the target status (bullied or not bullied) as measured by the self-labelling approach and the total score on the NAQ-R which is the operational method is 0.67, with p-value of ($p<0.001$), indicating criterion validity. This finding meant that a respondent's score on the 22 items was positively associated with the respondent's response to the direct question about being bullied. This means that there is a strong relationship between the total score of the nurses on the NAQ-R and targets status (bullied or not bullied).

Categories of WPB

The researcher sought to find out the category of WPB that the nurses were likely to suffer at the work place. To achieve this, the scores on the items on the NAQ-R relating to each of the three categories of WPB were reviewed into *Person Related Bullying* (PRB), Work Related Bullying (WRB) and Physical Intimidation (PI). This was done by calculating the overall mean for the items comprising each category. This was necessary to identify which

category of bullying respondents in this study were more likely to suffer. WRB recorded the highest mean score (M=2.15 SD=1.00). This was closely followed by PRB (M=2.03 SD=0.958), with PI (M=1.72 SD=0.837) being the least. This means that in most instances, the negative behaviours at work were directed at the nurses' work efforts and their persona or being. Also, PI was rarely observed as a form of WPB among the nurses. To the individual items that made up work related bullying, *"Being exposed to an unmanageable workload"* (M=2.48, SD=1.155), *"Excessive monitoring of your work"* (M=2.31, SD=1.054), and *"Being given tasks with unreasonable or impossible targets or deadlines"* (M=2.12, SD= 1.001) were the top three items that constituted WRB. Regarding PRB, the top three items were *"Persistent criticism of your work and effort"* (M=2.35, SD=1.131), *"Repeated reminders of errors or mistakes"* (M=2.26, SD=1.074), and *"Being humiliated or ridiculed in connection with your work"* (M=2.08, SD=0.955).

Prevalence of WPB and gender of the nurses

This hypothesis sought to establish any difference in prevalence among the nurses based on gender. The hypothesis tested here was;

> *H_{01}: There is no statistically significant difference between WPB prevalence and gender of the nurses*

From the initial descriptive statistics conducted, out of the 252 nurses bullied, 54% (n=136) were males compared to 46% (n=116) of their female counterparts. Further analysis was conducted to find out whether this difference in prevalence between male and female nurses was statistically significant using independent samples t-test as presented in Table 8.

Table 8: Relationship between Prevalence of WPB and Gender

		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Total perceived bullying	Equal variances assumed	.080	.777	.297	313	.766
	Equal variances not assumed			.298	311.816	.766

Source: Field Survey (2020).

Levene's Test for Equality of Variances was not significant (F=0.080; p=0.777). This means the assumption of equality of variances have not been violated. To the substantive test, the probability value was also greater than the cutoff point of 0.05. Since the probability value is greater than 0.05 (p=0.766>0.050), we fail to reject the null hypothesis and therefore conclude that there is no statistically significant difference in scores of bullying for males (M=44.8; SD=13.6) and females [(M=44.3; SD=13.3), t(315)=0.297; p=0.77]. Also, the magnitude of the difference in the means was very small (eta squared=0.0003). This meant that the prevalence of WPB was independent of the gender of a nurse. Thus, prevalence of WPB in this study group was not affected by the gender of the nurses.

Perpetrators of WPB from the Study

The perpetrators of WPB in the current study comprised of immediate supervisors and managers (51.1%), colleagues (10.8%), patients/customers (4.4%) and others (1%). Also, 58.8% of the perpetrators were females while 41.2% were males.

Intention of Nurses to quit the Profession

Regarding nurses' intention to quit, 64.4% (n=203) have indicated that they have considered leaving the nursing profession at some point in time while 35.6 (n=112) said they have never contemplated leaving the profession as shown in Table 9.

Table 9:Intention of Nurses to Quit the Profession

		Frequency	Percent
Valid	Never	112	35.6
	Rarely	63	20.0
	Sometimes	92	29.2
	Quite often	32	10.2
	Very often	16	5.1
	Total	**315**	**100.0**

Source: Field Survey (2020).

Prevalence of depression among the nurses

Regarding depression, 52.1% (n=164) of the nurses have been depressed at various levels based on scores on the DASS-21 as represented in Table 10.

Table 10: Prevalence of Depression among Nurses Based on DASS-21

		Frequency	Percent
Valid	Normal	151	47.9
	Mild depression	84	26.7
	Moderate depression	59	18.7
	Severe depression	16	5.1
	Extremely severe depression	5	1.6
	Total	315	100.0

Source: Field Survey (2020).

Research Objective 2: Relationship between WPB and demographic characteristics

The second objective of the study sought to determine whether there was a significant relationship between WPB and demographic characteristics of the respondents. The hypothesis of interest here was:

H_{02}: There are no statistically significant relationships between WPB and demographic factors.

The results of the analyses are presented in Table 11.

Table 11: Relationship between WPB and Demographic Variables (N=315)

Demographic Variables	Chi-Square	DF	p-value
Bullying cutoff points	34.419	2.000	0.000
The respondent's gender	0.537	1.000	0.464
Professional Nursing Background	1.146	1.000	0.284
Current Ranks of Respondents	72.124**	7000	0.000
Age Distribution	145.848**	2.000	0.000

Source: Field Survey, (2020) **Significant at p<0.001

This hypothesis was tested using Chi-squared. There was no violation of the assumptions for this test as all the cells had expected frequencies greater than 5. We observed from the output that only two of the four demographic variables were significantly related to WPB. This meant that in terms of the relationship between WPB and demographic variables of the respondents, current ranks as well as age distribution significantly related to WPB. Thus, the position a nurse occupied at the place of work, as well as his/her age category

to a very large extent has an effect on WPB. As a result, we could not entirely reject or accept the null hypothesis and further studies need to be conducted.

Research Objective 3: Relationship between WPB and the intention to quit

The relationship between WPB and the Intention of a nurse to quit his/her job in favour of another was also assessed. The hypothesis of concern was;

H_{03}: There is no statistically significant relationship between WPB and Nurses Intentions to Quit

The stated hypothesis sought to determine whether WPB was related to nurses' intentions to quit the profession. The results are presented in Table 12.

Table 12: Correlations of WPB and Intentions to Quit

		Intentions of Respondents to Quit Current Job
Total perceived bullying	Pearson Correlation	0.487**
	Sig. (2-tailed)	0.000
	N	**315**

Source: Field Survey (2020) **Significant at p<0.001

The relationship between perceived bullying at work (as measured by the NAQ-R) and nurses' intention to quit the profession (as measured by a single item on a 5-point Likert scale) was investigated using Pearson product-moment correlation coefficient. Initial investigations were carried out to rule out violation of the assumptions of normality, linearity and homoscedasticity. Because the p-value is less than 0.05, we reject the null hypothesis of no

relationship and accept the alternate hypothesis which states that there is a statistically significant relationship between WPB and nurses' intention to leave the profession. From the analysis, there was a strong, positive correlation between the two variables (r=0.487; N=315, p<0.001), with high levels of perceived WPB associated with increasing levels of the intentions of nurses to quit their job. This means that as the perceived level of WPB increases, the level of the intention of a nurse to quit his/her job increased and vice versa.

Research Objective 4: Relationship between WPB and depression among nurses

The final hypothesis was formulated to establish the relationship between WPB and depression among the respondents. Here, the relationship between perceived bullying at work (as measured by the NAQ-R) and depression among nurses (as measured by the DASS-21) was investigated using Pearson product-moment correlation coefficient. Initial investigations were carried out to rule out violation of the assumptions of normality, linearity and homoscedasticity. The hypothesis of concern was;

H_{04}: There is no statistically significant relationship between WPB and Depression among Nurses

The results are displayed in Table 13.

Table 13: Relationship between WPB and Depression

		Actual depression score
Total perceived bullying	Pearson Correlation	0.559**
	Sig. (2-tailed)	0.000
	N	**315**

Source: Field Survey (2020) **Significant at p<0.001

Now, since the *p*-value is less than 0.05, we reject the null hypothesis and accept the alternate hypothesis which states that there is a statistically significant relationship between WPB and depression among nurses. From the analysis, there was a strong, positive correlation between the two variables (r=0.559; N=315; $p<0.001$), with high levels of perceived WPB being associated with increasing levels of depression among nurses. Thus, the higher the perceived level of WPB, the higher the level of depression among the nurses and vice versa.

Discussion of Key Findings

The main findings from the study were discussed in this section, organized and presented around the four research objectives. The findings were discussed based on empirical and theoretical evidence on WPB from the literature review. This allowed for discussions of both divergent and convergent findings on the subject thus, making it possible for adducing reasons for the findings. It also facilitated the drawing of sound conclusions and the prescription of recommendations.

A major finding from this study was that WPB is prevalent among the nurses in this study with more than half of the sampled nurses indicating that

they have been bullied to some extent based on scores from both the operational and self-labelling approaches. Another finding showed that WPB was associated with respondents' age and current ranks but not professional background or gender of the nurses. WPB was also positively associated with both intentions to quit, and depression among nurses.

Prevalence of WPB among nurses

WPB can be said to be highly prevalent among the nurses in this study as 80% of the respondents have indicated that they have been bullied according to the operational method as against 54.6% by the self-labelling method. These findings are similar to earlier studies on the subject. For example, Nwaneri et al. (2016) conducted a cross-sectional study among 289 nurses in a Tertiary hospital and found that the prevalence of WPB among the nurses using the operational method was 82.6%. Also, Harb et al. (2019) in a cross-sectional study among 231 registered nurses in Jordan found the prevalence to be 73.6%. The high prevalence of bullying among the nurses could partly be due to the fact that nurses constitute an oppressed group according to the oppressed group behaviour theory (Freire, 1972) who use aggression towards their colleagues as defense mechanism since they do not have the power to face their oppressors at the workplace. Other reasons that could be responsible for the high prevalence of WPB among the nurses include the power difference between the nurses and their supervisors and other healthcare staffs including physicians, pharmacists and administrators; inadequate knowledge on what constitutes bullying at work because the phenomenon is relatively new; and lack of anti-bullying policies and clear reporting guidelines in cases of WPB in Ghana.

In this study, 80% of the respondents have been bullied according to the operational method while 54.6% have been bullied according to the self-labelling method. It can be seen that there is a substantial difference between the two approaches used to determine WPB prevalence. Earlier studies which employed both the operational and self-labelling methods also found differences in WPB prevalence. For example, when Chipps et al. (2013) conducted a quantitative study among 167 operation room staffs using both methods, they found a wide discrepancy of 34% and 6% between prevalence rates for the operational and self labelling methods respectively. Furthermore, Sauer and McCoy (2017) conducted a cross-sectional study among 345 licensed registered nurses in America and identified that 42% were bullied by the operational method while 40% of the nurses were bullied by the self-labelling method.

The self labelling method comes with a certain degree of underreporting (Lutgen-Sandvik *et al*., 2007). This in the view of Einarsen (1999) is because many participants refuse to accept the victim role, since this role implies weakness and passivity, which are personal attributes a lot of people do not want to be associated with. Therefore, though some of the nurses might have been bullied, they may find it difficult and sometimes embarrassing to label themselves as victims of bullying since that is a negative tag on the individual.

It must also be noted that the prevalence differs across cultures and geographical locations. The prevalence from this study is similar to that from Jordan (Harb et al., 2019) and Nigeria (Nwaneri et al., 2016) which have similar characteristics to Ghana. However, prevalence found by Sauer and McCoy (2017) and Chipps et al. (2013) conducted in America are lower than those

found in this current study. The difference in prevalence rates across studies might be attributed to the cultural backgrounds of the respondents and also the power structures within the health facilities. This argument is supported by Nielsen, Matthiessen and Einarsen (2010) who see the variations in prevalence rates to be accounted for by such factors as characteristics of the culture and changes in social values, and issues related to research methodology.

With regard to the categories of WPB, the highest mean score was reported for work related bullying (M=2.15 SD=1.00), followed by person related bullying (M=2.03 SD=0.958) and then physical intimidation (M=1.72 SD=0.837). These findings are consistent with the findings of Al-Ghabeesh and Qattom (2019), where the highest mean score was reported for work-related bullying (M= 2.08, SD = 0.78), followed by person-related bullying (M= 1.99, SD = 0.73), while the lowest mean score was reported for physically-intimidating bullying (M= 1.95, SD =0 .83). This sought to suggest that the negative behaviours that these nurses faced were mostly directed at their work efforts and personality. Once the nurses' work efforts and personality are targeted by these negative behaviours, the impact is felt by both the individual nurse and the facilities where they work. Productivity may suffer and the health and wellbeing of the nurses working in such environments might be compromised.

The nurses did not differ significantly on WPB based on gender. This means that male nurses were bullied as much as their female counterparts. One can therefore argue that being a target or victim of bullying is not dependent on one's gender. This finding is inconsistent with that of Chen et al. (2009) who conducted a follow-up study to determine the risks of workplace violence

among nurses in a psychiatry hospital. They found that being a female nurse increases one's risk of becoming a victim of workplace violence. This result is also partly in conflict with assertions of the relational aggression theory (Crick & Grotpeter, 1995) which indicates an association between gender (female gender) and being a target of WPB. It is also important to note that unlike other jurisdictions where nursing is dominantly a female profession, the narrative is different in Ghana where a lot of males are in the profession. It is plausible therefore to reason that the population dynamics in terms of the gender of the nurses might be responsible for this difference in the findings. Therefore, being a target of WPB cannot be solely attributed to one's gender but might include other factors such as the level of education, perception of the public, level of independence at work and self-esteem.

In this study, the primary perpetrators of bullying behaviours were the nurses' immediate superiors and managers in more than 51% of cases. 10.8% were bullied by their colleagues, 4.4% by patients, customers or students. Regarding the perpetrators of bullying, similar findings were established in a study among Turkish nurses by Yildirim (2009) where 40% of the participants reported being bullied by their administrators, 34% by their co-workers, and 5% by their subordinates. Also, Nwaneri et al. (2016) found that 76% of nurses bullied identified senior nurses overseeing hospital wards/units as perpetrators. It can be seen that in most cases of bullying at the study sites, the perpetrators were mostly people in positions of power or leadership. This situation is worrying because the power difference puts the nurses in a vulnerable and difficult position where they may find it difficult to protest or defend themselves.

Additionally, it can be seen that females were perpetrators of WPB in 58.8% (n=124) of cases compared to 41.2% (n=87) of males. The fact that more females were perpetrators of bullying might help lend support to assertions of the relational aggression theory (Crick & Grotpeter, 1995) where females are seen as having the natural tendency to bully others.

Also, the results on the self-labelling method were correlated with those on the operational method to test criterion validity. The Pearson correlation between the target status (bullied or not bullied) and the total NAQ-R score was 0.67 ($p<0.001$), indicating criterion validity. This finding meant that a respondent's score on the NAQ-R was positively associated with the respondent's response to the direct question about being bullied.

Relationship between WPB and demographic characteristics of nurses

The demographic characteristics of the respondents that were considered in this study included gender, age, professional nursing background and current rank. Attempts were made to determine if WPB was related to the demographic variables. The Chi-squared test indicated that WPB was related to the nurses age and current rank but not gender and professional nursing background.

Therefore, in this study, WPB is seen to be associated with been young (20-49 years) and been a junior staff (SN, SSN, EN, SEN, and PEN). The findings are similar to those of Ovayolu et al. (2014) who found that young nurses and those with less professional experience were more commonly bullied. Other studies (see Efe & Ayaz, 2010; Yildirim, 2009) have found been younger as associated with WPB. These could further be explained by the assertions that WPB is common in instances of disproportional power structures (Jackson et al., 2002; Yamada, 2000), where the senior staffs mostly target the

junior staffs. It can also be speculated that young and junior nurses were likely to be targeted by bullies due to their inexperience at the workplace and also lack of knowledge of what constitutes WPB. It is however instructive to note that WPB occurs irrespective of one's gender or professional nursing background (RGN or EN) and should be considered universal and not pertinent to certain genders or professional groupings.

Association between WPB and the intention of nurses to quit the profession

More than 60% of the nurses in this study have stated that they have contemplated leaving the profession at some point in time. This figure is huge considering the fact that most of the facilities in Ghana have a shortfall in the number of nurses. There was the need to ascertain whether WPB was related to the nurses' intentions to quit their job. The Pearson correlation coefficient indicated that WPB was positively related to nurses' intention to quit the profession. This means that an increase in WPB prevalence would lead to an increase in nurses' intention to leave their current profession. A number of studies have also established a positive association between WPB and nurses' intentions to leave the profession (Coetzee & Oosthuizen, 2017; Boafo et al., 2016; Blackstock et al., 2015; Houshmand et al., 2012; Bowling & Beehr, 2006).

Intention to quit as a consequence of WPB could result to actual staff turnover. Staff turnover leads to loss of qualified nurses, which can lead to a decline in patient safety (Crutcher et al., 2011), and high operational expenses (Hutchinson et al., 2010). Nurses who are victims of WPB have increased chances of falling sick and experiencing other health-related issues than workers

who are not bullied (Nielsen et al., 2016). It is also documented that employees who are victims of WPB may become distressed, worried, and confused (Einarsen et al., 1996). Because WPB is prevalent among nurses, it stands to reason that bullying will pose health and safety risks to the nurses which may ultimately trigger their intentions to leave the profession for other professions that are less stressful and risky; helping to explain the positive association between WPB and the nurses' intentions to quit the profession.

Though this study is quantitative and did not explore the other reasons for nurses intending to quit, one can speculate that, in Ghana, low salaries and renumerations, low prestige, discrimination and negative perceptions of the public about the nurse could be accountable. These are similar to the reasons identified in a study by Fochsen et al. (2005) who identified lack of professional opportunities, restricted professional autonomy and unsatisfactory salary as precursors to the decision to quit. Intention of workers to quit their professions has been found to strongly predict actual staff turnover and this indicator has been used widely in nurse turnover studies (Hayes et al., 2006). However, with the high unemployment levels among newly qualified nurses and the unavailability of alternative job opportunities for nurses in Ghana, one wonders whether the intention to quit would result to actual nurse turnover.

Relationship between WPB and Depression among Nurses

In this study, over 50% of the nurses have experienced various degrees of depression according to the DASS. However, it is important to note that DASS is a quantitative measure of distress (depression, anxiety and stress) and therefore not a categorical measure of clinical diagnosis (Lovibond & Lovibond, 1995). What this means is that the assessment scores obtained from

the DASS can be used to identify individuals experiencing considerable symptoms who might be at high risk of developing clinical depression. There is therefore the need to refer such people for further psychological evaluation.

Further investigations were conducted on the relationship between WPB and depression among nurses who took part in the study. It was determined from the Pearson correlation coefficient that there was a strong positive linear relationship between WPB and depression among the nurses. This is an indication that any increase in WPB prevalence subsequently would be associated with an increase in the nurses' depression states and vice versa. Hence, an increase in one variable leads to a corresponding increase in the other. This finding is consistent with earlier studies (see Karatza et al., 2016; Verkuil et al., 2015; Nielsen & Einarsen, 2012; Bowling & Beehr, 2006) which found positive linear relationship between WPB and depression.

Work offers livelihood for workers and at the same time can be seen as a source of great stress. As such, anything that will affect work or the working environment negatively will inadvertently increase employees stress levels and subsequently result in compromised wellbeing. This might account for the positive linear relationship between WPB and depression and supports Hoobler et al. (2010) view that workplace bullying has been recognized as a main source of distress that is associated with subsequent ill-health and decreased well-being. However, the findings in this study contradicts those of Doe (2016) who found no significant association between WPB and depression among a sample of university workers in Ghana. The reasons for the difference in findings are not readily known. However, in the study conducted by Doe (2016), the prevalence of depression among the workers was not determined. It is possible

that very few or none of the respondents was depressed at the time of data collection and this could help explain why WPB was not significantly associated with depression in that study.

Chapter Summary

It can be seen from the results of this study that WPB was a common health and safety hazard among the nurses with more than 50% of them being exposed to WPB according to the operational and self-labelling methods. Contrary to earlier notions that bullying constitutes a concept common among females, this study has established that WPB should not be considered as a phenomenon that is peculiar to certain genders or professional nursing groupings but as a menace that afflicts all nurses. However, young and junior nurses were more likely to be exposed to WPB and this could be accounted for by inexperience at the workplace and also lack of knowledge of what constitutes WPB. It has also been established that WPB has a positive linear relationship with both nurses' intentions to quit the profession, and depression among nurses.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to determine the prevalence of WPB and its associations among nurses working in the various public hospitals in the Upper West Region of Ghana. This section discusses the summary of findings, conclusions and recommendations as well as suggestions for further studies. This study was designed with the following research objectives in mind:

1) Measure the prevalence of WPB among nurses in the Upper West Region.
2) Determine the association between demographic variables (age, gender, professional background, rank/position) and WPB.
3) Ascertain the relationship between WPB and nurses' intention to quit.
4) Investigate the association between WPB and depression.

The study was conducted using an analytic cross-sectional method. Respondents were recruited from eight hospitals across eight districts in the UWR through a multistage sampling technique and data was collected with a structured questionnaire. The questionnaire was made up of 23 items from the NAQ-R and 21 items from the DASS-21 as well as questions on demographic variables and nurses' intention to quit. The questionnaire was piloted among 32 nurses and its reliability coefficient determined to ensure that it was actually measuring the variables it purported to be measuring as shown in Appendix D. Modifications were made to the questionnaire as required.

The questionnaires for the main study were distributed to 323 nurses by the principal researcher and two research assistants over a three-week period. At the end of the data collection process, a total of 318 questionnaires were retrieved. This represents a 98.5% response rate. The instruments were physically inspected for completeness and missing values, and then coded for entry into SPSS software for analysis. The instrument was tested for validity and reliability and the Cronbach's alpha values for the NAQ-R and DASS-21 were 0.929 and 0.895 respectively, indicating excellent internal consistencies as presented in Appendix D. Initially, descriptive statistics were conducted to describe the demographic characteristics of the respondents and determine the prevalence of the variables under investigation. Later, inferential statistics were used to investigate the differences and also to ascertain the relationship between some variables.

Summary of Findings

With respect to the demographic characteristics of respondents, the study revealed that there were slightly more female nurses (52.1%) than male nurses (47.9%) with an average age of 31years. Enrolled nurses represented 53% while the registered general nurses made up 47%. Most of the nurses (78%) were within the lower ranks in the profession (SN, SSN, EN, SEN and PEN) and could be considered junior staffs.

Regarding the prevalence of WPB among nurses in the region, the study revealed that majority (80%) of the nurses have been exposed to a number of negative behaviours at the workplace and could be considered bullied to some extent according to scores on the NAQ-R. On the other hand, about 55% of the nurses have labelled themselves as victims of WPB according to the self-

labelling method. The study has revealed that the prevalence rate was higher when using the operational method (80%) compared to the self-labelling method (54.6%).

The study further revealed that a respondent's score on the NAQ-R was positively associated with the respondent's response to the direct question about being bullied, indicating criterion validity. The findings also suggest that the category of bullying that nurses were most likely to be exposed to at the health facilities targeted their professional roles (work-related bullying). It was further observed that, the perpetrators of bullying among the nurses in this study were largely their immediate supervisors and managers (51.1%), colleagues (10.8%), and patients or customers (4.4%), with 58.8% being females while 41.2% were males.

Surprisingly, despite the high levels of unemployment among newly qualified nurses and the unavailability of alternative job opportunities for nurses in Ghana, about 64% of the nurses in this study have indicated their willingness to quit the profession while unfortunately, 52% of the nurses can be classified depressed based on scores on the DASS-21.

In terms of the relationship between WPB and demographic variables, the results showed that the respondents' professional ranks as well as their ages were significantly related to WPB. Thus, the position a nurse occupies at the place of work, as well as his/her age to a very large extent has effects on WPB, with nurses who are junior staffs and younger more likely to be targets than senior staffs and older nurses. However, I observed that the prevalence of WPB was independent of the gender of a nurse and his/her professional nursing

background. Thus, the nurses were not targeted based on their gender or particular nursing grouping.

Furthermore, with reference to the relationship between WPB and intention to quit one's profession, the study indicated that as the perceived level of WPB increases, the level of the intention of a nurse to quit his/her job increases and vice versa. Finally, in examining the relationship that exists between WPB and depression among nurses, the study revealed that the higher the perceived levels of WPB, the higher the level of depression among nurses and vice versa.

Conclusions

Based on the summary of findings, the following conclusions were drawn;

i) majority (80%) of the nurses have been exposed to negative behaviours at the workplace which constitutes WPB based on scores on the NAQ-R while 55% have labelled themselves as victims of WPB.

ii) the primary perpetrators of WPB were the nurses' immediate supervisors who in most cases were females.

iii) more than half of the nurses (64%) had intentions of quitting the profession while a further 52% were experiencing signs and symptoms of depression based on scores on the DASS-21.

iv) in terms of the relationship between WPB and demographic variables of the respondents, being younger as well as a junior staff increased one's risk of becoming a target of WPB among the nurses.

v) contrary to the initial notion that WPB was prevalent among females, this study has revealed that both male and female nurses were equally targeted and nurses' exposure risk was not dependent on gender.

vi) with reference to the relationship between WPB and intention to quit one's profession, the study indicates that as the perceived level of WPB increases, the level of the intention of a nurse to quit his/her job increases and vice versa.

vii) finally, in examining the relationship that exists between WPB and depression among nurses, the study reveals that the higher the perceived levels of WPB, the higher the level of depression and vice versa.

Recommendations

The following recommendations are made to the managements of the facilities where the study was conducted, the nurses at those facilities and the Upper West Regional Health Directorate.

Managements of the hospitals

Managements of the hospitals should consider WPB as a common negative behaviour which affects nurses. In order to reduce the incidence of WPB at the health facilities I recommend these four strategies:

1) Managements should organize training for all leaders within these facilities since they are the primary perpetrators of these negative behaviours at work.

2) Managements of the facilities should make efforts to educate all workers on WPB and its consequences and provide regular up-dates on the

subject. These programs should specifically target young and junior nurses since they are most vulnerable. When workers are well-informed, they will be in a position to defend themselves better.

3) Managements should extend the mandated annual medical examination for workers to include psychological assessment. This will help identify workers at risk of developing clinical depression and other psychological disturbances.

Nurses at the facilities

It is important for nurses to consider WPB as a safety and health hazard common in the workplace with consequences to themselves, patients and the health facilities. As a result, I recommend that:

1) Nurses should take keen interests in all educational programs on WPB to be equipped with the requisite knowledge on the subject. This is a relatively new area and many people do not understand its dynamics well.
2) Nurses must endeavor to report early, all incidents of bullying at the facility either as targets or witnesses. They should make frantic efforts in ensuring that the grievance process is duly followed and that the perpetrator is punished.
3) Nurses must take their psychological wellbeing seriously as this study suggests that a good number of the nurses might be at risk of developing clinical depression. Nurses can voluntarily and periodically visit the clinical psychologist for evaluations in order to prevent the development of clinical depression.

Upper West Regional Health Directorate

Initial findings from this study have identified WPB as a phenomenon that is highly prevalent among the nurses. As such, I recommend the following for consideration by the Upper West Regional Health Directorate.

1) There is the need to conduct a full-scale research into bullying at the health facilities to obtain statistics that could be generalized to nurses and other healthcare workers in the region.

Suggestions for Further Research

This study determined the prevalence of WPB among nurses in the UWR and also established the relationship between WPB and some variables using a descriptive cross-sectional approach involving only RGNs and ENs from eight hospitals across the region. This makes generalization of the findings problematic. As such, the following are suggestions for further research:

1) There is the need for a full-scale research into WPB in the UWR that will include all categories of nurses and healthcare facilities such that the findings can be generalized.
2) Though this study was able to establish the relationship between WPB and some of the variables, it must be noted that the study is cross-sectional and therefore could not be used to establish causality. Hence, there will be the need for further research on the topic using a longitudinal approach to establish cause and effect.
3) Further research is also required using a qualitative approach to explore the reasons for the high prevalence of bullying among the nurses and also the huge number of nurses willing to quit the profession.

4) Additionally, further research can be carried out to find the perspectives of perpetrators and witnesses on bullying at the health facilities.
5) Finally, a longitudinal study will be required to ascertain whether nurses' intentions to quit the profession really resulted to actual nurse turnover or not.

REFERENCES

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

Ahliquist, E., & Riehl, G. (2013). *Managing Lateral Violence and its impact on the team: Nurses and Students.* Available at https://www.slideshare. net/SaskQualitySummit/managing-lateral-violence-and-its-impact- on-the-team-nurses-and-students

Al-Ghabeesh, S. H., & Qattom, H. (2019). Workplace bullying and its preventive measures and productivity among emergency department nurses. *Israel journal of health policy research*, *8*(1), 44.

American Association of Critical-Care Nurses. (2005). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence*. Aliso Viejo, CA: American Association of Critical-Care Nurses.

American Nurses Association. (2015). Position statement: Incivility, bullying, and workplace violence. *Nursing World Web site. Availableat http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/ HealthyNurse/bullyingworkplaceviolence/Incivility-Bullying-and-WorkplaceViolence.html. Published*.

Ariza-Montes, A., Muniz, N. M., Montero-Simó, M. J., & Araque-Padilla, R. A. (2013). Workplace bullying among healthcare workers. *International journal of environmental research and public health*, *10*(8), 3121-3139.

Asamani, L. (2010). Organisational and individual consequences of workplace violence. Public Policy and Administration Research, 6, 9. Available at http://dx.doi.org/10.5430/jnep.v7n2p69

Ayranci, Ü., Yenilmez, Ç., Günay, Y., & Kaptanoglu, C. (2002). The frequency of being exposed to violence in the various health institutions and health profession groups. *Anatolian Journal of Psychiatry*, *3*, 147-154.

Baillien, E., & De Witte, H. (2009). Why is organizational change related to workplace bullying? Role conflict and job insecurity as mediators. *Economic and Industrial Democracy 30*(3):348–71.

Baillien, E., De Cuyper, N., & De Witte, H. (2011). Job autonomy and workload as antecedents of workplace bullying: a two-wave test of Karasek's Job Demand Control Model for targets and perpetrators. *Journal of Occupational and Organizational Psychology 84*:191–208.

Baldry, A. C., Farrington, D. P., & Sorrentino, A. (2017). School bullying and cyberbullying among boys and girls: Roles and overlap. *Journal of Aggression, Maltreatment and Trauma, 26*(9), 937–951. doi:10.1080 /10926771.2017.1330793

Bandura, A. (1972). "Modeling theory: Some traditions, trends, and disputes". In Parke, R.D. (ed.). *Recent trends in Social Learning Theory*. New York: Academic Press, Inc.

Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.

Bandura, A., & Walters, R. H. (1963). *Social learning and personality development*. New York: Holt, Rinehart and Winston.

Barbour, R. (2008). *Introducing Qualitative research. A student guide to the craft of doing based practice* (5th edn.). Elsevier, Texas.

Bardakçı, E., & Günüşen, N. P. (2016). Influence of workplace bullying on Turkish nurses' psychological distress and nurses' reactions to bullying. *Journal of Transcultural Nursing*, *27*(2), 166-171.

Bartlett, J. E., & Bartlett, M. E. (2011). Workplace Bullying: An integrative literature review. *Advances in Developing Human Resources, 13*(1), 69-84. doi:10.1177/1523422311410651

Belayachi, J., Berrechid, K., Amlaiky, F., Zekraoui, A., & Abouqal, R. (2010). Violence toward physicians in emergency departments of Morocco: prevalence, predictive factors, and psychological impact. *J Occup Med Toxicol 5*:27.

Bentley, T., Catley, B., Gardner, D., O'Driscoll, M. P., Trenberth, L., & Cooper-Thomas, H. (2009). *Understanding stress and bullying in New Zealand workplaces: Final report to OHS steering committee*. Wellington, New Zealand.

Berthelsen, M., Skogstad, A., Lau, B., & Einarsen, S. (2011). Do they stay or do they go? A longitudinal study of intentions to leave and exclusion from working life among targets of workplace bullying. *International Journal of Manpower, 32*(2), 178-193.

Bhui, K. S., Dinos, S., Stansfeld, S. A., & White, P. D. (2012). A synthesis of the evidence for managing stress at work: a review of the reviews reporting on anxiety, depression, and absenteeism. *Journal of environmental and public health*.

Blackstock, S., Harlos, K., Macleod, M. L., & Hardy, C. L. (2015). The impact of organisational factors on horizontal bullying and turnover intentions in the nursing workplace. *Journal of Nursing Management*, *23*(8), 1106-1114.

Blackwood, K. (2015). *Workplace bullying in the New Zealand nursing profession: The case for a tailored approach to intervention.* (PhD), Massey University, Albany. Retrieved from http://mro.massey.ac.nz/xmlui/bitstream/handle/10179/7212/02_whole.pdf?sequence=2&isAllowed=yMassey University database

Boafo, I. M., & Hancock, P. (2017). Workplace violence against nurses: a cross-sectional descriptive study of Ghanaian nurses. *Sage Open*, *7*(1), 2158244017701187.

Boafo, I. M., Hancock, P., & Gringart, E. (2016). Sources, incidence and effects of non-physical workplace violence against nurses in Ghana. *Nursing open, 3*(2), 99-109.

Boddy, C. R. (2011). Corporate psychopaths, bullying and unfair supervision in the workplace. *Journal of business ethics*, *100*(3), 367-379.

Bonde, J. P., Gullander, M., Hansen, Å. M., Grynderup, M., Persson, R., Hogh, A., ... & Kolstad, H. A. (2016). Health correlates of workplace bullying: a 3-wave prospective follow-up study. *Scandinavian Journal of Work, Environment & Health*, 17-25.

Bowling, N. A., & Beehr, T. A. (2006). Workplace harassment from the victim's perspective: a theoretical model and meta-analysis. *Journal of applied psychology, 91*(5), 998.

Branch, S., Ramsay, S., & Barker, M. (2013). Workplace bullying, mobbing and general harassment: A review. *International Journal of Management Reviews*, *15*(3), 280-299.

Brotheridge, C. & Lee, R. (2010). Restless and confused emotional responses to workplace bullying in men and women. *Career Development International, 15,* 687-707.

Brousse, G., Fontana, L., Ouchchane, L., Boisson, C., Gerbaud, L., Bourguet, D., & Chamoux, A. (2008). Psychopathological features of a patient population of targets of workplace bullying. *Occupational medicine, 58*(2), 122-128.

Burns, N. & Grove, S.K. (2011). *Understanding Nursing research*: *Building an evidence-based practice,* 5th edn. Elsevier, Texas.

Caponecchia, C., & Wyatt, A. (2009). Distinguishing between workplace bullying, harassment and violence: a risk management approach. *Journal of Occupational Health and Safety, Australia and New Zealand*, *25*(6), 439.

Caponecchia, C., & Wyatt, A. (2011). *Preventing workplace bullying: An evidence-based guide for managers and employees*. Routledge.

Carbo, J., & Hughes, A. (2010). Workplace bullying: Developing a human rights definition of workplace bullying from the perspective and experiences of targets. *Working USA, 13*(3), 387-403.

Carter, M., Thompson, N., Crampton, P., Morrow, G., Burford, B., Gray, C., & Illing, J. (2013). Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting. *BMJ open*, *3*(6), e002628.

Catley, B., Bentley, T., Forsyth, D., Cooper-Thomas, H., Gardner, D., O'Driscoll, M., & Trenberth, L. (2013). Managing workplace bullying in New Zealand: Perspectives from occupational health and safety practitioners. *Journal of Management & Organization, 19*(05), 598-612. doi:10.1017/jmo.2014.2

Cavanaugh, C., Campbell, J., & Messing, J. T. (2014). A longitudinal study of the impact of cumulative violence victimization on comorbid posttraumatic stress and depression among female nurses and nursing personnel. *Workplace health & safety, 62*(6), 224-232.

Chen, W. C., Sun, Y. H., Lan, T. H., & Chiu, H. J. (2009). Incidence and risk factors of workplace violence on nursing staffs caring for chronic psychiatric patients in Taiwan. *International journal of environmental research and public health*, *6*(11), 2812-2821.

Chipps, E., Stelmaschuk, S., Albert, N. M., Bernhard, L., & Holloman, C. (2013). Workplace bullying in the OR: Results of a descriptive study. *Association of Operating Room Nurses. AORN Journal, 98*(5), 479-93.

Coetzee, M., & Oosthuizen, R. M. (2017). Work-role psychosocial flourishing: Its mediation role on workplace bullying and employee turnover intention. *Journal of Psychology in Africa*, *27*(3), 211-215.

Coker, A. O., Coker, O. O., & Sanni, D. (2018). Psychometric properties of the 21-item Depression Anxiety Stress Scale (DASS-21). *African Research Review*, *12*(2), 135-142.

Cooper, C., Dewe, P., & O'Driscoll, M. (2001). *Organizational stress: A review and critique of theory, research, and applications*. Thousand Oaks, CA: Sage.

Cooper-Thomas, H., Gardner, D., O'Driscoll, M., Catley, T., Bentley, T., & Trenberth, L. (2013). Neutralizing Workplace Bullying: The buffering effects of contextual factors. *Journal of Management Psychology, 28*(4), 384-407. doi:10.1108/JMP-12-2012-0399

Cowan, R. L. (2011). "Yes, we have an anti-bullying policy, but…:" HR professionals' understandings and experiences with workplace bullying policy. *Communication Studies, 62*(3), 307-327. doi:10.1080/10510974.2011.553763

Crawshaw, L. (2007). *Taming the abrasive manager: How to end unnecessary roughness in the workplace*. John Wiley & Sons.

Creswell, J. W. (2014). *Research design: Qualitative, quantities, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: SAGE.

Crick, N., & Grotpeter, J. (1995). Relational aggression, gender, and social-psychological adjustment. *Child Development, 67*(1), 710-722.

Crimp, H. (2017). *Insights into effective interventions for the prevention and management of workplace bullying in the New Zealand public service.* Unpublished Master's Thesis. (Victoria University of Wellington).

Crutcher, R. A., Szafran, O., Woloschuk, W., Chatur, F., & Hansen, C. (2011). Family medicine graduates' perceptions of intimidation, harassment, and discrimination during residency training. *BMC medical education, 11*(1), 88.

Darko, G., Björkqvist, K., & Österman, K. (2019). Workplace Bullying and Psychological Distress in Public Institutions in Ghana. *European Journal of Social Science Education and Research*, *6*(1), 62-74.

D'Cruz, P., & Noronha, E. (2010). Protecting My Interests: HRM and Targets' Coping with Workplace Bullying. *Qualitative report*, *15*(3), 507-534.

Denzin, N. K., & Lincoln, Y. (2008). Introduction: Critical methodologies and indigenous inquiry. In N. Denzin, Y. Lincoln, & L. Tuhiwai Smith (Eds.), *Handbook of critical indigenous methodologies* (pp. 1–20). Thousand Oaks, CA: SAGE.

Djurkovic, N., McCormack, D., & Casimir, G. (2008). Workplace bullying and intention to leave: The moderating effect of perceived organisational support. *Human Resource Management Journal, 18*(4), 405-422. doi:10.1111/j.1748-8583.2008.00081.x

Doe, F. (2016). The impact of workplace bullying on workers' psychological and emotional well-being: a study of 139 university staff in Ghana. *International journal of innovative research and development*, *5* (3), e87993-e87993.

Duffy, M. (2009). Preventing workplace mobbing and bullying with effective organizational consultation, policies, and legislation. *Consulting Psychology Journal: Practice and Research, 61*(3), 242-262. doi:10.1037/a0016578

Efe, S. Y., & Ayaz, S. (2010). Mobbing against nurses in the workplace in Turkey. *International nursing review*, *57*(3), 328-334.

Einarsen, S. (1999). The nature and causes of bullying at work. *International Journal of Manpower, 20*, 16–27.

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

Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring Exposure to Bullying and Harassment at Work: Validity, Factor Structure and Psychometric Properties of the Negative Acts Questionnaire-Revised. *Work & Stress, 23,* 24-44. http://dx.doi.org/10.1080/02678370902815673

Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. (2003). *Bullying and emotional abuse in the workplace: international perspectives in research and practice*. London and New York: Taylor & Francis.

Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. L. (2005). Workplace Bullying: individual pathology or organizational culture. *Workplace violence*, 229-247.

Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. L. (2011). Bullying and harassment in the workplace: Developments in theory, research, and practice (2nd ed.). Boca Raton, FL: Taylor & Francis.

Einarsen, S., Raknes, B. I., Matthiesen, S. B., & Hellesoy, O. H. (1996). Bullying at work and its relationships with health complaints-Moderating effects of social support and personality. *Nordisk Psykologi*, *48*(2), 116-137.

Emdad, R., Alipour, A., Hagberg, J., & Jensen, I., B. (2013). The impact of by-standing to workplace bullying on symptoms of depression among women and men in industry in Sweden: an empirical and theoretical longitudinal study. *Int Arch Occup Environ Health 86*:709-16.

Farrell, G. A. (2001). From tall poppies to squashed weeds: why don't nurses pull together more?. *Journal of Advanced Nursing*, *35*(1), 26-33.

Finne, L., B., Christensen, J., O., & Knardahl, S. (2014). Psychologic Social Work Factors as Predictors of Mental Distress: A Prospective Study. *Plos One. 9*(7): el02514. http:// dx.doi.org/ 10.1371 /journal.pone.0 1 025 1 4

Fochsen, G., Josephson, M., Hagberg, M., Toomingas, A., & Lagerström, M. (2006). Predictors of leaving nursing care: a longitudinal study among Swedish nursing personnel. *Occupational and environmental medicine, 63*(3), 198-201.

Fochsen, G., Sjögren, K., Josephson, M., & Lagerström, M. (2005). Factors contributing to the decision to leave nursing care: a study among Swedish nursing personnel. *Journal of Nursing Management, 13*(4), 338-344.

Fowler, F. J., Jr. (2009). *Survey research methods* (4th ed.). Thousand Oaks, CA: SAGE.

Fox, S., & Cowan, R. L. (2015). Revision of the workplace bullying checklist: The importance of human resource management's role in defining and addressing workplace bullying. *Human Resource Management Journal, 25*(1), 116-130. doi:10.1111/1748-8583.12049

Fox, S., & Stallworth, L. E. (2009). Building a framework for two internal organizational approaches to resolving and preventing workplace bullying: Alternative dispute resolution and training. *Consulting Psychology Journal: Practice and Research, 61*(3), 220-241. doi:10.1037/a0016637

Freire, P. (1972). *Pedagogy of the oppressed*. Harmondsworth: Penguin.

Gardner, S., & Johnson, P. (2001). The leaner, meaner workplace: Strategies for handling bullies at work. *Employment Relations Today, 28*(2), 23-36. doi:10.1002/ert.1012

Gerrish, K., & Lathlean, J. (2015). *The Research Process in Nursing*. (J. W. and Sons, Ed.) (7th ed). West Sussex: Wiley Blackwell. Retrieved from www.wiley.com/wiley-blackwel

Ghana Labour Act (2003). *Act 651 Section 9(c).* Retrieved from http://www.ilo.org/legacy/english/inwork/cbpolicyguide/ghanalabouract2003section109.pdf

Ghana Statistical Service (2012). *2010 Population and housing census: Summary report of final results.* Sankoa Press Limited. Accra-Ghana.

Glambek, M., Matthiesen, S. B., Hetland, J., & Einarsen, S. (2014). Workplace bullying as an antecedent to job insecurity and intention to leave: a 6-month prospective study. *Human Resource Management Journal*, *24*(3), 255-268.

Griffeth, R. W., Hom, P. W., & Gaertner, S. (2000). A meta-analysis of antecedents and correlates of employee turnover: Update, moderator tests, and research implications for the next millennium. *Journal of management, 26*(3), 463-488.

Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing, 45*(12), 535–542.

Gullander, M., Hogh, A., Hansen, Å. M., Persson, R., Rugulies, R., Kolstad, H. A., ... & Bonde, J. P. (2014). Exposure to workplace bullying and risk of depression. *Journal of occupational and environmental medicine, 56*(12), 1258-1265.

Habibi, M., Dehghani, M., Pooravari, M., & Saleh, S. (2017). Confirmatory factor analysis of Persian version of depression, anxiety and stress scale: non-clinical sample. Razavit Int J Med, 5(4), e12021. Doi: 10.5812/rijm.12021.

Haig, B. D. (2013). The philosophy of quantitative methods. In T. Little (Ed.). *The Oxford handbook of quantitative research methods: Vol. 1. Foundations* (pp. 7–31). New York: Oxford University Press.

Hammond, W. P., Gillen, M., & Yen, I. H. (2010). Workplace discrimination and depressive symptoms: a study of multi-ethnic hospital employees. *Race and social problems*, *2*(1), 19-30.

Hansen, Å. M., Hogh, A., Persson, R., Karlson, B., Garde, A. H., & Ørbaek, P. (2006). Bullying at work, health outcomes, and physiological stress response. *Journal of psychosomatic research, 60*(1), 63-72.

Hansson, M., Chotai, J., & Bodlund, O. (2010). Patients' beliefs about the cause of their depression. *Journal of affective disorders, 124*(1-2), 54-59.

Harb, A., Rayan, A., & Al. khashashneh, O. Z. (2019). The relationship between workplace bullying and positive mental health among registered nurses. *Journal of the American Psychiatric Nurses Association*, 1078390319877223.

Hauge, L., H., Skogstad, A., & Einarsen, S. (2007). Relationships between stressful work environments and bullying: results of a large representative study. *Work & Stress 21*(3):220–42.

Hauge, L., H., Skogstad, A., Einarsen, S. (2009). Individual and situational predictors of workplace bullying: why do perpetrators engage in the bullying of others?. *Work and Stress 23*(4):349–58.

Hayes, L. J., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., ... & Stone, P. W. (2006). Nurse turnover: a literature review. *International journal of nursing studies*, *43*(2), 237-263.

Hill, W. F. (2001). *Learning: A Survey of Psychological Interpretations (7th Edition)* (7 ed.). Boston, MA: Allyn & Bacon.

Hockley, C. (2002). *Silent hell: Workplace violence & bullying*. Peacock Publications.

Hoel, H., & Cooper, C. L. (2001). Origins of bullying: Theoretical frameworks for explaining workplace bullying. In N. Tehrani (Ed.), *Building a culture of respect: Managing bullying at work* (pp. 3–19). London: Taylor & Francis.

Hoel, H., & Einarsen, S. (2011). Investigating complaints of bullying and harassment. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (2nd ed., pp. 341-357). Boca Raton, FL: CRC Press.

Hoel, H., Cooper, C. L., & Faragher, B. (2001). The experience of bullying in Great Britain: The impact of organizational status. *European journal of work and organizational psychology*, *10*(4), 443-465.

Hogh, A., Hoel, H., & Carneiro, I. G. (2011). Bullying and employee turnover among healthcare workers: a three-wave prospective study. *Journal of nursing management*, *19*(6), 742-751.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing*. (3rd edn.) Wiley- Blackwell, Iowa.

Hoobler, J. M., Rospenda, K. M., Lemmon, G., & Rosa, J. A. (2010). A within-subject longitudinal study of the effects of positive job experiences and generalized workplace harassment on well-being. *Journal of Occupational Health Psychology, 15*(4), 434.

Houshmand, M., O'Reilly, J., Robinson, S., & Wolff, A. (2012). Escaping bullying: The simultaneous impact of individual and unit-level bullying on turnover intentions. *Human Relations*, *65*(7), 901-918.

Hutchinson, M., Vickers, M., H., Wilkes, L., & Jackson, D. (2010). A typology of bullying behaviours: the experiences of Australian nurses. *J. Clin. Nurs 19*:2319-28.

Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: towards a more critical organizational perspective. *Nursing Inquiry, 13,* 118-126.

Hutchinson, M., Wilkes, L. Vickers, M., & Jackson, D. (2008). The development and validation of a bullying inventory for the nursing workplace. *Nursing Research, 53,* 19-29.

Israel, G. D. (2009). *Determining Sample Size*. *PEOD6*. Florida. Retrieved from http://www.webcitation.org/66kKEIC0b.

Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace–a factor in recruitment and retention. *Journal of nursing management*, *10*(1), 13-20.

Jahner, J. (2011). Building Bridges: An Inquiry into Horizontal Hostility in Nursing Culture and the use of Contemplative Practices to Facilitate Cultural Change.

Jenkins, M. (2011). Practice note: Is mediation suitable for complaints of workplace bullying? *Conflict Resolution Quarterly, 29*(1), 25-38. doi:10.1002/ crq.21035

Joa, T., S., & Morken, T. (2010). Violence towards personnel in out-of-hours primary care: a cross sectional study. *Scand J Prim Health Care 30*:55-60.

Johnson, S. L. (2009). International perspectives on workplace bullying among nurses: a review. *International nursing review*, *56*(1), 34-40.

Josephson, M., Lindberg, P., Voss, M., Alfredsson, L., & Vingård, E. (2008). The same factors influence job turnover and long spells of sick leave—a 3-year follow-up of Swedish nurses. *European journal of public health, 18*(4), 380-385.

Karatza, C., Zyga, S., Tziaferi, S., & Prezerakos, P. (2016). Workplace bullying and general health status among the nursing staff of Greek public hospitals. *Annals of general psychiatry, 15*(1), 7.

Keashly, L., & Nowell, B. L. (2003). Conflict, conflict resolution and bullying. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and emotional abuse in the workplace* (pp. 339-358). London: Taylor and Francis.

Kivimaki, M., Virtanen, M., Vartia, M., Elovainio, M., Vahtera, J., & Keltikangas-Jarvinen, L. (2003). Workplace Bullying and the Risk of Cardiovascular Disease and Depression. *Occupational and Environmental Medicine, 60,* 779-783.

Lamberth, B. (2015). Workplace Bullying in Healthcare: Part 1. *Radiology management*, *37*(1), 12-6.

Lamontagne, A. D., Keegel, T., Louie, A. M., Ostry, A., & Landsbergis, P. A. (2007). A systematic review of the job-stress intervention evaluation literature, 1990–2005. *International Journal of Occupational and Environmental Health, 13*(3), 268-280. doi:10.1179/oeh.2007.13.3.268

Leavy, P. (2017). *Quantitative, Qualitative, Mixed Methods, Arts-Based, and Community-Based Participatory Research Approaches*. The Guilford Press. New York, London.

Leymann, H. (1986). *Vuxenmobbing: om psykisvt våld I arbetslivet* (*Bullying-psychological violence at work*). Lund: Studentlitteratur.

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

Lipscomb, J., & London, M. (2015). *Not part of the job: How to take a stand against violence in the work setting.* Silver Spring, MD: Nursesbooks.org.

Loerbroks, A., Weigl, M., Li, J., Glaser, J., Degen, C., & Angerer, P. (2015). Workplace bullying and depressive symptoms: A prospective study among junior physicians in Germany. *Journal of psychosomatic research, 78*(2), 168-172.

Lovibond, P. F., & Lovibond, S. H. (1995b). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*, 335–343.

Lovibond, S. H., & Lovibond, P. F. (1995a). *Manual for the depression anxiety stress scales*. Sydney: Psychology Foundation.

Lutgen-Sandvik, P., Tracy, S. J., & Alberts, J. K. (2007). Burned by bullying in the American workplace: Prevalence, perception, degree and impact. *Journal of Management Studies*, *44*(6), 837-862.

MacIntosh, J., Wuest, J., Gray, M., M., & Cronkhite, M. (2010). Workplace bullying in health care affects the meaning of work. *Qual Health Res 20*: 1128-41.

Macneen, C. L., & McCabe, S. (2006). *Understanding Nursing Research. Reading and using research in evidence-based practice* (2nd ed). London: Lippincott Williams.

Matthiesen, S. B., Aasen, E., Holst, G., Wie, K., & Einarsen, S. (2003). The escalation of conflict: a case study of bullying at work. *International Journal of Management and Decision Making*, *4*(1), 96-112.

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of advanced nursing*, *42*(1), 90-96. http://dx.doi.org/10.1046/j.1365-2648.2003.02583.x

McNamara, S. (2012). Incivility in nursing: Unsafe nurse, unsafe patients. *Association of Operating Room Nurses Journal*,95(4),53-55

Meglich-Sespico, P., Faley, R. H., & Knapp, D. E. (2007). Relief and redress for targets of workplace bullying. *Employee Responsibilities and Rights Journal, 19*(1), 31-43. doi:10.1007/s10672-006-9030-y

Mikkelsen, E. G., & Einarsen, S. (2001). Bullying in Danish work-life: Prevalence and health correlates. *European journal of work and organizational psychology*, *10*(4), 393-413.

Mikkelsen, E. G., & Einarsen, S. (2006). *Psychosocial rehabilitation positively affects victims' health and well-being*. Paper presented at the Fifth International Conference on Bullying and Harassment in the Workplace, June 15-17, Dublin Ireland.

Moule, P., & Goodman, M. (2009). *Nursing research an introduction*. Sage, Los Angeles.

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Namie, G. (2007). The Workplace Bullying Institute 2007 US Workplace Bullying Survey. Available at https://www.academia.edu/7867044/Thechalleng eofworkplacebullying

Namie, G., & Namie, R. F. (2011). *The bully-free workplace: Stop jerks, weasels, and snakes from killing your organization*. John Wiley & Sons.

Namie, R., & Namie, G. (2009). *The bully at work: What you can do to stop the hurt and reclaim your dignity.* Naperville, IL: Sourcebooks Inc.

National Health Service (2014). *NHS staff survey 2014: Violence, bullying and harassment*. Available at http//:www.nhsstaffsurveys.com/Page/1019/ Latest-Results/Staff-Survey-2013-Detailed-Spreadsheets/.

Niedhammer, I., David, S., & Degioanni, S. (2006). Association between workplace bullying and depressive symptoms in the French working population. *Journal of psychosomatic research, 61*(2), 251-259.

Nielsen, M. B., & Einarsen, S. (2012). Outcomes of exposure to workplace bullying: A meta-analytic review. *Work & Stress*, *26*(4), 309-332.

Nielsen, M. B., Indregard, A. M. R., & Øverland, S. (2016). Workplace bullying and sickness absence: a systematic review and meta-analysis of the research literature. *Scandinavian journal of work, environment & health*, 359-370.

Nielsen, M. B., Magerøy, N., Gjerstad, J., & Einarsen, S. (2014). Workplace bullying and subsequent health problems. *Tidsskr Nor Laegeforen. 134*:1233-8. http://dx.doi.org/10.4045/ tidsskr. 13.0880.

Nielsen, M. B., Matthiesen, S. B., & Einarsen, S. (2010). The impact of methodological moderators on prevalence rates of workplace bullying. A meta-analysis. *Journal of Occupational and organizational Psychology*, *83*(4), 955-979.

Nielsen, M. B., Notelaers, G., & Einarsen, S. (2011). Measuring exposure to workplace bullying. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (2nd ed., pp. 149-174). Boca Raton, FL: CRC Press.

Notelaers, G., & Einarsen, S. (2013). The world turns at 33 and 45: Defining simple cutoff scores for the Negative Acts Questionnaire–Revised in a representative sample. *European Journal of Work and Organizational Psychology*, *22*(6), 670-682.

Nwaneri, A. C., Onoka, A. C., & Onoka, C. A. (2016). Workplace bullying among nurses working in tertiary hospitals in Enugu, Southeast Nigeria: Implications for health workers and job performance. *Journal of Nursing Education and Practice*, *7*(2), 69-78.

Olweus, D. (1996). Bully/Victim Problems at School: Facts and Effective Intervention. *Reclaiming Children and Youth: Journal of Emotional and Behavioral Problems*, *5*(1), 15-22.

Oppermann, S. (Ed.). (2008). *Workplace Bullying: Psychological Violence?* Retrieved from http://www.fedsmith.com/article/1780/workplace-bullying-psychological-violence.html

Ovayolu, Ö., Ovayolu, N., & Karadag, G. (2014). Workplace bullying in nursing. *Workplace health & safety*, *62*(9), 370-374.

Paice, E. (2009). Bullying of trainee doctors is a patient safety issue. *Clin Teach* *6*:13-7.

Pearson, C., & Porath, C. (2013). The price of incivility. *Harvard Business Review,* Retrieved from https://hbr.org/2013/01/the-price-of-incivility/

Phelps, C., & Wilson, B. (2013). JONA's Healthcare Law. *Ethics and Regulation 15*(1): 51-57. PMid:23429651http://dx.doi.org/10.1097/NHL.0b013e3182861503

Phillips, D. C., & Burbules, N. C. (2000). *Postpositivism and educational research*. Lanham, MD: Rowman & Littlefied.

Polit, D. F. & Beck, C. T. (2010). *Essentials of nursing research: Appraising Evidence for nursing practice*, (7th edn.). Lippincott, Williams and Wilkins, London.

Quine, L. (2001) Workplace bullying in nurses. *Journal of Health Psychology 6*(1), 73–84.

Rayner, C., & Lewis, D. (2011). Managing workplace bullying: The role of policies. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research and practice* (2nd ed., pp. 327-340). Boca Raton, FL: CRC Press.

Richards, J., & Daley, H. (2003). Bullying policy: Development, implementation and monitoring. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and emotional abuse in the workplace: International perspectives in research and practice* (pp. 247-258). London, England: Taylor & Francis.

Roberts, S. J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science*, *22*(4), 71-82.

Rouse, L., P., Gallagher-Garza, S., Gebhard, R., E., Harrison, S., L., & Wallace, L., S. (2016). Workplace bullying among family physicians: a gender focused study. *J Womens Health (Larchmt)25*:882-8.

Rowell, P. A. (2005). Being a "target" at work: Or William Tell and how the apple felt. *Journal of Nursing Administration*, *35*(9), 377-379.

Royal College of Nursing. (2002). *Dealing with bullying and harassment: A guide for nursing students.* London, U.K.

Rugulies, R., Madsen, I. E., Hjarsbech, P. U., Hogh, A., Borg, V., Carneiro, I. G., & Aust, B. (2012). Bullying at work and onset of a major depressive episode among Danish female eldercare workers. *Scandinavian journal of work, environment & health 38:* 218-227. http://dx.doi.org/10.527 l/sjweh.3278.

Saam, N. J. (2010). Interventions in workplace bullying: A multilevel approach. *European Journal of Work and Organizational Psychology, 19*(1), 51-75. doi:10.1080/13594320802651403

Salin, D. (2008a). Organisational responses to workplace harassment: An exploratory study. *Personnel Review, 38*(1), 26-44. doi:10.1108/0048 3480910920697

Salin, D. (2008b). The prevention of workplace bullying as a question of human resource management: Measures adopted and underlying organisational factors. *Scandinavian Journal of Management, 24*(1), 221-231. doi:10.1016/j.scaman.2008.04.004

Saltzberg, C. W. (2011.) Balancing in moments of vulnerability while dancing the dialectic. *Advances in Nursing Science, 34*(3), 229–242.

Sauer, P. A., & McCoy, T. P. (2017). Nurse bullying: Impact on nurses' health. *Western journal of nursing research*, *39*(12), 1533-1546.

Schalk, D., Bijl, M., Halfens, R., Hollands, L. & Cummings, G. (2010) Interventions aimed at improving the nursing work environment: a systematic review. *Implementation Science 5*, 34.

Schat, A. & Frone, M., R. (2011). Exposure to psychological aggression at work and job performance: the mediating role of job attitudes and personal health. *Work Stress 25*:23-40.

Schwickerath, J., & Zapf, D. (2011). Inpatient treatment of bullying victims. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research and practice* (pp. 397-422). Boca Raton, FL: CRC Press.

Sharma, S., Scafide, K., Dalal, R. S., & Maughan, E. (2019). Individual and organizational characteristics associated with workplace bullying of school nurses in Virginia. *The Journal of School Nursing*, 1059840519871606.

Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science,* 31(2), 48-59.

Skogstad, A., Matthiesen, S., B., & Einarsen, S. (2007). Organisational changes: a precursor of bullying at work. *International Journal of Organization Theory and Behavior 10(1)*:58–94.

Speedy, S. (2004). Organisation violations: Implications for leadership. *Nursing leadership*, 145-164.

Stelmaschuk, S. (2010). *Workplace bullying and emotional exhaustion among registered nurses and non-nursing, unit-based staff*. (Doctoral dissertation, The Ohio State University).

Taylor, B. (2001). Identifying and transforming dysfunctional nurse–nurse relationships through reflective practice and action research. *International Journal of Nursing Practice* 7: 406–13.

Tehrani, N. (2011). Workplace bullying: The role for counselling. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (pp. 381-396). Boca Raton, FL: CRC Press.

Trad, M., & Johnson, J. (2014). Bullying among radiation therapists: effects on job performance and work environment. *Radiol Technol 86*:122-31.

Twale, D. J., & De Luca, B. M. (2008). *Faculty incivility: The rise of the academic bully culture and what to do about it* (Vol. 128). John Wiley & Sons.

Upper West Regional Health Services [UWRHS]. (2017). *2016 Annual report*.

Van Dyk, J. (2016). *The mediating effect of a psychological well-being profile in the bullying and turnover intention relation* (Unpublished doctoral thesis) University of South Africa, Pretoria, South Africa.

Vartia, M. A. (2001). Consequences of workplace bullying with respect to the well-being of its targets and the observers of bullying. *Scandinavian journal of work, environment & health*, *27*(1), 63-69.

Vartia, M., & Leka, S. (2011). Interventions for the prevention and management of bullying at work. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (2nd ed., pp. 359-379). Boca Raton, FL: CRC Press.

Verkuil, B., Atasayi, S., Molendijk, M., L. (2015). Workplace Bullying and Mental Health: A Meta-Analysis on Cross-Sectional and Longitudinal Data. *Plos One. 10*(8). http:// dx.doi.org/ 1 0. 1 37 1/journal.pone.0 1 35225

Vessey, J. A., DeMarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. *Annual Review of Nursing Research, 28*, 133–157.

Waldman, J. D., Kelly, F., Aurora, S., & Smith, H. L. (2004). The shocking cost of turnover in health care. *Health care management review, 29*(1), 2-7.

Washington State Department of Labor & Industries. (2008). *Workplace Bullying: What Everyone Needs to Know*. Retrieved from http://www.lni.wa. gov/Safety/Research/Files/Bullying.pdf

Washington State Department of Labor and Industries, Safety and Health Assessment and Research for Prevention Program. (2011). *Workplace bullying and disruptive behavior: What everyone needs to know.*

Watts, R. J., Griffith, D. M., & Abdul-Adil, J. (1999). Sociopolitical development as an antidote for oppression—theory and action. *American Journal of Community Psychology*, *27*(2), 255-271.

Weiss, H. M., & Cropanzano, R. (1996). Affective events theory: A theoretical discussion of the structure, causes and consequences of affective experiences at work. *Research in Organizational Behavior, 18,* 1–74.

Welman, J. C., Kruger, S. J. & Mitchell, B. (2005) *Research Methodology*. (3rd edn.). Oxford University Press, Cape Town.

Westhues, K. (Ed.). (2004). *Workplace mobbing in academe: Reports from twenty universities*. Edwin Mellen Press.

Wheeler, A.R., Halbesleben, J.R.B. & Shanine, K. (2010). Eating their cake and everyone else's cake, too: Resources as the main ingredient to workplace bullying. *Business Horizons, 53*, 553-560.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., ... & Burstein, R. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet, 382*(9904), 1575-1586.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., ... & Fratiglioni, L. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European neuropsychopharmacology, 21*(9), 655-679.

Yamada, D. C. (2000). The phenomenon of "workplace bullying" and the need for status-blind hostile work environment protection. *Georgetown Law Journal, 88*, 475–536.

Yamane, T. (1967). *Statistics; An Introductory Analysis* (2nd ed.). New York, US: Harper & Row. Retrieved September, 2019 from http://www.gbv .de/dms/zbw/252 560191.pdf

Yıldırım, D. (2009). Bullying among nurses and its effects. *International nursing review*, *56*(4), 504-511.

Zapf, D., & Gross, C. (2001). Conflict escalation and coping with workplace bullying: A replication and extension. *European Journal of Work and Organizational Psychology, 10*(4),497-522.

Zapf, D., Escartin, J., Einarsen, S., Hoel, H., & Vartia, M. (2011). Empirical findings on prevalence and risk groups of bullying in the workplace. In: Einarsen S, Hoel H, Zapf D, Cooper CL editor(s). *Bullying and Harassment in the Workplace: Developments in Theory, Research, and Practice*. Boca Raton, Florida: CRC Press, Taylor & Frances, 75–105.

APPENDICES

Appendix A: Data Collection Instrument

STRUCTURE OF THE QUESTIONNAIRE

UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH
Research Instrument@2020

Background

Dear Respondent,

My name is Emmanuel Dapilah, a Registered General Nurse (RGN) and Master of Nursing (MN) student of the School of Nursing and Midwifery, University of Cape Coast (UCC). I am conducting a research on the "***Prevalence of workplace bullying among nurses in the Upper West Region***" as part of the requirements for the award of the Master of Nursing Degree. This study will determine the magnitude of bullying and create awareness of the existence of the phenomenon in our health facilities. This will serve as the starting point for the formulation and implementation of policies by stakeholders and managements aimed at either preventing or reducing it in the workplace. Your participation in this study is absolutely voluntary and will mean completing a questionnaire which will take 10-15 minutes of your time. You may also pull out of the study at any time during the study without any punitive actions against you. Your responses are completely anonymous and be assured that the information you give will be kept confidentially. If you have any questions about this survey, please email me at emmanuel.dapilah@stu.ucc.edu.gh or call me on 0200955210/0241356185. Thank you for your decision to take part in this study.

PLEASE ANSWER THE FOLLOWING QUESTIONS AS OBJECTIVELY AS POSSIBLE BY TICKING (√) THE RESPONSES THAT APPLY IN EACH CASE OR WRITING DOWN THE ANSWERS IN THE SPACES PROVIDED

SECTIONS A: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Gender:
   a. Male ☐
   b. Female ☐
2. What is your age? (*please specify*)

   .....years
3. Please indicate your professional nursing background
   a. Enrolled Nurse ☐
   b. Registered General Nurse ☐
4. What is your current rank (position) in your profession? (*please specify*)
   .....

SECTION B: INTENTIONS TO QUIT

1. Have you considered quitting your present job over the last six (6) months?

   A. Never ☐
   B. Rarely ☐
   C. Sometimes ☐
   D. Quite often ☐
   E. Very often ☐

SECTION C: PREVALENCE OF WORKPLACE BULLYING AMONG NURSES

The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, please indicate how often have you been subjected to the following negative acts at work. Use the key in the first table to guide you.

Please circle the number that best corresponds with your experience over the last six months:

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

1)	Someone withholding information which affects your performance	1	2	3	4	5
2)	Being humiliated or ridiculed in connection with your work	1	2	3	4	5
3)	Being ordered to do work below your level of competence	1	2	3	4	5
4)	Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1	2	3	4	5
5)	Spreading of gossip and rumours about you	1	2	3	4	5
6)	Being ignored or excluded (being 'sent to Coventry')	1	2	3	4	5
7)	Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life	1	2	3	4	5
8)	Being shouted at or being the target of spontaneous anger (or rage)	1	2	3	4	5
9)	Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1	2	3	4	5
10)	Hints or signals from others that you should quit your job	1	2	3	4	5
11)	Repeated reminders of your errors or mistakes	1	2	3	4	5
12)	Being ignored or facing a hostile reaction when you approach	1	2	3	4	5
13)	Persistent criticism of your work and effort	1	2	3	4	5

14)	Having your opinions and views ignored	1	2	3	4	5
15)	Practical jokes carried out by people you don't get on with	1	2	3	4	5
16)	Being given tasks with unreasonable or impossible targets or deadlines	1	2	3	4	5
17)	Having allegations made against you	1	2	3	4	5
18)	Excessive monitoring of your work	1	2	3	4	5
19)	Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)	1	2	3	4	5
20)	Being the subject of excessive teasing and sarcasm	1	2	3	4	5
21)	Being exposed to an unmanageable workload	1	2	3	4	5
22)	Threats of violence or physical abuse or actual abuse	1	2	3	4	5

23. Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will <u>not</u> refer to a one-off incident as bullying.

Using the above definition, please state whether you have been bullied at work over the last six months?

No ☐

Yes, but only rarely ☐

Yes, now and then ☐

Yes, several times per week ☐

Yes, almost daily ☐

25. If your answer to the previous question was "**Yes**", please tick the appropriate box(es) below to state who you were bullied by:

My immediate superior ☐

Other superiors/managers in the organisation ☐

Colleagues ☐

Subordinates ☐

Customers/patients/students, etc. ☐

Others ☐

25. Please state the number and gender of your perpetrators:

Male perpetrators ☐

Female perpetrators ☐

SECTION D: LEVEL OF DEPRESSION AMONG NURSES

The statements below are on the level of depression among nurses. Please indicate how much the statement applied to you over the past weeks by circling a number; 0, 1, 2 or 3. There are no right or wrong answers. Do not spend too much time on any statement. Use the rating scale below to guide you

The rating scale:

0 Did not apply to me at all-NEVER (N)

1 Applied to me to some degree, or some of the time-SOMETIMES (S)

2 Applied to me to a considerable degree or a good part of time-OFTEN (O)

3 Applied to me very much or most of the time-ALMOST ALWAYS (AA)

		N	S	O	AA
1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3

9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

Appendix B: Ethical Clearance from IRB-UCC

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/608
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

C/O Directorate of Research, Innovation and Consultancy

20TH FEBRUARY, 2020

Mr. Dapilah Emmanuel
School of Nursing and Midwifery
University of Cape Coast

Dear Mr. Dapilah,

ETHICAL CLEARANCE – ID (UCCIRB/CHAS/2019/209)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled **Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region of Ghana.** This approval is valid from 20th February, 2020 to 19th February, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

Appendix C: Authorization from the Hospitals

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

LETTER RECEIVED
08 APRIL 20
REGIONAL HOSPITAL, WA

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: **"Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region."**

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

DDNS
Forwarded to director for necessary action pls

DDNS
Approval given for the above exercise to be conducted, kindly provide the necessary support to ensure a smooth exercise.

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

RECEIVED DATE 23/3/20

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: "**Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region.**"

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

Seen
10-04-20
Approval granted
cc
Research Office

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: "**Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region.**"

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

LAWRA DISTRICT HOSPITAL RECEIVED DATE 3/2/19 LAWRA-U.WR

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: "**Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region.**"

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

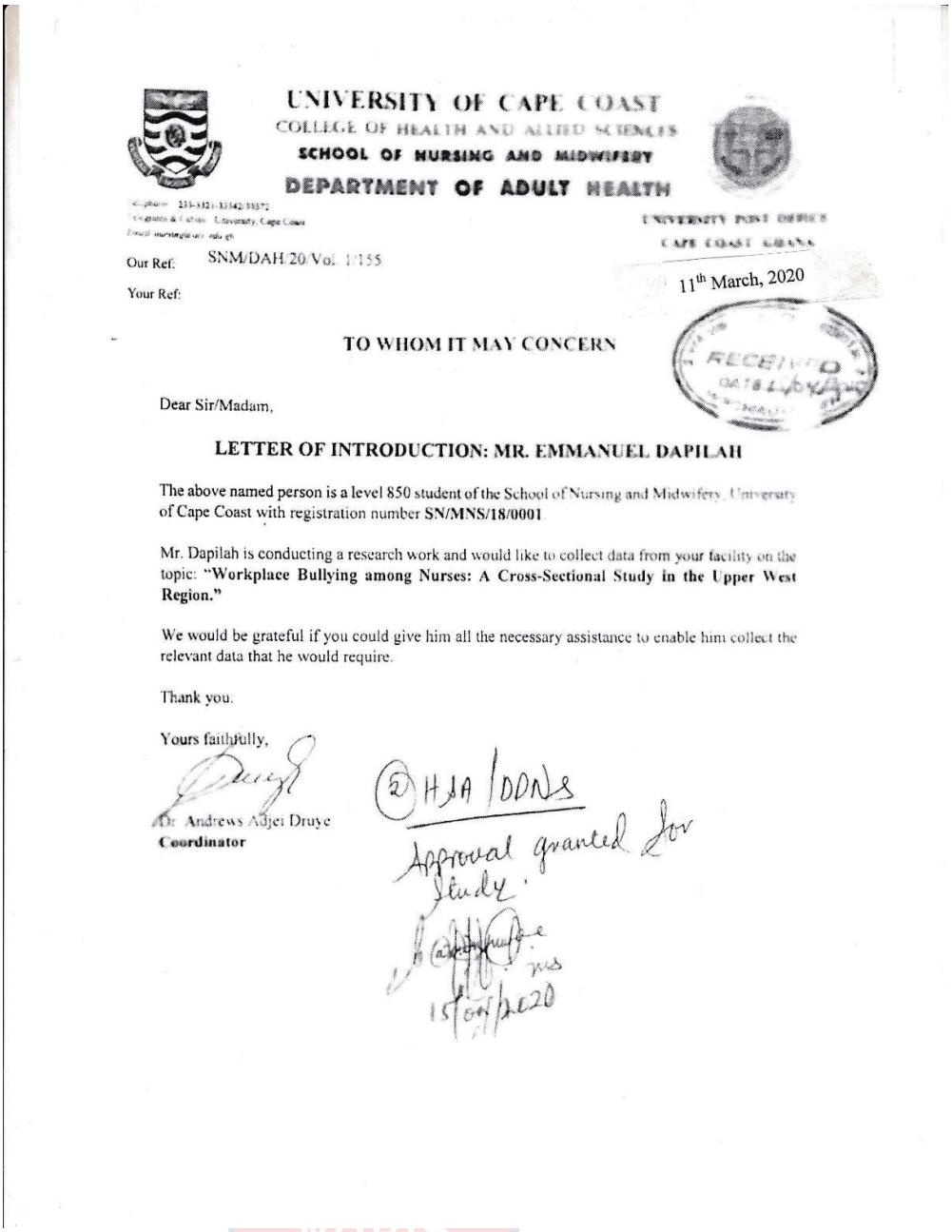
Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

(3) Received noted Permission granted 06/04/20

DIRECTOR OF NURSING SERVICES LAWRA DISTRICT HOSPITAL U/W/R

(2) DDNS



UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

UNIVERSITY POST OFFICE
CAPE COAST GHANA

Our Ref: SNM/DAH.20/Vol. 1/155

Your Ref:

11th March, 2020

RECEIVED

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: **"Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region."**

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

② HSA/DDNS
Approval granted for study.
15/04/2020

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

LETTER RECEIVED
08 APRIL 20
NADOWLI HOSPITAL

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: **"Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region."**

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

Med Supt
Seen and Noted.
Research officers please assist student.
20/04/20

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: **"Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region."**

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

DDNS
Permission granted.
NB students should ~~fund~~ share findings with facility
20/03/20
MS

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/DAH/20/Vol. 1/155

Your Ref:

11th March, 2020

GWOLLU HOSPITAL
RECEIVED
DATE 6/04/2020
GHANA HEALTH SERVICE

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION: MR. EMMANUEL DAPILAH

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with registration number **SN/MNS/18/0001**.

Mr. Dapilah is conducting a research work and would like to collect data from your facility on the topic: **"Workplace Bullying among Nurses: A Cross-Sectional Study in the Upper West Region."**

We would be grateful if you could give him all the necessary assistance to enable him collect the relevant data that he would require.

Thank you.

Yours faithfully,

Dr. Andrews Adjei Druye
Coordinator

HSA
pls, copy the Nurse manager and In-charges of all nursing units
29/04/2020

Mui(2) HSA
For your attention and action
Dr. Yaw Fon
24/04/2020

CC: All Units.

Appendix D: Results of Reliability Tests for the Various Scales

a. Reliability tests during the pilot study

Reliability Statistics for NAQ-R

Cronbach's Alpha	N of Items
.929	22

Reliability Statistics for DASS-21

Cronbach's Alpha	N of Items
.744	21

b. Reliability tests doing the main study

Reliability Statistic for NAQ-R

Cronbach's Alpha	N of Items
.929	22

Reliability Statistic for DASS-21

Cronbach's Alpha	N of Items
.895	21

Reliability Statistic for the depression subscale on DASS-21

Cronbach's Alpha	N of Items
.740	7

Appendix E: Normality Test of the Various Scales

Normality test during the pilot study

Tests of Normality for NAQ-R and DASS-21

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
total score on NAQ-R	.205	32	.001	.909	32	.011
total score on DASS-21	.080	32	.200*	.970	32	.488

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Appendix F: Pilot study results

Frequency distribution table of respondents' demographic variables

Variable	Frequency	Percentage (%)
Gender		
Male	16	50
Female	16	50
Age (years)		
21-30	12	37.5
31-49	19	59.4
50+	1	3.1
Professional background		
Registered general nurses	17	53.1
Enrolled nurses	15	46.9
Current rank		
SN	6	18.8
SSN	3	9.4
NO	5	15.6
SNO	2	6.3
PNO	1	3.1
EN	4	12.5
SEN	6	18.8
PEN	5	15.6
Number of years of practice		
1-10	29	90.6
11-20	2	6.3
21-30	1	3.1
31+		
Academic qualification		
Post-secondary	7	21.9
Diploma	18	56.3
Degree	6	18.8
Masters	1	3.1
Marital status		
Single	8	25.0
Married	21	65.6
Divorced	3	9.4
Residential area		
Peri-urban	25	78.1
urban	7	21.9

N=32

Prevalence of WPB measured by scores on the NAQ-R

		Frequency	Percent
Valid	not bullied	6	18.8
	occasionally bullied/targets of bullying	11	34.4
	victims of bullying	15	46.9
	Total	**32**	**100.0**

Prevalence of WPB according to the Self-labelling Method

		Frequency	Percent
Valid	no	19	59.4
	yes, but rarely	3	9.4
	yes, now and then	8	25.0
	yes, several times per week	1	3.1
	yes, almost daily	1	3.1
	Total	**32**	**100.0**

Prevalence of nurses Intentions to quit the profession

		Frequency	Percent
Valid	never	7	21.9
	rarely	6	18.8
	sometimes	16	50.0
	quite often	1	3.1
	very often	2	6.3
	Total	**32**	**100.0**