



# Workplace psychological harassment in Canadian nurses: A descriptive study

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## Abstract

This descriptive study investigated workplace psychological harassment in a sample of 1179 Canadian nurses. Two complementary types of assessment were used: exposure to negative behaviors and perceived victimization. Results revealed that exposure to negative behaviors was associated with certain sociodemographic variables (i.e. job status and the amount of overtime performed weekly), lower psychological health, and poorer functioning at work. Although many nurses reported being exposed to negative behaviors, few perceived these behaviors as psychological harassment per se. However, regardless of perceptions of victimization, exposure to negative behaviors was detrimental to nurses' psychological health and functioning at work. Practical implications are discussed.

## Keywords

health care, psychological distress, self-perception, sociodemographic variables, well-being

Workplace psychological harassment has been identified as a serious organizational issue in the nursing profession (Quine, 2001; Zapf et al., 2003). Up to 33% of nurses report experiencing this phenomenon on a regular basis (Laschinger et al., 2010; Sá and Fleming, 2008). This alarming statistic has severe implications, not only for nursing staff and the organization, but also for health care services. Specifically, workplace psychological harassment is related to employees' ill-being, which can be expressed as psychological distress (Skogstad et al., 2007), anxiety, depression, psychosomatic symptoms (Zapf et al., 1996), and decreased life satisfaction (Bowling and Beehr, 2006). At the organizational level, psychological harassment

undermines employees' functioning at work, given its association with decreased motivation, performance, job satisfaction (Yildirim, 2009), greater turnover intention (Quine, 2001), absenteeism (Kivimaki et al., 2000), and risk of committing clinical errors (Farrell et al., 2006). These detrimental outcomes contribute to the already salient nursing shortage (Farrell et al., 2006) and generate considerable costs for the

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health care system in terms of retention and recruitment (Hoel et al., 2003).

Also referred to as workplace bullying (Einarsen and Skogstad, 1996), psychological harassment is defined as a situation in which an employee feels constantly and persistently subjected to repeated negative behaviors by others at work (Einarsen and Skogstad, 1996; Mikkelsen and Einarsen, 2001). Such negative behaviors can take many forms but can be regrouped into specific categories: (1) work-related behaviors (e.g. negative interference with one's work); (2) person-related behaviors (e.g. social exclusion and personal offences); and (3) physical intimidation (e.g. threats of physical violence; Einarsen, 2005; Einarsen et al., 2003, 2009). Key parameters of workplace psychological harassment relate to the frequency and duration of the negative behaviors and the victim's feeling of helplessness. In fact, psychological harassment does not refer to isolated and sporadic events, but rather repeated and prolonged exposure to negative behaviors against which one feels unable to defend oneself. These parameters enable distinguishing between workplace psychological harassment and other social stressors at work, such as interpersonal conflicts (Einarsen et al., 2003).

There are two common ways to evaluate workplace psychological harassment: exposure to specific negative behaviors and perceived victimization (self-labeling; Nielsen et al., 2009). The former assesses the number of negative behaviors one has been exposed to in the previous six months, with no reference to psychological harassment or judgments regarding victimization. It is generally agreed that psychological harassment requires exposure to at least two negative behaviors weekly or daily in the previous six months (e.g. Lutgen-Sandvik et al., 2007; Mikkelsen and Einarsen, 2001). The second assessment, perceived victimization, examines perceptions of being subjected to psychological harassment in the workplace according to a formal

definition of psychological harassment. The two types of assessment lead to substantial differences in reported prevalence across studies (Agervold, 2007; Nielsen et al., 2009), suggesting that they capture different aspects of the concept (Mikkelsen and Einarsen, 2001; Nielsen et al., 2009). Exposure to negative behaviors provides information on the nature of such behaviors and the self-labeling assessment provides information on perceptions of victimization at work.

Although considerable advances have been made in the understanding of psychological harassment and its impact on the nursing profession, several issues need to be further explored. First, because the majority of studies have focused on samples in European countries, the knowledge of psychological harassment in the Canadian nursing profession is sparse at best. This is unfortunate given that the nursing shortage is becoming a major concern in Canada (Canadian Nurses Association, 2009) and that this shortage has been said to be routed in the failure to recognize and control issues such as workplace psychological harassment (Rocker, 2008). Second, studies have generally used either one of the above-mentioned types of assessment to examine psychological harassment, which may prevent a comprehensive understanding of the actual extent of workplace psychological harassment (Nielsen et al., 2009) in nurses.

The present descriptive study aimed to fill these gaps by investigating psychological harassment in Canadian nurses. More precisely, both types of assessment were used to examine: (1) the rate and nature of workplace psychological harassment; (2) sociodemographic differences between self-reported victims and non-victims of psychological harassment; and (3) associations between self-reported psychological harassment and primary work-related outcomes (turnover intention and work motivation) and psychological health outcomes (psychological distress and psychosomatic complaints).

## Method

### Participants

A random list of 5000 nurses working in the public health care sector in the province of Quebec, Canada was obtained from the *Ordre des Infirmières et des Infirmiers du Québec* (OIIQ; Quebec Nursing Association). All 5000 of these members received a letter at home explaining the purpose of the study and inviting them to fill out an online questionnaire. A total of 1179 nurses participated in the study, for a 23% participation rate. Table 1 presents the sociodemographic characteristics of the sample.

### Measures

All measures were administered in French. Instruments originally written in English were translated using the back translation method (Vallerand and Halliwell, 1983). More specifically, all English scales were translated into French by bilingual experts. These translated scales were then translated back to English by separate bilingual experts in order to verify the semantic correspondence between the original items and translated items.

**Psychological harassment.** The French Canadian version (Trépanier et al., 2012) of the Negative Acts Questionnaire – Revised (NAQ-R; Einarsen et al., 2009) was used to assess psychological harassment in the workplace. This 22-item scale measures the frequency of exposure to three forms of negative behaviors (person-related, work-related, and physical intimidation) that qualify as psychological harassment if they occur regularly. All items are formulated in behavioral terms, with no reference to the term ‘psychological harassment’. On a five-point Likert scale ranging from 1 (*never*) to 5 (*daily*), participants were asked to answer the following question: ‘In the last six months, how often have you been exposed to the following negative behaviors at work?’ Sample items are ‘Spreading gossip

and rumors about you’ (person-related behaviors [seven items;  $\alpha = .92$ ]); ‘Excessively monitoring your work’ (work-related behaviors [12 items;  $\alpha = .81$ ]); and ‘Being shouted at or being the target of spontaneous anger’ (physical intimidation [three items;  $\alpha = .77$ ]). The NAQ-R also measures perceived victimization. Participants were given the following formal definition of psychological harassment: ‘Psychological harassment occurs when an individual is subjected over a long period of time to systematic and persistent negative treatment from one or more persons at work, and when that individual has difficulty defending him/herself against this treatment’ (Einarsen and Skogstad, 1996: 191). According to this definition, participants were asked to indicate on a five-point Likert scale from 1 (*never*) to 5 (*daily*) how often in the last six months they had been exposed to psychological harassment at work. Participants were then asked to identify the main perpetrator of this harassment (head nurse, colleague, patient, subordinate, doctor, or other).

**Turnover intention.** Turnover intention was assessed with a four-item scale adapted from O’Driscoll and Beehr’s (1994) scale. Items were scored on a seven-point scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). A sample item is ‘I am thinking about quitting my job’. Cronbach’s alpha was .84.

**Work motivation.** The Revised Motivation at Work Scale (R-MAWS; Gagné et al., 2012) was used to assess participants’ motivation at work. This 19-item scale assesses specific motivational dimensions. Participants rated on a seven-point scale from 1 (*not at all for this reason*) to 7 (*exactly for this reason*) their primary reasons for accomplishing their work. The scale assesses five motivational dimensions: external regulation ( $\alpha = .73$ ; e.g. ‘Because my superiors reward me financially’), introjected regulation ( $\alpha = .64$ ; e.g. ‘Because I need to prove to myself that I am capable of doing it’), identified regulation ( $\alpha = .60$ ; e.g. ‘Because this job has a personal

**Table 1.** Sociodemographic characteristics of the sample and differences between self-reported victims and non-victims in exposure to specific negative behaviors and psychological harassment

Variable	Total sample n(%) / mean(SD) (N= 1179)	Exposure to negative behaviors <sup>a</sup>		Perceived victimization	
		n(%) / median(n)		n(%) / median(n)	
		Non-victims n=930 (79.0%)	Victims n=241 (20.4%)	Non-victims n=1114 (94.6%)	Victims n=45 (3.8%)
Gender					
Female	1073 (91.0%)	850 (91.4%)	216 (89.6%)	1017 (91.1%)	41 (91.1%)
Male	103 (8.7%)	78 (8.4%)	24 (10.0%)	96 (8.6%)	4 (8.9%)
Job position					
Nurse	490 (41.6%)	383 (41.2%)	103 (42.7%)	466 (41.8%)	16 (35.6%)
Clinician nurse	385 (32.7%)	312 (33.5%)	72 (29.9%)	368 (33.0%)	14 (31.1%)
Other	301 (25.5%)	233 (25.1%)	65 (27.0%)	279 (25.0%)	15 (33.3%)
Job tenure					
Permanent	1075 (91.2%)	844 (90.8%)	225 (93.4%)	1019 (91.3%)	40 (88.9%)
Non- permanent	100 (8.5%)	83 (8.9%)	15 (6.2%)	94 (8.4%)	4 (8.9%)
Job status					
Full-time	784 (66.5%)	604 (64.9%)	174 (72.2%)*	740 (66.3%)	32 (71.1%)
Part-time	371 (31.5%)	306 (32.9%)	63 (26.1%)	355 (31.8%)	12 (26.7%)
Working shift					
Day	798 (67.7%)	627 (67.4%)	166 (68.9%)	759 (68.0%)	28 (62.2%)
Evening/ night	283 (24.0%)	223 (24.0%)	57 (23.7%)	264 (23.7%)	13 (28.9%)
Varying	91 (7.7%)	74 (8.0%)	17 (7.1%)	86 (7.7%)	4 (8.9%)
Regular hours per week	34.1 (8.73)	35.0 (910)	36.3 (236)	35.0 (1093)	36.3 (44)
Overtime (hr/week)	4.5 (496)	3.0 (817)	5.0 (208)***	3.0 (979)	4.5 (37)
Education level					
College degree	490 (41.6%)	381 (41.0%)	107 (44.4%)	465 (41.7%)	19 (42.2%)
Bachelor's degree	485 (41.1%)	393 (42.3%)	87 (36.1%)	461 (41.3%)	16 (35.6%)
Other	203 (17.2%)	156 (16.8%)	46 (19.1%)	190 (17.0%)	9 (20.0%)
Age	42.7 (10.8)	43.0 (928)	44.0 (241)	43.0 (1114)	47.0 (45)
Experience (years)	19.1 (10.9)	19.0 (924)	18.5 (236)	18.5 (1107)	20.0 (43)

Note: <sup>a</sup>Exposure to at least two negative behaviors on a daily or weekly basis.

\*p < .05; \*\*\*p < .001.

significance for me'), and intrinsic motivation ( $\alpha = .86$ ; e.g. 'Because my work is stimulating'). Self-determination theory (SDT; Deci and Ryan, 1985, 2008) makes an important distinction

between two forms of motivation: autonomous (i.e. acting with a sense of volition, pleasure, and self-endorsement) and controlled (i.e. acting with a sense of pressure and obligation). In

contrast to controlled motivation, autonomous motivation leads to greater adaptive functioning in the workplace, such as job satisfaction and commitment (Lam and Gurland, 2008), fewer burnout symptoms (Fernet et al., 2004), and lower turnover intention (Richer et al., 2002). Following commonly used procedures in the SDT literature (e.g. Vansteenkiste et al., 2004), identified regulation and intrinsic motivation were combined to represent autonomous motivation, and external and introjected regulation were combined to represent controlled motivation.

**Psychological distress.** The Kessler Psychological Distress Scale (K10; Kessler et al., 2002) was used to assess psychological distress. This 10-item scale provides a global measure of psychological distress based on anxiety and depressive symptoms experienced in the past month. Participants were asked to indicate on a five-point scale from 1 (*never*) to 5 (*very often*) the frequency with which they had experienced different feelings in the past month. Sample items are 'I felt nervous', and 'I felt that everything was an effort'. Cronbach's alpha was .93.

**Psychosomatic complaints.** Psychosomatic complaints were assessed using an eight-item instrument adapted from Knäuper et al. (2004). Participants were asked to rate on a seven-point scale from 1 (*never*) to 7 (*almost always*) how often they experienced specific physical symptoms (e.g. 'headaches', 'chest pains'). Cronbach's alpha was .88.

### Statistical analysis

Descriptive statistics (percentage, frequency, means, and standard deviation) were used in the data analysis. Because the data were not normally distributed, we used non-parametric tests: chi-square tests to examine differences between self-reported victims and non-victims on categorical sociodemographic variables and the Mann-Whitney test to examine differences on continuous sociodemographic variables. The Mann-Whitney test also allowed determining

associations between workplace psychological harassment and work-related and psychological health outcomes. Effect sizes were calculated for significant results (chi-square =  $\phi$ ; Mann-Whitney =  $r$ ). For  $\phi$ , effect sizes of 0.1, 0.3, and 0.5 were considered small, moderate and large respectively (Gravetter and Wallnau, 2007), while 0.1, 0.25, and 0.4 were used as guidelines for the  $r$  statistic (Kline, 2009).

## Results

### Preliminary analysis

Exposure to negative behaviors was positively related to turnover intention ( $r = .29, p < .01$ ), controlled motivation ( $r = .10, p < .01$ ), psychological distress ( $r = .34, p < .01$ ), psychosomatic complaints ( $r = .20, p < .01$ ) and was negatively related to autonomous motivation ( $r = -.10, p < .01$ ). Perceived victimization was significantly related to turnover intention ( $r = .19, p < .01$ ), psychological distress ( $r = .25, p < .01$ ), and psychosomatic complaints ( $r = .17, p < .01$ ) but not to controlled motivation ( $r = .04, p = .15$ ) or autonomous motivation ( $r = -.05, p = .07$ ). Exposure to negative behaviors and perceived victimization were significantly related ( $r = .42, p < .01$ ).

### Rate and nature of workplace psychological harassment

Results reveal that 20.4% of the nurses reported being frequently exposed to negative behaviors at work in the last six months. The most commonly reported behaviors were work-related in nature: 'Being ordered to do work below your level of competence', 'Being exposed to an unmanageable workload', 'Having your opinions ignored', and 'Having someone withholding information which affects your performance'.

Psychological harassment was also assessed in terms of perceived victimization. When a formal definition of workplace psychological harassment was provided, 3.8% of nurses reported being regularly subjected to such

treatment in the past six months. The main perpetrators were the head nurse (37.3%), colleagues (27.1%), and doctors (16.9%).

Results reveal a considerable discrepancy between the rates obtained with the two assessments of workplace psychological harassment: exposure to negative behaviors (20.4%) vs perceived victimization (3.8%). To further investigate this discrepancy, participants were regrouped into mutually exclusive categories according to their classification on the two types of assessment. Of the sample, 917 nurses (77.8%) did not perceive themselves as either on the receiving end of negative behaviors at work or as victims of psychological harassment, according to the definition. In contrast, 41 nurses (3.5%) reported that they were regularly exposed to at least two negative behaviors at work and that they had experienced psychological harassment in the last six months. Of the discrepancy cases, 198 nurses (16.8%) reported that they experienced negative behaviors on a daily or weekly basis, without perceiving that they were victims of psychological harassment, and only four nurses (0.3%)<sup>1</sup> reported that they were not exposed to negative behaviors but perceived that they were victims of harassment. These categories were later used to examine differences between self-reported victims in terms of psychological health and work-related outcomes.

### *Sociodemographic factors associated with workplace psychological harassment*

The sociodemographic differences between self-reported victims and non-victims of psychological harassment in terms of exposure to negative behaviors are presented in Table 1. Results reveal only two significant differences. Self-reported victims of negative behaviors were significantly more likely than non-victims to work full-time ( $\chi^2(1, N = 1147) = 4.28, p = .04, \phi = .061, p = .039$ ). Victims also reported working more overtime per week ( $U = 67,376.5, p < .001, r = .14$ ). In order to gain further insight

into how these sociodemographic factors are associated with workplace psychological harassment, we analyzed whether these factors differed according to each form of workplace psychological harassment (person-related, work-related, and physical intimidation). Results show that nurses exposed to person-related ( $U = 30,073.0, p < .001, r = .11$ ) and work-related ( $U = 47,797.5, p < .001, r = .13$ ) workplace psychological harassment behaviors work more overtime hours. As for job status, no statistically significant differences were found for the three specific forms of workplace psychological harassment.

When psychological harassment was assessed in terms of perceived victimization, no significant differences were found for any of the sociodemographic variables.

### *Workplace psychological harassment and outcomes*

Nurses who reported that they were exposed to negative behaviors had significantly higher turnover intention ( $U = 61,338.0, p < .001, r = .29$ ) and controlled motivation ( $U = 90,125.0, p = .001, r = .09$ ). They also reported significantly lower autonomous motivation ( $U = 89,585.5, p = .001, r = .10$ ). In addition, self-reported victims reported greater psychological distress ( $U = 52,979.5, p < .001, r = .34$ ) and psychosomatic complaints ( $U = 74,733.0, p < .001, r = .20$ ) than non-victims. Once again, we examined whether these work-related and psychological health outcomes differed according to the three forms of workplace psychological harassment. A very similar pattern of results was obtained. Self-reported victims of work-related and person-related psychological harassment behaviors exhibited poorer functioning at work (higher turnover intention [person-related:  $U = 29,326.0, p < .001, r = .21$ ] [work-related:  $U = 40,452.0, p < .001, r = .28$ ] and controlled motivation [person-related:  $U = 43,204.0, p = .02, r = .07$ ] [work-related:  $U = 67,393.5, p = .04, r = .06$ ] and less autonomous motivation [person-related:  $U = 41,967.5, p = .003, r = .09$ ]

[work-related:  $U = 62,297.0, p < .001, r = .10$ ]) as well as lower psychological health (more psychological distress [person-related:  $U = 28,070.5, p < .001, r = .22$ ] [work-related:  $U = 33,662.0, p < .001, r = .33$ ] and psychosomatic complaints [person-related:  $U = 35,755.5, p < .001, r = .15$ ] [work-related:  $U = 52,307.5, p < .001, r = .18$ ]). As for nurses exposed to physical intimidation behaviors, they reported greater turnover intention ( $U = 16,048.0, p < .001, r = .11$ ), psychological distress ( $U = 14,253.0, p < .001, r = .14$ ) and psychosomatic complaints ( $U = 15,812.5, p < .001, r = .12$ ).

The analyses were repeated based on the assessment of perceived victimization. Nurses who perceived themselves as victims of psychological harassment reported greater turnover intention ( $U = 13,778.0, p < .001, r = .14$ ) compared to non-victims. No significant differences were found for autonomous motivation ( $U = 22,986.5, p = .53$ ) or controlled motivation ( $U = 22,632.5, p = .43$ ). For psychological health outcomes, nurses who perceived themselves as victims reported greater psychological distress ( $U = 17,972.0, p < .001, r = .17$ ) and more psychosomatic complaints ( $U = 13,778.0, p = .004, r = .09$ ).

As mentioned above, we investigated differences in outcome variables between two categories of self-reported victims: nurses who reported victimization as well as exposure to negative behaviors and nurses who reported exposure to negative behaviors only. Results indicated no significant differences for any of the outcome variables. This means that, in terms of psychological health and functioning at work, nurses who perceived themselves as both exposed to negative behaviors and victimized did not differ from nurses who perceived exposure to negative behaviors only. To more thoroughly explore this issue, a series of hierarchical regressions was conducted to test whether perceived victimization predicted work-related and psychological health outcomes over and above exposure to negative behaviors. Results were nonsignificant,<sup>2</sup> suggesting that perceived victimization did not significantly add to the

explained variance in any outcome to what was accounted for by exposure to negative behaviors.

## Discussion

The aim of this descriptive study was to investigate workplace psychological harassment in a sample of Canadian nurses using two complementary types of assessment: specific negative behaviors and perceived victimization. Results indicate that whereas nurses reported frequent exposure to negative behaviors at work, few considered themselves victims of psychological harassment. Nurses who were exposed to negative behaviors generally worked full-time and did more overtime. Furthermore, self-reported victims of workplace psychological harassment generally reported lower psychological health and less optimal functioning at work than did non-victims.

### *Rate and nature of workplace psychological harassment*

When workplace psychological harassment was assessed in terms of exposure to specific negative behaviors, our findings reveal that 20.4% of nurses were victims of negative behaviors at work. This rate is similar to that of Fornés et al. (2011), who found that 18.9% of their sample of Spanish nurses was frequently exposed to negative behaviors at work. However, our rate is substantially lower than those obtained in other studies (e.g. Simons, 2006; Yildirim, 2009), including studies conducted in other Canadian provinces (e.g. Ontario; Laschinger et al., 2010; Out, 2006), which have similar laws against workplace psychological harassment as those in Quebec. In Out's (2006) study, 47.2% of nurses were victims of psychological harassment. Note that in the latter study, workplace psychological harassment was assessed using the criterion of one negative act on a daily or weekly basis, which has

been said to overly inflate the reported rates of psychological harassment (Mikkelsen and Einarsen, 2001). Using this criterion, the present study obtains a significantly increased rate of 32.0%. Furthermore, Laschinger et al. (2010) found that 33% of newly registered nurses were exposed to at least two negative behaviors at work weekly. However, research shows that newly graduated nurses are particularly vulnerable to stress (Cho et al., 2006) as well as psychological harassment and mistreatment (Randle, 2003) in the workplace. Nonetheless, results of the present study did not reveal significant difference in terms of years of experience. Further studies are needed to better examine these differential rates in order to determine potential disparities between nurses in Canadian provinces as well as between Canadian nurses and nurses abroad.

When psychological harassment was assessed in terms of perceived victimization, the rate of psychological harassment dropped to 3.8%. Although there is a considerable gap between the rates obtained by the two assessments, such discrepancies are not uncommon (Agervold, 2007), and both measures appear to converge in the same direction. For instance, nurses who perceived themselves as victims of psychological harassment at work most commonly reported the head nurse as the perpetrator. This finding is consistent with the fact that the most frequently reported negative behaviors were work-related in nature, including 'Being ordered to do work below your level of competence' and 'Being exposed to an unmanageable workload', which head nurses have the power to impose. There is some empirical evidence in support of this contention, suggesting that workplace psychological harassment in the nursing profession is most often perpetrated by head nurses (Vessey et al., 2009).

Interestingly, in our sample, although 20.4% of nurses were regularly exposed to negative behaviors at work, only 17.0% of these nurses perceived themselves as victims

of workplace psychological harassment. This suggests that, whereas many nurses may be frequently exposed to negative behaviors that could be construed as psychological harassment, they do not view themselves as victims of the harassment. This could be because the nursing profession is a particularly stressful and demanding one (Chan et al., 2000; Tyler and Cushway, 1998), where exposure to these types of negative behaviors is considered part of the job (Fisher et al., 1995), and is not seen as abuse per se. Thus, because negative behaviors are normalized within the nursing culture (Stevens, 2002; Vessey et al., 2009), nurses may rationalize their exposure to them. This may explain the considerable discrepancy between the rates obtained for exposure to negative behaviors and perceived victimization.

### *Sociodemographic factors associated with workplace psychological harassment*

Our results revealed a significant difference between self-reported victims and non-victims of negative behaviors in terms of job status and the amount of overtime performed weekly: nurses who worked full-time and nurses who worked more overtime reported more frequent exposure to negative behaviors at work. One possible explanation for this difference would be that working full-time or overtime implies being at work more frequently, resulting in more contacts with others at work. Frequent contact with others would increase the probability of encountering negative behaviors at work (Hoel and Cooper, 2000; Rayner et al., 2002).

### *Workplace psychological harassment and outcomes*

In this study, victims of negative behaviors at work reported lower psychological health and functioning at work compared to non-victims. Specifically, nurses who were confronted with

negative behaviors reported greater turnover intention, psychological distress, and psychosomatic complaints than nurses who were not exposed to such behaviors. These results are similar to those obtained in previous studies (Bowling and Beehr, 2006; Quine, 2001; Skogstad et al., 2007; Zapf et al., 1996). In their meta-analysis, Bowling and Beehr (2006) found that psychological harassment was associated with employee turnover intention as well as greater physical symptoms (i.e. psychosomatic complaints). Moreover, Matthiesen and Einarsen (2004) showed that victims of workplace psychological harassment experienced particularly high psychological distress (measured in terms of anxiety, depression, and somatization), even when compared to other traumatized groups (e.g. employees affected by major organizational transitions, recently divorced individuals).

The results of the present study also revealed that exposure to negative behaviors is associated with poor quality work motivation. Supporting and extending previous findings (e.g. Yildirim, 2009), our results indicate that nurses who were exposed to negative behaviors reported that they performed their work more out of a sense of pressure and obligation (i.e. controlled motivation) and less out of a sense of volition, pleasure, and self-endorsement (i.e. autonomous motivation). In other words, victims of negative behaviors are more likely to feel that they *have to* rather than *want to* work. These results are in line with those obtained by Gagné and Schabram (2011) in employees of a Canadian manufacturing company. They found that employees' perceptions of violence at work – including psychological harassment – were negatively related to autonomous motivation. However, perceptions of violence were not related to controlled motivation. The findings of the present study call for concern, given that poor quality work motivation has consistently been related to undesirable outcomes such as poor performance and job dissatisfaction (Deci and Ryan, 2008). In order to gain more insight into *how* psychological harassment leads to

motivational disengagement and possibly other relevant consequences, future research could examine the role of psychological needs. According to self-determination theory (Deci and Ryan, 1985), the social environment – which allows the satisfaction of basic psychological needs – plays a crucial role in self-motivation and optimal functioning. Our findings are in line with this contention, as exposure to negative behaviors at work is liable to thwart the satisfaction of needs, and ultimately leads to suboptimal motivation and poor adjustment. Future research is needed to examine the relationships between psychological harassment, psychological needs, work motivation, and employee psychological health.

The results of this study also revealed that nurses who simultaneously reported exposure to negative behaviors and victimization at work did not experience lower psychological health or functioning at work than those who reported exposure to negative behaviors only. Moreover, whereas nurses who perceived themselves as victimized at work reported greater psychological distress and psychosomatic complaints, perceived victimization did not predict nurses' psychological health or functioning at work over and above exposure to negative behaviors. These findings suggest that negative behaviors yield considerable harmful effects on the victims' psychological health and functioning at work, regardless of whether or not the exposure is perceived as psychological harassment. This finding is supported by a study in Norwegian employees which revealed that intense exposure to negative behaviors was related to greater psychological and psychosomatic problems, independently of the individuals' appraisal of being victimized or not (Vie et al., 2011).

### Limitations

This study has certain limitations that should be mentioned. First, because this study relied on a cross-sectional design, the data do not allow drawing firm conclusions about

causality. The relationship between workplace psychological harassment and work-related and psychological health variables may be more complex than what is presented in this study. For example, certain psychological health variables may alter how nurses perceive events: psychologically distressed nurses may be more likely to interpret ambiguous events as hostile, and consequently report more frequent exposure to negative behaviors or victimization at work (Aquino and Thau, 2009). It is also possible that highly controlled motivated nurses or nurses who intend to leave their job may be less involved in their work, or may not put in the effort required to adequately accomplish their mandate. This could cause frustration in their superiors and colleagues, who might then resort to negative behaviors in order to release their frustration (Aquino and Thau, 2009). These alternative explanations could be tested with longitudinal designs. A second limitation is the use of self-reported data, which raises the question of how victims were identified. However, the aim of this study was to assess nurses' perceptions of their experience of psychological harassment and how these perceptions were associated with their psychological health and functioning at work. In this respect, given that they are better predictors of victims' responses and reactions (Aquino and Thau, 2009; Einarsen et al., 2003), self-reported measures (i.e. subjective assessments) are the most convenient way to assess workplace psychological harassment (Niedl, 1995, cited in Einarsen et al., 2003). Nonetheless, given that little is known about inter-rater reliability in workplace psychological harassment (Einarsen et al., 2003), future research could use a variety of sources to evaluate exposure to negative behaviors in order to examine the concordance between self-reported victims and external observers. Third, given the recruitment strategy adopted in this study, the risk for self-selection bias is present. However, the sample fairly represented the overall demographic distribution of

the members of the OIIQ, with the exemption of job status. Nurses working full-time were slightly overrepresented (67% of respondents vs 57.5% of members of the OIIQ). Overall, this suggests that the sample of the present study is fairly representative of Quebec nurses in general and that self-selection bias does not overly limit the interpretation of our results. Lastly, the present study obtained a relatively low participation rate of 23%, which is however not uncommon in the nursing profession (Driscoll, 2008; Hutchinson et al., 2010).

### *Practical implications*

Despite these limitations, our findings shed light on several practical points. First, although many nurses reported exposure to negative behaviors at work, only a small proportion considered these negative behaviors as psychological harassment per se. This finding suggests that negative behaviors are perceived as part of the nursing culture (Stevens, 2002; Vessey et al., 2009). This is alarming, because whether or not victimization is perceived, exposure to negative behaviors alone is harmful to employees' psychological health and functioning at work. Thus, the first step in addressing this concern would be to provide nurses with educational programs aimed at recognizing and acknowledging such negative behaviors as psychological harassment and as being harmful. Second, clear policies targeting psychological harassment need to be implemented. Ideally, these policies should be drawn up by a group of designated representatives, including management, human resources staff, head nurses, union representatives, and staff nurses. These policies need to clarify which behaviors are considered unacceptable and will not be tolerated (Richards and Daley, 2003). Nurses need to know exactly what procedures to undertake if they feel exposed to such harassment. This is especially important given that, in this study, psychological harassment was often perpetrated by the head nurse. Nurses need to know where to turn when they feel psychologically harassed by

their immediate superior (e.g. the head nurse's manager or the head nurse's colleagues). Furthermore, considering that the second most commonly reported perpetrators of psychological harassment were nurses' colleagues, nurse managers must be responsible for preventing nurse-to-nurse psychological harassment. Therefore, nurse managers need appropriate training in how to deal with such problems. More specifically, nurse managers should be trained to recognize harassment, deal with it effectively, and implement policies against psychological harassment. Lastly, it is important to note that some Canadian provinces, including Quebec (where the present study was conducted) have specific anti-psychological harassment laws. Unfortunately, such laws are not always well known within the nursing profession (Rocker, 2008). Therefore, health care managers need to raise awareness regarding existing governmental legislation and explain what legal options are available to nurses exposed to psychological harassment when in-house management of the situation is not sufficient.

## Conclusion

Taken together, the findings of this study indicate that exposure to negative behaviors is a significant concern in the Canadian nursing profession, with adverse effects on nurses' psychological health and functioning at work. It is important to acknowledge and address this issue by implementing measures to prevent and deal with psychological harassment in the Canadian nursing profession. If left ignored, this problem is likely to result in poorly motivated, distressed nurses, and may ultimately affect the quality of care provided.

## Competing Interests

None declared.

## Notes

1. Note that a 0.1% is left out due to missing data.

2. A total of five series of hierarchical regression analyses were conducted, for each outcome (dependent variable). In step 1, exposure to negative behaviors was entered, while perceived victimization was entered in step 2. Exposure to negative behaviors significantly predicted all outcomes variables and significantly contributed to their explained variance: psychosomatic complaints ( $[\beta = .228, t(1176) = 7.806, p < .001]$ ;  $[\Delta R^2 = .052, F(1, 1116) = 60.939, p < .001]$ ), psychological distress  $[\beta = .382, t(1176) = 13.767, p < .001]$ ;  $[\Delta R^2 = .146, F(1, 1109) = 189.520, p < .001]$ ), turnover intention  $[\beta = .325, t(1176) = 11.45, p < .001]$ ;  $[\Delta R^2 = .106, F(1, 1111) = 131.177, p < .001]$ ), autonomous motivation  $[\beta = -.111, t(1176) = -3.76, p < .001]$ ;  $[\Delta R^2 = .012, F(1, 1133) = 14.086, p < .001]$ ), and controlled motivation  $[\beta = .095, t(1176) = 3.210, p = .001]$ ;  $[\Delta R^2 = .009, F(1, 1132) = 10.407, p = .001]$ ). Perceived victimization did not significantly predict any of the outcome variables nor significantly contribute to additional explained variance to what was accounted for by exposure to negative behaviors by psychosomatic complaints ( $[\beta = -.030, t(1176) = -1.022, p = .307]$ ;  $[\Delta R^2 = .001, F(1, 1115) = 1.044, p = .307]$ ), psychological distress ( $[\beta = -.032, t(1176) = -1.144, p = .253]$ ;  $[\Delta R^2 = .001, F(1, 1108) = 1.309, p = .253]$ ), turnover intention ( $[\beta = .007, t(1176) = .250, p = .803]$ ;  $[\Delta R^2 = .000, F(1, 1110) = .062, p = .803]$ ), autonomous motivation ( $[\beta = -.019, t(1176) = -.656, p = .512]$ ;  $[\Delta R^2 = .000, F(1, 1132) = .430, p = .512]$ ), or controlled motivation ( $[\beta = -.040, t(1176) = -1.358, p = .175]$ ;  $[\Delta R^2 = .002, F(1, 1131) = 1.844, p = .175]$ ).

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